RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

August 19, 2025

600 Jackson Street, Board Room 208
Fredericksburg, VA, 22401

AGENDA

I. Call to Order, *Parcell*

II. *Minutes, Board of Directors, June 17, 2025, *Parcell*……..4
III. *Executive Committee Meeting Minutes, June 30, 2025, *Parcell*……11
IV. *Minutes, Strategic Plan Work Group Meeting, July 7, 2025, *Parcell*……..17

V. Public Comment, *Parcell*

VI. Employee Service Awards, *Wickens*

A. Five Years:
   1. Doris Laniyi, Direct Support Professional, New Hope
   2. Heather Cuozzo, Licensed Outpatient Therapist, Fredericksburg
   3. Amenah Heath, MH Residential Coordinator, PSH

B. Ten Years:
   1. Blaise Forzi, Direct Support Professional, Churchill
   2. Angie, Reiordan-Horn, Nurse Manager, ICF
   3. Laura Payne, MH Nurse RN, Outpatient, Fredericksburg

C. Fifteen Years:
   1. Shaborah Noriega, Developmental Services Support Coordinator

D. Twenty Years:
   1. Lacey Fisher Curtis, Coordinator, RAAI
   2. Sherry Norton-Williams, Prevention Specialist

E. Twenty-Five Years:
   1. Donna Andrus, Supervisor, Child/Adolescent

VII. Employee of the 4th Quarter (Apr – June) – Anne Martin, Peer Recovery Specialist, PSH

VIII. Board Core Behaviors, *Parcell*……..18

IX. **Presentation**: Board Financial Report and Governance for the year ended 6/30/2024, *Robinson, Farmer, Cox & Associates, Roller*……..19

**Attachment: Financial Report Year-End 2024*

X. Program Reports

A. Prevention & Early Intervention

B. Deputy Executive Director

C. Community Support Services

D. Clinical Services

E. Compliance

F. Communications

G. Finance

June 2025 Board of Directors Meeting Minutes

I. CALL TO ORDER

A meeting of the Board of Directors of the Rappahannock Area Community Services Board was held on June 17, 2025, at 600 Jackson Street and called to order by Chair, Nancy Beebe at 3:00 p.m. *Attendees included*: Claire Curcio, Matthew Zurasky, Bridgette Williams, Carol Walker, Ken Lapin Melissa White, Greg Sokolowski, and Jacob Parcell. *Not Present*: Susan Gayle, Sarah Ritchie, and Shawn Kiger.

II. MINUTES, BOARD OF DIRECTORS, **May 20, 2025**

The Board of Directors approved the minutes from the May 20, 2025 meeting.

ACTION TAKEN: The Board approved the May 20, 2025 minutes.
Moved by: Ms. Carol Walker
Seconded by: Mr. Matt Zurasky

III. MINUTES, BOARD OF DIRECTORS STRATEGIC PLAN WORK GROUP, **June 2, 2025**

The Board of Directors approved the minutes from the June 2, 2025 meeting.

ACTION TAKEN: The Board approved the June 2, 2025 minutes.
Moved by: Ms. Bridgette Williams
Seconded by: Ms. Melissa White

IV. MINUTES, EXECUTIVE COMMMITTEE MEETING, **June 2, 2025**

The Board of Directors approved the minutes from the June 2, 2025 meeting.

ACTION TAKEN: The Board approved the June 2, 2025 minutes.
Moved by: Mr. Matt Zurasky
Seconded by: Ms. Bridgette Williams

V. MINUTES, BOARD OF DIRECTORS STRATEGIC PLAN WORK GROUP, **June 16, 2025**

The Board of Directors approved the minutes from the June 16, 2025 meeting.

ACTION TAKEN: The Board approved the June 16, 2025 minutes.
Moved by: Ms. Claire Curcio
Seconded by: Mr. Jacob Parcell

VI. PUBLIC COMMENT

No Action Taken

VII. SERVICE AWARDS

Mr. Joe Wickens recognized all employees with awards:

5 years

Melissa Dannemiller, Licensed Outpatient Therapist, Spotsylvania

Suzanne Haskell, Coordinator, Early Intervention

Brittany Makufka, Licensed Outpatient Therapist, Fredericksburg
(not in attendance)

10 years

Stephanie Terrell, Director of Compliance

VIII. Employee Recently Licensed, **Portia Bennett**, Licensed Professional Counselor

IX. BOARD CORE BEHAVIORS, *Mr. Jacob Parcell*

Mr. Parcell asked the Board to keep the core behaviors in mind throughout the discussions.

X. BOARD PRESENTATION-FISCAL YEAR 2026 OPERATING BUDGET, *Ms. Sara Keeler*

Ms. Keeler took the Board through the fiscal year 2026 operating budget challenges and changes for all programs.

The Board of Directors approved the FY2026 Operating Budget.

ACTION TAKEN:
Moved by: Mr. Jacob Parcell
Seconded by: Mr. Matt Zurasky

XI. PROGRAM REPORTS

A. COMMUNITY SUPPORT SERVICES, *Ms. Amy Jindra*

1. **Program Update** – Ms. Jindra noted that the Art of Recovery was a success that ran the month of May. No other additions to her program update.
2. **Sunshine Lady House** – Ms. Jindra said they received 54 prescreens for the month of May and accepted 46. Sunshine Lady House declined 2 prescreens for admission due to current violent and dangerous behaviors. In total, the program served 45 individuals for a 61% utilization rate.
3. **Mental Health and Developmental Disabilities Residential Vacancies** – Ms. Jindra shared that during the month of May, Mental Health and Developmental Disabilities Residential programs experienced a lot of momentum in program enrollment and vacancies. They have housed 7 individuals since January. Currently, there are 4 individuals interested in Myers and 3 to move in the next month. Programs actively seek referrals from support coordination, case management, hospital liaisons and other community members. Currently, Permanent Supportive Housing program has housed 72 formerly homeless individuals and they have 91 total that can be housed.

B. CLINICAL SERVICES, *Ms. Jacque Kobuchi*

1. **Program Update** – In addition to her program update, Ms. Kobuchi announced the exciting news that they received approval from the City of Fredericksburg for the Therapeutic Docket.
2. **State Hospital Census Report** -Ms. Kobuchi shared that there are currently three individuals on the Extraordinary Barriers List. They have 35 individuals that are at state hospitals receiving treatment.
3. **Emergency Custody Order (ECO)/ Temporary Detention Order (TDO) Report – May 2025**. Ms. Kobuchi stated that Emergency Services staff

completed 191 emergency evaluations in May. Seventy individuals were assessed under an emergency custody order and seventy-six total temporary detention orders were served. Staff facilitated one admission to Western State Hospital and one admission to Commonwealth Center for Children and Adolescents. A total of four individuals were involuntarily hospitalized outside of our catchment area in May. Data reports submitted.

4. **CIT and Co-Response Report**- Ms. Kobuchi reported that the CIT Assessment Center served 32 individuals in the month of May. She took the Board through a chart indicating the number of Emergency Custody orders by locality, those that were able to be transferred into CAC custody, and those who could have used the assessment center if there was additional capacity. The Co-Response Team served 19 individuals in May. The therapist for the Fredericksburg team remains vacant.
5. **Outpatient Waitlist and Same Day Access** – Ms. Kobuchi stated that waitlists remain resolved in the month of May and all clinics are providing intakes through Same Day Access. Data report submitted. Ms. Kobuchi asked the Board if they wanted to continue to receive this report as it was a fiscal year goal and we are now at the end of the fiscal year. The Board said they would like to continue to receive the graph of percentage of intakes completed through same day access in order to continue to see the trends (pg. 47).

C. COMPLIANCE, *Ms. Stephanie Terrell*

1. **Program Update** – Ms. Terrell reported that in addition to her program update her department is currently in the middle of a DMAS Quality Management Review audit. There are four auditors on site. They are looking at a total of 128 records.
2. **3rd Quarter FY 2025 Incident Report Review** – Ms. Terrell said the compliance team triaged 852 Incident Reports from January 1, 2025 through March 31, 2025 (an overall increase of 138 reports from last quarter). Of those 852 incident reports received, 117 incidents were reported to the Department of Behavioral Health and Development Services (DBHDS).
3. **Quality Assurance Report** – Ms. Terrell said the Quality Assurance staff completed chart reviews for the following programs: Mental Health Outpatient, Spotsylvania; Mental Health Outpatient, King George; Developmental Disability Support Coordination, Spotsylvania; Developmental Disability Support Coordination, Stafford; and Mental Health Outpatient, Caroline. Corrective Action Plans were submitted for all discrepancies within the charts.
4. **Licensing Report** – Ms. Terrell said we received three licensing reports relating to human rights allegations in May: Ross Drive Intermediate Care Facility (ICF), Spotsylvania Day Support, and Wolfe Street (ICF). Submitted Corrective Action Plan's provided additional details regarding the citations and RACSB's responses.

The Board moved to approve the Licensing Reports
ACTION TAKEN: The Board approved the Licensing Reports
Moved by: Ms. Bridgette Williams
Seconded by: Ms. Claire Curcio

D. COMMUNICATIONS, *Ms. Amy Umble*

1. **Monthly Update** – Ms. Umble pointed out that she changed this report format to give more highlights of how we are telling our story.
2. **Social Media Analysis** – Ms. Umble provided social media analysis on performance overview for top performing content on Facebook, LinkedIn and Instagram.

The Board took a ten-minute break

E. PREVENTION, *Ms. Brandie Williams*

1. **Program Update** – Ms. Williams presented the Prevention program update and focused on the Top 5 Prevention Services for June.
2. **Notice of Award** – Ms. Williams shared that we were selected for another Behavioral Health Wellness Initiative Grant with DBHDS' Office of Behavioral Wellness. The project will be funded in the amount of $11,960.

F. FINANCE, *Ms. Sara Keeler*

1. **Program Update** – Ms. Keeler provided her program update and highlighted exciting news, that they have filed the FY24 Financial Audit. The auditors will present at the next Board meeting in August.
2. Ms. Keeler reviewed the Summary of Cash Investments.

ACTION

Mr. Parcell asked if we were still on track for August/September to take a look at our investment portfolio options. Ms. Keeler said yes, and that we will find out which meeting we will have the bank attend to give us an overview.

3. Ms. Keeler reviewed the Other Post Employment Benefit.
4. Ms. Keeler reviewed the Health Insurance.
5. Ms. Keeler reviewed the Summary of Investments.
6. Ms. Keeler reviewed the Fee Revenue Reimbursement and Collections.
7. Ms. Keeler reviewed the Write-Off Report.
8. Ms. Keeler reviewed the Payroll Statistics.
9. Ms. Keeler reviewed the Financial Summary.

The Board moved to approve the financial summary.
ACTION TAKEN: The Board approved the financial summary.
Moved by: Ms. Carol Walker
Seconded by: Ms. Bridgette Williams

10. **Proposed revision to Financial Policies and Procedures** – Ms. Keeler provided a recommendation to the Board regarding the removal of no-show fees from Medicare insured clients.

The Board moved to approve the recommendation.
ACTION TAKEN: The Board approved recommendation.
Moved by: Ms. Bridgette Williams
Seconded by: Ms. Claire Curcio

G. HUMAN RESOURCES, *Mr. Derrick Mestler*

1. **Program Update** – Mr. Mestler provided his program update and said that benefits open enrollment has been completed for 540 eligible staff, the new selections start July 1st. Also, performance evaluations for all employees have been completed as of the end of May.
2. **Applicant and Recruitment Update** – Mr. Mestler noted that for the month of May, RACSB received 395 applications. Of the applications, 43 applicants listed the RACSB applicant portal as their recruitment source, 13 stated employee referrals as their recruitment source, and 339 listed job boards as their recruitment source. At the end of May, there were 8 open positions, 6 full-time, 2 part-time.
3. **Turnover Report** – Mr. Mestler shared that HR processed a total of 10 employee separations for the month of May. Of the separations, 9 were voluntary and 1 was involuntary.
4. **DBHDS Workforce Reporting Overview** – Mr. Mestler provided the Board with workforce data for certain position categories for reporting vacancy rate, turnover rate, and salary information submitted to the Department of Behavioral Health and Developmental Services (DBHDS) for the third quarter of FY2025.

H. DEPUTY EXECUTIVE DIRECTOR, *Ms. Brandie Williams*

1. **Program Update** – Ms. Williams shared that the RACSB performance contract has been posted on our website for public comment. It will be there for 30 days. She will have a report for the Board next meeting and go into more detail prior to asking the Board for approval. Ms. Williams said that we are also on track to transition to the new data exchange for the July 1 deadline.
2. **Combined Dashboard Data Report** – Ms. Williams reviewed the data report and noted there were still discrepancies in the services sent and received by DBHDS for some of the measures. The IT teams are working with Netsmart to identify the issue and resolve the technical error.
3. **Legislative Updates and Priorities**– Ms. Williams provided an overview of the legislative updates and priorities. She focused on DBHDS funding actions, with estimated allocations for one-time funding support to build I/DD Support Coordination. RACSB is estimated to receive $1,000,000 in these one-time funds. We were also awarded funding of our application for an automated dispensing device for Sunshine Lady House. Ms. Williams went over the latest on Federal Medicaid Cuts.
4. **State of the Workforce and Compensation Update FY2025** – Ms. Williams took the Board through the update in order to evaluate the agency recruitment, retention, and compensation actions since June 2024. She covered the barriers and threats to the RACSB workforce, living wage criteria, financial position and consideration, followed by a recommendation for the Board to approve a merit-based one-time bonus. She said the approximate $268,635 in FY26 state funding restricted to salary actions will be used to cover the majority of expected cost.

The Board moved to approve the merit-based one-time bonus.
ACTION TAKEN: The Board approved merit-based one-time bonus
Moved by: Mr. Ken Lapin
Seconded by: Ms. Bridgette Williams

XII. REPORT FROM THE EXECUTIVE DIRECTOR, *Mr. Joseph Wickens*

Mr. Wickens reminded the Board that there would be no board meeting in the month of July. The next board meeting will be on August 19, 2025.

XIII. APPOINTMENT OF OFFICERS, *Ms. Nancy Beebe*

Ms. Beebe called a vote on the new officers nominated at the May Board of Directors meeting.

Chairman, Jacob Parcell
Vice Chairman, Matt Zurasky
Secretary, Claire Curcio

The Board moved to approve the new officers.
ACTION TAKEN: The Board approved the new officers as listed above.
Nominated by: Mr. Ken Lapin
Seconded by: Ms. Carol Walker

XIV. BOARD TIME

A. Ms. Curcio, thank you for electing me. I am overwhelmed at the amount of work you all do, it amazes me every month, thank you.
B. Ms. White, thank you staff, thank you Nancy for taking the role as Chairman, I appreciate your time. Congratulations to everyone else and thank you to the team.
C. Ms. Walker, you all have done a phenomenal job with budget and finance and hiring, waitlist, the things presented at this meeting shows you are going in the right direction and I appreciate staff and leadership of this Board as well, thank you.
D. Ms. Beebe, thank you very much.
E. Ms. Williams, everyone is doing a great job.
F. Mr. Zurasky, thank you for your two years of service, Nancy, also thank you for picking Jacob. I'd like to say that the Board made a decision earlier this year to raise salaries and it was the right thing to do and the fact that we are only a $1 million in the hole at the end of the year is amazing. Everyone really did a great job in watching what we we're doing and thank you for preparing a budget that reflects that in still uncertain times, we are preparing for this next year with a conservative estimate on revenues and we'll do well. Thank you.
G. Mr. Lapin, excellent budget presentation and thank you to all for what you're doing.
H. Mr. Sokolowski, thank you all for what you're doing.

XV. CLOSED MEETING – VA CODE § 2.2 – 3711 A (4), A (7), and A (15)

Ms. Beebe requested a motion for a closed meeting. Matters to be discussed:
- CRC Update

It was moved by Ms. Beebe and seconded by Ms. Curcio that the Board of

Directors of the Rappahannock Area Community Services Board convene in a closed meeting pursuant to Virginia Code § 2.2 – 3711 A (4) for the protection and privacy of individuals in personal matters not related to public business; and Virginia Code § 2.2 – 3711 A (15) to discuss medical records excluded from 2.2 – 3711 pursuant to subdivision 1 of 2.2 – 3705.5.

The motion was unanimously approved.

Upon reconvening, Mr. Sokolowski called for a certification from all members that, to the best of their knowledge, the Board discussed only matters lawfully exempted from statutory open meeting requirements of the Freedom of Information Act; and only public business matters identified in the motion to convene the closed meeting.

A roll call vote was conducted:

Claire Curcio – Voted Aye
Nancy Beebe – Voted Aye
Greg Sokolowski – Voted Aye
Melissa White – Voted Aye
Jacob Parcell – Voted Aye
Matthew Zurasky – Voted Aye
Ken Lapin – Voted Aye
Carol Walker – Voted Aye

XVI. ADJOURNMENT

The meeting adjourned at 6:11 PM.

Nancy Beebe

Board of Directors Chair

Executive Director

Rappahannock Area Community Services Board
Executive Committee Meeting Minutes
Monday, June 30, 2025 at 10:00 a.m.
600 Jackson Street, Board Room 208, Fredericksburg, VA

Attendees: *Executive Committee:* Nancy Beebe, Jacob Parcell, Matt Zurasky, Ken Lapin and *Staff Members:* Joseph Wickens

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MINUTES

Call to Order – Nancy Beebe
A meeting of the Executive Committee of the Rappahannock Area Community Services Board was held at 600 Jackson Street on June 30, 2025.

I. Executive Director FY25 Work Plan Review (attachment) — Wickens

Mr. Wickens reviewed his FY 2025 work plan and progress with the Executive Committee.

The Executive Committee unanimously approved the work plan. Mr. Zurasky shared that the current work plan detailed many objectives and deliverables and recommended fewer, broader goals that could line up with the performance based evaluation tool currently used by all staff.

II. Closed Session – VA CODE § 2.2 – 3711 A (4), A (7), and A (15) — Beebe

Ms. Beebe requested a motion for a closed meeting. Matter to be discussed: CRC update and Executive Director Employment Agreement

> It was moved by Mr. Zurasky and seconded by Mr. Parcell that the Board of Directors of the Rappahannock Area Community Services Board convene in a closed meeting pursuant to Virginia Code § 2.2 – 3711 A (4) for the protection and privacy of individuals in personal matters not related to public business; and Virginia Code § 2.2 – 3711 A (15) to discuss medical records excluded from 2.2 – 3711 pursuant to subdivision 1 of 2.2 – 3705.5.

The motion was unanimously approved.

> Upon reconvening, Ms. Beebe called for a certification from all members that, to the best of their knowledge, the Board discussed only matters lawfully exempted from statutory open meeting requirements of the Freedom of Information Act; and only public business matters identified in the motion to convene the closed meeting.

A roll call vote was conducted:

Nancy Beebe – Voted Aye	Jacob Parcell – Voted Aye
Matt Zurasky – Voted Aye	Ken Lapin – Voted Aye

The motion was unanimously approved.

III. Action on Closed Session: — Beebe

The Executive Committee unanimously approved the Executive Director Employment Agreement as well as a one-time bonus amount based on staff performance that was approved by the Board in the last meeting.

IV. Other Business — Beebe

Mr. Wickens shared that Sarah Ritchie's term on the Board was ending this month. She secured an opportunity to be the Assistant Chair of the Board for VSCA and so she would not be renewing another term with RACSB.

V. Adjournment — Beebe

The meeting adjourned at 11:18 AM.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Executive Director Work Plan

Fiscal Year 2025

Name: Joseph Wickens

Date: June 30, 2025

GOALS:

No.	Objectives	Key Deliverables	Status	Progress/Outcome
Develop and construct a Crisis Receiving Center (CRC) to help fill a gap in the community within crisis services and add to RACSB's mental health continuum of services				
1	Develop CRC program	Create program policies and procedures	Ongoing	Delays in obtaining design and construction approval as well as changes with DBHDS operational and licening requirements has pushed this objective out yet another year. In the meantime, we have sent key staff to a crisis conference, and have received information regarding staffing structure and budgets.
		Create operating budget	Ongoing	
		Create staffing plan	Ongoing	
2	Develop CRC facility	Complete Phase I, II, III assessments and evaluations as required by the City	Completed	Completed Phase I, II, III, and Site Plans for Roxbury property. Ongoing delays with locality, however, have resulted in search for alternatives. Researched 37 other available locations in the immediate area consisting of both raw land and facilities. Pivoted efforts to possibilities of renovations with current main office building. Focused current efforts to acquisition of a building for renovation after negotiating and securing additional funding and commitment from DBHDS. Started floor plan development with architect of the new building in March.
		Complete building design	Completed	
		Submit and obtain approved site review	Completed	
		Submit and obtain approved building construction documentation and permit	Paused	
		Contract with builder	Paused	
		Begin construction	Paused	
Increase services in current programs to meet the need in our community				
1	Increase outpatient services	Eliminate outpatient waiting lists for at all clinics utilizing same day access	Completed	All five clinics are providing same day access and all waitlists were resolved as of February.
2	Increase developmental disability services	Fill 50% of current number of group home bed vacancies	Ongoing	There were eight group home vacancies in the beginning of the fiscal year. We have a remaining total of five net vacancies; a 44% reduction in vacancies. Important to note that nine placements were actually made but six discharges also occurred since. Aso noteworthy is Leeland Road, whcih was completely vacant due to temporary closing, was also
3	Increase Permanent Supportive Housing (PSH) services	Secure units to an additional 12 individuals for a total of 65 individuals	Completed	PSH has housed 20 individuals from July 2024-2025. It currently has three individuals with pending applications to apartments and working to house another eight individuals.

4	Increase Assertive Community Treatment (ACT) services	Increase supports by 10% to serve an additional 5 individuals for a total of 55 individuals in the program.	Completed	ACT admitted 19 individuals and discharged 10 over the last 12 months. Current enrollment is 58.
5	Increase crisis stabilization services	Increase Sunshing Lady House utilization from current 40% to state requirement of 75%.	Ongoing	SLH served 388 invidivuals, 61 more than in FY22 prior to its temporary closing. Current utilization is 61%, a 21% increase.
Increase staff retention and recruitment				
1	Research PD16 job market to evaluate and elevate RACSB positioning for our labor force.	Increase staff compensation by providing merit, living wage, and scale adjustments in July, 2024	Completed	Provided 3-4% merit increase based on performance, as well as significant boost to salary scales with goal to reach living wage average in PD16 for lowes grade.
		Provide second staff compensation increase by providing cost of living and possible scale adjustments in January, 2025		Complensation evaluated but determined that it was not needed at the time due to the substantial July salary adjustment which continued to show improvement our position in the market.
2	Fill vacant staff positions	Hire Finance Director	Completed	Hired in December, 2024
		Hire Crisis Stabilization Coordinator	Completed	Hired in August, 2024
		Hire Crisis Stabilization Nurse Manager	Completed	Hired in September, 2024
		Hire a psyhiatrist	Completed	Hired 3 Psychiatrists; one in December, 2024, one in January, 2024, and in June, 2025.
		Reduce current open positions by 40%	Completed	60 vacancies beginning of the fiscal year. Currently have 6 vacancies, a 90% reduction.
		Increase staff retention by 5%. Reduce voluntary resignations by 5%.	Incomplete	Staff retention decreased 3% from 81% to 78%. Voluntary resignations increased 27% from 75 to 95 staff.
Develop and improve staff trainings to increase staff performance and quality of care for individuals				
1	Improve trainings for staff to build confidence in their ability to perform and take pride in their duties	Improve development of onboarding and ongoing training curriculum	Completed	Reduced delinquint trainngs 85% and currently maintain a 6-month compliance rate of 94%. HR improved new employee orientation curriculum and scheduling. Programs developed onboarding process and checklists by position. Held all-staff inservice day in April. Implementation of Relias Learning Management Platform provided training specific to licensure for CEU's, skill enhancement, and compliance. Workgroup established to support changes for QMHP/T and new supervision requirements.
2	Develop new and strengthen leadership skills among employees	Create growth/leadership track for staff to provide greater opportunity for advancement within the agency	Completed	Hired TBD Solutions to provide management and leadership trainings to middle managers, coordinators, and directors. Also utilized TBD Solutions for leadership training sessions at the RACSB in-service. Promoted 12 staff to leadership roles.

		Identify/create and implement required leadership trainings for leadership and management team members		Program on boarding and training expectations are shared and developed through CSS. Includes reporting/sharing training logs and supervision materials with director, site leader training processes that include peer mentoring, weekly on site support by assistant coordinators, and reference materials.
3	Utilize Relias online training platform	Transition from Netsmart University to Relias	Completed	Leadership staff trainings up to this fiscal year lead to successfully transition to Relias starting July, 2024.
		Integrate Relias dynamic reporting tool	Completed	Training reports created, ability to share with supervisors across Relias dashboard, and program policy mechanism implemented.
4	Develop professional skills and training as an Executive Director	Attend nationally recognized leadership training/conference to include director/board relations and financial	Completed	Attended executive leadership retreat with Open Minds in September in Gettysburg, PA. Open Minds is a nationally recognized firm providing market intelligence, management consulting, and marketing services specializing exclusively in the markets of the health and human service field incluiding mental health and developmental disabilities.
		Attend a national conference on mental health and/or developmental disability	Completed	
Drive operational efficiency to increase quality administrative services				
1	Streamline processes and improve operational efficiency	Implement AVATAR and GL Mapping Project to improve reimbursement processes	Partially completed	Currently not re-engaging due to possibiliy of needing a new GL in the next year/year and a half due to sunset of GP.
		Implement electronic procurement and accounts payable system papersave	Completed	Utilized an electronic invoicing system called Papersave as well as an electronic procurement system.
		Implement a contract oversight and monitoring process to enable contract extension or re-negotiation.	Completed	Utilized contracting capability with state procurement system through eVA.
2	Review and revise policies and procedures to address and clarify current requirements and practices	Update Employee Handbook	Ongoing	Handbook is continually being revised, updated by executive leadership team and approved by the Board of Directors.
3	Evaluate and implement organizational restructure to better align programs and divisions.	Establish program services under 3 divisions: Clinical Services, Behavioral Health Crisis Services, and Community Support Services.	Completed	Crisis Services division developed to include: Emergency Services, Crisis Receving Center, Crisis Stabilization Unit, and Assertive Community Treatment. Community Support Services division also reduced: ACT and SLH moved to Crisis Services division, and Early Intervention services moved to Prevention services division
4	Transition to new pharmacy	Transition from Genoa to Altruix on site pharmacy to better meet agency needs		Successful transition occurred in September with an official Grand Opening on October 22nd.
5	Work with Board to improve meetings and material	Update Bylaws	Completed	Bylaws revised and approved by Board of Directors in August.
		Streamline Committee meetings	Completed	Four separate committees were eliminated and the topics and information was directed into one revamped monthly Board of Directors

		Update committee agendas by adding and replacing items with more relevant, meaningful, and measureable material	Completed	Board Meeting agendas were updated in August and include more relevant reports, metrics, and change in start time that was more conducive to Board members time, commitment, and availability.
Maintain elevated standards of care, quality, and services				
1	Demonstrate the value of RACSB services by meeting an internationally recognized organizational and program standards.	Achieve 3-year Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation	Ongoing	Work towards accreditation to incude initial application was submitted in June. CARF visit to include audit expected in October, 2025.

July 7, 2025 Board of Directors
Strategic Plan Work Group

I. Work Group

A work group of the Board of Directors of the Rappahannock Area Community Services Board was called to order on July 7, 2025, at 600 Jackson Street at 8:30 a.m. *Attendees included*: Claire Curcio. *Other attendees included*: RACSB management team and Brandie Williams.

II. Finalize Strategic Goals/Key Strategic Initiatives for each priority

Ms. Williams provided the group with an agenda, a final draft of Key Performance Initiatives, a rough draft of the large format strategic plan and a one-year profile. She worked with the group to confirm the total number of individuals served percentage that was still outstanding. The group settled on 5% over three years. She then took the group through each key performance initiative/action for each goal and year of the plan.

III. Wrap Up

The group provided feedback which Ms. Williams collected and will use to finalize the strategic goals/key strategic initiatives for each priority in the drafting of the strategic plan to be sent to the Board of Directors ahead of the August Board meeting for review and consideration. Ms. Williams will send updated correspondence of discussion points to all for final review. No future meetings planned.

IV. Adjournment

The meeting adjourned at 10:30 AM.

_____ _____

Board of Directors Chair Executive Director

Board Core Behaviors

Open and Honest
Communication

Ask
Tough Questions

Next Level
Decision Making

RFC
CPAs | Consultants

ROBINSON, FARMER, COX ASSOCIATES, PLLC
Certified Public Accountants

INDEPENDENT AUDITORS' REPORT

To the Board of Directors
Rappahannock Area Community Services Board
Fredericksburg, Virginia

Report on the Audit of the Financial Statements

Opinions

We have audited the accompanying financial statements of the business-type activities and the aggregate remaining fund information of Rappahannock Area Community Services Board, as of and for the year ended June 30, 2024 and the related notes to the financial statements, which collectively comprise Rappahannock Area Community Services Board's basic financial statements as listed in the table of contents.

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the aggregate remaining fund information of Rappahannock Area Community Services Board, as of June 30, 2024, and the changes in financial position, and cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and the *Specifications for Audits of Authorities, Boards, and Commissions,* issued by the Auditor of Public Accounts of the Commonwealth of Virginia. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Rappahannock Area Community Services Board, and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Rappahannock Area Community Services Board's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards, *Government Auditing Standards*, and the *Specifications for Audits of Authorities, Boards, and Commissions* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, *Government Auditing Standards*, and the *Specifications for Audits of Authorities, Boards, and Commissions*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Rappahannock Area Community Services Board's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Rappahannock Area Community Services Board's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis and schedules related to pension and OPEB funding as listed in the table of contents be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Report on Summarized Comparative Information

We have previously audited the Rappahannock Area Community Services Board's 2023 financial statements, and we expressed an unmodified audit opinion on those audited financial statements in our report dated November 30, 2023. In our opinion, the summarized comparative information presented herein as of and for the year ended June 30, 2023, is consistent, in all material respects, with the audited financial statements from which it has been derived.

Supplementary Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise Rappahannock Area Community Services Board's basic financial statements. The accompanying combining financial statements and schedule of expenditures of federal awards, as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, are presented for purposes of additional analysis and are not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the combining financial statements and the schedule of expenditures of federal awards are fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated January 24, 2025, on our consideration of Rappahannock Area Community Services Board's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of Rappahannock Area Community Services Board's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Rappahannock Area Community Services Board's internal control over financial reporting and compliance.

Robinson, Farmer, Cox, Associates

Charlottesville, Virginia
January 24, 2025

The following Management's Discussion and Analysis (MD&A) of the Rappahannock Area Community Services Board's (RACSB) financial performance provides the reader with an introduction and overview to the financial statements of the RACSB for the fiscal year ended June 30, 2024.

Following this MD&A are the basic financial statements of the RACSB together with the notes thereto which are essential to a full understanding of the data contained in the financial statements. In addition to the basic financial statements and accompanying notes, there is certain information regarding the schedule of expenditures of federal awards. Please read this information in conjunction with the RACSB's financial statements.

OVERVIEW OF THE FINANCIAL STATEMENTS

The Rappahannock Area Community Services Board presents five basic financial statements for the purpose of analyzing the financial position of the RACSB as of June 30, 2024. These are: (1) a Statement of Net Position; (2) a Statement of Revenues, Expenses and Changes in Net Position; (3) a Statement of Cash Flows; (4) Statement of Fiduciary Net Position; and (5) Statement of Changes in Fiduciary Net Position.

RACSB's financial position is measured in terms of resources (assets and deferred outflows) owned and obligations (liabilities and deferred inflows) owed as of June 30, 2024. This information is reported on the statement of net position, which reflects RACSB's assets and deferred outflows in relation to its debts to its suppliers, employees and other creditors, and deferred inflows. The excess of assets and deferred outflows over liabilities and deferred inflows is the net position.

Information regarding the results of RACSB's operations during fiscal year 2024 is reported in the Statement of Revenues, Expenses and Changes in Net Position. This statement shows how much overall net position increased or decreased during the year as a result of operations.

The Statement of Cash Flows discloses the flow of cash resources into and out of RACSB during fiscal year 2024 (from operations, contributions and other sources) and how those funds were applied (for example: payment of expenses, repayment of debt, purchase of new property, etc.).

Component unit organizations Rappahannock Community Services, Inc., Churchill Drive Group Home, Devon Drive Group Home, Galveston Road Group Home, Igo Road Group Home, Leeland Road Group Home, New Hope Estates Group Home, Piedmont Drive Group Home, Scottsdale Estates Group Home and Stonewall Estates Group Home are included as a part of the financial reporting entity of RACSB.

Financial Summary

Financial Position: A summary of RACSB's Statement of Net Position for fiscal years 2024 and 2023 is presented below.

Condensed Statement of Net Position

	2024	2023
Current assets	$ 34,276,975	$ 33,774,578
Restricted assets	672,392	621,497
Capital assets	24,231,631	25,491,866
Other assets	10,090,668	7,722,696
Total assets	$ 69,271,666	$ 67,610,637
Deferred outflows of resources	$ 1,181,947	$ 1,494,447
Total assets and deferred outflows of resources	$ 70,453,613	$ 69,105,084
Current liabilities	$ 9,283,808	$ 6,200,470
Liabilities payable from restricted assets	138,364	157,631
Long-term liabilities	1,300,962	1,831,436
Total liabilities	$ 10,723,134	$ 8,189,537
Deferred inflows of resources	$ 2,901,658	$ 2,262,994
Net Position:		
Net investment in capital assets	$ 23,686,290	$ 24,425,901
Restricted	10,622,808	8,184,677
Unrestricted	22,519,723	26,041,975
Total net position	$ 56,828,821	$ 58,652,553
Total liabilities, deferred inflows of resources and net position	$ 70,453,613	$ 69,105,084

The financial position of the Rappahannock Area Community Services Board remains strong. This is evidenced by strong liquidity. The current ratio (current assets /current liabilities) of the RACSB was 3.69 as of June 30, 2024 and 5.45 at June 30, 2023. The liquidity remains strong as a current ratio of 2:1 is considered favorable.

Change in net position: A summary of the RACSB's Statement of Revenues, Expenses and Changes in Net Position for 2024 and 2023 is presented below.

Condensed Statement of Revenues, Expenses and Changes in Net Position

	2024	2023
Operating revenue	$ 29,731,839	$ 34,656,193
Operating expenses	56,414,110	46,725,408
Operating income (loss)	$ (26,682,271)	$ (12,069,215)
Total nonoperating revenues (expenses)	24,858,539	20,559,678
Change in net position	$ (1,823,732)	$ 8,490,463

Financial Summary (continued)

Operating Revenue is the amount of revenue received from providing patient services. The vast majority of those funds, approximately 81% (2024) and 86% (2023), were received from Medicaid (see Note 13). During 2024, Operating Revenue decreased 14.21% as compared to a increase of 21.34% in 2023.

Operating Expenses are comprised of the direct and indirect costs of operating the RACSB. These include salaries and benefits, occupancy, payments to contracting agencies, depreciation, etc. Please see the full Statement of Revenues, Expenses and Changes in Net Position for a complete breakdown of these expenses for 2024 and 2023. During 2024, Operating Expenses increased approximately 20.74%, compared to an increase of 2.49% in 2023.

Nonoperating Revenue is comprised of income received as appropriations or grants as well as other income. Appropriations and grants from the State of Virginia constitute 60.54% for 2024, and 57.78% for 2023 of the net nonoperating revenue while grants from the federal government constitute 13.17% for 2024 and 17.58% for 2023. Appropriations from local governments constituted 8.00% for 2024 and 9.17% for 2023. The remaining Nonoperating Revenue (expenses) and Capital Contributions consist of Other Income, Interest Income and Expense, and Gains (Losses) on the Disposition of Capital Assets. Nonoperating Revenue (expenses) increased 20.91% in 2024.

Net Position decreased $1,823,732 in 2024 and increased $8,453,159 in 2023.

Cash flows: A summary of the RACSB's Statement of Cash Flows for 2024 and 2023 is presented below.

Condensed Statement of Cash Flows

	2024	2023
Cash flows from operating activities	$ (21,872,954)	$ (14,127,506)
Cash flows from non capital financing activities	25,237,015	20,863,625
Cash flows from capital and related financing activities	(1,206,451)	(834,011)
Cash flows from investing activities	809,008	393,657
Net increase (decrease) in cash and cash equivalents	$ 2,966,618	$ 6,295,765
Cash and cash equivalents, beginning of year	27,207,543	20,911,778
Cash and cash equivalents, end of year	$ 30,174,161	$ 27,207,543

Cash flows from operating activities reconcile the Operating Loss recorded on the Statement of Revenues, Expenses and Changes in Net Position to cash provided by operating activities. In this process, the Operating Loss is decreased by the amount of any non-cash items (depreciation) and adjusted for changes in assets and liabilities (please see the full Statement of Cash Flows for a complete listing of these items). Of these adjustments, the significant entries are $1,936,997 (2024), and $2,000,040 (2023) in depreciation.

Cash flows from noncapital financing transactions are comprised of income received as appropriations or grants (please see Statement of Revenues, Expenses and Changes in Net Position discussion above). Cash flows from capital and related financing activities are comprised of the acquisition of capital assets by the RACSB, and principal and interest payments on mortgages and loans payable (please see Note 4 for a breakdown of Capital Assets). Cash flows from investing activities are comprised of interest income.

There was a net increase of $2,966,618 in 2024, and a net increase of $6,295,765 in 2023 in cash and cash equivalents.

Capital Assets and Debt Administration

Capital Assets

On June 30, 2024, the Rappahannock Area Community Services Board had $24,231,631 in Net Capital Assets. This is comprised of $43,401,604 in capital assets less $19,169,973 in accumulated depreciation (please see Note 4). Of the total capital assets, equipment and vehicles (including information technology assets and vehicles) constitutes 12%, land constitutes 8%, lease assets 1%, subscription asset 3%, and buildings and improvements constitute 66%. Construction in progress constitutes the remaining 10% and consists of renovation projects.

Summary

The Statement of Net Position shows that, on June 30, 2024, the RACSB had approximately 3.7times more current assets than current liabilities. In addition, RACSB had $56,828,821 in total net position.

The Statement of Revenues, Expenses and Changes in Net Position shows the net position of the RACSB decreased $1,823,732 during 2024.

The Statement of Cash Flows shows that cash increased $2,966,618 in 2024.

The financial position of the Rappahannock Area Community Services Board measured, in terms of the five basic financial statements presented as of June 30, 2024, is very strong and secure.

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- Basic Financial Statements -

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Statement of Net Position
At June 30, 2024
(With Comparative Totals for 2023)

	2024	2023
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 29,586,699	$ 26,692,730
Accounts receivable, less allowance for uncollectibles	4,441,993	6,927,121
Grants and other receivables	213,967	124,481
Prepaid items	34,316	30,246
Total current assets	$ 34,276,975	$ 33,774,578
Restricted Assets:		
Cash and cash equivalents	$ 587,462	$ 514,813
Grants and other receivables	67,952	91,221
Prepaid items	16,978	15,463
Total restricted assets	$ 672,392	$ 621,497
Capital Assets:		
Property and equipment, less accumulated depreciation	$ 24,231,631	$ 25,491,866
Other Assets:		
Net pension asset	$ 8,365,267	$ 6,886,300
Net OPEB assets	1,725,401	836,396
Total other assets	$ 10,090,668	$ 7,722,696
Total assets	$ 69,271,666	$ 67,610,637
DEFERRED OUTFLOWS OF RESOURCES		
Pension related items	$ 531,191	$ 780,441
OPEB related items	650,756	714,006
Total deferred outflows of resources	$ 1,181,947	$ 1,494,447
LIABILITIES		
Current Liabilities:		
Accounts payable and accrued expenses	$ 513,075	$ 647,872
Compensated absences	1,892,180	1,349,996
Accrued health insurance liabilities	2,785,303	1,343,472
Unexpended grant funds and other unearned revenue	3,598,671	2,338,506
Subscription liability, current portion	456,117	446,081
Lease liabilities, current portion	38,462	74,543
Total current liabilities	$ 9,283,808	$ 6,200,470
Liabilities Payable from Restricted Assets:		
Accounts payable and accrued expenses	$ 113,760	$ 133,652
Tenant security deposits	24,604	23,979
Total liabilities payable from restricted assets	$ 138,364	$ 157,631
Long-term Liabilities:		
Subscription liability, less current portion	$ -	$ 456,117
Lease liabilities, less current portion	50,762	89,224
Net OPEB liabilities	1,250,200	1,286,095
Total long-term liabilities	$ 1,300,962	$ 1,831,436
Total liabilities	$ 10,723,134	$ 8,189,537
DEFERRED INFLOWS OF RESOURCES		
Pension related items	$ 1,650,414	$ 1,596,890
OPEB related items	1,251,244	666,104
Total deferred inflows of resources	$ 2,901,658	$ 2,262,994
NET POSITION		
Net investment in capital assets	$ 23,686,290	$ 24,425,901
Restricted	10,622,808	8,184,677
Unrestricted	22,519,723	26,041,975
Total net position	$ 56,828,821	$ 58,652,553

The accompanying notes to financial statements are an integral part of this statement.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Statement of Revenues, Expenses and Changes in Net Position
Year Ended June 30, 2024
(With Comparative Totals for 2023)

	2024	2023
Operating revenue:		
Net patient service revenue	$ 29,731,839	$ 34,656,193
Operating expenses:		
Salaries and benefits	$ 39,395,221	$ 32,876,641
Staff development	398,052	249,774
Facilities	3,193,888	2,542,087
Supplies	2,801,666	2,194,962
Travel	735,377	687,268
Contractual and consulting	5,384,933	5,722,681
Depreciation	1,936,997	2,000,040
Other	2,567,976	451,955
Total operating expenses	$ 56,414,110	$ 46,725,408
Operating income (loss)	$ (26,682,271)	$ (12,069,215)
Nonoperating revenues (expenses):		
Capital contributions:		
Commonwealth of Virginia	$ 15,048,347	$ 11,879,692
Federal government	3,273,082	3,614,797
Local governments	1,988,872	1,864,970
Other	3,748,295	2,857,370
Interest income	809,008	393,657
Interest expense	(24,215)	(34,029)
Gain (loss) on disposition of capital assets	15,150	(16,779)
Net nonoperating revenues (expenses)	$ 24,858,539	$ 20,559,678
Change in net position	$ (1,823,732)	$ 8,490,463
Net position, beginning of year	58,652,553	50,162,090
Net position, end of year	$ 56,828,821	$ 58,652,553

The accompanying notes to financial statements are an integral part of this statement.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Statement of Cash Flows
Year Ended June 30, 2024
(With Comparative Totals for 2023)

	2024	2023
Cash flows from operating activities:		
Receipts from customers	$ 32,232,496	$ 32,561,797
Payments to suppliers	(14,843,489)	(14,084,241)
Payments to and for employees	(39,261,961)	(32,605,062)
Net cash flow provided by (used for) operating activities	$ (21,872,954)	$ (14,127,506)
Cash flows from noncapital financing activities:		
Government grants	$ 21,480,980	$ 17,972,368
Other	3,756,035	2,891,257
Net cash flow provided by (used for) noncapital financing activities	$ 25,237,015	$ 20,863,625
Cash flows from capital and related financing activities:		
Purchase of capital assets	$ (676,762)	$ (299,110)
Proceeds from sale of capital assets	15,150	92,848
Issuance of lease liabilities	-	-
Principal paid on lease liabilities	(74,543)	(72,045)
Amount paid on subscription liabilities	(446,081)	(436,265)
Principal payments on mortgages and loans payable	-	(85,410)
Interest expense	(24,215)	(34,029)
Net cash flow provided by (used for) capital and related financing activities	$ (1,206,451)	$ (834,011)
Cash flows from investing activities:		
Interest income	$ 809,008	$ 393,657
Net increase (decrease) in cash and cash equivalents	$ 2,966,618	$ 6,295,765
Cash and cash equivalents, beginning of year (including restricted cash of $514,813)	27,207,543	20,911,778
Cash and cash equivalents, end of year (including restricted cash of $587,462)	$ 30,174,161	$ 27,207,543
Reconciliation of operating income (loss) to net cash provided by (used for) operating activities:		
Operating income (loss)	$ (26,682,271)	$ (12,069,215)
Adjustments to reconcile operating income (loss) to net cash provided by (used for) operating activities:		
Depreciation	1,936,997	2,000,040
Changes in assets, deferred outflows of resources, liabilities, and deferred inflows of resources:		
Accounts receivable	2,500,657	(2,094,396)
Prepaid items	(5,585)	(8,065)
Net pension asset	(1,478,967)	3,481,992
Net OPEB assets	(889,005)	29,091
Deferred outflows of resources	312,500	679,679
Accounts payable and accrued expenses	1,287,142	(1,134,330)
Compensated absences	542,184	(131,628)
Net OPEB liabilities	(35,895)	20,067
Deferred inflows of resources	638,664	(4,901,320)
Other	625	579
Net cash provided by (used for) operating activities	$ (21,872,954)	$ (14,127,506)

The accompanying notes to financial statements are an integral part of this statement.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Statement of Fiduciary Net Position
Fiduciary Funds
At June 30, 2024

	Private-Purpose Trust Funds	Investment Trust Funds
ASSETS		
Cash and cash equivalents	$ 291,676	$ -
Investments designated for postemployment benefits other than pensions:		
VML/VACO Pooled OPEB Trust Portfolio I	-	4,163,720
Total assets	$ 291,676	$ 4,163,720
NET POSITION		
Restricted:		
Client funds	$ 291,676	$ -
Postemployment benefits other than pensions	-	4,163,720
Total net position	$ 291,676	$ 4,163,720

The accompanying notes to the financial statements are an integral part of this statement.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Statement of Changes in Fiduciary Net Position
Fiduciary Funds
For the Year Ended June 30, 2024

	Private-Purpose Trust Funds	Investment Trust Funds
ADDITIONS		
Contributions:		
Employer	$ -	$ 61,953
Social security income	1,531,915	-
Other income	340,972	-
Investment Earnings:		
Net increase (decrease) in fair value of investments	-	360,908
Total investment earnings	$ -	$ 360,908
Total additions	$ 1,872,887	$ 422,861
DEDUCTIONS		
Retirement and disability benefits	$ -	$ 61,953
Administrative expenses	-	4,247
Food and housing	337,062	-
Client's personal use of funds	1,558,845	-
Total deductions	$ 1,895,907	$ 66,200
Net increase (decrease) in fiduciary net position	$ (23,020)	$ 356,661
Net position, beginning	314,696	3,807,059
Net position, ending	$ 291,676	$ 4,163,720

The accompanying notes to the financial statements are an integral part of this statement.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES:

A. Description and Purpose of Organization:

The Board operates as an agent for the Counties of Stafford, King George, Caroline, Spotsylvania and the City of Fredericksburg in the establishment and operation of community mental health, intellectual disabilities and substance abuse programs as provided for in Chapter 10 of Title 37.1 of the Code of Virginia (1950), relating to the Virginia Department of Behavioral Health and Developmental Services. In addition, the Board provides a system of community mental health, intellectual disabilities and substance abuse services which relate to and are integrated with existing and planned programs. The Board's activities also include Healthy Families, Kids on the Block and Rappahannock Adult Activities. The Board was established in 1970.

B. Financial Reporting Entity:

For financial reporting purposes the Board includes all organizations for which it is considered financially accountable.

Blended Component Units:

Blended component units, although legally separate entities are, in substance, part of the Organization's operations, and so data from these units are combined with data of the Organization. The Organization has the following blended component units: Rappahannock Community Services, Inc., Churchill Drive Group Home, Devon Drive Group Home, Galveston Road Group Home, Igo Road Group Home, Leeland Road Group Home, New Hope Estates Group Home, Piedmont Drive Group Home, Scottsdale Estates Group Home, and Stonewall Estates Group Home. All of these organizations has been included as part of the reporting entity. These entities are not-for-profit organizations exempt under Section 501(c)(3) of the Internal Revenue Code and were organized to own and operate facilities for handicapped individuals. Rappahannock Community Services has a June 30 fiscal year. All of the other organizations have fiscal years which end on December 31.

C. Deferred Outflows/Inflows of Resources:

In addition to assets, the statement of financial position includes a separate section for deferred outflows of resources. Deferred outflows of resources represent a consumption of net assets that applies to a future period(s) and so will not be recognized as an outflow of resources (expense) until then. The Board has one item that qualifies for reporting in this category. It is comprised of certain items related to pension and OPEB. For more detailed information on these items, reference the related notes.

In addition to liabilities, the statement of financial position includes a separate section for deferred inflows of resources. Deferred inflows of resources represent an acquisition of net assets that applies to a future period(s) and so will not be recognized as an inflow of resources (revenue) until that time. The Board has one type of item that qualifies for reporting in this category. It is comprised of certain items related to pension and OPEB. For more detailed information on these items, reference the related notes.

D. Basis of Accounting:

The Board is funded by Federal, State and local funds. Its accounting policies are governed by applicable provisions of these grants and applicable pronouncements and publications of the grantors. The Board utilizes the accrual basis of accounting where revenues are recorded when earned and expenses recorded when incurred, regardless of when the related cash flow takes place.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES: (CONTINUED)

E. Financial Statement Presentation:

The accompanying financial statements are prepared in accordance with pronouncements issued by the Governmental Accounting Standards Board and the Virginia Department of Behavioral Health and Developmental Services. The principles prescribed by GASB represent generally accepted accounting principles applicable to governmental units.

F. Enterprise Fund Accounting:

Rappahannock Area Community Services Board is a governmental health care entity and is required to follow the accounting and reporting practices of the Governmental Accounting Standards Board. For financial reporting purposes, the Board utilizes the enterprise fund method of accounting whereby revenue and expenses are recognized on the accrual basis. Substantially all revenues and expenses are subject to accrual.

G. Use of Estimates:

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Accordingly, actual results could differ from those estimates.

H. Cash and Cash Equivalents:

The Board maintains cash accounts with financial institutions in accordance with the Virginia Security for Public Deposits Act of the Code of Virginia. The Act requires financial institutions to meet specific collateralization requirements. Cash and cash equivalents include investments in highly liquid financial instruments with an original maturity of three months or less at the date of acquisition. The Board considers all certificates of deposit to be cash and cash equivalents. The certificates of deposit have maturity dates of more than three months at the date of acquisition; however, the certificates may be redeemed without interest penalty at any time, and thus are considered to be cash and cash equivalents.

I. Investments:

Money market investments, participating interest-earning investment contracts (repurchase agreements) that have a remaining maturity at time of purchase of one year or less, nonparticipating interest-earning investment contracts (nonnegotiable certificates of deposit (CDs)) and external investment pools are measured at amortized cost. All other investments are reported at fair value.

J. Net Client Service Revenue:

Net client service revenue is reported at the estimated net realizable amounts from residents, third-party payers, and others for services rendered. Revenue under third-party payer agreements is subject to audit and retroactive adjustment. Retroactive adjustments are reported in operations in the year of settlement.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES: (CONTINUED)

K. Financial Assistance:

The Board is required to collect the cost of services from third party sources and those individuals who are able to pay. However, the payment of amounts charged is based on individual circumstances and unpaid balances are pursued to the extent of the client's ability to pay. The Board has established procedures for granting financial assistance in cases of hardship. The granting of financial assistance results in a substantial reduction and/or elimination of charges to individual clients. Because the Board does not pursue the collection of amounts determined to qualify for financial assistance, they are not reported as revenue.

L. Rental Income:

Rental income is recognized on a monthly basis pursuant to lease agreements, which generally have terms of one year or less. Rental revenue is reported in other nonoperating income.

M. Capital Assets:

Capital assets acquired that cost $5,000 or more are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Donated capital assets are recorded at their acquisition value at the time of the gift. The range of estimated useful lives for depreciation of capital assets is as follows:

Buildings and improvements	10 to 40 years
Furniture and equipment	3 to 10 years
Equipment and vehicles	4 years
Lease items: buildings	5 years

N. Restricted Assets:

The Board segregates monies held on behalf of third parties and restricted donations which have not yet been totally expended for their intended purposes.

O. Compensated Absences:

Employees are entitled to certain compensated absences based upon length of employment. Sick leave does not vest with the employee and is recorded as an expense when paid. Vacation pay does vest with the employee and is accrued when earned. Provision for the estimated liability for these compensated absences has been recorded in the financial statements. Because the timing of the use of the benefit cannot be reasonably estimated, all of the liability has been classified as current.

P. Budgetary Accounting:

The Board follows these procedures in establishing its budgets.

1. In response to Letters of Notification received from the Virginia Department of Behavioral Health and Developmental Services (the Department), the Board submits a Performance Contract to the Department. This application contains complete budgets for all core services.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES: (CONTINUED)

P. Budgetary Accounting: (Continued)

2. The Board's Performance reports are filed with the Department at the start of the fiscal year, and mid-year through the fiscal year. The final report is generally due by August 31, unless extended, following the end of the fiscal year.

3. If any changes are made during the fiscal year in state or federal block grants, or local match funds, the Board submits Performance Contract revisions which reflect these changes in time to be received by the Department by required deadlines.

Q. Fiscal Agent:

The City of Fredericksburg is the fiscal agent for the Rappahannock Area Community Services Board.

R. Comparative Totals:

The financial statements include certain prior year summarized comparative information in total but not by net asset class. Such information does not include sufficient detail to constitute a presentation in conformity with GAAP. Prior year totals on the financial statements are presented for informational purposes only. Accordingly, such information should be read in conjunction with the Board's financial statements for the year ended June 30, 2023, from which the summarized information was derived.

S. Operating and Nonoperating Revenues and Expenses:

Operating revenues and expenses are defined as those items that result from providing services and include all transactions and events which are not capital and related financing, noncapital financing or investing activities. Nonoperating revenues are defined as grants, investment and other income. Nonoperating expenses are defined as capital and noncapital related financing and other expenses.

T. Net Position:

The difference between assets and deferred outflows of resources less liabilities and deferred inflows of resources is called net position. Net position is comprised of three components: net investment in capital assets, restricted, and unrestricted.

- Net investment in capital assets consists of capital assets, net of accumulated depreciation/amortization and reduced by outstanding balances of bonds, notes, and other debt that are attributable to the acquisition, construction, or improvement of those assets. Deferred outflows of resources and deferred inflows of resources that are attributable to the acquisition, construction, or improvement of those assets or related debt are included in this component of net position.

- Restricted net position consists of restricted assets reduced by liabilities and deferred inflows of resources related to those assets. Assets are reported as restricted when constraints are placed on asset use either by external parties or by law through constitutional provision or enabling legislation.

- Unrestricted net position is the net amount of the assets, deferred outflows of resources, liabilities and deferred inflows of resources that does not meet the definition of the two preceding categories.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES: (CONTINUED)

U. Net Position Flow Assumption:

The Board may fund outlays for a particular purpose from both restricted and unrestricted resources. In order to calculate the amounts to report as restricted net position and unrestricted net position in the financial statements, a flow assumption must be made about the order in which the resources are considered to be applied. It is the Board's policy to consider restricted net position to have been depleted or used before unrestricted net position is applied.

V. Pensions:

For purposes of measuring the net pension asset, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, information about the fiduciary net position of the Board's Retirement Plan and the additions to/deductions from the Board's Retirement Plan's net fiduciary position have been determined on the same basis as they were reported by the Virginia Retirement System (VRS). For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

W. Other Postemployment Benefits (OPEB):

For purposes of measuring the net VRS related OPEB liabilities, deferred outflows of resources and deferred inflows of resources related to the OPEB, and OPEB expense, information about the fiduciary net position of the VRS GLI, HIC and VLDP OPEB Plans and the additions to/deductions from the VRS OPEB Plans' net fiduciary position have been determined on the same basis as they were reported by VRS. In addition, benefit payments are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

X. Leases and Subscription-Based IT Arrangements:

Leases

The Board has various lease assets and subscription-based IT arrangements (SBITAs) requiring recognition. A lease is a contract that conveys control of the right to use another entity's nonfinancial asset. Lease recognition does not apply to short-term leases, contracts that transfer ownership, leases of assets that are investments, or certain regulated leases. A SBITA is defined as a contract that conveys control of the right to use another party's (a SBITA vendor's) information technology (IT) software, alone or in combination with tangible capital assets (the underlying IT assets), as specified in the contract for a period of time in an exchange or exchange-like transaction.

Lessee

The Board recognizes lease liabilities and intangible right-to-use lease assets (lease assets) with an initial value of $5,000, individually or in the aggregate. At the commencement of the lease, the lease liability is measured at the present value of payments expected to be made during the lease term (less any lease incentives). The lease liability is reduced by the principal portion of payments made. The lease asset is measured at the initial amount of the lease liability, plus any payments made to the lessor at or before the commencement of the lease term and certain direct costs. The lease asset is amortized over the shorter of the lease term or the useful life of the underlying asset.

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES: (CONTINUED)

X. Leases and Subscription-Based IT Arrangements: (Continued)

Subscriptions

The Board recognizes intangible right-to-use subscription assets (subscription assets) and corresponding subscription liabilities with an initial value of $3,500, in individually or in the aggregate, in the government-wide financial statements. At the commencement of the subscription, the subscription liability is measured at the present value of payments expected to be made during the subscription liability term (less any contract incentives). The subscription liability is reduced by the principal portion of payments made. The subscription asset is measured at the initial amount of the subscription liability payments made to the SBITA vendor before commencement of the subscription term, and capitalizable implementation costs, less any incentives received from the SBITA vendor at or before the commencement of the subscription term. The subscription asset is amortized over the shorter of the subscription term or the useful life of the underlying IT asset.

Key Estimates and Judgments

Lease and subscription-based IT arrangement accounting includes estimates and judgments for determining the (1) rate used to discount the expected lease and subscription payments to present value, (2) lease and subscription term, and (3) lease and subscription payments.

- The Board uses the interest rate stated in lease or subscription contracts. When the interest rate is not provided or the implicit rate cannot be readily determined, the Board uses its estimated incremental borrowing rate as the discount rate for leases and subscriptions.

- The lease and subscription terms include the noncancellable period of the lease or subscription and certain periods covered by options to extend to reflect how long the lease or subscription is expected to be in effect, with terms and conditions varying by the type of underlying asset.

- Fixed and certain variable payments as well as lease or subscription incentives and certain other payments are included in the measurement of the lease receivable (lessor), lease liability (lessee) or subscription liability.

The Board monitors changes in circumstances that would require a remeasurement or modification of its leases and subscriptions. The Board will remeasure the lease receivable and deferred inflows of resources (lessor), the lease asset and liability (lessee) or the subscription asset and liability if certain changes occur that are expected to significantly affect the amount of the lease receivable, lease liability or subscription liability.

NOTE 2 - DEPOSITS AND INVESTMENTS:

Deposits:

Deposits with banks are covered by the Federal Deposit Insurance Corporation (FDIC) and collateralized in accordance with the Virginia Security for Public Deposits Act (the "Act") Section 2.2-4400 et. seq. of the Code of Virginia. Under the Act, banks and savings institutions holding public deposits in excess of the amount insured by the FDIC must pledge collateral to the Commonwealth of Virginia Treasury Board. Financial Institutions may choose between two collateralization methodologies and depending upon that choice, will pledge collateral that ranges in the amounts from 50% to 130% of excess deposits. Accordingly, all deposits are considered fully collateralized.

Investments:

Statutes authorize local governments and other public bodies to invest in obligations of the United States or agencies thereof, obligations of the Commonwealth of Virginia or political subdivisions thereof, obligations of the International Bank for Reconstruction and Development (World Bank), the Asian Development Bank, the African Development Bank, "prime quality" commercial paper that has received at least two of the following ratings: P-1 by Moody's Investors Service, Inc.; A-1 by Standard & Poor's; or F1 by Fitch Ratings, Inc. (Section 2.2-4502), banker's acceptances, repurchase agreements, and the State Treasurer's Local Government Investment Pool (LGIP).

Custodial Credit Risk (Investments):

The Board's investment policy requires the minimizing of custodial credit risk for its investments.

Credit Risk of Debt Securities:

As described above, the Board's investment policy mirrors the state statutes relating to investments.

The Board's rated debt investments as of June 30, 2024 were rated by Standard & Poor's and the ratings are presented below using the Standard & Poor's rating scale.

Rated Debt Investments' Values

Rated Debt Investments		Fair Quality Ratings
		AAAm
Virginia Local Government Investment Pool	$	35,047

Concentration of Credit Risk:

The Board's investment policy regarding the concentration of credit risk requires the investment of funds to be diversified by limiting investments to avoid over concentration in securities from a specific issuer or business sector (excluding U.S. Treasury securities).

NOTE 2 - DEPOSITS AND INVESTMENTS: (CONTINUED)

Interest Rate Risk:

The Board's investment policy for interest rate risk requires that securities mature to meet cash requirements for on-going operations and investing primarily in short-term securities, money market mutual funds, or similar investment pools. The following details the Board's investments at June 30, 2024.

Investment Type	Fair Value	Less Than One Year
Virginia Local Government Investment Pool	$ 35,047	$ 35,047

The repurchase agreements are collateralized by U.S. Government Securities.

External Investment Pools:

The value of the positions in the external investment pool (Local Government Investment Pool) is the same as the value of the pool shares. As LGIP is not SEC registered, regulatory oversight of the pool rests with the Virginia State Treasury. LGIP is an amortized cost basis portfolio. There are no withdrawal limitations or restrictions imposed on participants.

Cash and Cash Equivalents:

A summary of unrestricted cash and cash equivalents follows:

	2024	2023
Unrestricted:		
Cash on hand and petty cash	$ 585	$ 585
Cash in banks	29,551,067	26,658,962
Investments	35,047	33,183
Total	$ 29,586,699	$ 26,692,730

The Board serves as the agent for the receipt and disbursement of certain client funds. These amounts are reported as restricted assets on the Statement of Net Position.

NOTE 3 - ACCOUNTS RECEIVABLE:

At June 30, 2024 and 2023 the Board had accounts receivable due from the following primary sources:

	2024	2023
Client fees:		
Virginia Department of Medical Assistance Services (Medicaid)	$ 3,007,291	$ 3,205,391
Direct client and third party	4,319,686	4,346,544
Other	1,714,899	576,697
Total	$ 9,041,876	$ 8,128,632
Less: Allowances for uncollectibles	4,599,883	1,201,511
Net client fees receivable	$ 4,441,993	$ 6,927,121
Grants and other:		
Other	$ 281,919	$ 215,702
Total grants and other receivables	$ 281,919	$ 215,702
Total receivables	$ 4,723,912	$ 7,142,823

NOTE 4 - CAPITAL ASSETS:

Capital assets (including component units) consist of the following:

	Beginning Balances	Increases	Decreases	Ending Balances
Capital assets not being depreciated:				
Land	$ 3,377,168	$ -	$ -	$ 3,377,168
Construction in progress	4,160,956	334,832	205,432	4,290,356
Total capital assets not being depreciated	$ 7,538,124	$ 334,832	$ 205,432	$ 7,667,524
Capital assets being depreciated:				
Building and improvements	$ 28,560,842	$ 205,431	$ 2,617	$ 28,763,656
Lease buildings and improvements	297,775	-	-	297,775
Subscription assets	1,338,463	-	-	1,338,463
Equipment and vehicles	5,042,537	1,103,528	811,879	5,334,186
Total capital assets being depreciated	$ 35,239,617	$ 1,308,959	$ 814,496	$ 35,734,080
Accumulated depreciation:				
Building and improvements	$ 11,974,584	$ 1,004,233	$ -	$ 12,978,817
Lease buildings and improvements	138,306	74,089	-	212,395
Subscription assets	384,410	385,464	-	769,874
Equipment and vehicles	4,788,575	473,211	52,899	5,208,887
Total accumulated depreciation	$ 17,285,875	$ 1,936,997	$ 52,899	$ 19,169,973
Net capital assets being depreciated	$ 17,953,742	$ (628,038)	$ 761,597	$ 16,564,107
Net capital assets	$ 25,491,866	$ (293,206)	$ 967,029	$ 24,231,631

Total depreciation expense was $1,936,997 for 2024 and $2,000,040 for 2023.

NOTE 5 - COMPENSATED ABSENCES:

The Board has accrued the liability arising from compensated absences. Board employees earn leave based on length of service. The Board has outstanding accrued leave pay totaling $1,892,180 and $1,349,996 at June 30, 2024 and 2023, respectively. All of the leave balance is reported as current because the long-term portion is not determinable.

NOTE 6 - PENSION PLAN:

Plan Description

All full-time, salaried permanent employees of the Board are automatically covered by a VRS Retirement Plan upon employment. This is an agent multiple-employer plan administered by the Virginia Retirement System (the System) along with plans for other employer groups in the Commonwealth of Virginia. Members earn one month of service credit for each month they are employed and for which they and their employer pay contributions to VRS. Members are eligible to purchase prior service, based on specific criteria as defined in the Code of Virginia, as amended. Eligible prior service that may be purchased includes prior public service, active military service, certain periods of leave, and previously refunded service.

Benefit Structures

The System administers three different benefit structures for covered employees - Plan 1, Plan 2 and Hybrid. Each of these benefit structures has different eligibility criteria, as detailed below.

a. Employees with a membership date before July 1, 2010, vested as of January 1, 2013, and have not taken a refund, are covered under Plan 1, a defined benefit plan. Non-hazardous duty employees are eligible for an unreduced retirement benefit beginning at age 65 with at least 5 years of service credit or age 50 with at least 30 years of service credit. Non-hazardous duty employees may retire with a reduced benefit as early as age 55 with at least 5 years of service credit or age 50 with at least 10 years of service credit.

b. Employees with a membership date from July 1, 2010 to December 31, 2013, that have not taken a refund or employees with a membership date prior to July 1, 2010 and not vested before January 1, 2013, are covered under Plan 2, a defined benefit plan. Non-hazardous duty employees are eligible for an unreduced benefit beginning at their normal social security retirement age with at least 5 years of service credit or when the sum of their age plus service credit equals 90. Non-hazardous duty employees may retire with a reduced benefit as early as age 60 with at least 5 years of service credit.

c. Non-hazardous duty employees with a membership date on or after January 1, 2014 are covered by the Hybrid Plan combining the features of a defined benefit plan and a defined contribution plan. Plan 1 and Plan 2 members also had the option of opting into this plan during the election window held January 1 - April 30, 2014 with an effective date of July 1, 2014. Employees covered by this plan are eligible for an unreduced benefit beginning at their normal social security retirement age with at least 5 years of service credit, or when the sum of their age plus service credit equals 90. Employees may retire with a reduced benefit as early as age 60 with at least 5 years of service credit. For the defined contribution component, members are eligible to receive distributions upon leaving employment, subject to restrictions.

NOTE 6 - PENSION PLAN: (CONTINUED)

Average Final Compensation and Service Retirement Multiplier

The VRS defined benefit is a lifetime monthly benefit based on a retirement multiplier as a percentage of the employee's average final compensation multiplied by the employee's total service credit. Under Plan 1, average final compensation is the average of the employee's 36 consecutive months of highest compensation and the multiplier is 1.70% for non-hazardous duty employees. Under Plan 2, average final compensation is the average of the employee's 60 consecutive months of highest compensation and the retirement multiplier is 1.65% for non-hazardous duty employees. Under the Hybrid Plan, average final compensation is the average of the employee's 60 consecutive months of highest compensation and the multiplier is 1.00%. For members who opted into the Hybrid Retirement Plan from Plan 1 or Plan 2, the applicable multipliers for those plans will be used to calculate the retirement benefit for service credited in those plans.

Cost-of-Living Adjustment (COLA) in Retirement and Death and Disability Benefits

Retirees with an unreduced benefit or with a reduced benefit with at least 20 years of service credit are eligible for an annual COLA beginning July 1 after one full calendar year from the retirement date. Retirees with a reduced benefit and who have less than 20 years of service credit are eligible for an annual COLA beginning on July 1 after one calendar year following the unreduced retirement eligibility date. Under Plan 1, the COLA cannot exceed 5.00%. Under Plan 2 and the Hybrid Plan, the COLA cannot exceed 3.00%. The VRS also provides death and disability benefits. Title 51.1 of the Code of Virginia, as amended, assigns the authority to establish and amend benefit provisions to the General Assembly of Virginia.

Employees Covered by Benefit Terms

As of the June 30, 2022 actuarial valuation, the following employees were covered by the benefit terms of the pension plan:

	Number
Inactive members or their beneficiaries currently receiving benefits	172
Inactive members:	
Vested inactive members	144
Non-vested inactive members	400
Long-term disability (LTD)	4
Inactive members active elsewhere in VRS	166
Total inactive members	714
Active members	437
Total covered employees	1,323

NOTE 6 - PENSION PLAN: (CONTINUED)

Contributions

The contribution requirement for active employees is governed by §51.1-145 of the Code of Virginia, as amended, but may be impacted as a result of funding options provided to political subdivisions by the Virginia General Assembly. Employees are required to contribute 5.00% of their compensation toward their retirement.

The Board's contractually required employer contribution rate for the year ended June 30, 2024 was 3.07% of covered employee compensation. This rate was based on an actuarially determined rate from an actuarial valuation as of June 30, 2021.

This rate, when combined with employee contributions, was expected to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. Contributions to the pension plan from the Board were $522,595 and $462,878 for the years ended June 30, 2024 and June 30, 2023, respectively.

Net Pension Asset

The net pension asset (NPA) is calculated separately for each employer and represents that particular employer's total pension liability determined in accordance with GASB Statement No. 68, less that employer's fiduciary net position. For the Board, the net pension asset was measured as of June 30, 2023. The total pension liability used to calculate the net pension asset was determined by an actuarial valuation performed as of June 30, 2022, rolled forward to the measurement date of June 30, 2023.

Actuarial Assumptions - General Employees

The total pension liability for General Employees in the Board's Retirement Plan was based on an actuarial valuation as of June 30, 2022, using the Entry Age Normal actuarial cost method and the following assumptions, applied to all periods included in the measurement and rolled forward to the measurement date of June 30, 2023.

Inflation	2.50%
Salary increases, including inflation	3.50% - 5.35%
Investment rate of return	6.75%, net of pension plan investment expenses, including inflation

NOTE 6 - PENSION PLAN: (CONTINUED)

Actuarial Assumptions - General Employees (Continued)

Mortality rates:

All Others (Non-10 Largest) - Non-Hazardous Duty: 15% of deaths are assumed to be service related

Pre-Retirement:
Pub-2010 Amount Weighted Safety Employee Rates projected generationally; 95% of rates for males; 105% of rates for females set forward 2 years

Post-Retirement:
Pub-2010 Amount Weighted Safety Healthy Retiree Rates projected generationally; 110% of rates for males; 105% of rates for females set forward 3 years

Post-Disablement:
Pub-2010 Amount Weighted General Disabled Rates projected generationally; 95% of rates for males set back 3 years; 90% of rates for females set back 3 years

Beneficiaries and Survivors:
Pub-2010 Amount Weighted Safety Contingent Annuitant Rates projected generationally; 110% of rates for males and females set forward 2 years

Mortality Improvement:
Rates projected generationally with Modified MP-2020 Improvement Scale that is 75% of the MP-2020 rates

The actuarial assumptions used in the June 30, 2022 valuation were based on the results of an actuarial experience study for the period from July 1, 2016 through June 30, 2020, except the change in the discount rate, which was based on VRS Board action effective as of July 1, 2021. Changes to the actuarial assumptions as a result of the experience study and VRS Board action are as follows:

All Others (Non-10 Largest) - Non-Hazardous Duty:

Mortality Rates (pre-retirement, post-retirement healthy, and disabled)	Update to Pub-2010 public sector mortality tables. For future mortality improvements, replace load with a modified Mortality Improvement Scale MP-2020
Retirement Rates	Adjusted rates to better fit experience for Plan 1; set separate rates based on experience for Plan 2/Hybrid; changed final retirement age
Withdrawal Rates	Adjusted rates to better fit experience at each age and service decrement through 9 years of service
Disability Rates	No change
Salary Scale	No change
Line of Duty Disability	No change
Discount Rate	No change

NOTE 6 - PENSION PLAN: (CONTINUED)

Long-Term Expected Rate of Return

The long-term expected rate of return on pension System investments was determined using a log-normal distribution analysis in which best-estimate ranges of expected future real rates of return (expected returns, net of pension System investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The target asset allocation and best estimate of arithmetic real rates of return for each major asset class are summarized in the following table:

Asset Class (Strategy)	Long-term Target Asset Allocation	Arithmetic Long-Term Expected Rate of Return	Weighted Average Long-Term Expected Rate of Return*
Public Equity	34.00%	6.14%	2.09%
Fixed Income	15.00%	2.56%	0.38%
Credit Strategies	14.00%	5.60%	0.78%
Real Assets	14.00%	5.02%	0.70%
Private Equity	16.00%	9.17%	1.47%
MAPS - Multi-Asset Public Strategies	4.00%	4.50%	0.18%
PIP - Private Investment Partnership	2.00%	7.18%	0.14%
Cash	1.00%	1.20%	0.01%
Total	100.00%		5.75%
		Inflation	2.50%
		**Expected arithmetic nominal return	8.25%

* The above allocation provides a one-year expected return of 8.25%. However, one-year returns do not take into account the volatility present in each of the asset classes. In setting the long-term expected return for the System, stochastic projections are employed to model future returns under various economic conditions. These results provide a range of returns over various time periods that ultimately provide a median return of 7.14%, including expected inflation of 2.50%.

**On June 15, 2023, the VRS Board elected a long-term rate of return of 6.75% which is roughly at the 45th percentile of expected long-term results of the VRS fund asset allocation at that time, providing a median return of 7.14%, including expected inflation of 2.50%.

NOTE 6 - PENSION PLAN: (CONTINUED)

Discount Rate

The discount rate used to measure the total pension liability was 6.75%. The projection of cash flows used to determine the discount rate assumed that System member contributions will be made per the VRS Statutes and the employer contributions will be made in accordance with the VRS funding policy at rates equal to the difference between actuarially determined contribution rates adopted by the VRS Board of Trustees and the member rate. Consistent with the phased-in funding provided by the General Assembly for state and teacher employer contributions; the Board was also provided with an opportunity to use an alternative employer contribution rate. For the year ended June 30, 2023, the alternate rate was the employer contribution rate used in FY 2012 or 100% of the actuarially determined employer contribution rate from the June 30, 2022 actuarial valuations, whichever was greater. From July 1, 2023 on, participating employers are assumed to continue to contribute 100% of the actuarially determined contribution rates. Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees. Therefore, the long-term expected rate of return was applied to all periods of projected benefit payments to determine the total pension liability.

Changes in Net Pension Asset

	Increase (Decrease)		
	Total Pension Liability (a)	Plan Fiduciary Net Position (b)	Net Pension Liability (Asset) (a) - (b)
Balances at June 30, 2022	$ 49,689,831	$ 56,576,131	$ (6,886,300)
Changes for the year:			
Service cost	$ 1,719,786	$ -	$ 1,719,786
Interest	3,398,781	-	3,398,781
Differences between expected and actual experience	(1,389,495)	-	(1,389,495)
Contributions - employer	-	474,723	(474,723)
Contributions - employee	-	1,108,540	(1,108,540)
Net investment income	-	3,659,336	(3,659,336)
Benefit payments, including refunds of employee contributions	(2,114,618)	(2,114,618)	-
Administrative expenses	-	(36,037)	36,037
Other changes	-	1,477	(1,477)
Net changes	$ 1,614,454	$ 3,093,421	$ (1,478,967)
Balances at June 30, 2023	$ 51,304,285	$ 59,669,552	$ (8,365,267)

NOTE 6 - PENSION PLAN: (CONTINUED)

Sensitivity of the Net Pension Asset to Changes in the Discount Rate

The following presents the net pension asset of the Board using the discount rate of 6.75%, as well as what the Board's net pension asset would be if it were calculated using a discount rate that is one percentage point lower (5.75%) or one percentage point higher (7.75%) than the current rate:

	Rate		
	1% Decrease (5.75%)	Current Discount (6.75%)	1% Increase (7.75%)
Board's Net Pension Liability (Asset)	$ (227,701)	$ (8,365,267)	$ (14,667,686)

Pension Expense and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions

For the year ended June 30, 2024, the Board recognized pension expense of ($641,753). At June 30, 2024, the Board reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 8,596	$ 805,674
Net difference between projected and actual earnings on pension plan investments	-	844,740
Employer contributions subsequent to the measurement date	522,595	-
Total	$ 531,191	$ 1,650,414

NOTE 6 - PENSION PLAN: (CONTINUED)

Pension Expense and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions (Continued)

There was $522,595 reported as deferred outflows of resources related to pensions resulting from the Board's contributions subsequent to the measurement date will be recognized as a reduction of the Net Pension Liability in the fiscal year ending June 30, 2025. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense in future reporting periods as follows:

Year ended June 30		
2025	$	(1,202,199)
2026		(1,277,511)
2027		809,803
2028		28,089
2029		-
Thereafter		-

Pension Plan Data

Information about the VRS Political Subdivision Retirement Plan is also available in the separately issued VRS 2023 Annual Comprehensive Financial Report (Annual Report). A copy of the 2023 VRS Annual Report may be downloaded from the VRS website at https://www.varetire.org/pdf/publications/2023-annual-report.pdf, or by writing to the System's Chief Financial Officer at P.O. Box 2500, Richmond, VA 23218-2500.

NOTE 7 - LONG-TERM LIABILITIES:

Summary of Changes in Long-Term Liabilities:

Changes in the Board's long-term liabilities for the year ended June 30, 2024, are as follows:

	Balance July 1, 2023	Increases	Decreases	Balance June 30, 2024	Current Portion
Net OPEB liability:					
Group life Insurance	$ 1,286,095	$ 520,612	$ 558,222	$ 1,248,485	$ -
HIC	-	17,256	15,541	1,715	-
Total net OPEB liability	$ 1,286,095	$ 537,868	$ 573,763	$ 1,250,200	$ -
Lease liabilites	$ 163,767	$ -	$ 74,543	$ 89,224	$ 38,462
Subscription liabilites	$ 902,198	$	$ 446,081	$ 456,117	$ 456,117
Total	$ 2,352,060	$ 537,868	$ 1,094,387	$ 1,795,541	$ 494,579

NOTE 7 - LONG-TERM LIABILITIES: (CONTINUED)

Leases

The Board has entered into lease agreements for two buildings. The terms and conditions for these leases vary. The leases have fixed, monthly payments over the lease term. Individual lease information for long-term leases held as of June 30, 2024 is presented below.

Lease Description	Initial Term	Installments	Discount Rate	Year
Building - 4605 Carr Drive	60 Months	$3,065 per month	2.00%	2025
Building - 4815 Carr Drive	60 Months	$3,196 per month	1.75%	2026
				2027

The future principal and interest payments as of June 30, 2024 were as follows:

Lease Liabilities			Subscription Liabilities		
Principal	Interest	Total	Principal	Interest	Total
$ 38,462	$ -	$ 38,462	$ 456,117	$ -	$ 456,117
40,447	-	40,447	-	-	-
10,315	-	10,315	-	-	-
$ 89,224	$ -	$ 89,224	$ 456,117	$ -	$ 456,117

NOTE 8 - DEFERRED COMPENSATION PLAN:

The Board provides a deferred compensation plan whereby eligible employees elect to defer a portion of their compensation until some later date. The amount deferred is placed in a contract on behalf of the participant where it is not subject to federal income tax until withdrawn. The Board does not contribute to this plan. The plan assets are not subject to claims of the Board's creditors.

NOTE 9 - COMMITMENTS AND CONTINGENCIES:

Federal programs in which the Board participates were audited in accordance with the provisions of Uniform Guidance. Pursuant to the provisions of this guidance all major programs were tested for compliance with applicable grant requirements. While no matters of noncompliance were disclosed by audit, the federal government may subject grant programs to additional compliance tests which may result in disallowed expenditures. In the opinion of management, any future disallowances of current grant program expenditures, if any, would be immaterial.

NOTE 10 - RISK MANAGEMENT:

The Board participates in the Commonwealth of Virginia Risk Sharing Association for general, professional liability, and directors and officers liability coverage which have up to $1,700,000 per occurrence of coverage limits. Other insurance coverage for property, workers compensation, crime, dishonesty and related coverage are purchased from a commercial insurance carrier. Coverage for these items varies from stated property values to $1,000,000. There are no surety bonds for directors. The Board assumes risks related to co-insurance, policy deductibles and claims which exceed insurance coverage. There have been no settlements that have exceeded the insurance coverage in the last three years and there has been no reduction in the amount of insurance coverage from the prior year.

Employee Health Insurance:

The Board has a self-insurance plan for its employee health program. The program is administered by a private insurance carrier. Premium payments are based on the number of employees insured and benefits.

Claims liabilities are reevaluated periodically to take into consideration recently settled claims, the frequency of claims and other economic and social factors. Incurred but not reported claims have been accrued based upon history and estimates from the insurance carrier.

Fiscal Year Ended	Estimated Claims Liability Beginning of Fiscal Year	Current Year Claims and Changes in Estimates	Claims Payments	Estimated Claims Liability End of Fiscal Year
June 30, 2024	$ 1,343,472	$ 4,551,000	$ 3,109,169	$ 2,785,303
June 30, 2023	-	4,591,623	3,248,151	1,343,472
June 30, 2022	48,256	3,614,209	3,662,465	-

NOTE 11 - CONTRIBUTIONS FROM LOCAL PARTICIPATING GOVERNMENTAL UNITS:

The participating local governmental units contributed funds for the Board's operations as follows:

	2024	2023
City of Fredericksburg	$ 356,713	$ 302,359
County of Spotsylvania	671,439	575,164
County of Stafford	662,586	718,457
County of Caroline	131,961	124,492
County of King George	166,173	144,498
Total	$ 1,988,872	$ 1,864,970

NOTE 12 - NET PATIENT SERVICE REVENUE SOURCES:

Net patient service revenues for 2024 and 2023 were from the following sources:

	2024	2023
Medicaid	$ 23,962,096	$ 29,714,021
Direct client and third party	1,211,748	904,201
Other	4,557,995	4,037,971
Total	$ 29,731,839	$ 34,656,193

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB):

Group Life Insurance (GLI) Plan (OPEB Plan):

Plan Description

The Group Life Insurance (GLI) Plan was established pursuant to §51.1-500 et seq. of the Code of Virginia, as amended, and which provides the authority under which benefit terms are established or may be amended. All full-time, salaried permanent employees of the state agencies, teachers, and employees of participating political subdivisions are automatically covered by the VRS GLI Plan upon employment. This is a cost-sharing multiple-employer plan administered by the Virginia Retirement System (the System), along with pensions and other OPEB plans, for public employer groups in the Commonwealth of Virginia.

In addition to the Basic GLI benefit, members are also eligible to elect additional coverage for themselves as well as a spouse or dependent children through the Optional GLI Plan. For members who elect the optional GLI coverage, the insurer bills employers directly for the premiums. Employers deduct these premiums from members' paychecks and pay the premiums to the insurer. Since this is a separate and fully insured plan, it is not included as part of the GLI Plan OPEB.

The specific information for GLI OPEB, including eligibility, coverage and benefits is described below:

Eligible Employees

The GLI Plan was established July 1, 1960, for state employees, teachers, and employees of political subdivisions that elect the plan. Basic GLI coverage is automatic upon employment. Coverage ends for employees who leave their position before retirement eligibility or who take a refund of their accumulated retirement member contributions and accrued interest.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Group Life Insurance (GLI) Plan (OPEB Plan): (Continued)

Benefit Amounts

The GLI Plan is a defined benefit plan with several components. The natural death benefit is equal to the employee's covered compensation rounded to the next highest thousand and then doubled. The accidental death benefit is double the natural death benefit. In addition to basic natural and accidental death benefits, the plan provides additional benefits provided under specific circumstances that include the following: accidental dismemberment benefit, seatbelt benefit, repatriation benefit, felonious assault benefit, and accelerated death benefit option. The benefit amounts are subject to a reduction factor. The benefit amount reduces by 25% on January 1 following one calendar year of separation. The benefit amount reduces by an additional 25% on each subsequent January 1 until it reaches 25% of its original value. For covered members with at least 30 years of service credit, the minimum benefit payable was set at $8,000 by statute in 2015. This will be increased annually based on the VRS Plan 2 cost-of-living adjustment calculation. The minimum benefit adjusted for the COLA was $9,254 as of June 30, 2024.

Contributions

The contribution requirements for the GLI Plan are governed by §51.1-506 and §51.1-508 of the Code of Virginia, as amended, but may be impacted as a result of funding provided to state agencies and school divisions by the Virginia General Assembly. The total rate for the GLI Plan was 1.34% of covered employee compensation. This was allocated into an employee and an employer component using a 60/40 split. The employee component was 0.80% (1.34% x 60%) and the employer component was 0.54% (1.34% x 40%). Employers may elect to pay all or part of the employee contribution; however, the employer must pay all of the employer contribution. Each employer's contractually required employer contribution rate for the year ended June 30, 2024 was 0.54% of covered employee compensation. This rate was the final approved General Assembly rate, which was based on an actuarially determined rate from an actuarial valuation as of June 30, 2021. The actuarially determined rate, when combined with employee contributions, was expected to finance the costs of benefits payable during the year, with an additional amount to finance any unfunded accrued liability. Contributions to the GLI Plan from the entity were $157,559 and $132,413 for the years ended June 30, 2024 and June 30, 2023, respectively.

In June 2023, the Commonwealth made a special contribution of approximately $10.1 million to the Group Life Insurance Plan. This special payment was authorized by Chapter 2 of the Acts of Assembly of 2022, Special Session I, as amended by Chapter 769, 2023 Acts of Assembly Reconvened Session, and is classified as a special employer contribution. The entity's proportionate share is reflected in the State revenues of the financial statements.

GLI OPEB Liabilities, GLI OPEB Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to the GLI Plan OPEB

At June 30, 2024, the entity reported a liability of $1,248,485 for its proportionate share of the Net GLI OPEB Liability. The Net GLI OPEB Liability was measured as of June 30, 2023 and the total GLI OPEB liability used to calculate the Net GLI OPEB Liability was determined by an actuarial valuation performed as of June 30, 2022, and rolled forward to the measurement date of June 30, 2023. The covered employer's proportion of the Net GLI OPEB Liability was based on the covered employer's actuarially determined employer contributions to the GLI Plan for the year ended June 30, 2023 relative to the total of the actuarially determined employer contributions for all participating employers. At June 30, 2023, the participating employer's proportion was .1041% as compared to .1068% at June 30, 2022.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Group Life Insurance (GLI) Plan (OPEB Plan): (Continued)

GLI OPEB Liabilities, GLI OPEB Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to the GLI Plan OPEB (Continued)

For the year ended June 30, 2024, the participating employer recognized GLI OPEB expense of $66,766. Since there was a change in proportionate share between measurement dates, a portion of the GLI OPEB expense was related to deferred amounts from changes in proportion.

At June 30, 2024, the employer reported deferred outflows of resources and deferred inflows of resources related to the GLI OPEB from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 124,693	$ 37,898
Net difference between projected and actual earnings on GLI OPEB program investments	-	50,171
Change in assumptions	26,687	86,500
Changes in proportionate share	22,343	47,909
Employer contributions subsequent to the measurement date	157,559	-
Total	$ 331,282	$ 222,478

$157,559 was reported as deferred outflows of resources related to the GLI OPEB resulting from the employer's contributions subsequent to the measurement date will be recognized as a reduction of the Net GLI OPEB Liability in the fiscal year ending June 30, 2025. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to the GLI OPEB will be recognized in the GLI OPEB expense in future reporting periods as follows:

Year Ended June 30	
2025	$ (8,101)
2026	(53,646)
2027	14,089
2028	(7,774)
2029	6,677
Thereafter	-

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Group Life Insurance (GLI) Plan (OPEB Plan): (Continued)

Actuarial Assumptions

The total GLI OPEB liability was based on an actuarial valuation as of June 30, 2022, using the Entry Age Normal actuarial cost method and the following assumptions, applied to all periods included in the measurement and rolled forward to the measurement date of June 30, 2023. The assumptions include several employer groups. Salary increases and mortality rates included herein are for relevant employer groups. Information for other groups can be referenced in the VRS Annual Report.

Inflation	2.50%
Salary increases, including inflation:	
Locality - General employees	3.50%-5.35%
Investment rate of return	6.75%, net of program investment expenses, including inflation

Mortality Rates - Non-Largest Ten Locality Employers - General Employees

Pre-Retirement:
Pub-2010 Amount Weighted Safety Employee Rates projected generationally; males set forward 2 years; 105% of rates for females set forward 3 years

Post-Retirement:
Pub-2010 Amount Weighted Safety Healthy Retiree Rates projected generationally; 95% of rates for males set forward 2 years; 95% of rates for females set forward 1 year

Post-Disablement:
Pub-2010 Amount Weighted General Disabled Rates projected generationally; 110% of rates for males set forward 3 years; 110% of rates for females set forward 2 years

Beneficiaries and Survivors:
Pub-2010 Amount Weighted Safety Contingent Annuitant Rates projected generationally

Mortality Improvement Scale:
Rates projected generationally with Modified MP-2020 Improvement Scale that is 75% of the MP-2020 rates

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Group Life Insurance (GLI) Plan (OPEB Plan): (Continued)

Actuarial Assumptions: (Continued)

The actuarial assumptions used in the June 30, 2022 valuation were based on the results of an actuarial experience study for the period from July 1, 2016 through June 30, 2020, except the change in the discount rate, which was based on VRS Board action effective as of July 1, 2021. Changes to the actuarial assumptions as a result of the experience study and VRS Board action are as follows:

Mortality Rates (pre-retirement, post-retirement healthy, and disabled)	Update to Pub-2010 public sector mortality tables. For future mortality improvements, replace load with a modified Mortality Improvement Scale MP-2020
Retirement Rates	Adjusted rates to better fit experience for Plan 1; set separate rates based on experience for Plan 2/Hybrid; changed final retirement age from 75 to 80 for all
Withdrawal Rates	Adjusted rates to better fit experience at each age and service decrement through 9 years of service
Disability Rates	No change
Salary Scale	No change
Line of Duty Disability	No change
Discount Rate	No change

NET GLI OPEB Liability

The net OPEB liability (NOL) for the GLI Plan represents the plan's total OPEB liability determined in accordance with GASB Statement No. 74, less the associated fiduciary net position. As of the measurement date of June 30, 2023, NOL amounts for the GLI Plan are as follows (amounts expressed in thousands):

		GLI OPEB Plan
Total GLI OPEB Liability	$	3,907,052
Plan Fiduciary Net Position		2,707,739
GLI Net OPEB Liability	$	1,199,313
Plan Fiduciary Net Position as a Percentage of the Total GLI OPEB Liability		69.30%

The total GLI OPEB liability is calculated by the System's actuary, and each plan's fiduciary net position is reported in the System's financial statements. The net GLI OPEB liability is disclosed in accordance with the requirements of GASB Statement No. 74 in the System's notes to the financial statements and required supplementary information.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Group Life Insurance (GLI) Plan (OPEB Plan): (Continued)

Long-Term Expected Rate of Return

The long-term expected rate of return on the System's investments was determined using a log-normal distribution analysis in which best-estimate ranges of expected future real rates of return (expected returns, net of System's investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The target asset allocation and best estimate of arithmetic real rates of return for each major asset class are summarized in the following table:

Asset Class (Strategy)	Long-term Target Asset Allocation	Arithmetic Long-term Expected Rate of Return	Weighted Average Long-term Expected Rate of Return*
Public Equity	34.00%	6.14%	2.09%
Fixed Income	15.00%	2.56%	0.38%
Credit Strategies	14.00%	5.60%	0.78%
Real Assets	14.00%	5.02%	0.70%
Private Equity	16.00%	9.17%	1.47%
MAPS - Multi-Asset Public Strategies	4.00%	4.50%	0.18%
PIP - Private Investment Partnership	2.00%	7.18%	0.14%
Cash	1.00%	1.20%	0.01%
Total	100.00%		5.75%
		Inflation	2.50%
		**Expected arithmetic nominal return	8.25%

*The above allocation provides a one-year return of 8.25%. However, one-year returns do not take into account the volatility present in each of the asset classes. In setting the long-term expected return for the System, stochastic projections are employed to model future returns under various economic conditions. These results provide a range of returns over various time periods that ultimately provide a median return of 7.14%, including expected inflation of 2.50%.

**On June 15, 2023, the VRS Board elected a long-term rate of return of 6.75% which was roughly at the 40th percentile of expected long-term results of the VRS fund asset allocation at that time, providing a median return of 7.14%, including expected inflation of 2.50%.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Group Life Insurance (GLI) Plan (OPEB Plan): (Continued)

Discount Rate

The discount rate used to measure the total GLI OPEB liability was 6.75%. The projection of cash flows used to determine the discount rate assumed that employer contributions will be made in accordance with the VRS funding policy and at rates equal to the actuarially determined contribution rates adopted by the VRS Board of Trustees. Through the fiscal year ended June 30, 2023, the rate contributed by the entity for the GLI OPEB will be subject to the portion of the VRS Board-certified rates that are funded by the Virginia General Assembly which was 113% of the actuarially determined contribution rate. From July 1, 2023 on, employers are assumed to contribute 100% of the actuarially determined contribution rates. Based on those assumptions, the GLI OPEB's fiduciary net position was projected to be available to make all projected future benefit payments of eligible employees. Therefore, the long-term expected rate of return was applied to all periods of projected benefit payments to determine the total GLI OPEB liability.

Sensitivity of the Employer's Proportionate Share of the Net GLI OPEB Liability to Changes in the Discount Rate

The following presents the employer's proportionate share of the net GLI OPEB liability using the discount rate of 6.75%, as well as what the employer's proportionate share of the net GLI OPEB liability would be if it were calculated using a discount rate that is one percentage point lower (5.75%) or one percentage point higher (7.75%) than the current rate:

	Rate		
	1% Decrease (5.75%)	Current Discount (6.75%)	1% Increase (7.75%)
Board's proportionate share of the Group Life Insurance Plan Net OPEB Liability	$ 1,850,645	$ 1,248,485	$ 761,635

GLI Plan Fiduciary Net Position

Detailed information about the GLI Program's Fiduciary Net Position is available in the separately issued VRS 2023 Annual Comprehensive Financial Report (Annual Report). A copy of the 2023 VRS Annual Report may be downloaded from the VRS website at http://www.varetire.org/pdf/publications/2023-annual-report.pdf, or by writing to the System's Chief Financial Officer at P.O. Box 2500, Richmond, VA, 23218-2500.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Virginia Local Disability Program (VLDP) (OPEB Plan):

Plan Description

Political subdivisions are required by Title 51.1 of the Code of Virginia, as amended, to provide short-term and long-term disability benefits for their hybrid plan employees either through a local plan or through the Virginia Local Disability Program (VLDP). This is a multiple-employer, cost-sharing plan administered by the Virginia Retirement System (the System), along with pension and other OPEB plans, for eligible public employer groups in the Commonwealth of Virginia.

The specific information for the VLDP OPEB, including eligibility, coverage, and benefits is described below:

Eligible Employees

The Political Subdivision VLDP was implemented January 1, 2014 to provide benefits for non-work-related and work-related disabilities for employees with hybrid plan retirement benefits. All full-time, salaried general employees; including local law enforcement officers, firefighters, or emergency medical technicians of political subdivisions who do not provide enhanced hazardous duty benefits; who are in the VRS Hybrid Retirement Plan benefit structure and whose employer has not elected to opt out of the VRS-sponsored program are automatically covered by the VRS Political Subdivision VLDP.

Benefit Amounts

The VLDP provides a short-term disability benefit beginning after a seven-calendar-day waiting period from the first day of disability. Employees become eligible for non-work-related short-term disability coverage after one year of continuous participation in VLDP with their current employer. During the first five years of continuous participation in VLDP with their current employer, employees are eligible for 60% of their pre-disability income if they go out on non-work-related or work-related disability. Once the eligibility period is satisfied, employees are eligible for higher income replacement levels.

The VLDP provides a long-term disability benefit beginning after 125 workdays of short-term disability. Members are eligible if they are unable to work at all or are working fewer than 20 hours per week. Members approved for long-term disability will receive 60% of their pre-disability income. If approved for work-related long-term disability, the VLDP benefit will be offset by the workers' compensation benefit. Members will not receive a VLDP benefit if their workers' compensation benefit is greater than the VLDP benefit.

VLDP Notes

Members approved for short-term or long-term disability at age 60 or older will be eligible for a benefit, provided they remain medically eligible. VLDP Long-Term Care Plan is a self-funded program that assists with the cost of covered long-term care services.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Virginia Local Disability Program (VLDP) (OPEB Plan): (Continued)

Contributions

The contribution requirements for active hybrid plan employees is governed by §51.1-1178(C) of the Code of Virginia, as amended, but may be impacted as a result of funding provided to political subdivisions by the Virginia General Assembly. Each political subdivision's contractually required employer contribution rate for the year ended June 30, 2024 was 0.85% of covered employee compensation for employees in the VRS Political Subdivision VDLP. This rate was based on an actuarially determined rate from an actuarial valuation as of June 30, 2021. The actuarially determined rate was expected to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. Contributions from the Board to the VRS Political Subdivision VDLP were $168,257 and $132,958 for the years ended June 30, 2024 and June 30, 2023, respectively.

VLDP OPEB Liabilities, VLDP OPEB Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to VLDP OPEB

At June 30, 2024, the Board reported an asset of $41,120 for its proportionate share of the VLDP Net OPEB Asset. The Net VLDP OPEB Asset was measured as of June 30, 2023 and the total VLDP OPEB liability used to calculate the Net VLDP OPEB Asset was determined by an actuarial valuation as of June 30, 2022, and rolled forward to the measurement date of June 30, 2023. The Board's proportion of the Net VLDP OPEB Asset was based on the Board's actuarially determined employer contributions to the VLDP OPEB plan for the year ended June 30, 2023 relative to the total of the actuarially determined employer contributions for all participating employers. At June 30, 2023, the Board's proportion of the VLDP was 2.5556% as compared to 3.0124% at June 30, 2022.

For the year ended June 30, 2024, the Board recognized VLDP OPEB expense of $103,083. Since there was a change in proportionate share between measurement dates a portion of the VLDP Net OPEB expense was related to deferred amounts from changes in proportion.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Virginia Local Disability Program (VLDP) (OPEB Plan): (Continued)

VLDP OPEB Liabilities, VLDP OPEB Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to VLDP OPEB: (Continued)

At June 30, 2024, the Board reported deferred outflows of resources and deferred inflows of resources related to the VLDP OPEB from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 15,438	$ 25,617
Net difference between projected and actual earnings on VLDP OPEB plan investments	100	-
Change in assumptions	273	3,766
Changes in proportion and differences between employer contributions and proportionate share of contributions	56	2,264
Employer contributions subsequent to the measurement date	168,257	-
Total	$ 184,124	$ 31,647

$168,257 was reported as deferred outflows of resources related to the VLDP OPEB resulting from the Board's contributions subsequent to the measurement date will be recognized as a reduction of the Net VLDP OPEB Liability in the fiscal year ending June 30, 2025. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to the VLDP OPEB will be recognized in the VLDP OPEB expense in future reporting periods as follows:

Year Ended June 30	
2025	$ (2,080)
2026	(7,183)
2027	659
2028	(1,177)
2029	(2,747)
Thereafter	(3,252)

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Virginia Local Disability Program (VLDP) (OPEB Plan): (Continued)

Actuarial Assumptions

The total VLDP OPEB liability for the VLDP was based on an actuarial valuation as of June 30, 2022, using the Entry Age Normal actuarial cost method and the following assumptions, applied to all periods included in the measurement and rolled forward to the measurement date of June 30, 2023.

Inflation	2.50%
Salary increases, including inflation	3.50%-5.35%
Investment rate of return	6.75%, net of program investment expenses, including inflation

Mortality Rates - Non-Largest Ten Locality Employers - General and Non-Hazardous Duty Employees

Pre-Retirement:
Pub-2010 Amount Weighted General Employee Rates projected generationally; males set forward 2 years; 105% of rates for females set forward 3 years

Post-Retirement:
Pub-2010 Amount Weighted General Healthy Retiree Rates projected generationally; 95% of rates for males set forward 2 years; 95% of rates for females set forward 1 year

Post-Disablement:
Pub-2010 Amount Weighted General Disabled Rates projected generationally; 110% of rates for males set forward 3 years; 110% of rates for females set forward 2 years

Beneficiaries and Survivors:
Pub-2010 Amount Weighted General Contingent Annuitant Rates projected generationally

Mortality Improvement Scale:
Rates projected generationally with Modified MP-2020 Improvement Scale that is 75% of the MP-2020 rates

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Virginia Local Disability Program (VLDP) (OPEB Plan): (Continued)

Actuarial Assumptions: (Continued)

The actuarial assumptions used in the June 30, 2022 valuation were based on the results of an actuarial experience study for the period from July 1, 2016 through June 30, 2020, except the change in the discount rate, which was based on VRS Board action effective as of July 1, 2021. Changes to the actuarial assumptions as a result of the experience study and VRS Board action are as follows:

Mortality Rates (pre-retirement, post-retirement healthy, and disabled)	Update to Pub-2010 public sector mortality tables. For future mortality improvements, replace load with a modified Mortality Improvement Scale MP-2020
Retirement Rates	Adjusted rates to better fit experience for Plan 1; set separate rates based on experience for Plan 2/Hybrid; changed final retirement age from 75 to 80 for all
Withdrawal Rates	Adjusted rates to better fit experience at each age and service decrement through 9 years of service
Disability Rates	No change
Salary Scale	No change
Line of Duty Disability	No change
Discount Rate	No change

Net VLDP OPEB Liability

The net OPEB liability (NOL) for the Political Subdivision VLDP represents the program's total OPEB liability determined in accordance with GASB Statement No. 74, less the associated fiduciary net position. As of June 30, 2023, NOL amounts for the VRS Political Subdivision VLDP is as follows (amounts expressed in thousands):

	Political Subdivision VLDP OPEB Plan
Total Political Subdivision VLDP OPEB Liability	$ 9,525
Plan Fiduciary Net Position	11,134
Political Subdivision net VLDP OPEB Liability (Asset)	$ (1,609)
Plan Fiduciary Net Position as a Percentage of the Total Political Subdivision VLDP OPEB Liability	116.89%

The total Political Subdivision VLDP OPEB liability is calculated by the System's actuary, and the plan's fiduciary net position is reported in the System's financial statements. The net Political Subdivision VLDP OPEB liability is disclosed in accordance with the requirements of GASB Statement No. 74 in the System's notes to the financial statements and required supplementary information.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Virginia Local Disability Program (VLDP) (OPEB Plan): (Continued)

Long-Term Expected Rate of Return

The long-term expected rate of return on VRS System investments was determined using a log-normal distribution analysis in which best-estimate ranges of expected future real rates of return (expected returns, net of VRS System investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The target asset allocation and best estimate of arithmetic real rates of return for each major asset class are summarized in the following table:

Asset Class (Strategy)	Target Allocation	Arithmetic Long-term Expected Rate of Return	Weighted Average Long-term Expected Rate of Return*
Public Equity	34.00%	6.14%	2.09%
Fixed Income	15.00%	2.56%	0.38%
Credit Strategies	14.00%	5.60%	0.78%
Real Assets	14.00%	5.02%	0.70%
Private Equity	16.00%	9.17%	1.47%
MAPS - Multi-Asset Public Strategies	4.00%	4.50%	0.18%
PIP - Private Investment Partnership	2.00%	7.18%	0.14%
Cash	1.00%	1.20%	0.01%
Total	100.00%		5.75%
		Inflation	2.50%
		Expected arithmetic nominal return**	8.25%

*The above allocation provides a one-year return of 8.25%. However, one-year returns do not take into account the volatility present in each of the asset classes. In setting the long-term expected return for the System, stochastic projections are employed to model future returns under various economic conditions. These results provide a range of returns over various time periods that ultimately provide a median return of 7.14%, including expected inflation of 2.50%.

**On June 15, 2023, the VRS Board elected a long-term rate of return of 6.75% which was roughly at the 45th percentile of expected long-term results of the VRS fund asset allocation at that time, providing a median return of 7.14%, including expected inflation of 2.50%.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Virginia Local Disability Program (VLDP) (OPEB Plan): (Continued)

Discount Rate

The discount rate used to measure the total VLDP OPEB was 6.75%. The projection of cash flows used to determine the discount rate assumed that employer contributions will be made in accordance with the VRS funding policy at rates equal to the actuarially determined contribution rates adopted by the VRS Board of Trustees. Through the fiscal year ended June 30, 2023, the rate contributed by the Board for the VLDP was subject to the portion of the VRS Board-certified rates that are funded by the Virginia General Assembly, which was 100% of the actuarially determined contribution rate. From July 1, 2023 on, all agencies are assumed to continue to contribute 100% of the actuarially determined contribution rates. Based on those assumptions, the VLDP OPEB plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees. Therefore, the long-term expected rate of return was applied to all periods of projected benefit payments to determine the total VLDP OPEB liability.

Sensitivity of the Board's Proportionate Share of the VLDP Net OPEB Liability to Changes in the Discount Rate

The following presents the Board's proportionate share of the net VLDP OPEB liability using the discount rate of 6.75%, as well as what the Board's proportionate share of the net VLDP OPEB liability would be if it were calculated using a discount rate that is one percentage point lower (5.75%) or one percentage point higher (7.75%) than the current rate:

	Rate		
	1% Decrease (5.75%)	Current Discount (6.75%)	1% Increase (7.75%)
Board's proportionate share of the Net VLDP OPEB Liability	$ (21,545)	$ (41,120)	$ (58,273)

VLDP OPEB Fiduciary Net Position

Detailed information about the VRS Political Subdivision VLDP's Fiduciary Net Position is available in the separately issued VRS 2023 Annual Comprehensive Financial Report (Annual Report). A copy of the 2023 VRS Annual Report may be downloaded from the VRS website at https://www.varetire.org/pdf/publications/ 2023-annual-report.pdf, or by writing to the System's Chief Financial Officer at P.O. Box 2500, Richmond, VA, 23218-2500.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Health Insurance Credit (HIC) Plan (OPEB Plan):

Plan Description

The Political Subdivision Health Insurance Credit (HIC) Plan was established pursuant to §51.1-1400 et seq. of the Code of Virginia, as amended, and which provides the authority under which benefit terms are established or may be amended. All full-time, salaried permanent employees of participating political subdivisions are automatically covered by the VRS Political Subdivision HIC Plan upon employment. This is an agent multiple-employer plan administered by the Virginia Retirement System (the System), along with pension and other OPEB plans, for public employer groups in the Commonwealth of Virginia. Members earn one month of service credit toward the benefit for each month they are employed and for which their employer pays contributions to VRS. The HIC is a tax-free reimbursement in an amount set by the General Assembly for each year of service credit against qualified health insurance premiums retirees pay for single coverage, excluding any portion covering the spouse or dependents. The credit cannot exceed the amount of the premiums and ends upon the retiree's death. The specific information about the Political Subdivision HIC Plan OPEB, including eligibility, coverage and benefits is described below:

Eligible Employees

The Political Subdivision Retiree HIC Plan was established July 1, 1993 for retired political subdivision employees of employers who elect the benefit and retire with at least 15 years of service credit. Eligible employees include full-time permanent salaried employees of the participating political subdivision who are covered under the VRS pension plan. These employees are enrolled automatically upon employment.

Benefit Amounts

The Political Subdivision Retiree HIC Plan is a defined benefit plan that provides a credit toward the cost of health insurance coverage for retired political subdivision employees of participating employers. For employees who retire, the monthly benefit is $1.50 per year of service per month with a maximum benefit of $45.00 per month. For employees who retire on disability or go on long-term disability under the Virginia Local Disability Program (VLDP), the monthly benefit is $45.00 per month.

HIC Plan Notes

The monthly HIC benefit cannot exceed the individual premium amount. There is no HIC for premiums paid and qualified under LODA; however, the employee may receive the credit for premiums paid for other qualified health plans. Employees who retire after being on long-term disability under VLDP must have at least 15 years of service credit to qualify for the HIC as a retiree.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Health Insurance Credit (HIC) Plan (OPEB Plan): (Continued)

Employees Covered by Benefit Terms

As of the June 30, 2022 actuarial valuation, the following employees were covered by the benefit terms of the HIC OPEB plan:

	Number
Inactive members or their beneficiaries currently receiving benefits	41
Inactive members:	
Vested inactive members	8
Total inactive members	49
Active members	421
Total covered employees	470

Contributions

The contribution requirements for active employees is governed by §51.1-1402(E) of the Code of Virginia, as amended, but may be impacted as a result of funding options provided to political subdivisions by the Virginia General Assembly. The Board's contractually required employer contribution rate for the year ended June 30, 2024 was .04% of covered employee compensation. This rate was based on an actuarially determined rate from an actuarial valuation as of June 30, 2021. The actuarially determined rate was expected to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. Contributions from the Board to the HIC Plan were $11,634 and $9,785 for the years ended June 30, 2024 and June 30, 2023, respectively.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Health Insurance Credit (HIC) Plan (OPEB Plan): (Continued)

Net HIC OPEB Liability (Asset)

The Board's net HIC OPEB liability (asset) was measured as of June 30, 2023. The total HIC OPEB liability was determined by an actuarial valuation performed as of June 30, 2022, using updated actuarial assumptions, applied to all periods included in the measurement and rolled forward to the measurement date of June 30, 2023.

Actuarial Assumptions

The total HIC OPEB liability was based on an actuarial valuation as of June 30, 2022, using the Entry Age Normal actuarial cost method and the following assumptions, applied to all periods included in the measurement and rolled forward to the measurement date of June 30, 2023.

Inflation	2.50%
Salary increases, including inflation:	
Locality - General employees	3.50%-5.35%
Investment rate of return	6.75%, net of investment expenses, including inflation

Mortality Rates - Non-Largest Ten Locality Employers - General Employees

Pre-Retirement:
Pub-2010 Amount Weighted Safety Employee Rates projected generationally; 95% of rates for males; 105% of rates for females set forward 2 years

Post-Retirement:
Pub-2010 Amount Weighted Safety Healthy Retiree Rates projected generationally; 110% of rates for males; 105% of rates for females set forward 3 years

Post-Disablement:
Pub-2010 Amount Weighted General Disabled Rates projected generationally; 95% of rates for males set back 3 years; 90% of rates for females set back 3 years

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Health Insurance Credit (HIC) Plan (OPEB Plan): (Continued)

Mortality Rates - Non-Largest Ten Locality Employers - General Employees: (Continued)

Beneficiaries and Survivors:
Pub-2010 Amount Weighted Safety Contingent Annuitant Rates projected generationally; 110% of rates for males and females set forward 2 years

Mortality Improvement Scale:
Rates projected generationally with Modified MP-2020 Improvement Scale that is 75% of the MP-2020 rates

The actuarial assumptions used in the June 30, 2022 valuation were based on the results of an actuarial experience study for the period from July 1, 2016 through June 30, 2020, except the change in the discount rate, which was based on VRS Board action effective as of July 1, 2021. Changes to the actuarial assumptions as a result of the experience study and VRS Board action are as follows:

Mortality Rates (pre-retirement, post-retirement healthy, and disabled)	Update to Pub-2010 public sector mortality tables. For future mortality improvements, replace load with a modified Mortality Improvement Scale MP-2020
Retirement Rates	Adjusted rates to better fit experience for Plan 1; set separate rates based on experience for Plan 2/Hybrid; changed final retirement age from 75 to 80 for all
Withdrawal Rates	Adjusted rates to better fit experience at each age and service decrement through 9 years of service
Disability Rates	No change
Salary Scale	No change
Line of Duty Disability	No change
Discount Rate	No change

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Health Insurance Credit (HIC) Plan (OPEB Plan): (Continued)

Long-Term Expected Rate of Return

The long-term expected rate of return on the System's investments was determined using a log-normal distribution analysis in which best-estimate ranges of expected future real rates of return (expected returns, net of System's investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The target asset allocation and best estimate of arithmetic real rates of return for each major asset class are summarized in the following table:

Asset Class (Strategy)	Long-term Target Asset Allocation	Arithmetic Long-term Expected Rate of Return	Weighted Average Long-term Expected Rate of Return*
Public Equity	34.00%	6.14%	2.09%
Fixed Income	15.00%	2.56%	0.38%
Credit Strategies	14.00%	5.60%	0.78%
Real Assets	14.00%	5.02%	0.70%
Private Equity	16.00%	9.17%	1.47%
MAPS - Multi-Asset Public Strategies	4.00%	4.50%	0.18%
PIP - Private Investement Partnership	2.00%	7.18%	0.14%
Cash	1.00%	1.20%	0.01%
Total	100.00%		5.75%
		Inflation	2.50%
		Expected arithmetic nominal return**	8.25%

*The above allocation provides a one-year expected return of 8.25%. However, one-year returns do not take into account the volatility present in each of the asset classes. In setting the long-term expected return for the System, stochastic projections are employed to model future returns under various economic conditions. These results provide a range of returns over various time periods that ultimately provide a median return of 7.14%, including expected inflation of 2.50%. On June 15, 2023, the VRS Board elected a long-term rate of return of 6.75% which was roughly at the 45th percentile of expected long-term results of the VRS fund asset allocation at that time, providing a median return of 7.14%, including expected inflation of 2.50%.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Health Insurance Credit (HIC) Plan (OPEB Plan): (Continued)

Discount Rate

The discount rate used to measure the total HIC OPEB liability was 6.75%. The projection of cash flows used to determine the discount rate assumed that employer contributions will be made in accordance with the VRS funding policy at rates equal to the difference between actuarially determined contribution rates adopted by the VRS Board of Trustees and the member rate. Through the fiscal year ended June 30, 2023, the rate contributed by the entity for the HIC OPEB was 100% of the actuarially determined contribution rate. From July 1, 2023 on, employers are assumed to continue to contribute 100% of the actuarially determined contribution rates. Based on those assumptions, the HIC OPEB's fiduciary net position was projected to be available to make all projected future benefit payments of eligible employees. Therefore, the long-term expected rate of return was applied to all periods of projected benefit payments to determine the total HIC OPEB liability.

Changes in Net HIC OPEB Liability (Asset)

	Increase (Decrease)		
	Total HIC OPEB Liability (a)	Plan Fiduciary Net Position (b)	Net HIC OPEB Liability (Asset) (a) - (b)
Balances at June 30, 2022	$ 405,759	$ 424,411	$ (18,652)
Changes for the year:			
Service cost	$ 9,428	$ -	$ 9,428
Interest	27,377	-	27,377
Differences between expected and actual experience	18,311	-	18,311
Contributions - employer	-	9,757	(9,757)
Net investment income	-	24,781	(24,781)
Benefit payments	(19,208)	(19,208)	-
Administrative expenses	-	(583)	583
Other changes	-	794	(794)
Net changes	$ 35,908	$ 15,541	$ 20,367
Balances at June 30, 2023	$ 441,667	$ 439,952	$ 1,715

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Health Insurance Credit (HIC) Plan (OPEB Plan): (Continued)

Sensitivity of the Board's Health Insurance Credit Net OPEB Liability (Asset) to Changes in the Discount Rate

The following presents the Board's HIC Program net HIC OPEB liability (asset) using the discount rate of 6.75%, as well as what the Board's net HIC OPEB liability (asset) would be if it were calculated using a discount rate that is one percentage point lower (5.75%) or one percentage point higher (7.75%) than the current rate:

	Rate		
	1% Decrease (5.75%)	Current Discount (6.75%)	1% Increase (7.75%)
Board's Net HIC OPEB Liability/(Asset)	$ 57,229	$ 1,715	$ (44,215)

HIC Plan OPEB Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to HIC Plan OPEB

For the year ended June 30, 2024, the Board recognized HIC Plan OPEB expense of $13,471. At June 30, 2024, the Board reported deferred outflows of resources and deferred inflows of resources related to the Board's HIC Program from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 20,346	$ 1,312
Net difference between projected and actual earnings on HIC OPEB plan investments	-	3,288
Change in assumptions	19,967	2,236
Employer contributions subsequent to the measurement date	11,634	-
Total	$ 51,947	$ 6,836

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Health Insurance Credit (HIC) Plan (OPEB Plan): (Continued)

HIC Plan OPEB Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to HIC Plan OPEB: (Continued)

$11,634 was reported as deferred outflows of resources related to the HIC OPEB resulting from the Board's contributions subsequent to the measurement date will be recognized as a reduction of the Net HIC OPEB Liability in the fiscal year ending June 30, 2025. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to the HIC OPEB will be recognized in the HIC OPEB expense in future reporting periods as follows:

Year Ended June 30		
2025	$	6,265
2026		3,483
2027		15,407
2028		6,629
2029		1,693
Thereafter		-

HIC Plan Data

Information about the VRS Political Subdivision HIC Program is available in the separately issued VRS 2023 Annual Comprehensive Financial Report (Annual Report). A copy of the 2023 VRS Annual Report may be downloaded from the VRS website at http://www.varetire.org/pdf/publications/2023-annual-report.pdf, or by writing to the System's Chief Financial Officer at P.O. Box 2500, Richmond, VA, 23218-2500.

Medical, Dental, and Life Insurance - (OPEB Plan):

Plan Description

The Post-Retirement Medical Plan (The Plan) is a single-employer defined benefit healthcare plan which offers health insurance for retired employees. Retirees are eligible for postretirement medical coverage if they are a full-time employee who retires directly from the Rappahannock Area Community Services Board and is eligible for retirement from VRS. The Board's post-retirement medical plan does not issue a separate, audited GAAP basis report.

Plan Administration

Management of The Plan is vested in the Plan Trustees, which consists of the Board members of the Rappahannock Area Community Services Board.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Medical, Dental, and Life Insurance - (OPEB Plan): (Continued)

Benefits Provided

The Rappahannock Area Community Services Board has established an irrevocable trust pursuant to Section 15.2-1544 of the Code of Virginia, as amended for the purpose of accumulating and investing assets to fund Other Postemployment Benefits (OPEB) and to participate in the Virginia Pooled OPEB Trust Fund and has established a Local Finance Board to become a Participating Employer in the Trust Fund. The Trust Fund provides administrative, custodial and investment services to the Participating Employers in the Trust Fund. The Board participates in the Virginia Pooled OPEB Trust Fund, an irrevocable trust established for the purpose of accumulating assets to fund postemployment benefits other than pensions. The Trust Fund issues a separate report, which can be obtained by requesting a copy from the plan administrator, Virginia Municipal League (VML) at P.O. Box 12164, Richmond, Virginia 23241.

Postemployment benefits are provided to eligible retirees include Medical, Dental, and Life insurance. The benefits that are provided for active employees are the same for eligible retirees, spouses and dependents of eligible retirees. All permanent employees of the Board who meet eligibility requirements of the pension plan are eligible to receive postemployment health care benefits. Retirees are reimbursed for the allowable portion of premiums paid. Coverage ceases when retirees reach the age of 65. Surviving spouses are not allowed access to the plan.

Plan Membership

At June 30, 2024 (measurement date), the following employees were covered by the benefit terms:

	Total
Total active employees with coverage	439
Total retirees with coverage	15
Total	454

The Board establishes rates based on an actuarially determined rate. For the year ended June 30, 2024, the Board's average contribution rate was 0.26% percent of covered- payroll. For the year ended June 30, 2024, the Board contributed $61,953 to the Plan. Plan members are not required to contribute to the plan.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Medical, Dental, and Life Insurance - (OPEB Plan): (Continued)

Investment Policy

The Board's policy in regard to the allocation of invested assets is established and may be amended by the Board by a majority vote of its members. It is the policy of the Board to pursue an investment strategy that reduces risk through the prudent diversification of the portfolio across a broad selection of distinct asset classes. The investment policy discourages the use of cash equivalents, except for liquidity purposes, and aims to refrain from dramatically shifting asset class allocations over short time spans. The following was the Board's adopted asset allocation policy as of June 30, 2024:

Asset Class	Target Percentage
Core Fixed Income	20.00%
Large Cap US Equities	21.00%
Small Cap US Equities	10.00%
Developed Foreign Equities	13.00%
Emerging Market Equities	5.00%
Private Real Estate	15.00%
Private Equity	10.00%
Hedge FOF Strategic	6.00%
Total	100.00%

Concentrations

The Trust does not hold investments in any one organization that represent five percent or more of the OPEB Trust's Fiduciary Net Position.

Rate of Return

For the year ended June 30, 2024, the annual money-weighted rate of return on investments, net of investment expense, was 9.49% percent. The money-weighted rate of return expresses investment performance, net of investment expense, adjusted for the changing amounts actually invested.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Medical, Dental, and Life Insurance - (OPEB Plan): (Continued)

Schedule of Investment Returns

Last 8 Fiscal Years

	Annual Money-Weighted Rate of Return Net of Investment Expense
6/30/2017	12.73%
6/30/2018	9.53%
6/30/2019	4.56%
6/30/2020	3.04%
6/30/2021	30.02%
6/30/2022	-9.44%
6/30/2023	7.59%
6/30/2024	9.49%

The chart is intended to show information for 10 years. More data will be added as it becomes available.

Net OPEB Liability

The Board's net OPEB liability was measured as of June 30, 2024. The total OPEB liability used to calculate the net OPEB liability was determined by an actuarial valuation as of January 1, 2023.

Actuarial Assumptions

The total OPEB liability in the January 1, 2023 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.50%
Salary Increases	3.00%
Discount Rate	6.50%
Investment Rate of Return	6.50%

Mortality rates were based on the RP-2014 Healthy Annuitant Mortality Table for Males or Females, as appropriate, with adjustments for mortality improvements based on Scale BB.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Medical, Dental, and Life Insurance - (OPEB Plan): (Continued)

Actuarial Assumptions: (Continued)

The actuarial assumptions used in the June 30, 2024 valuation were based on the results of an actuarial experience study at January 1, 2023.

The long-term expected rate of return on OPEB plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. Best estimates of geometric real rates of return for each major asset class included in the target asset allocation as of June 30, 2024 (see the discussion of The Plan's investment policy) are summarized in the following table:

Asset Class	Long-Term Expected Geometric Real Rate of Return
Core Fixed Income	2.08%
Large Cap US Equities	3.80%
Small Cap US Equities	4.39%
Developed Foreign Equities	5.13%
Emerging Market Equities	6.21%
Private Real Estate	3.91%
Private Equity	6.25%
Hedge FOF Strategic	1.94%
Assumed Inflation	2.30%
Portfolio Real Mean Return	4.71%
Portfolio Nominal Mean Return	7.12%
Portfolio Standard Deviation	13.16%
Long-Term Expected Rate of Return	**6.50%**

Discount Rate

The discount rate used to measure the total OPEB liability was 6.50 percent. The projection of cash flows used to determine the discount rate assumed that contributions will be made at rates equal to the actuarially determined contribution rates. Based on those assumptions, the OPEB plan's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on OPEB plan investments was applied to all periods of projected benefit payments to determine the total OPEB liability.

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Medical, Dental, and Life Insurance - (OPEB Plan): (Continued)

Changes in Net OPEB Liability (Asset)

	Increase (Decrease)		
	Total OPEB Liability (a)	Plan Fiduciary Net Position (b)	Net OPEB Liability (Asset) (a)-(b)
Balances at June 30, 2023	$ 3,007,027	$ 3,807,059	$ (800,032)
Changes for the year:			
Service cost	$ 127,298	$ -	$ 127,298
Interest	201,749	-	201,749
Effect of economic/demographic gains or losses	(308,064)	-	(308,064)
Changes in assumptions	(486,618)	-	(486,618)
Contributions - employer	-	61,953	(61,953)
Net investment income	-	360,908	(360,908)
Administrative expenses	-	(4,247)	4,247
Benefit payments	(61,953)	(61,953)	-
Net changes	$ (527,588)	$ 356,661	$ (884,249)
Balances at June 30, 2024	$ 2,479,439	$ 4,163,720	$ (1,684,281)

Sensitivity of the Net OPEB Liability (Asset) to Changes in the Discount Rate

The following amounts present the net OPEB liability (asset) of the Board, as well as what the net OPEB liability (asset) would be if it were calculated using a discount rate that is one percentage point lower (5.50%) or one percentage point higher (7.50%) than the current discount rate:

Rate		
1% Decrease (5.50%)	Current Discount Rate (6.50%)	1% Increase (7.50%)
$ (1,356,793)	$ (1,684,281)	$ (1,964,487)

NOTE 13 - OTHER POSTEMPLOYMENT BENEFITS (OPEB): (CONTINUED)

Medical, Dental, and Life Insurance - (OPEB Plan): (Continued)

Sensitivity of the Net OPEB Liability (Asset) to Changes in the Healthcare Cost Trend Rates

The following presents the net OPEB liability (asset) of the Board, as well as what the net OPEB liability (asset) would be if it were calculated using healthcare cost trend rates that are one percentage point lower (4.30%) or one percentage point higher (6.30%) than the current healthcare cost trend rates:

Rates		
1% Decrease (3.90%)	Healthcare Cost Trend (4.90%)	1% Increase (5.90%)
$ (1,932,043)	$ (1,684,281)	$ (1,386,810)

OPEB Expense and Deferred Outflows of Resources and Deferred Inflows of Resources

For the year ended June 30, 2024, the Board recognized OPEB expense in the amount of ($49,893). At June 30, 2024, the Board reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	Deferred Outflows of Resouces	Deferred Inflows of Resources
Net difference between projected and actual earnings on OPEB plan investments	$ -	$ 4,015
Change in assumptions	27,898	598,264
Differences between expected and actual experience	55,505	388,004
Total	$ 83,403	$ 990,283

Amounts reported as deferred outflows of resources and deferred inflows of resources will be recognized in OPEB expense in future reporting periods as follows:

Year Ended June 30	
2025	$ (153,967)
2026	(26,760)
2027	(145,307)
2028	(137,629)
2029	(113,628)
Thereafter	(329,589)

Additional disclosures on changes in net OPEB liability, related ratios, and employer contributions can be found in the required supplementary information following the notes to the financial statements.

Medical, Dental, and Life Insurance - (OPEB Plan): (Continued)

Aggregate OPEB Pension Information:

	Rappahannock Area Community Services Board				
	Deferred Outflows	Deferred Inflows	Net OPEB Asset	Net OPEB Liability	OPEB Expense
VRS OPEB Plans:					
Group Life Insurance Plan	$ 331,282	$ 222,478	$ -	$ 1,248,485	$ 66,766
Health Insurance Credit Plan	51,947	6,836	-	1,715	13,471
Virginia Local Disability Program	184,124	31,647	41,120	-	103,083
Stand-Alone Plan	83,403	990,283	1,684,281	-	(49,893)
Totals	$ 650,756	$ 1,251,244	$ 1,725,401	$ 1,250,200	$ 133,427

NOTE 14 - RESTRICTED NET POSITION:

Restricted net position consists of the net position of the component units with HUD funding less the net investment in capital assets or $532,140 at June 30, 2024 and $461,981 at June 30, 2023. The net position is considered restricted due to the regulatory oversight over the Organization by the U.S. Department of Housing and Urban Development and the restrictions on the use of the property pursuant to the acceptance of capital advance funds by the Organization. There is also restricted net position of $10,090,668 for the net pension asset and net OPEB assets.

NOTE 15 - UPCOMING PRONOUNCEMENTS:

Statement No. 101, *Compensated Absences*, updates the recognition and measurement guidance for compensated absences. It aligns the recognition and measurement guidance under a unified model and amends certain previously required disclosures. The requirements of this Statement are effective for fiscal years beginning after December 15, 2023.

Statement No. 102, *Certain Risk Disclosures*, provides users of government financial statements with essential information about risks related to a government's vulnerabilities due to certain concentrations or constraints. The requirements of this Statement are effective for fiscal years beginning after June 15, 2024.

Statement No. 103, *Financial Reporting Model Improvements*, improves key components of the financial reporting model to enhance its effectiveness in providing information that is essential for decision making and assessing a government's accountability. The requirements of this Statement are effective for fiscal years beginning after June 15, 2025.

Management is currently evaluating the impact these standards will have on the financial statements when adopted.

- Required Supplementary Information -

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Schedule of Changes in Net Pension Liability (Asset) and Related Ratios - Pension Plan
For the Measurement Dates of June 30, 2014 through June 30, 2023

	2023	2022	2021	2020	2019
Total pension liability					
Service cost	$ 1,719,786	$ 1,624,100	$ 1,645,401	$ 1,575,288	$ 1,492,503
Interest	3,398,781	3,198,828	2,828,423	2,602,040	2,395,418
Differences between expected and actual experience	(1,389,495)	41,656	(29,222)	779,680	561,269
Changes of assumptions	-	-	1,192,243	-	1,302,924
Benefit payments	(2,114,618)	(1,881,405)	(1,665,520)	(1,540,842)	(1,306,415)
Net change in total pension liability	$ 1,614,454	$ 2,983,179	$ 3,971,325	$ 3,416,166	$ 4,445,699
Total pension liability - beginning	49,689,831	46,706,652	42,735,327	39,319,161	34,873,462
Total pension liability - ending (a)	$ 51,304,285	$ 49,689,831	$ 46,706,652	$ 42,735,327	$ 39,319,161
Plan fiduciary net position					
Contributions - employer	$ 474,723	$ 402,883	$ 388,492	$ 209,391	$ 256,415
Contributions - employee	1,108,540	1,084,070	1,008,985	982,691	937,400
Net investment income	3,659,336	(70,450)	12,355,858	850,529	2,813,847
Benefit payments	(2,114,618)	(1,881,405)	(1,665,520)	(1,540,842)	(1,306,415)
Administratior charges	(36,037)	(35,240)	(30,157)	(28,672)	(27,191)
Other	1,477	1,329	1,171	(1,015)	(1,778)
Net change in plan fiduciary net position	$ 3,093,421	$ (498,813)	$ 12,058,829	$ 472,082	$ 2,672,278
Plan fiduciary net position - beginning	56,576,131	57,074,944	45,016,115	44,544,033	41,871,755
Plan fiduciary net position - ending (b)	$ 59,669,552	$ 56,576,131	$ 57,074,944	$ 45,016,115	$ 44,544,033
Board's net pension asset - ending (a) - (b)	$ (8,365,267)	$ (6,886,300)	$ (10,368,292)	$ (2,280,788)	$ (5,224,872)
Plan fiduciary net position as a percentage of the total pension liability	116.31%	113.86%	122.20%	105.34%	113.29%
Covered payroll	$ 24,445,794	$ 23,150,063	$ 22,386,497	$ 22,075,863	$ 20,672,063
Board's net pension asset as a percentage of covered payroll	-34.22%	-29.75%	-46.31%	-10.33%	-25.28%

Schedule of Changes in Net Pension Liability (Asset) and Related Ratios - Pension Plan
For the Measurement Dates of June 30, 2014 through June 30, 2023

	2018	2017	2016	2015	2014
Total pension liability					
Service cost	$ 1,446,958	$ 1,497,145	$ 1,480,553	$ 1,514,991	$ 1,453,677
Interest	2,213,618	2,123,849	2,016,286	1,870,481	1,701,667
Differences between expected and actual experience	278,214	(523,148)	(863,558)	(442,973)	-
Changes of assumptions	-	(496,368)	-	-	-
Benefit payments	(1,376,882)	(1,261,255)	(932,066)	(787,076)	(700,350)
Net change in total pension liability	$ 2,561,908	$ 1,340,223	$ 1,701,215	$ 2,155,423	$ 2,454,994
Total pension liability - beginning	32,311,554	30,971,331	29,270,116	27,114,693	24,659,699
Total pension liability - ending (a)	$ 34,873,462	$ 32,311,554	$ 30,971,331	$ 29,270,116	$ 27,114,693
Plan fiduciary net position					
Contributions - employer	$ 358,568	$ 370,563	$ 713,143	$ 689,023	$ 983,504
Contributions - employee	902,891	894,895	808,979	791,251	761,729
Net investment income	2,892,557	4,269,791	617,675	1,473,770	4,236,654
Benefit payments	(1,376,882)	(1,261,255)	(932,066)	(787,076)	(700,350)
Administratior charges	(24,571)	(24,174)	(20,392)	(19,191)	(21,737)
Other	(2,599)	(3,823)	(254)	(313)	224
Net change in plan fiduciary net position	$ 2,749,964	$ 4,245,997	$ 1,187,085	$ 2,147,464	$ 5,260,024
Plan fiduciary net position - beginning	39,121,791	34,875,794	33,688,709	31,541,245	26,281,221
Plan fiduciary net position - ending (b)	$ 41,871,755	$ 39,121,791	$ 34,875,794	$ 33,688,709	$ 31,541,245
Board's net pension asset - ending (a) - (b)	$ (6,998,293)	$ (6,810,237)	$ (3,904,463)	$ (4,418,593)	$ (4,426,552)
Plan fiduciary net position as a percentage of the total pension liability	120.07%	121.08%	112.61%	115.10%	116.33%
Covered payroll	$ 19,787,291	$ 19,145,833	$ 17,277,503	$ 16,124,859	$ 15,309,883
Board's net pension asset as a percentage of covered payroll	-35.37%	-35.57%	-22.60%	-27.40%	-28.91%

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Schedule of Employer Contributions - Pension Plan
Years Ended June 30, 2015 through June 30, 2024

Date	Contractually Required Contribution (1)*	Contributions in Relation to Contractually Required Contribution (2)*	Contribution Deficiency (Excess) (3)	Employer's Covered Payroll (4)	Contributions as a % of Covered Payroll (5)
2024	$ 522,595	$ 522,595	$ -	$ 29,070,004	1.80%
2023	462,878	462,878	-	24,445,794	1.89%
2022	383,250	383,250	-	23,150,063	1.66%
2021	371,014	371,014	-	22,386,497	1.66%
2020	220,163	220,163	-	22,075,863	1.00%
2019	242,886	242,886	-	20,672,063	1.17%
2018	359,668	359,668	-	19,787,291	1.82%
2017	470,988	470,988	-	19,145,833	2.46%
2016	772,304	772,304	-	17,277,503	4.47%
2015	720,781	720,781	-	16,124,859	4.47%

* Excludes contributions (mandatory and match on voluntary) to the defined contribution portion of the Hybrid plan.

Changes of benefit terms - There have been no actuarially material changes to the System benefit provisions since the prior actuarial valuation.

Changes of assumptions - The actuarial assumptions used in the June 30, 2022 valuation were based on the results of an actuarial experience study for the period from July 1, 2016 through June 30, 2020, except the change in the discount rate, which was based on VRS Board action effective as of July 1, 2021. Changes to the actuarial assumptions as a result of the experience study and VRS Board action are as follows:

All Others (Non 10 Largest) - Non-Hazardous Duty:

Mortality Rates (pre-retirement, post-retirement healthy, and disabled)	Update to Pub-2010 public sector mortality tables. For future mortality improvements, replace load with a modified Mortality Improvement Scale MP-2020
Retirement Rates	Adjusted rates to better fit experience for Plan 1; set separate rates based on experience for Plan 2/Hybrid; changed final retirement age
Withdrawal Rates	Adjusted rates to better fit experience at each age and service decrement through 9 years of service
Disability Rates	No change
Salary Scale	No change
Line of Duty Disability	No change
Discount Rate	No change

Schedule of Changes in the Board's Net OPEB Liability (Asset) and Related Ratios - Health Plan
Years Ended June 30, 2017 and June 30, 2024

	2017	2018	2019	2020
Total OPEB liability				
Service cost	$ 124,720	$ 133,450	$ 147,754	$ 131,907
Interest	124,910	140,751	167,114	162,367
Changes in assumptions	-	-	(147,135)	(105,785)
Effect of economic/demographic gains or losses	-	-	123,473	-
Benefit payments	(27,036)	(37,282)	(33,392)	(49,353)
Net change in total OPEB liability	$ 222,594	$ 236,919	$ 257,814	$ 139,136
Total OPEB liability - beginning	1,673,007	1,895,601	2,132,520	2,390,334
Total OPEB liability - ending (a)	$ 1,895,601	$ 2,132,520	$ 2,390,334	$ 2,529,470
Plan fiduciary net position				
Contributions - employer	$ 271,062	$ 175,677	$ 204,649	$ 198,779
Net investment income	189,753	181,705	101,688	76,200
Administrative expenses	(2,236)	(2,579)	(2,884)	(3,228)
Benefit payments	(27,036)	(37,282)	(33,392)	(49,353)
Net change in plan fiduciary net position	$ 431,543	$ 317,521	$ 270,061	$ 222,398
Plan fiduciary net position - beginning	1,473,689	1,905,232	2,222,753	2,492,814
Plan fiduciary net position - ending (b)	$ 1,905,232	$ 2,222,753	$ 2,492,814	$ 2,715,212
Board's net OPEB liability (asset) - ending (a) - (b)	$ (9,631)	$ (90,233)	$ (102,480)	$ (185,742)
Plan fiduciary net position as a percentage of the total OPEB liability	100.51%	104.23%	104.29%	107.34%
Covered payroll	$ 18,964,868	$ 18,964,868	$ 21,000,512	$ 22,074,590
Board's net OPEB liability (asset) as a percentage of covered payroll	-0.05%	-0.48%	-0.49%	-0.84%

Schedule is intended to show information for 10 years. Additional years will be included as they become available.

Schedule of Changes in the Board's Net OPEB Liability (Asset) and Related Ratios - Health Plan
Years Ended June 30, 2017 and June 30, 2024

	2021	2022	2023	2024
Total OPEB liability				
Service cost	$ 116,959	$ 116,192	$ 119,677	$ 127,298
Interest	170,285	169,104	183,537	201,749
Changes in assumptions	(69,720)	-	35,868	(486,618)
Effect of economic/demographic gains or losses	(176,576)	-	-	(308,064)
Benefit payments	(54,172)	(62,658)	(70,939)	(61,953)
Net change in total OPEB liability	$ (13,224)	$ 222,638	$ 268,143	$ (527,588)
Total OPEB liability - beginning	2,529,470	2,516,246	2,738,884	3,007,027
Total OPEB liability - ending (a)	$ 2,516,246	$ 2,738,884	$ 3,007,027	$ 2,479,439
Plan fiduciary net position				
Contributions - employer	$ 191,597	$ 277,275	$ 95,913	$ 61,953
Net investment income	812,266	(351,219)	265,864	360,908
Administrative expenses	(3,538)	(4,418)	(4,124)	(4,247)
Benefit payments	(54,172)	(62,658)	(70,939)	(61,953)
Net change in plan fiduciary net position	$ 946,153	$ (141,020)	$ 286,714	$ 356,661
Plan fiduciary net position - beginning	2,715,212	3,661,365	3,520,345	3,807,059
Plan fiduciary net position - ending (b)	$ 3,661,365	$ 3,520,345	$ 3,807,059	$ 4,163,720
Board's net OPEB liability (asset) - ending (a) - (b)	$ (1,145,119)	$ (781,461)	$ (800,032)	$ (1,684,281)
Plan fiduciary net position as a percentage of the total OPEB liability	145.51%	128.53%	126.61%	167.93%
Covered payroll	$ 21,707,442	$ 21,707,442	$ 21,707,442	$ 24,164,866
Board's net OPEB liability (asset) as a percentage of covered payroll	-5.28%	-3.60%	-3.69%	-6.97%

Schedule is intended to show information for 10 years. Additional years will be included as they become available.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Schedule of Employer Contributions - Health Plan
Years Ended June 30, 2015 through June 30, 2024

Date	Actuarially Determined Contribution (ADC) (1)	Contributions in Relation to ADC (2)	Contribution Deficiency (Excess) (3)	Covered Payroll (4)	Contributions as a % of Covered Payroll (5)
2024	$ -	$ 61,953	$ (61,953)	$ 24,164,866	0.26%
2023	62,530	95,913	(33,383)	$ 21,707,442	0.44%
2022	60,708	277,275	(216,567)	21,707,442	1.28%
2021	153,909	191,597	(37,688)	21,707,442	0.88%
2020	149,426	198,779	(49,353)	22,074,590	0.90%
2019	145,073	204,649	(59,576)	21,000,512	0.97%
2018	154,000	175,677	(21,677)	18,964,868	0.93%
2017	149,500	271,062	(121,562)	18,964,868	1.43%
2016	87,100	114,000	(26,900)	16,297,400	0.70%
2015	80,900	80,900	-	16,297,400	0.50%

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Schedule of Investment Returns - Health Plan
Last Ten Fiscal Years

	2024	2023	2022	2021	2020	2019	2018	2017
Annual money-weighted rate of return, net of investment expense	9.49%	7.59%	-9.44%	30.02%	3.04%	4.56%	9.53%	12.73%

Schedule is intended to show information for 10 years. Information prior to the 2017 valuation is not available. Additional years will be included as they become available.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Notes to Required Supplementary Information - Health Plan
Year Ended June 30, 2024

Valuation Date: 1/1/2023
Measurement Date: 6/30/2024

Methods and assumptions used to determine contribution rates:

Actuarial Cost Method	Entry Age Normal, Level Percentage of Pay
Amortization Method/Period	Level Percentage of Payroll, Closed, 15 Years Remaing as of January 1, 2024, Amortization growth rate of 3.00%
Asset Valuation Method	Market Value
Inflation	2.50%
Medical Trend Rate	The medical trend rate assumption starts at 5.60% in 2021 and gradually declines to 4.00% by the year 2073.
Salary Increases	3.00%
Investment Rate of Return	6.50%
Retirement Age	The average age at retirement is 62
Mortality Rates	The mortality rates for active and healthy retirees was calculated using the RP-2014 using scale BB to 2020. The mortality rates for disabled retirees was calculated using the RP-2014 Disabled Mortality Rates with scale BB to 2020.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Schedule of Board's Share of Net OPEB Liability
Group Life Insurance (GLI) Plan
For the Measurement Dates of June 30, 2017 through June 30, 2023

Date (1)	Employer's Proportion of the Net GLI OPEB Liability (Asset) (2)	Employer's Proportionate Share of the Net GLI OPEB Liability (Asset) (3)	Employer's Covered Payroll (4)	Employer's Proportionate Share of the Net GLI OPEB Liability (Asset) as a Percentage of Covered Payroll (3)/(4) (5)	Plan Fiduciary Net Position as a Percentage of Total GLI OPEB Liability (6)
2023	0.1041%	$ 1,248,485	$ 24,520,956	5.09%	69.30%
2022	0.1068%	1,286,095	23,233,774	5.54%	67.21%
2021	0.1087%	1,266,028	22,451,426	5.64%	67.45%
2020	0.1077%	1,797,670	22,169,153	8.11%	52.64%
2019	0.1059%	1,723,601	20,763,628	8.30%	52.00%
2018	0.1046%	1,588,000	19,881,849	7.99%	51.22%
2017	0.1041%	1,567,000	19,200,442	8.16%	48.86%

Schedule is intended to show information for 10 years. Information prior to the 2017 valuation is not available. However, additional years will be included as they become available.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Schedule of Employer Contributions
Group Life Insurance (GLI) Plan
Years Ended June 30, 2017 through June 30, 2024

Date	Contractually Required Contribution (1)	Contributions in Relation to Contractually Required Contribution (2)	Contribution Deficiency (Excess) (3)	Employer's Covered Payroll (4)	Contributions as a % of Covered Payroll (5)
2024	$ 157,559	$ 157,559	$ -	$ 29,177,528	0.54%
2023	132,413	132,413	-	24,520,956	0.54%
2022	125,462	125,462	-	23,233,774	0.54%
2021	121,238	121,238	-	22,451,426	0.54%
2020	115,280	115,280	-	22,169,153	0.52%
2019	107,971	107,971	-	20,763,628	0.52%
2018	103,386	103,386	-	19,881,849	0.52%
2017	99,842	99,842	-	19,200,442	0.52%

Schedule is intended to show information for 10 years. Information prior to 2017 is not available. However, additional years will be included as they become available.

Changes of benefit terms - There have been no actuarially material changes to the System benefit provisions since the prior actuarial valuation.

Changes of assumptions - The actuarial assumptions used in the June 30, 2022 valuation were based on the results of an actuarial experience study for the period from July 1, 2016 through June 30, 2020, except the change in the discount rate, which was based on VRS Board action effective as of July 1, 2021. Changes to the actuarial assumptions as a result of the experience study and VRS Board action are as follows:

Non-Largest Ten Locality Employers - General Employees

Mortality Rates (pre-retirement, post-retirement healthy, and disabled)	Update to Pub-2010 public sector mortality tables. For future mortality improvements, replace load with a modified Mortality Improvement Scale MP-2020
Retirement Rates	Adjusted rates to better fit experience for Plan 1; set separate rates based on experience for Plan 2/Hybrid; changed final retirement age from 75 to 80 for all
Withdrawal Rates	Adjusted rates to better fit experience at each age and service decrement through 9 years of service
Disability Rates	No change
Salary Scale	No change
Line of Duty Disability	No change
Discount Rate	No change

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Schedule of Board's Share of Net OPEB Liability
Virginia Local Disability Program (VLDP)
For the Measurement Dates of June 30, 2017 through June 30, 2023

Date (1)	Employer's Proportion of the Net VLDP OPEB Liability (Asset) (2)	Employer's Proportionate Share of the Net VLDP OPEB Liability (Asset) (3)	Employer's Covered Payroll (4)	Employer's Proportionate Share of the Net VLDP OPEB Liability (Asset) as a Percentage of Covered Payroll (3)/(4) (5)	Plan Fiduciary Net Position as a Percentage of Total VLDP OPEB Liability (6)
2023	2.5556%	$ (41,120)	$ 15,642,137	-0.26%	116.89%
2022	3.0124%	(17,712)	14,113,002	-0.13%	107.99%
2021	3.2120%	(32,515)	12,903,297	-0.25%	119.59%
2020	3.2337%	32,279	12,049,745	0.27%	76.84%
2019	3.3070%	66,994	10,219,361	0.66%	49.19%
2018	3.7252%	29,000	9,045,116	0.32%	51.39%
2017	4.2128%	24,000	7,735,910	0.31%	38.40%

Schedule is intended to show information for 10 years. Information prior to the 2017 valuation is not available. However, additional years will be included as they become available.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Schedule of Employer Contributions
Virginia Local Disability Program (VLDP)
Years Ended June 30, 2017 through June 30, 2024

Date	Contractually Required Contribution (1)	Contributions in Relation to Contractually Required Contribution (2)	Contribution Deficiency (Excess) (3)	Employer's Covered Payroll (4)	Contributions as a % of Covered Payroll (5)
2024	$ 168,257	$ 168,257	$ -	$ 19,794,977	0.85%
2023	132,958	132,958	-	15,642,137	0.85%
2022	117,138	117,138	-	14,113,002	0.83%
2021	107,097	107,097	-	12,903,297	0.83%
2020	86,758	86,758	-	12,049,745	0.72%
2019	73,579	73,579	-	10,219,361	0.72%
2018	54,321	54,321	-	9,045,116	0.60%
2017	46,415	46,415	-	7,735,910	0.60%

Schedule is intended to show information for 10 years. Information prior to 2017 is not available. However, additional years will be included as they become available.

Changes of benefit terms - There have been no actuarially material changes to the System benefit provisions since the prior actuarial valuation.

Changes of assumptions - The actuarial assumptions used in the June 30, 2022 valuation were based on the results of an actuarial experience study for the period from July 1, 2016 through June 30, 2020, except the change in the discount rate, which was based on VRS Board action effective as of July 1, 2021. Changes to the actuarial assumptions as a result of the experience study and VRS Board action are as follows:

Non-Largest Ten Locality Employers - General and Non-Hazardous Duty Employees

Mortality Rates (pre-retirement, post-retirement healthy, and disabled)	Update to Pub-2010 public sector mortality tables. For future mortality improvements, replace load with a modified Mortality Improvement Scale MP-2020
Retirement Rates	Adjusted rates to better fit experience for Plan 1; set separate rates based on experience for Plan 2/Hybrid; changed final retirement age from 75 to 80 for all
Withdrawal Rates	Adjusted rates to better fit experience at each age and service decrement through 9 years of service
Disability Rates	No change
Salary Scale	No change
Line of Duty Disability	No change
Discount Rate	No change

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Schedule of Changes in the Board's Net OPEB Liability and Related Ratios
Health Insurance Credit (HIC) Plan
For the Measurement Dates of June 30, 2017 through June 30, 2023

	2023	2022	2021	2020	2019	2018	2017
Total HIC OPEB Liability							
Service cost	$ 9,428	$ 13,113	$ 13,786	$ 12,675	$ 11,888	$ 11,684	$ 12,056
Interest	27,377	24,708	22,344	21,495	20,525	19,519	18,858
Differences between expected and actual experience	18,311	706	10,825	(2,331)	(140)	(1,603)	-
Changes in assumptions	-	25,209	(3,946)	-	8,742	-	(10,813)
Benefit payments	(19,208)	(21,823)	(20,381)	(18,138)	(13,415)	(17,046)	(4,277)
Net change in total HIC OPEB liability	$ 35,908	$ 41,913	$ 22,628	$ 13,701	$ 27,600	$ 12,554	$ 15,824
Total HIC OPEB Liability - beginning	405,759	363,846	341,218	327,517	299,917	287,363	271,539
Total HIC OPEB Liability - ending (a)	$ 441,667	$ 405,759	$ 363,846	$ 341,218	$ 327,517	$ 299,917	$ 287,363
Plan fiduciary net position							
Contributions - employer	$ 9,757	$ 16,212	$ 15,680	$ 15,440	$ 14,463	$ 17,809	$ 17,229
Net investment income	24,781	601	87,062	6,625	20,047	20,704	29,448
Benefit payments	(19,208)	(21,823)	(20,381)	(18,138)	(13,415)	(17,046)	(4,277)
Administrative expense	(583)	(733)	(1,024)	(636)	(439)	(491)	(495)
Other	794	14,797	-	(3)	(24)	(1,437)	1,437
Net change in plan fiduciary net position	$ 15,541	$ 9,054	$ 81,337	$ 3,288	$ 20,632	$ 19,539	$ 43,342
Plan fiduciary net position - beginning	424,411	415,357	334,020	330,732	310,100	290,561	247,219
Plan fiduciary net position - ending (b)	$ 439,952	$ 424,411	$ 415,357	$ 334,020	$ 330,732	$ 310,100	$ 290,561
Board's net HIC OPEB liability (asset) - ending (a) - (b)	$ 1,715	$ (18,652)	$ (51,511)	$ 7,198	$ (3,215)	$ (10,183)	$ (3,198)
Plan fiduciary net position as a percentage of the total HIC OPEB liability (asset)	99.61%	104.60%	114.16%	97.89%	100.98%	103.40%	101.11%
Covered payroll	$ 24,462,643	$ 23,160,566	$ 22,388,279	$ 22,073,211	$ 20,672,063	$ 19,881,849	$ 19,200,442
Board's net HIC OPEB liability (asset) as a percentage of covered payroll	0.01%	-0.08%	-0.23%	0.03%	-0.02%	-0.05%	-0.02%

Schedule is intended to show information for 10 years. Information prior to the 2017 valuation is not available. However, additional years will be included as they become available.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Schedule of Employer Contributions
Health Insurance Credit (HIC) Plan
Years Ended June 30, 2017 through June 30, 2024

Date	Contractually Required Contribution (1)	Contributions in Relation to Contractually Required Contribution (2)	Contribution Deficiency (Excess) (3)	Employer's Covered Payroll (4)	Contributions as a % of Covered Payroll (5)
2024	$ 11,634	$ 11,634	$ -	$ 29,084,291	0.04%
2023	9,785	9,785	-	24,462,643	0.04%
2022	16,212	16,212	-	23,160,566	0.07%
2021	15,672	15,672	-	22,388,279	0.07%
2020	15,451	15,451	-	22,073,211	0.07%
2019	14,470	14,470	-	20,672,063	0.07%
2018	17,825	17,825	-	19,881,849	0.09%
2017	17,229	17,229	-	19,200,442	0.09%

Schedule is intended to show information for 10 years. Information prior to 2017 is not available. However, additional years will be included as they become available.

Changes of benefit terms - There have been no actuarially material changes to the System benefit provisions since the prior actuarial valuation.

Changes of assumptions - The actuarial assumptions used in the June 30, 2022, valuation were based on the results of an actuarial experience study for the period from July 1, 2016 though June 30, 2020, except the change in the discount rate, which was based on VRS Board action effective as of July 1, 2021. Changes to the actuarial assumptions as a result of the experience study and VRS Board action are as follows:

Non-Largest Ten Locality Employers - General Employees

Mortality Rates (pre-retirement, post-retirement healthy, and disabled)	Update to Pub-2010 public sector mortality tables. For future mortality improvements, replace load with a modified Mortality Improvement Scale MP-2020
Retirement Rates	Adjusted rates to better fit experience for Plan 1; set separate rates based on experience for Plan 2/Hybrid; changed final retirement age from 75 to 80 for all
Withdrawal Rates	Adjusted rates to better fit experience at each age and service decrement through 9 years of service
Disability Rates	No change
Salary Scale	No change
Line of Duty Disability	No change
Discount Rate	No change

- Supplementary Information -

Combining Financial Statements

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Combining Statement of Net Position
At June 30, 2024

	Rappahannock Area Community Services Board	Rappahannock Community Services, Inc.	Churchill Drive Group Home	Devon Drive Group Home
ASSETS				
Current Assets:				
Cash and cash equivalents	$ 29,300,871	$ 285,828	$ -	$ -
Accounts receivable, less allowance for uncollectibles	4,425,324	16,669	-	-
Grants and other receivables	213,967	-	-	-
Prepaid items	-	34,316	-	-
Total current assets	$ 33,940,162	$ 336,813	$ -	$ -
Restricted Assets:				
Cash and cash equivalents	$ -	$ 14,328	$ 64,177	$ 33,267
Grants and other receivables	-	-	4,404	14,618
Prepaid items	-	-	2,203	1,590
Total restricted assets	$ -	$ 14,328	$ 70,784	$ 49,475
Capital Assets:				
Property and equipment, less accumulated depreciation	$ 19,785,321	$ 984,786	$ 524,524	$ 153,277
Other Assets:				
Net pension asset	$ 8,365,267	$ -	$ -	$ -
Net OPEB assets	1,725,401	-	-	-
Total other assets	$ 10,090,668	$ -	$ -	$ -
Total assets	$ 63,816,151	$ 1,335,927	$ 595,308	$ 202,752
DEFERRED OUTFLOWS OF RESOURCES				
Pension related items	$ 531,191	$ -	$ -	$ -
OPEB related items	650,756	-	-	-
Total deferred outflows of resources	$ 1,181,947	$ -	$ -	$ -
LIABILITIES				
Current Liabilities:				
Accounts payable and accrued expenses	$ 495,691	$ 17,384	$ -	$ -
Compensated absences	1,892,180	-	-	-
Accrued health insurance liabilities	2,785,303	-	-	-
Unexpended grant funds and other unearned revenue	3,598,671	-	-	-
Subscription liability, current portion	456,117	-	-	-
Lease liabilities, current portion	38,462	-	-	-
Total current liabilities	$ 9,266,424	$ 17,384	$ -	$ -
Liabilities Payable from Restricted Assets:				
Accounts payable and accrued expenses	$ -	$ -	$ 3,791	$ 14,436
Tenant security deposits	-	12,440	1,216	1,068
Total liabilities payable from restricted assets	$ -	$ 12,440	$ 5,007	$ 15,504
Long-term Liabilities:				
Lease liabilities, less current portion	$ 50,762	$ -	$ -	$ -
Net OPEB liabilities	1,250,200	-	-	-
Total long-term liabilities	$ 1,300,962	$ -	$ -	$ -
Total liabilities	$ 10,567,386	$ 29,824	$ 5,007	$ 15,504
DEFERRED INFLOWS OF RESOURCES				
Pension related items	$ 1,650,414	$ -	$ -	$ -
OPEB related items	1,251,244	-	-	-
Total deferred inflows of resources	$ 2,901,658	$ -	$ -	$ -
NET POSITION				
Net investment in capital assets	$ 19,239,980	$ 984,786	$ 524,524	$ 153,277
Restricted	10,090,668	-	65,777	33,971
Unrestricted	22,198,406	321,317	-	-
Total net position	$ 51,529,054	$ 1,306,103	$ 590,301	$ 187,248

Galveston Road Group Home	Igo Road Group Home	Leeland Road Group Home	New Hope Estates Group Home	Piedmont Drive Group Home	Scottsdale Estates Group Home	Stonewall Estates Group Home	Intercompany Eliminations	Total
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 29,586,699
-	-	-	-	-	-	-	-	4,441,993
-	-	-	-	-	-	-	-	213,967
-	-	-	-	-	-	-	-	34,316
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 34,276,975
$ 53,052	$ 61,434	$ 53,339	$ 104,704	$ 83,602	$ 90,223	$ 29,336	$ -	$ 587,462
19,285	1,811	1,893	4,774	14,048	2,159	4,960	-	67,952
1,937	1,997	1,624	2,239	1,551	2,148	1,689	-	16,978
$ 74,274	$ 65,242	$ 56,856	$ 111,717	$ 99,201	$ 94,530	$ 35,985	$ -	$ 672,392
$ 539,702	$ 341,476	$ 139,556	$ 514,112	$ 349,372	$ 754,264	$ 145,241	$ -	$ 24,231,631
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,365,267
-	-	-	-	-	-	-	-	1,725,401
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,090,668
$ 613,976	$ 406,718	$ 196,412	$ 625,829	$ 448,573	$ 848,794	$ 181,226	$ -	$ 69,271,666
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 531,191
-	-	-	-	-	-	-	-	650,756
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,181,947
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 513,075
-	-	-	-	-	-	-	-	1,892,180
-	-	-	-	-	-	-	-	2,785,303
-	-	-	-	-	-	-	-	3,598,671
-	-	-	-	-	-	-	-	456,117
-	-	-	-	-	-	-	-	38,462
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 9,283,808
$ 8,970	$ 8,175	$ 18,861	$ 8,554	$ 13,621	$ 14,053	$ 23,299	$ -	$ 113,760
2,278	1,488	1,280	1,825	677	1,322	1,010	-	24,604
$ 11,248	$ 9,663	$ 20,141	$ 10,379	$ 14,298	$ 15,375	$ 24,309	$ -	$ 138,364
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 50,762
-	-	-	-	-	-	-	-	1,250,200
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,300,962
$ 11,248	$ 9,663	$ 20,141	$ 10,379	$ 14,298	$ 15,375	$ 24,309	$ -	$ 10,723,134
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,650,414
-	-	-	-	-	-	-	-	1,251,244
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,901,658
$ 539,702	$ 341,476	$ 139,556	$ 514,112	$ 349,372	$ 754,264	$ 145,241	$ -	$ 23,686,290
63,026	55,579	36,715	101,338	84,903	79,155	11,676	-	10,622,808
-	-	-	-	-	-	-	-	22,519,723
$ 602,728	$ 397,055	$ 176,271	$ 615,450	$ 434,275	$ 833,419	$ 156,917	$ -	$ 56,828,821

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Combining Statement of Revenues, Expenses and Changes in Net Position
Year Ended June 30, 2024

	Rappahannock Area Community Services Board	Rappahannock Community Services, Inc.	Churchill Drive Group Home	Devon Drive Group Home
Operating revenue:				
Net patient service revenue	$ 29,731,839	$ -	$ -	$ -
Operating expenses:				
Salaries and benefits	$ 39,395,221	$ -	$ -	$ -
Staff development	398,052	-	-	-
Facilities	2,452,656	519,482	29,614	25,935
Supplies	2,801,666	-	-	-
Travel	735,377	-	-	-
Contractual and consulting	5,384,933	-	-	-
Depreciation	1,701,808	73,447	17,839	14,373
Other	2,555,670	12,306	-	-
Total operating expenses	$ 55,425,383	$ 605,235	$ 47,453	$ 40,308
Operating income (loss)	$ (25,693,544)	$ (605,235)	$ (47,453)	$ (40,308)
Nonoperating revenues (expenses):				
Capital contributions:				
Commonwealth of Virginia	$ 15,048,347	$ -	$ -	$ -
Federal government	3,273,082	-	-	-
Local governments	1,988,872	-	-	-
Other	2,944,437	512,034	39,600	35,018
Interest income	808,139	784	4	10
Interest expense	(24,215)	-	-	-
Gain (loss) on disposition of capital assets	15,150	-	-	-
Net nonoperating revenues (expenses)	$ 24,053,812	$ 512,818	$ 39,604	$ 35,028
Change in net position	$ (1,639,732)	$ (92,417)	$ (7,849)	$ (5,280)
Net position, beginning of year	53,168,786	$ 1,398,520	$ 598,150	$ 192,528
Net position, end of year	$ 51,529,054	$ 1,306,103	$ 590,301	$ 187,248

Galveston Road Group Home	Igo Road Group Home	Leeland Road Group Home	New Hope Estates Group Home	Piedmont Drive Group Home	Scottsdale Estates Group Home	Stonewall Estates Group Home	Intercompany Eliminations	Total
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 29,731,839
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 39,395,221
-	-	-	-	-	-	-	-	398,052
35,287	25,562	22,895	31,544	23,952	30,895	25,966	(29,900)	3,193,888
-	-	-	-	-	-	-	-	2,801,666
-	-	-	-	-	-	-	-	735,377
-	-	-	-	-	-	-	-	5,384,933
16,940	16,119	13,662	18,900	20,901	24,214	18,794	-	1,936,997
-	-	-	-	-	-	-	-	2,567,976
$ 52,227	$ 41,681	$ 36,557	$ 50,444	$ 44,853	$ 55,109	$ 44,760	$ (29,900)	$ 56,414,110
$ (52,227)	$ (41,681)	$ (36,557)	$ (50,444)	$ (44,853)	$ (55,109)	$ (44,760)	$ 29,900	$ (26,682,271)
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,048,347
-	-	-	-	-	-	-	-	3,273,082
-	-	-	-	-	-	-	-	1,988,872
39,552	23,580	22,224	52,722	33,766	50,782	24,480	(29,900)	3,748,295
4	5	3	8	6	41	4	-	809,008
-	-	-	-	-	-	-	-	(24,215)
-	-	-	-	-	-	-	-	15,150
$ 39,556	$ 23,585	$ 22,227	$ 52,730	$ 33,772	$ 50,823	$ 24,484	$ (29,900)	$ 24,858,539
$ (12,671)	$ (18,096)	$ (14,330)	$ 2,286	$ (11,081)	$ (4,286)	$ (20,276)	$ -	$ (1,823,732)
$ 615,399	$ 415,151	$ 190,601	$ 613,164	$ 445,356	$ 837,705	$ 177,193	$ -	$ 58,652,553
$ 602,728	$ 397,055	$ 176,271	$ 615,450	$ 434,275	$ 833,419	$ 156,917	$ -	$ 56,828,821

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Combining Statement of Cash Flows
Year Ended June 30, 2024

	Rappahannock Area Community Services Board	Rappahannock Community Services, Inc.	Churchill Drive Group Home	Devon Drive Group Home
Cash flows from operating activities:				
Receipts from customers	$ 32,232,496	$ -	$ -	$ -
Payments to suppliers	(14,076,617)	(523,715)	(33,765)	(25,635)
Payments to and for employees	(39,261,961)	-	-	-
Net cash provided by (used for) operating activities	$ (21,106,082)	$ (523,715)	$ (33,765)	$ (25,635)
Cash flows from noncapital financing activities:				
Government grants	$ 21,480,980	$ -	$ -	$ -
Other	2,944,437	496,505	35,196	20,400
Net cash provided by (used for) noncapital financing activities	$ 24,425,417	$ 496,505	$ 35,196	$ 20,400
Cash flows from capital and related financing activities:				
Purchase of capital assets	$ (676,762)	$ -	$ -	$ -
Proceeds from sale of capital assets	15,150	-	-	-
Principal paid on lease liabilities	(74,543)	-	-	-
Amount paid on subscription liabilities	(446,081)	-	-	-
Interest expense	(24,215)	-	-	-
Net cash provided by (used for) capital and related financing activities	$ (1,206,451)	$ -	$ -	$ -
Cash flows from investing activities:				
Interest income	$ 808,139	$ 784	$ 4	$ 10
Net increase (decrease) in cash and cash equivalents	$ 2,921,023	$ (26,426)	$ 1,435	$ (5,225)
Cash and cash equivalents, beginning of year	26,379,848	326,582	62,742	38,492
Cash and cash equivalents, end of year	$ 29,300,871	$ 300,156	$ 64,177	$ 33,267
Reconciliation of operating income (loss) to net cash provided by (used for) operating activities:				
Operating income (loss)	$ (25,693,544)	$ (605,235)	$ (47,453)	$ (40,308)
Adjustments to reconcile operating income (loss) to net cash provided by (used for) operating activities:				
Depreciation	1,701,808	73,447	17,839	14,373
Changes in assets, deferred outflows of resources, liabilities, and deferred inflows of resources:				
Accounts receivable	2,500,657	-	-	-
Prepaid items	-	(4,070)	(210)	(182)
Net pension asset	(1,478,967)	-	-	-
Net OPEB assets	(889,005)	-	-	-
Deferred outflows of resources	312,500	-	-	-
Accounts payable and accrued expenses	1,295,516	11,518	(3,941)	482
Compensated absences	542,184	-	-	-
Net OPEB liabilities	(35,895)	-	-	-
Deferred inflows of resources	638,664	-	-	-
Other	-	625	-	-
Net cash provided by (used for) operating activities	$ (21,106,082)	$ (523,715)	$ (33,765)	$ (25,635)

Galveston Road Group Home	Igo Road Group Home	Leeland Road Group Home	New Hope Estates Group Home	Piedmont Drive Group Home	Scottsdale Estates Group Home	Stonewall Estates Group Home	Intercompany Eliminations	Total
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 32,232,496
(36,378)	(44,576)	(23,343)	(31,803)	(23,820)	(30,877)	(22,860)	29,900	(14,843,489)
-	-	-	-	-	-	-	-	(39,261,961)
$ (36,378)	$ (44,576)	$ (23,343)	$ (31,803)	$ (23,820)	$ (30,877)	$ (22,860)	$ 29,900	$ (21,872,954)
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 21,480,980
26,897	71,742	26,642	47,948	44,363	48,623	23,182	(29,900)	3,756,035
$ 26,897	$ 71,742	$ 26,642	$ 47,948	$ 44,363	$ 48,623	$ 23,182	$ (29,900)	$ 25,237,015
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (676,762)
-	-	-	-	-	-	-	-	15,150
-	-	-	-	-	-	-	-	(74,543)
-	-	-	-	-	-	-	-	(446,081)
-	-	-	-	-	-	-	-	(24,215)
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,206,451)
$ 4	$ 5	$ 3	$ 8	$ 6	$ 41	$ 4	$ -	$ 809,008
$ (9,477)	$ 27,171	$ 3,302	$ 16,153	$ 20,549	$ 17,787	$ 326	$ -	$ 2,966,618
$ 62,529	$ 34,263	$ 50,037	$ 88,551	$ 63,053	$ 72,436	$ 29,010	$ -	$ 27,207,543
$ 53,052	$ 61,434	$ 53,339	$ 104,704	$ 83,602	$ 90,223	$ 29,336	$ -	$ 30,174,161
$ (52,227)	$ (41,681)	$ (36,557)	$ (50,444)	$ (44,853)	$ (55,109)	$ (44,760)	$ 29,900	$ (26,682,271)
16,940	16,119	13,662	18,900	20,901	24,214	18,794	-	1,936,997
-	-	-	-	-	-	-	-	2,500,657
(154)	(168)	(195)	43	(161)	(228)	(260)	-	(5,585)
-	-	-	-	-	-	-	-	(1,478,967)
-	-	-	-	-	-	-	-	(889,005)
-	-	-	-	-	-	-	-	312,500
(937)	(18,846)	(253)	(302)	293	246	3,366	-	1,287,142
-	-	-	-	-	-	-	-	542,184
-	-	-	-	-	-	-	-	(35,895)
-	-	-	-	-	-	-	-	638,664
-	-	-	-	-	-	-	-	625
$ (36,378)	$ (44,576)	$ (23,343)	$ (31,803)	$ (23,820)	$ (30,877)	$ (22,860)	$ 29,900	$ (21,872,954)

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- Compliance -

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ROBINSON, FARMER, COX ASSOCIATES, PLLC
Certified Public Accountants

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of Directors
Rappahannock Area Community Services Board
Fredericksburg, Virginia

We have audited, in accordance with the auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and the *Specifications for Audits of Authorities, Boards, and Commissions,* issued by the Auditor of Public Accounts of the Commonwealth of Virginia, the financial statements of the business-type activities and the aggregate remaining fund information of Rappahannock Area Community Services Board, as of and for the year ended June 30, 2024, and the related notes to the financial statements, which collectively comprise Rappahannock Area Community Services Board's basic financial statements and have issued our report thereon dated January 24, 2025.

Report on Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered Rappahannock Area Community Services Board's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Rappahannock Area Community Services Board's internal control. Accordingly, we do not express an opinion on the effectiveness of Rappahannock Area Community Services Board's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or, significant deficiencies. We identified certain deficiencies in internal control, described in the accompanying schedule of findings and questioned costs as items 2024-001 that we consider to be material weaknesses.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether Rappahannock Area Community Services Board's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Rappahannock Area Community Services Board's Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on Rappahannock Area Community Services Board's response to the findings identified in our audit and described in the accompanying schedule of findings and questioned costs. Rappahannock Area Community Services Board's response was not subjected to the audited procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Rappahannock Area Community Services Board's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Rappahannock Area Community Services Board's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Robinson, Farmer, Cox, Associates

Charlottesville, Virginia
January 24, 2025

INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR PROGRAM AND ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY THE UNIFORM GUIDANCE

To the Board of Directors
Rappahannock Area Community Services Board
Fredericksburg, Virginia

Report on Compliance for Each Major Federal Program

Opinion on Each Major Federal Program

We have audited the Rappahannock Area Community Services Board's compliance with the types of compliance requirements identified as subject to audit in the *OMB Compliance Supplement* that could have a direct and material effect on each of the Rappahannock Area Community Services Board's major federal programs for the year ended June 30, 2024. Rappahannock Area Community Services Board's major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs.

Rappahannock Area Community Services Board's basic financial statements include the operations of the component unit organizations Churchill Drive Group Home, Devon Drive Group Home, Galveston Road Group Home, Igo Road Group Home, Leeland Road Group Home, New Hope Estates Group Home, Piedmont Drive Group Home, Scottsdale Estates Group Home and Stonewall Estates Group Home, which received $4,566,842 in federal awards which is not included in the schedule of expenditures of federal awards during the year ended June 30, 2024. Our audit, described below, did not include the operations of the above component units because each of the component units issues separate financial statements, and audits in compliance with the Uniform Guidance are performed at the component unit level, where applicable.

In our opinion, the Rappahannock Area Community Services Board complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2024.

Basis for Opinion on Each Major Federal Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditors' Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of Rappahannock Area Community Services Board and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on compliance for each major federal program. Our audit does not provide a legal determination of Rappahannock Area Community Services Board's compliance with the compliance requirements referred to above.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules, and provisions of contracts or grant agreements applicable to Rappahannock Area Community Services Board's federal programs.

Auditors' Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on Rappahannock Area Community Services Board's compliance based on our audit. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards, Government Auditing Standards, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about Rappahannock Area Community Services Board's compliance with the requirements of each major federal program as a whole.

In performing an audit in accordance with generally accepted auditing standards, *Government Auditing Standards*, and the Uniform Guidance, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding Rappahannock Area Community Services Board's compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.

- Obtain an understanding of Rappahannock Area Community Services Board's internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of Rappahannock Area Community Services Board's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Report on Internal Control over Compliance

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Report on Internal Control over Compliance: (Continued)

Our consideration of internal control over compliance was for the limited purpose described in the Auditors' Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance. Given these limitations, during our audit we did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, material weaknesses or significant deficiencies in internal control over compliance may exist that were not identified.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Robinson, Farmer, Cox, Associates

Charlottesville, Virginia
January 24, 2025

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Schedule of Expenditures of Federal Awards
Year Ended June 30, 2024

Federal Grantor/ Pass-Through Grantor/ Program or Cluster Title	Federal Assistance Listing Number	Pass-Through Entity Identifying Number	Expenditures
Department of Treasury			
Pass-Through Payments:			
Virginia Department of Behavioral Health and Developmental Services:			
COVID-19 - Coronavirus State and Local Fiscal Recovery Funds	21.027	Not available	$ 570,171
Department of Health and Human Services			
Pass-Through Payments:			
Virginia Department of Behavioral Health and Developmental Services:			
Projects for Assistance in Transition from Homelessness (PATH)	93.150	Not available	$ 78,770
Opioid STR	93.788	5H79TI080220-02	679,566
Block Grants for Community Mental Health Services	93.958	2B090SM010053-18	188,335
Block Grants for Prevention and Treatment of Substance Abuse	93.959	2B08TI010053-18	857,786
Virginia Department of Health:			
ACA Maternal, Infant, and Early Childhood Home Visiting Program	93.505	Not available	189,260
Virginia Department of Social Services:			
Temporary Assistance for Needy Families (TANF)	93.558	FAM-18-106A-19	294,108
Total Department of Health and Human Services			$ 2,287,825
Department of Education			
Pass-Through Payments:			
Virginia Department of Education:			
Special Education - Grants for Infants and Families	84.181	H181A190017	$ 415,086
Total expenditures of federal awards			$ 3,273,082

Notes to the Schedule of Expenditures of Federal Awards

Note A - Basis of Presentation

The accompanying schedule of expenditures of federal awards (the Schedule) includes the federal award activity of the Rappahannock Area Community Services Board under programs of the federal government for the year ended June 30, 2024. The information in this Schedule is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Because the Schedule presents only a selected portion of the operations of Rappahannock Area Community Services Board, it is not intended to and does not present the financial position, changes in net position, or cash flows of the Rappahannock Area Community Services Board.

Note B - Summary of Significant Accounting Policies

(1) Expenditures reported on the Schedule are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement.

(2) Pass-through entity identifying numbers are presented where available.

Note C - Subrecipients

No awards were passed through to subrecipients.

Note D - Indirect Cost Recovery

The entity has elected not to use the 10% de minimis indirect cost rate allowed under Uniform Guidance.

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Schedule of Findings and Questioned Costs
Year Ended June 30, 2024

Section I - Summary of Auditors' Results

Financial Statements

Type of auditors' report issued:	Unmodified
Internal control over financial reporting:	
Material weakness(es) identified?	No
Significant deficiency(ies) identified	None reported
Noncompliance material to financial statements noted?	No

Federal Awards

Internal control over major programs:	
Material weakness(es) identified?	No
Significant deficiency(ies) identified	None reported
Type of auditors' report issued on compliance for major programs:	Unmodified
Any audit findings disclosed that are required to be reported in accordance with 2 CFR Section 200.516(a)?	No

Identification of major programs:

Assistance Listing #	Name of Federal Program or Cluster
93.959	Block Grants for Prevention and Treatment of Substance Abuse

Dollar threshold used to distinguish between Type A and Type B programs	$750,000
Auditee qualified as low-risk auditee?	No

Section II - Financial Statement Findings

2024-001 Material Weakness - Adjusting Journal Entries and Year End Accruals

Condition:

The financial statements, as presented for audit, did not contain all necessary adjustments to comply with generally accepted accounting principles (GAAP).

Criteria:

Identification of material adjustments to the financial statements that were not detected by the entity's internal controls indicates that a material weakness may exist.

Cause:

Controls in place were inadequate to identify all year end adjustments that were necessary for the financial statements to be presented in accordance with current reporting standards.

Effect:

There is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected by the entity's internal controls over financial reporting.

Recommendation:

We recommend journal entries needed for year end accruals are posted to the correct account, and accounting period.

Management's response:

Management concurs with the recommendation, and will develop procedures to ensure journal entries are correctly recorded.

Section III - Federal Award Findings and Questioned Costs

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD

Summary Schedule of Prior Audit Findings
Year Ended June 30, 2024

There were no findings were reported for the year ended June 30, 2023.

Prevention and Early Intervention Services Program Updates

Michelle Wagaman, Director
mwagaman@rappahannockareacsb.org
540-374-3337, ext. 7520

Top 5 for August:

1. National Night Out was August 5, 2025 from 5:00 p.m. to 8:00 p.m. at the Spotsylvania Towne Centre. It is hosted by the Spotsylvania County Sheriff's Office. RACSB trained 100 people in REVIVE!
2. RACSB has been invited to provide REVIVE! training at a fentanyl awareness event being hosted by the Office of the Attorney General on August 19, 2025 at 5:00 p.m. This is part of a "One Pill Can Kill" awareness campaign.
3. RACSB Prevention Services and Healthy Families Rappahannock Area also have strategies included in the 2025-2028 Community Health Improvement Plan. Three school divisions independently selected increasing Mental Health First Aid trainings as part of their strategies (refer to Mental Health First Aid section for details). Additionally, RACSB Prevention Services has been awarded a grant from the Rappahannock Area Health District to support strategies addressing adolescent mental health.
4. With the addition of teenMHFA, we have now trained more than 5K people in our community in Mental Health First Aid! We're now at 5,351.
5. Prevention Specialists completed the train-the-trainer for the new DBHDS Problem Gaming and Gambling curriculum on June 26, 2025.

Parent Education – Infant Development Program

There are currently 546 children enrolled in the program receiving a combination of services to include service coordination, speech therapy, physical therapy, occupational therapy, and educational developmental services. PE-ID is scheduling 16 consistent assessments per week. There were 57 referrals in July. There are currently 15 providers on staff. PE-ID has no open positions at this time.

Part C and Infant/Child Case Management

Our annual chart reviews indicated only one (1) area of non-compliance with federal regulations, timely initiation of services. We demonstrated correction prior to DBHDS issuing their public report. Appreciation to the team for their efforts to aid us in returning to compliance.

Alison Standring, Part C System Manager, represented RACSB and/or the Council Coordinators Association (CoCoA) as co-chairperson in the following groups and/or meetings: Rappahannock Area Interagency Coordinating Council meeting; VACSB Public Policy committee meeting; HB1760 Workgroup; CoCoA Steering committee meeting; Substance Exposed Infants workgroup (HB1157); VALIDD meeting; and Regional Local System Managers meeting.

Substance Abuse Prevention

RACSB Prevention Services continues substance abuse prevention efforts specifically targeting youth. In response to the opioid epidemic and legalization of adult-use cannabis, our target demographics includes adults.

Youth Education/Evidence Based Curriculums – Jennifer Bateman, Prevention Specialist, continues this round of facilitation of the Second Step social emotional learning curriculum with St. Paul's and 4Seasons day care/preschool centers in King George County. A total of 109 children received those curriculums in FY 2025. Scheduling preparation for Year 3 facilitation of the Second Step Bully Prevention curriculum for the elementary grade levels 3-5 within Caroline County Public Schools is nearing finalization in preparation for the new academic year. In FY 2025, a total of 2,048 students received that curriculum.

Coalitions – The Community Collaborative for Youth and Families hosted its quarterly meeting on July 11. Attendees learned more about the prevention of problem gambling efforts and development of a new high school education curriculum from Anne Rogers, DBHDS Prevention Problem Gambling Coordinator. There was also a presentation from Juanita Shanks with FailSafe ERA to discuss the "Sound the Alarm" Initiative in response to recent events of teen violence. The next meeting is scheduled for October 10. To learn more: https://www.thecommunitycollaborative.org/

Tobacco Control – The Prevention Services Team is actively working to complete the new cycle of the merchant education by June 30, 2026. We will be visiting nearly 300 tobacco and vape merchants to provide education and complete store audits.

DBHDS recently provided the 2024 Synar Inspection Results by CSB Catchment Area. RACSB, Health Planning Region 1 and the state all saw decreases in the violation rate compared to the prior year. Inspections are completed by the FDA and ABC (Synar and supplemental visits). We are working to revisit those stores that sold to individuals under age 21 and address those who have already violated in 2025 (11 stores cited).

2024 Synar Inspection Results by CSB Catchment Area

HPR I	Outlets Inspected	Violations	Violation Rate	2023 Rate	2022 Rate	2019 Rate	2018 Rate
Alleghany-Highlands	2	0	0.00%	20.00%	0.00%	33.33%	n/a
Harrisonburg-Rockingham	10	1	10.00%	14.29%	7.69%	0.00%	0.00%
Horizon	22	4	18.18%	12.00%	6.90%	10.53%	4.76%
Northwestern	24	2	8.33%	13.04%	8.00%	7.69%	20.00%
Rappahannock Area	**28**	**2**	**7.14%**	**22.73%**	**20.00%**	**13.33%**	**5.26%**
Rappahannock Rapidan	13	1	7.69%	14.29%	9.09%	0.00%	37.50%
Region Ten	16	2	12.50%	0.00%	0.00%	5.56%	40.00%
Rockbridge	1	0	0.00%	0.00%	22.22%	20.00%	0.00%
Valley	16	1	6.25%	20.00%	9.09%	57.14%	0.00%
Regional Totals	**132**	**13**	**9.85%**	**12.24%**	**9.15%**	**12.63%**	**11.83%**
State Total	**608**	**57**	**9.38%**	**12.40%**	**16.50%**	**16.80%**	**10.60%**

*2020 and 2021 data missing due to COVID-19.

Alcohol and Vaping Prevention Education – In FY 2025, Jennifer Bateman, Prevention Specialist, presented to 1,362 students on the dangers of tobacco and vaping. She presented to 574 students about alcohol and 594 students about cannabis. Scheduling for the new academic year is underway with increased outreach to middle school leadership.

Suicide Prevention Initiatives

RACSB Prevention Services takes an active role in suicide prevention initiatives including:

ASIST (Applied Suicide Intervention Skills Training) – This Living Works curriculum is a 2-day interactive workshop in suicide first aid. Participants learn how to recognize when someone may have thoughts of suicide and to work with the individual to create a plan that will support their immediate safety. LivingWorks has updated their trainer portal and facilitation guidance.

The training held June 4-5 ended up with 18 participants and our July 29-30 training had 11 (was limited to 15 registrations due to room reservations). Participants have come from the following organizations: Rappahannock Juvenile Detention Center; Department of Justice; State Department; Micah Ecumenical Ministries; Kaiser Permanente; Alleghany Highlands CSB; Region Ten CSB; and other partner organizations and interested community members.

We have one additional training scheduled for 2025 on October 23-24. In FY 2025, we hosted three (3) ASIST trainings for a total of 56 participants.

To register: https://www.signupgenius.com/go/RACSB-ASIST-Training2025

Mental Health First Aid – This 8-hour course teaches adults how to identify, understand, and respond to signs of mental health and substance use disorders. The training introduces common mental health challenges and gives participants the skills to reach out and provide initial support to someone who may be developing a mental health or substance use problem and connect them to the appropriate care.

Adult Mental Health First Aid trainings will be held on the remaining dates in 2025: September 4; and December 9 (from 8:30 a.m. to 5:00 p.m.).

Mental Health First Aid in Spanish trainings are scheduled for the remaining dates in 2025: August 19; and November 13.

Youth Mental Health First Aid training is scheduled for the remaining dates in 2025: October 7; and December 2 (from 8:30 a.m. to 5:00 p.m.). The training scheduled for June 17 was cancelled due to low registrations.

In FY 2025, RACSB hosted 21 Adult Mental Health First Aid trainings for a total of 394 participants (includes Spanish, Corrections, and Public Safety modules). RACSB hosted a total of seven (7) Youth Mental Health First Aid trainings for a total of 109 participants. Combined, Adult and Youth MHFA trained 503 community members. Additionally, two high schools implemented teenMHFA for a total of 557 students trained. This is the first year teenMHFA has been facilitated in our community. Our total trained is now 5,351 (since 2014).

To register for Adult Mental Health First Aid Training:
https://www.signupgenius.com/go/RACSB-MHFA-Training2025

To register for Adult Mental Health First Aid in Spanish Training:
https://www.signupgenius.com/go/RACSB-MHFA-Spanish2025

To register for Youth Mental Health First Aid Training:
https://www.signupgenius.com/go/RACSB-YouthMHFA-Training2025

Mental Health First Aid expansion is a strategy provided by several school divisions in addition to RACSB Prevention Services in the 2025-2028 Community Health Improvement Plan. This falls under Goal 1.2: Prevent adverse behavioral health outcomes by minimizing risk factors and promoting protective factors. The identified outcomes are increased education and awareness about behavioral health.

- By June 2026, RACSB will expand Teen Mental Health First Aid into a third high school in Planning District 16.
- By June 2028, all high school students in Fredericksburg City Public Schools will have received Teen Mental Health First Aid.
- Through June 2027, all health services staff in Spotsylvania County Public Schools will earn and maintain Youth Mental Health First Aid training certification. [RACSB is scheduled to train this staff on September 22, 2025.]
- By June 2028, ad additional 5% of Stafford County Public School staff will be trained in Mental Health First Aid annually, increasing the total number of trained to 115.

safeTALK – This 3-hour suicide alertness training encourages participants to learn how to prevent suicide by recognizing signs, engaging the individual, and connecting them to community resources for additional support.

safeTALK is scheduled for these remaining dates in 2025: September 23 (9:00 a.m. to noon); and November 17 (1:00 p.m. to 4:00 p.m.). The training scheduled for June 22 was cancelled due to last minute participant cancellations. We no longer had the minimum number of participants required to host the course. As we have cancelled three (3) of these trainings in 2025 due to low registration, we are evaluating whether to continue offering to the community in 2026.

To register: https://www.signupgenius.com/go/RACSB-safeTALK2025

Lock and Talk Virginia – The new awareness campaign for September as Suicide Prevention Month is nearly complete. It will build upon the May campaign and provide tips and tools (call to action) in the lead up to International Overdose Awareness Day on September 10, 2025.

We partnered with DBHDS to host the training "Delivering Lock and Talk to Service Members, Veterans, and their Families" on July 23, 2025. This four-hour course is a lethal means safety project as part of the Suicide Mortality Review Collaboration of Virginia and was sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and U.S. Department of Veterans Affairs. Participants also received gun locks, medication lock boxes, posters, and other materials to help them educate community groups on Lock and Talk Virginia and lethal means safety. A total of nine (9) community members attended.

Increasing community awareness of lethal means safety, distribution of lethal means safety devices, and hosting Lock and Talk Virginia presentations is a strategy in the 2025-2028 Community Health Improvement Plan.

Suicide Prevention Coalition – The subgroups formed to address focus areas of teens/young adults; older adults; and first responders/veterans continue to meet and develop goals. The next coalition meeting will be held August 25, 2025 at 1:00 p.m. at River Club. A virtual lunch and learn is scheduled for September 10 at noon. The coalition will be working to create a community toolkit with national and local resources as part of the 2025-2028 Community Health Improvement Plan. This is a strategy for the Behavioral Health priority area with the goal to increase access to behavioral health services, including treatment and recovery.

State Opioid Response (SOR)

RACSB Prevention Services is actively engaged with community partners to address the opioid response in the areas of prevention, harm reduction, treatment, and recovery.

Coalitions – The Opioid Workgroup meets monthly and is an interdisciplinary professional group. Meetings continued to be scheduled and held with local medical providers as we work to increase knowledge and understanding of prevention and harm reduction strategies. The workgroup has created draft proclamations for local governments to consider in recognition of International Overdose Awareness Day on August 31, 2025. The group hosted a representative from the Virginia Opioid Abatement Authority at their July meeting. They are working to identify the top needs as it relates to the ongoing epidemic and plan to provide the recommendations to local governments for their consideration.

We will be hosting a Hidden in Plain Sight on August 27, 2025 at the mall substation from noon to 1:00 p.m. Following the tour of a mock adolescent bedroom, attendees will hear from a local panel.

The coalition also has a strategy in the 2025 – 2028 Community Health Improvement Plan. Under Goal 1.1 Increase access to behavioral health services, including treatment and recovery; outcome 1 Reduced rates of overdose: Through June 2028, the Planning District 16 Opioid Workgroup will distribute no-cost naloxone to high-risk individuals and those close to them, supporting the VDH Division of Pharmacy Services' goal of distributing 26,549 naloxone kits annually to the VDH Northwest Region (or approximately 7,500 kits per year within PD16).

To learn more about the Save 1 Life harm reduction initiative: https://www.save1lifefxbg.org/

REVIVE! Naloxone Training and Dispensing – RACSB continues to host virtual trainings twice a month. Additionally, we schedule and host trainings upon the request of community partners. We continue to experience an increase in training/dispensing requests from community organizations. In FY 2025, RACSB trained 1,661 individuals in REVIVE! and dispensed 1,424 boxes of Narcan (2,848 doses).

Virtual training dates for 2025: https://www.signupgenius.com/go/5080F48A5A629A5FF2-54093052-opioid

RACSB is collaborating with Rappahannock Area Health District to support local school divisions implement the new requirement that high school students receive overdose awareness training prior to graduation.

We have been asked to provide REVIVE training at a fentanyl awareness event being hosted by the Office of the Attorney General on August 19, 2025 at 5:00 p.m. at Salem Fields Community Church. This is part of a "**One Pill Can Kill**" awareness campaign. (flyer attached)

Additional Initiatives

Responsible Gaming and Gambling – Michelle Wagaman is serving on a DBHDS committee that has created a statewide awareness campaign titled "Beyond the Bet." The campaign includes social media graphics (provided); brochure; bus ads; billboards; and flyers. A school curriculum is also now available.

RACSB is a member of the Virginia Council on Problem Gambling. To learn about this organization, please visit www.vcpg.net.

ACEs Interface – RACSB Prevention Services offers in-person trainings for community members to learn more about the impact of adversity in childhood on brain development and how toxic stress can impact individual and community health.

The Understanding ACEs training will be held on the remaining dates in 2025: September 9 (9:00 a.m. to noon); and October 28 (9:00 a.m. to noon). The August 5th training was cancelled due to low registrations.

To register: https://www.signupgenius.com/go/RACSB-ACEs-Training2025

The next train-the-trainer will be held August 27-28-29, 2025. Keith Cartwright from DBHDS will co-train with RACSB Master Trainers Amy Jindra and Michelle Wagaman. The August cohort already has 25 individuals registered.

To register: https://www.signupgenius.com/go/RACSB-ACE-Presenter2025

RACSB Prevention is part of the Trauma Informed Care Workgroup under the Criminal Justice Reform Alliance. We are working on a second book club and hosting virtual lunch and learns in 2026.
Community Resilience Initiative –Course 1 Trauma Informed and Course 2 Trauma Supportive are each 6-hour courses that cover brain science, the individual experiences and ways to build individual and community resilience. (Course 1 is a pre-requisite for Course 2). The training is held from 9:00 a.m. to 4:00 p.m.

In 2025, have one remaining Course 1 scheduled for September 25 and one remaining Course 2 on December 4. These curriculums were facilitated for 58 individuals in FY 2025.

To register: https://www.signupgenius.com/go/RACSB-CRI-Training2025

Activate Your Wellness – DBHDS initiative that is primarily a social norms campaign with social media, print materials, and short videos. RACSB continues utilizing this content for "Wellness Wednesday" posts.

Rappahannock Area Kids on the Block

Rappahannock Area Kids on the Block (RAKOB) returned to the Thurman Brisben Center in July to host a 1-day puppet camp for youth. They learned about puppetry before creating and performing their own show.

Healthy Families Rappahannock Area

HFRA helps parents **IDENTIFY** the best version of themselves, **PARTNERS** with parents with success in parenting, and **EMPOWERS** parents to raise healthy children.

June 2025

LOCALITY	NUMBER OF REFERRALS	ASSESSMENTS	NUMBER OF FAMILIES RECEIVING HOME VISITS	NEW ENROLLEES YEAR-TO-DATE
CAROLINE COUNTY	3	2	5	5
CITY OF FREDERICKSBURG	11	5	37	11
KING GEORGE COUNTY	1	0	7	2
SPOTSYLVANIA COUNTY	39	7	56	42
STAFFORD COUNTY	26	2	47	23
OUT OF AREA (REFERRED TO OTHER HF SITES)	7	0	0	0
TOTAL	**87**	**16**	**148**	**83**

- HFRA team attended the Mary Washington Hospital Community Baby Shower on June 21, 2025. The program collected 70 referral screens. Parent Ambassadors volunteered with HFRA staff.
- HFRA Board nominated four (4) new Board members to join starting FY 2026.
- HFRA team conducted a playgroup for residents of Thurman Brisben Center.
- Partnered with Lifepoint Church which financially supported a Family Fun Day at Funland.
- Partnered with Sparks Daycare to offer arts and crafts for the Thurman Brisben Center Families.
- Made connections with Wilderness Resorts for free day passes to share with families.
- Partnered with Fredericksburg Department of Social Services for the Father Basket Giveaway.
- Received donations from St. Georges Episcopal Church, Spotswood Baptist Church, Community Threads and Little Hands VA.

OUTCOMES
4th Quarter (June 2025)

Child Health

- **94% (66 of 70) of children received scheduled Well Care Visits**
- **98% (98 of 100) immunization completion**

Developmental Screening

- **100% (20 of 20) received scheduled developmental screen (ASQ)**
- **100% (12 of 12) received scheduled Social Emotional Screening (ASQ SE)**
- **100% (2 of 2) received Referrals to developmental concerns**

Maternal Health

- **100% (4 of 4) received scheduled Postpartum Care**

Positive Parenting Practices

- **100% (7of 7) Positive Child Interaction Observation**
- **87% (7 of 8) identify Positive Male Role Models**

July 2025

LOCALITY	NUMBER OF REFERRALS	ASSESSMENTS	NUMBER OF FAMILIES RECEIVING HOME VISITS	NEW ENROLLEES YEAR-TO-DATE
CAROLINE COUNTY	5	1	6	0
CITY OF FREDERICKSBURG	8	3	37	2
KING GEORGE COUNTY	5	0	7	0
SPOTSYLVANIA COUNTY	16	7	54	1
STAFFORD COUNTY	13	12	45	3
OUT OF AREA (REFERRED TO OTHER HF SITES)	0	0	0	0
TOTAL	**47**	**23**	**149**	**6**

- Submitted application for the CBCAP Grant renewal in the amount of $50,000.
- Pending Board approval, submitted application for the FORGE Fatherhood project with Grants.gov in the amount of $536,852. This would be a new project to support, expand, and enhance Village Fathers.
- Started the Monthly Giving Circle with a goal to secure at least $625 (flyer attached) in reoccurring monthly donations – https://www.zeffy.com/donation-form/together-we-grow-2
- Hosting the Tiny Caps and Gold Hats Celebration Carnival with Jubilation 55+ community on September 13, 2025. Seeking face painters and balloon animal volunteers.
- HFRA strategy selected for the 2025-2028 Community Health Improvement Plan to address Goal 3.1: Improve health service access, coordination, and collaboration to meet the needs of all members of the community and the identified outcome: Improved maternal and infant health outcomes:
    - Through June 2028, Healthy Families Rappahannock Area will provide culturally responsive, evidence-based home visiting services to 365 expectant and new parents per year, ensuring early identification of health and safety risks, connection to prenatal and postpartum care, and ongoing support to promote safe sleep practices, maternal mental health, and infant well-being.

July 2025

Healthy Families Rappahannock Area Newsletter

Beyond the Office: Why Home Visiting is Transforming Family Support

When Family Support Specialists (FSS) step beyond the four walls of their offices and into the homes of families, something powerful happens: trust deepens, understanding grows, and real change begins.
Home visiting programs—where professionals meet families in their own environments—are gaining renewed attention as a vital tool for early childhood development, health interventions, and social support. From newborn care to school readiness and mental health, these visits offer a rare and honest glimpse into the day-to-day lives of families, especially those facing economic or social challenges.

Kathleen, an FSS for Healthy Families Rappahannock Area (HFRA), shared that she believes home visiting vs coming to the office works best because "They are in their natural state! Baby, mom, family we get a better understanding of home life and they feel at ease being in their natural state". Carley, a former participant of a Healthy Families program and now an FSS for HFRA shared "Also, we are able to help those who otherwise may not be able to receive services due to them not having their own transportation". Ivy (FSS) also shared "we're able to support the families in creating safe environments in their homes".

Experts say this approach not only helps tailor services to each family's unique needs, but also builds relationships grounded in empathy and mutual respect. For parents, especially those who might feel judged or overwhelmed, the comfort of their own home can be the difference between shutting down and opening up.
Studies consistently show that home visiting improves outcomes in child development, reduces rates of abuse and neglect, and even boosts school performance down the line. As policymakers look for effective ways to support vulnerable families, the message from practitioners is clear: if we want to make a lasting impact, we need to start where life actually happens—at home.

If you are looking for ways to support Healthy Families Rappahannock Area, please feel free to reach out at hfra@rappahannockareacsb.org
or check out our website
www.healthyfamiliesrappahannock.org

Village Shoutouts

This month's shout outs belong to

- **St. George's Episcopal Church**
- **Life Point Church**
- **Spotswood Baptist Church**
- **Community Threads**
- **Little Hands VA**

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Be A Part of the Village
Scan to Donate
www.healthyfamiliesrappahannock.org

Yvette's Story:

A Go-Getter Mom Building Community and Confidence

July 2025

Two years ago, Yvette and her husband made a big move from California to Virginia with their two young daughters. It was a leap of faith—starting over in a new state without knowing anyone and leaving behind the community they once called home. However, Yvette was determined to make the most of the transition for herself and her family.

Thankfully, her connection to Healthy Families didn't end with the move. Yvette was seamlessly transferred to Healthy Families Rappahannock Area (HFRA) and quickly began meeting regularly with her Family Support Specialist, Missy. From day one, Yvette showed her commitment—never missing a visit and always eager to learn about local resources, parenting tools, and fun activities for her children.

As her journey with HFRA continued, so did her family's growth. Yvette gave birth to another beautiful daughter, and suddenly, life meant balancing two older children and a newborn. It was a major life change, but she embraced it with determination, curiosity, and grace.

Despite the demands at home, Yvette didn't stop there. She became an active HFRA Parent Ambassador, sharing her story and offering encouragement to other families. But she also felt a desire to connect more deeply with her new community—to meet people, give back, and fill her own cup in the process.

Through conversations and "Exploring and Wondering" sessions with Missy, Yvette discovered the perfect next step: volunteering at the YMCA. It offered not only a way to help others, but a path to build friendships and community ties. Yvette jumped in wholeheartedly—and her passion and presence were quickly recognized.

Recently, Yvette was offered a position working at the YMCA, a role she proudly accepted. She loves what she does and the connections she's built along the way.

Yvette is the definition of a go-getter: a loving and dedicated mom who shows up fully for her family while also making space for her own growth and joy. Her story is a testament to the power of support, community, and self-belief—and HFRA is proud to be part of her journey

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www.healthyfamiliesrappahannock.org

What's Happening This Month

July 2025

EMPOWER · IDENTIFY · PARTNER
Healthy Families Rappahannock Area

Wednesday July 9, 2025

Exploring the Outdoors Playgroup:
10-aa a.m - Brisben Center (Residents only)
1-2 p.m. Heritage Park (open to community)

We're always looking to grow our impact through meaningful community partnerships.

If your organization shares our commitment to supporting families and building stronger communities,

We'd love to explore opportunities to work together.

CONTACT US

hfra@rappahannocareacsb.org
540-374-3366
www.healthyfamiliesrappahannock.org

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August 2025

Healthy Families Rappahannock Area Newsletter

CALL TO ACTION:

Support Healthy Families and Strengthen Our Community

Every day in our community, Healthy Families is walking alongside parents during one of the most important—and often overwhelming—chapters of their lives. From pregnancy through a child's earliest years, this nonprofit home-visiting program offers free, voluntary support to help families build strong, safe, and nurturing homes.

But this vital work can't continue without you.

Healthy Families relies on community support to reach new parents with the resources, education, and guidance they need. By supporting this program, you're not just helping individual families—you're investing in better outcomes for children, reduced rates of abuse and neglect, and a healthier future for us all.

Now is the time to act.

Whether through a **donation, volunteering, or spreading the word**, you can make a lasting difference.

Join us in strengthening families—because when families thrive, communities do too.

Village Shoutouts

This month's shout outs belong to

- **Mary Washington Hospital**
- **Brittani G. (Intern)**
- **Little Hands of Richmond, VA**

Be A Part of the Village

Scan to Donate

www.healthyfamiliesrappahannock.org

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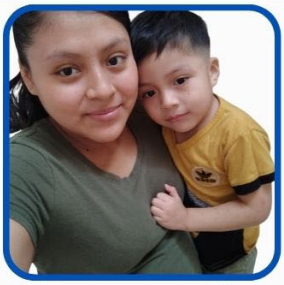
Glendy's Story:

A Journey of Determination and Resilience

August 2025



When Glendy enrolled in Healthy Families, she was pregnant and faced many challenges. Despite these barriers, Glendy was determined to become self-sufficient and learn how to navigate this journey of parenthood.

With support and guidance from Lixlia, her Family Support Specialist, Glendy was given simple but essential tools to help her on her journey—including a notebook she used as a personal directory, where she kept important phone numbers and instructions. Lixlia helped her enroll in programs like WIC and taught her how to make phone calls independently by using her notebook, which included step-by-step directions on how to request the support she needed.

Throughout her pregnancy and after her son Anderson was born, Glendy successfully applied for Medicaid and WIC benefits. She also learned the importance of WellCare visits and vaccinations for Anderson. Through her visits with Lixlia, she was introduced to developmental play activities, which she actively engaged in to support Anderson's growth.

Glendy has a strong support system, including her uncle and her current partner, who has been a devoted father figure to Anderson. Glendy worked full-time for a period, but recently had to stop due to her advanced pregnancy; she is expecting her second child in December.

This month, Glendy will graduate from the Healthy Families program. We are proud to highlight her success as a shining example of determination and resilience. She has made the most of every resource available and fully embraced the knowledge shared with her—particularly regarding child development, which has prepared Anderson well for preschool.

Scan to Donate

Glendy feels confident and prepared to care for her second child and plans to apply all she has learned during her home visits with Lixlia.

Congratulations, Glendy and Anderson!

www.healthyfamiliesrappahannock.org

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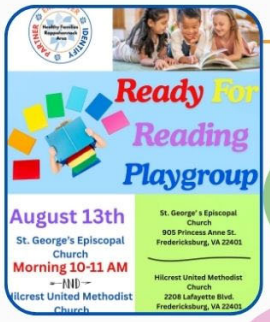
What's Happening This Month

August 2025



PARTNER EMPOWER IDENTIFY
Healthy Families Rappahannock Area

Wednesday August 13, 2025

Ready for Reading
10-aa a.m - St. George's Episcopal Church
1-2 p.m. Hillcrest United Methodist Church

Thursday August 28, 2025
HFRA In-Person Board Meeting
6:00 p.m. - 7:30 p.m. Riverclub

If your organization shares our commitment to supporting families and building stronger communities,

VOLUNTEERS NEEDED

September 13, 2025
Tiny Caps and Gold Hats Graduation Carnival
11 a.m. - 1 p.m. Jubilation 55+ Pavilion

Scan to Donate

CONTACT US

hfra@rappahannocareacsb.org
540-374-3366
www.healthyfamiliesrappahannock.org

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Join Our Monthly Giving Circle: Help Us Sustain Our Mission

Every month, families in our community face challenges that no one should have to face alone. Your monthly gift helps us to continue to stand beside them, offering hope, resources, and support during their most vulnerable moments.
And right now, it's easier than ever to help.
We can now accept secure electronic donations, allowing you to give from anywhere, in just minutes, allowing you the opportunity to **Make a Difference!**

Why Give Monthly?

- **Impact you can see:** Your monthly gift helps us plan ahead and support families without interruption.
- **Easy and flexible**: You choose an amount that fits your budget.
- **Community-powered sustainability**: Your steady support helps us focus on families, not fundraising emergencies.

How You Can Help?

Consider joining our **Monthly Giving Circle** today
at one of these levels:
💚 **$10/month** – Every gift counts and brings us closer.
💚 **$25/month** – Covers program materials for one family.
💚 **$50/month** – Helps us keep our dues current and our programs thriving.
💚 **Other amount** – Every consistent gift adds up and sustains our mission.

How to Set Up Your Monthly Gift:

- **Visit** https://www.zeffy.com/donation-form/together-we-grow-2 or scan the QR code
- **Select** "Monthly" as your giving option.
- **Choose** your amount and complete your gift securely.

www.healthyfamiliesrappahannock.org

ONE PILL CAN KILL

Attorney General
Jason S. Miyares

State Senator
Tara Durant

State

FENTANYL AWARENESS & NARCAN TRAINING

Salem Fields Community Church

11120 GORDON ROAD
FREDERICKSBURG, VA 22407

REVIVE! Lay Rescuer Training

This FREE training is open to the community. It will cover understanding opioids, how opioid overdoses happen, risk factors for opioid overdoses, and how to respond to an opioid overdose emergency with the administration of Naloxone.

August 19th, 2025
5:00 pm- 7:00 pm

RSVP BY: August 18th, 2025

To RSVP please Scan the QR Code:

Strengthen your detective skills as a parent or caregiver.

Wednesday, August 27 | 12:00 pm - 1:00 p.m.

Spotsylvania Towne Centre

Spotsylvania County Sheriff's Substation (near the Post Office)
137 Spotsylvania Mall Drive, Suite 420, Fredericksburg, VA 22407

Join the Spotsylvania County Sheriff's Office, Rappahannock Area Community Services Board, Save 1 Life Harm Reduction Coalition, and The Community Collaborative for Youth and Families for "**Hidden in Plain Sight**"— an informative and eye-opening exhibit designed to help you recognize signs of teen substance use and mis-use.

Explore a simulated teen's bedroom filled with clues—hidden compartments, room décor, and concealed items—that may indicate your child is experimenting with or using drugs or alcohol.

After a 30-minute guided tour, you'll have the chance to ask questions and gain insights from a panel of experts, including representatives from local law enforcement, school leaders, mental health professionals, pediatricians, and recovery specialists. Rapid REVIVE! training available. Those trained can receive a box of Naloxone with a response kit. Community resources available onsite.

This event is for adults and caregivers only.

Questions? Email prevention@rappahannockareacsb.org

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The Community Collaborative for Youth and Families
SAVE 1 One Life

This presentation is in recognition of International Overdose Awareness Day on August 31, 2025.

To: Joe Wickens, Executive Director
From: Alison Standring, ICC & Part C Services Manager
Subject: Monitoring Results for FFY24/SFY25, Report 1 of 2
Date: July 11, 2025

Kyla Patterson's memo and the accompanying chart provide the first of two reporting cycles for the results of our annual chart review to determine compliance with Part C federal regulations for FFY24/SFY25.

MEMORANDUM

To: Joe Wickens, Executive Director
From: Alison Standring, ICC & Part C Services Manager
Subject: Monitoring Results for Indicators 1, 7, and 8a, 8b, and 8c FFY24/SFY25 (July 1, 2024 through June 30, 2025) Report 1 of 2
Date: July 11, 2025

The attached memo from Kyla Patterson provides Part C Compliance Measures and Results Measures for three of 14 federally identified indicators and a chart summarizing each of the indicators for the period of July 1, 2024 through June 30, 2025 (Federal Fiscal Year 2024). The Department of Behavioral Health and Developmental Services monitors each Part C system in the Commonwealth to assure that it is in compliance with federal Part C requirements.

The chart indicates that the Rappahannock Area, through the Parent Education - Infant Development Program and Infant/Child Support Coordinators, achieved 100% compliance in all areas. We did not demonstrate 100% compliance at the time of the review in February/March in the area of timely initiation of services, but have since corrected the deficiency to the satisfaction of DBHDS.

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

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

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

COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

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

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

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

FROM: Kyla Patterson
Early Intervention Program Manager

DATE: June 30, 2025

RE: Summary of local early intervention system (LEIS) monitoring results for FFY24/SFY25 (July 1, 2024 – June 30, 2025) for Part C of IDEA indicators C-1, C-7, and C-8

---

20 U.S.C. §1416(b)(2)(C)(ii)(II) requires each state to measure and report results on Part C of the Individuals with Disabilities Education Act (IDEA) federally identified indicators in an annual performance report (APR). The review period for Virginia's next APR—to be submitted in February 2026—will cover FFY24/SFY25 (July 1, 2024 – June 30, 2025). In addition to reporting this APR data to the U.S. Department of Education, Office of Special Education Programs (OSEP), it will also be reported publicly and used to make local determinations as required by20 U.S.C. §1416(b)(2)(C)(ii)(I) and 34 CFR §303.700(a)(2).

As the state lead agency (SLA) for Part C implementation in Virginia, staff recently completed a monitoring review of your local system data for the following annual compliance measures—

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

We appreciate the time your local early intervention system (LEIS) spent participating in the annual compliance indicators measurement and verification (CIMV) process, entering relevant data into TRAC-IT and SLA-provided Excel spreadsheets, and working with both your technical assistance consultant and monitoring consultant throughout the year. Your time and assistance in the monitoring process is critical to ensuring that the data reported to OSEP and to the public is accurate and timely.

The results for the indicators reviewed for your LEIS are documented on the enclosed "Local Early Intervention System (LEIS) Monitoring Results & Determination – Copy 1/2 – Results (06/2025)" report. Final scores for all items and sections—including your LEIS determination for FFY24/SFY25—will be reflected in copy 2 of 2 of the report to be disseminated later this year.

The reauthorized IDEA of 2004 set the state target for all compliance indicators at 100% and requires correction of identified noncompliance as soon as possible but no later than one (1) year from the date of official notification—i.e., the date of this memorandum. If your LEIS monitoring results for compliance indicator C1 (timely initiation of services, aka "30-day timeline"), compliance indicator C7 (45-day timeline for initial meeting to develop the IFSP) and/or compliance indicators C8A, C8B, C8C (transition) are less than 100% and were *not* corrected prior to receipt of this memo, your locality should begin structured and supervised local monitoring (SSLM) in July 2025. Instructions for completing SSLM are available on the ITCVA GSM Framework Manual page of our website (see Appendix I: Structured and Supervised Local Monitoring).

Please note:

- For all compliance indicators where noncompliance has been identified (i.e., results of less than 100%), the State Lead Agency must verify that noncompliance has been corrected as soon as possible and in no case later than June 30, 2026. In accordance with OSEP QA 23-01 dated July 24, 2023, this requires confirming that the LEIS is now implementing the requirement correctly and that the local system has corrected each individual case of noncompliance (unless the child is no longer in the system.) Additional record reviews or other monitoring activities may be needed in order to verify correction of noncompliance.

- The SLA is required under 20 U.S.C. §1416(e) to implement appropriate enforcement action(s) any time a LEIS: 1) fails to correct noncompliance within one (1) year; 2) receives a determination of Needs Assistance two or more years in a row; and/or 3) receives a determination of Needs Intervention or Needs Substantial Intervention. Local determinations and any required enforcement action(s) will be included on copy 2 of 2 of the local determination report (to be disseminated later this year.) Your technical assistance consultant and monitoring consultant are available to support your local system in achieving timely correction.

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

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

Enclosures

cc: Local System Manager
Local System Manager Supervisor
Nelson Smith, Commissioner, DBHDS
Heather Norton, Chief Deputy Commissioner, Community Services, DBHDS
Kari Savage, Director, Office of Child and Family Services, DBHDS
Richard Corbett, Early Intervention Team Leader, Infant & Toddler Connection of Virginia, DBHDS
Monitoring Consultant, Infant & Toddler Connection of Virginia, DBHDS
Technical Assistance Consultant, Infant & Toddler Connection of Virginia, DBHDS

Infant & Toddler Connection of

Rappahannock Area

Section A
Compliance Indicators; Longstanding Noncompliance; Accurate & Timely Data

Annual Compliance Measures (Indicator 01, Indicator 07 and Indicator 08)

Scoring
- CPN = N/A → 2
- CPN = Y → 2
- CPN = N and ARR >= 95% → 2
- CPN = N and ARR >= 75% → 1
- CPN = N and ARR < 75% → 0

Indicator	State Target	State Result	Annual Record Review (ARR) Result	Corrected Prior to Notification (CPN) (Y/N/NA)	Full Correction FFY23/SFY24 Noncompliance (Y/N/NA)	Points Awarded
01: Timely Services	100%	**97.95%**	**99.59%**	**Y**		
07: 45-Day Timeline	100%	**98.45%**	**100.00%**	**N/A**		
08A: Transition Steps and Services	100%	**99.49%**	**100.00%**	**N/A**		
08B: Transition Notification to LEA & VDOE	100%	**94.32%**	**100.00%**	**N/A**		
08C: Transition Conference	100%	**98.79%**	**100.00%**	**N/A**		

Longstanding Noncompliance

Scoring
- No longstanding noncompliance → 2
- Noncompliance corrected within one (1) year; if repeated, compliance at ARR >= 95% → 2
- Noncompliance corrected within one (1) year; if repeated, compliance at ARR < 95% → 1
- Noncompliance exceeding one (1) year → 0

Accurate & Timely Data

Scoring
- True → 1
- False → 0

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

Section A Points and % Score

Scoring
- Total points = SUM of points awarded
- Section A % score = SUM ÷ TOTAL POSSIBLE POINTS[2]

SECTION A POINTS	
SECTION A % SCORE	

[1] All FFY24/SFY25 contract deliverables submitted and 4 of 5 deliverables submitted on time in order to receive full credit.
[2] FFY24/SFY25 total possible points for Section A = 16.

Section B
Results Indicators; Data Anomalies; Data Completeness

Primary Service Setting (Indicator 02)

Scoring
- PSS >= State target → 1
- PSS < State target → 0

State Target	State Result	Local Result	Points Awarded
98.00%			

Child Outcomes (Indicator 03)

Scoring
- Local results reported but not scored

	State Target	State Result	Local Result
03A-S1: Positive social-emotional skills	64.90%.		
03A-S2: Positive social-emotional skills	57.60%		
03B-S1: Acquisition and use of knowledge and skills	68.70%		
03B-S2: Acquisition and use of knowledge and skills	46.90%		
03C-S1: Use of appropriate behaviors to meet needs	68.60%		
03C-S2: Use of appropriate behaviors to meet needs	50.70%		

Data Anomalies

Scoring
- 3 child outcomes x 5 progress categories (a-e) = 15 results
- 15 results – total anomalies = Score
  - Score = 13, 14 or 15 → 2 points
  - Score = 10, 11 or 12 → 1 point
  - Score < 10 → 0 points

Anomalies	Score	Points Awarded

Children w/ Exit Scores

Scoring
- # score captured ÷ total # eligible for scores = LEIS %
  - LEIS % >= 90% → 2 points
  - LEIS % between 80% and 90% → 1
  - LEIS % < 80% → 0 points

Eligible	Captured	LEIS %	Points Awarded

Family Outcomes (Indicator 04)

Scoring
- Meaningful difference = NA[3] → 1
- Meaningful difference = N → 1
- Meaningful difference = Y → 0

	State Target	State Result	Local Result	Meaningful Difference (Y/N/NA)	Points Awarded
04A: Family Outcomes (Know their rights)	75.00%				
04B: Family Outcomes (Communicate needs)	71.90%				
04C: Family Outcomes (Help child learn)	85.90%				

Family Survey Response Rate

Scoring
- [Surveys connected[4] minus (-) surveys returned] ÷ surveys connected = LEIS %
  - LEIS % >= 26% OR at or above 75th percentile → 2
  - LEIS % >= 22% OR between 25th and 75th percentile→ 1
  - LEIS % at or below 25th PERCENTILE → 0

Surveys Connected	Surveys Returned	LEIS %	Points Awarded

[3] Local result >= state target = NA

[4] *Surveys connected* means surveys sent minus (-) surveys returned as undeliverable. It is assumed that surveys not returned as undeliverable "connected" with the intended recipient household.

Section B: Results (continued)

Child Find (Indicator 05; Indicator 06)

Scoring • Meaningful difference = NA[5] → 1 • Meaningful difference = N → 1 • Meaningful difference = Y → 0	**State Target**	**State Result**	**Local Result**	**Meaningful Difference (Y/N/NA)**	**Points Awarded**
05: Child Find 0-1	1.83%				
06: Child Find 0-3	3.62%				

Section B Points and % Score

Scoring • Total points = SUM of points awarded • Section B % score = SUM ÷ TOTAL POSSIBLE POINTS[6]	**SECTION B POINTS**	
	SECTION B % SCORE	

Cumulative Score and Determination

Scoring • Cumulative % Score = 50% Section A % Score + 50% Section B % Score • Determination ○ 80%-100% → Meets Requirements (MR) AND no noncompliance exceeding one (1) year ○ 60%-79% → Needs Assistance (NA) ○ 50%-59% → Needs Intervention (NI) ○ 0%-49% → Needs Substantial Intervention (NSI)	**FFY24/SFY25 CUMULATIVE % SCORE**	
	FFY24/SFY25 DETERMINATION	

Enforcement Actions (if applicable)

Local EIS Determination History

FFY06/SFY07 (July 1, 2006 – June 30, 2007)	**FFY07/SFY08** (July 1, 2007 – June 30, 2008)	**FFY08/SFY09** (July 1, 2008 – June 30, 2009)	**FFY09/SFY10** (July 1, 2009 – June 30, 2010)	**FFY10/SFY11** (July 1, 2010 – June 30, 2011)	**FFY11/SFY12** (July 1, 2011 – June 30, 2012)	**FFY12/SFY13** (July 1, 2012 – June 30, 2013)
FFY13/SFY14 (July 1, 2013 – June 30, 2014)	**FFY14/SFY15** (July 1, 2014 – June 30, 2015)	**FFY15/SFY16** (July 1, 2015 – June 30, 2016)	**FFY16/SFY17** (July 1, 2016 – June 30, 2017)	**FFY17/SFY18** (July 1, 2017 – June 30, 2018)	**FFY18/SFY19** (July 1, 2018 – June 30, 2019)	**FFY19/SFY20** (July 1, 2019 – June 30, 2020)
FFY20/SFY21 (July 1, 2020 – June 30, 2021)	**FFY21/SFY22** (July 1, 2021 – June 30, 2022)	**FFY22/SFY23** (July 1, 2022 – June 30, 2023)	**FFY23/SFY24** (July 1, 2023 – June 30, 2024)	**FFY24/SFY25** (July 1, 2024 – June 30, 2025)		

[5] Local result >= state target = NA

[6] FFY23/SFY24 total possible points for Section B = 12

Local Early Intervention System (LEIS) Monitoring Results & Determination

Based on monitoring data from FFY 20## (July 1, 20## - June 30, 20##) [as required by OSEP]

☐ Copy 1/2 – Results (6/##) • ☐ Copy 2/2 – FINAL Results & Determination (10/##)

Infant & Toddler Connection of

LEIS

GENERAL INFO
- Scoring is done on Copy 2/2 (October)
- Points are positive (awarded if criteria is met)
- Meaningful difference calculators are used to determine whether differences from targets are statistically significant for Child Outcome Progress Categories, Family Outcomes and Child Count.

Section A
Compliance Indicators; Longstanding Noncompliance; Accurate & Timely Data

Annual Compliance Measures (Indicator 01, Indicator 07 and Indicator 08)

Scoring
- CPN = N/A → 2
- CPN = Y → 2
- CPN = N and ARR >= 95% → 2
- CPN = N and ARR >= 75% → 1
- CPN = N and ARR < 75% → 0

Indicator	State Target	Annual Record Review (ARR) Result	Corrected Prior to Notification (CPN) (Y/N/NA)	Full Correction of FFY##/SFY## Noncompliance (Y/N/NA)	Points Awarded
01: Timely Services	100%				
07: 45-Day Timeline	100%				
08A: Transition Steps and Services	100%				
08B: Transition Notification to LEA & SEA	100%				
08C: Transition Conference	100%				

Target for all Compliance Indicators is 100%

Longstanding Noncompliance

Scoring
- No longstanding noncompliance → 2
- Noncompliance corrected within one (1) year; if repeated, compliance
- Noncompliance corrected within one (1) year; if repeated, compliance
- Noncompliance exceeding one (1) year → 0

Noncompliance not corrected within one year OR noncompliance that is corrected and then repeated in a subsequent ARR

Accurate & Timely Data

Scoring
- True → 1
- False → 0

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

Review of data submitted with ARR confirmed accuracy

No changes in 12/1 child count due to late data entry

No children on report more than 2 of 3 months reviewed

X of Y required deliverables submitted on time

Section A Points and % Score

Scoring
- Total points = SUM of points awarded
- Section A % score = SUM ÷ TOTAL POSSIBLE POINTS[2]

SECTION A POINTS	
SECTION A % SCORE	

[1] All FFY##/SFY## contract deliverables submitted and X of Y deliverables submitted on time in order to receive full credit.
[2] FFY##/SFY## total possible points for Section A = X.

Section B
Results Indicators; Data Anomalies; Data Completeness

Primary Service Setting (Indicator 02)

Scoring
- PSS >= State target → 1
- PSS < State target → 0

State Target	Local Result		Points Awarded
98.0%			

Child Outcomes (Indicator 03)

Scoring
- Local results reported but not scored

03A-S1: Positive social-emotional skills	69.5%			
03A-S2: Positive social-emotional skills	66.4%			
03B-S1: Acquisition and use of knowledge and skills	74.7%			
03B-S2: Acquisition and use of knowledge and skills	55.3%			
03C-S1: Use of appropriate behaviors to meet needs	78.7%			
03C-S2: Use of appropriate behaviors to meet needs	56.4%			

Scoring is determined by using a meaningful difference calculator; points received if local results are not meaningfully different from expected patterns. "Anomalies" is the terminology OSEP uses to describe results that vary from the expected patterns.

Data Anomalies

Scoring
- 3 child outcomes x 5 progress categories (a-e) = 15 results
- 15 results – total anomalies = Score
  - Score = 13, 14 or 15 → 2 points
  - Score = 10, 11 or 12 → 1 point
  - Score < 10 → 0 points

Anomalies	Score	Points Awarded

Children w/ Exit Scores

Scoring
- # score captured ÷ total # eligible for scores = LEIS %
  - LEIS % >= 90% → 2 points
  - LEIS % between 80% and 90% → 1
  - LEIS % < 80% → 0 points

Eligible	Captured	LEIS %	Points Awarded

Comparison of the number of children eligible for scores (6+ months between initial IFSP date and date of closure) to the number of children with scores.

Family Outcomes (Indicator 04)

Scoring
- Meaningful difference = NA[3] → 1
- Meaningful difference = N → 1
- Meaningful difference = Y → 0

State Target	Local Result	Meaningful Difference (Y/N/NA)	Points Awarded
04A: Family Outcomes (Know their rights)	76.4%			
04B: Family Outcomes (Communicate needs)	74.4%			
04C: Family Outcomes (Help child learn)	84.9%			

Family Survey Response Rate

Scoring
- [Surveys connected[4] minus (-) surveys returned] ÷ surveys connected = LEIS %
  - LEIS % >= 26% → 2
  - LEIS % between 22% and 26% → 1
  - LEIS % < 22% → 0

Surveys Connected	Surveys Returned	LEIS %	Points Awarded

[3] Local result >= state target = NA

[4] *Surveys connected* means surveys sent minus (-) surveys returned as undeliverable. It is assumed that surveys not returned as undeliverable "connected" with the intended recipient household.

Section B: Results (continued)

Child Find (Indicator 05; Indicator 06)

Scoring • Meaningful difference = NA[5] → 1 • Meaningful difference = N → 1 • Meaningful difference = Y → 0	**State Target**	**Local Result**	**Meaningful Difference (Y/N/NA)**	**Points Awarded**
05: Child Find 0-1	1.20%			
06: Child Find 0-3	2.76%			

Section B Points and % Score

Scoring • Total points = SUM of points awarded • Section B % score = SUM ÷ TOTAL POSSIBLE POINTS[6]	**SECTION B POINTS**	
	SECTION B % SCORE	

Cumulative Score and Determination

Scoring • Cumulative % Score = 50% Section A % Score + 50% Section B % Score • Determination ○ 80%-100% → Meets Requirements (MR) AND no noncompliance exceeding one (1) year ○ 60%-79% → Needs Assistance (NA) ○ 50%-59% → Needs Intervention (NI) ○ 0%-49% → Needs Substantial Intervention (NSI)	**FFY##/SFY## CUMMULATIVE % SCORE**	
	FFY##/SFY## DETERMINATION	

Enforcement Actions (if applicable)

[5] Local result >= state target = NA

[6] FFY##/SFY## total possible points for Section B = X.

540-374-3366
healthyfamiliesrappahannock.org
600 Jackson St. Fredericksburg VA 22401

Child Abuse and Neglect Prevention Services
CBCAP Grant

Healthy Families Rappahannock Area is pleased to submit the renewal application for funding through the **Child Abuse and Neglect Prevention Services Grant** in the amount of **$50,000**. This funding will continue to **partially support the position of one existing full-time Family Support Specialist**, who plays an essential role in our prevention and early intervention efforts.

Child abuse prevention remains a core component of our mission and aligns with the longstanding goals of the Virginia Department of Social Services' Division of Family Services. With continued funding, the Family Support Specialist will maintain her work in providing critical home visiting services, parenting education, and resource coordination to families with young children, focusing on strengthening protective factors and reducing risk.

This grant has historically helped us create safer, healthier environments for children, and we are proud to continue this work with your support. The outcomes of this initiative are evident in the strong, trusting relationships our team builds with families and in the measurable progress we see in family resilience and child well-being.

540-374-3366
healthyfamiliesrappahannock.org
600 Jackson St. Fredericksburg VA 22401

Family, Opportunity, Resilience, Grit, Engagement—Fatherhood FORGE Fatherhood Project

Healthy Families Rappahannock Area (HFRA) has submitted an application, pending Board approval, in the amount of **$536,852** to implement the FORGE Fatherhood project a five-year initiative to strengthen responsible fatherhood across Planning District 16. If awarded, this project will serve fathers aged 18 and older who have children under the age of 24, including biological, adoptive, stepfathers, expectant fathers, and father figures actively engaged in parenting. The application was due July 29, 20205.

Our community faces persistent challenges with family instability, limited economic mobility, and gaps in healthy parenting and relationship skills, particularly among low- to moderate-income fathers. Fathers in our region often face barriers to employment, stable co-parenting relationships, and sustained engagement with their children, contributing to cycles of poverty and family stress.

FORGE Fatherhood will address these needs by implementing a comprehensive, evidence-informed program to:

- Promote responsible parenting through the use of 24:7 Dad®, an evidence-based fatherhood program, by providing curriculum-driven workshops focusing on child development, positive discipline, communication, and father-child engagement.
- Promote and sustain healthy marriage and relationship education, emphasizing communication, conflict resolution, financial literacy, and co-parenting strategies to strengthen family stability.
- Foster economic stability through case-managed employment supports, job readiness training, and partnerships with local workforce development agencies to connect fathers with in-demand career pathways and retention supports.

FORGE Fatherhood will provide at least 24 hours of curriculum-based workshops and individualized case management, ensuring fathers receive holistic, father-focused services to build resilience, opportunity, and grit. This program will leverage community partnerships to enhance recruitment, retention, and wraparound supports. FORGE Fatherhood aims to increase fathers' engagement with their children, improve healthy relationships, and enhance economic stability, strengthening families and communities across Planning District 16.

RACSB DEPUTY EXECUTIVE DIRECTOR REPORT
June and July 2025 Monthly Updates

Opportunities for Partnership/Input:

- Presented on panel for Virginia LEAD alumni at their annual retreat held at Germanna Community College.
- Attended the DMAS Behavioral Health Re-Design webinar and coordinated internal efforts to submit the required provider readiness survey.
- Attended a meeting with Stafford County to explore uses of their direct distribution Opioid Abatement Authority funding.
- Met minimum of three times a week regarding transition to new statewide data exchange. RACSB and Netsmart began testing the last week of January. Please see detailed information below on the status of this project.
- Served on the DBHDS Charter Finance Group to work towards streamlining fiscal requirements and building in flexibility around funding lines.
- Participated in individual and community level Community Health Improvement Plan development with RAHD/MWH.
- Attended townhall hosted by Senator Warner on Federal level changes.
- Ongoing participation at least twice a month on the VACSB CCBHC Steering Committee and selected as chair for the Data and Outcomes sub-work group for this project.
- Supported the strategic plan activities and workgroup meetings.
- Attended a second small group feedback session with VACSB leaders and the Behavioral Health Commission staff.
- Attended the Behavioral Health Commission meeting held at Western State Hospital.

Community Consumer Submission 3

DBHDS staff and CSB staff continue to meet weekly about the CCS 3 replacement project. Rappahannock Area Community Services Board continues to be the lead Netsmart Community Services Board, for those that use MyAvatar. We successfully went live on June 30, 2025. We continue to troubleshoot any errors that are identified. We currently have 96% of messages accepted without intervention.

Information Technology Department Data		
Number of IT Tickets Completed	**Zoom Meetings**	**Total Zoom Participants**
June 2025- 1,148	2,087	4,464

Information Technology Department Data		
Number of IT Tickets Completed	**Zoom Meetings**	**Total Zoom Participants**
July 2025- 1,193	2,125	4,521

To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: DBHDS Data Dashboard Report

Date: August 5, 2025

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.

Dashboard Report				
Measure	**Month of Measure**	**State Target**	**State Average**	**RACSB**
Same Day Access-Appointment Offered	March 2025	86%	81.80%	96.90%
Same Day Access-Appointment Kept	Feb 2025	70%	81.50%	90.30%
SUD Engagement	Apr 2025	50%	60.80%	66.70%
Universal Adult Columbia Screenings	March 2025	86%	79.80%	74.89% *Impacted by technical error
Universal Child/Adolescent Columbia Screenings	March 2025	86%	81.80%	67.21% * Impacted by technical error
DLA-Adult	FY2025 Q1-Q3	35%		44.80%
DLA-Child	FY2025 Q1-Q3	35%		60.50%
Percent Receiving Face to Face Case Management Services ECM	May 2025	90%	N/A	78.11%*Impacted by technical error
Percent Receiving In-home Case Management Services ECM	May 2025	90%	N/A	70.94%*Impacted by technical error
Percent Receiving Targeted Case Management	FY2025Q3	90%	N/A	95.6%* DBHDS Dashboard not working cannot provide updated information

*Significant discrepancies in the services sent and received by DBHDS for these measures. The IT team is working to identify the issue and resolve the technical error.

To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive Director

Re: Amended and Restated FY2026 and FY2027 Community Services Performance Contract Master Agreement and Supplemental Documents.

Date: August 1, 2025

The Rappahannock Area Community Services Board (RACSB) has a biennial agreement with the state's Department of Behavioral Health and Developmental Services (DBHDS) called the Performance Contract (PC). Specific changes for the upcoming fiscal year are noted in the attached letter from DBHDS. Also included is an executive summary grid of changes which equate to new requirements. This performance contract needs to be approved by our governing bodies, by RACSB, and by the Department, on or before September 30th in order to continue to receive state-controlled funds.

RACSB has submitted the FY26-27 Amended and Restated Community Services Performance Contract to all localities for review and approval. These approvals are anticipated to be completed prior to the September Board of Directors meeting where the contract will be brought to the Board for approval. All approvals must be received and the contract executed prior to September 30, 2025.

The amendments were posted on the RACSB website for public comment on June 16, 2025. During the required 30-day comment period, there were no comments submitted. The document is still available for review at the link below.

https://rappahannockareacsb.org/wp-content/uploads/2025/06/Amendments.pdf

COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

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

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

June 27, 2025

RE: AMENDMENT 3 AMENDED AND RESTATED FY2026 AND FY2027 COMMUNITY SERVICES PERFORMANCE CONTRACT MASTER AGREEMENT AND SUPPLEMENTAL DOCUMENTS – Contract No. P

Dear CSB Executive Directors,

The attached final FY26-27 amended Community Services Performance Contract (PC) and supplemental documents are ready for your execution through DocuSign.

It is important for the smooth continuity of the process to have signed performance contracts returned to the Department as soon as practicable. Please keep in mind that Code requires CSBs on or before September 30th to:

1. Make the proposed contract available for public review and solicit public comments for a period of 30 days before submitting it for local approval.
2. Submit its proposed performance contract to the governing body (city council or board of supervisors) for review and approval. CSBs to have their PC approved or renewed by the governing body of each city or county that established it. If no action is taken by the governing body of each city or county that established it by the deadline, the contract is deemed approved or renewed.
3. Sign its PC

To avoid disruptions in service continuity and allow sufficient time to complete public review and comment about the contract and negotiation and approval of the contract, the Department provides semi-monthly payments of state-controlled funds to the community services boards. It is important for the smooth continuity of the process to have signed performance contracts returned to the Department as soon as practicable.

The performance contract is a transactional agreement between the Department and the Community Services Boards and Behavioral Health Authority community partners. Changes to this agreement may be made periodically to improve the business relationship, funding and delivery of program services for better alignment with the strategic initiatives of the Commonwealth.

We encourage you take the time to familiarize yourself with all these documents to understand what is required but we would like to bring your attention to certain changes from this review period.

AMENDMENTS - FY2026 and 2027 Community Services Performance Contract

Certain amendments provided below are in compliance with required Code of Virginia and Budget amendment changes. The provisions of subsection C of §§ 37.2-508 and 37.2-608 of the Code of Virginia, as amended and budget amendment Item 295#9c shall become effective July 1, 2024. Outlined here are the material changes to the PC for your review.

1.1 **CCS and Taxonomy Sunset –** effective July 1, 2025, any reference to CCS3/CCS or Core Services Taxonomy has been removed from all performance contract documents. CCS as the data reporting mechanism for the Department has been replaced as part of the Data Modernization Program and the project to sunset CCS3 and direct alignment with industry standard reporting codes which also makes the core services taxonomy obsolete.

1.2 **Section 6 – Service Change Management –** amended from the 45 day to 30 day requirement for submission of a service modification. Effective June 19, 2025 the regulation changed to require submission of a service modification at least 30 days in advance 12VAC35-105-60. Modification.

1.3 **Section 13 Compliance with Laws –** this amendment incorporates revised privacy and data sharing language that was added through PC amendment P1636.2 that expires June 30, 2025. This section has been amended to relieve CSBs of perceived risk related to sharing PHI with DBHDS. In particular, PHI governed by 42 CFR Part 2 that has been a long-standing concern for some CSBs, and the proposed amendments address this concern.

1. Section 13.A. has been renamed from HIPAA to Data Privacy.

2. Language has been removed from Section 13.A related to DBHDS facilitating, initiating, or otherwise requiring BAAs or other data sharing agreements for which DBHDS is not a party to said agreements.

3. Language has been removed from Section 13.A. that previously required CSBs to execute a BAA with third party business associates of the Department to facilitate access to PHI/PII required by DBHDS for CSBs to provide. The OAG has stated clearly this is neither necessary nor appropriate.

1.4 **Exhibit B: Continuous Quality Improvement (CQI)-** this Exhibit has been amended based on the work done internally and externally to establish and refine BH QMS core measures, establish measure benchmarks and track progress toward targets, facilitates the provision of TA, and develops Quality Improvement Initiatives to address systemic issues.

1. **Section II. Measure Development** – the Department's Behavioral Health Measure Development and Review process has been added as Attachment 1

2. **Section V. Performance Measures** – certain program service measures have been revised (See Exhibit B for more details)
   B. Same Day Access Measures – ISERV measure development for FY26-27

Definition finalized in program workgroup, in conjunction with the CSB/DBHDS Data SME's, and will begin messaging with the mutually (CSB/DBHDS reps at Program Workgroup) created job-aide.

C. **SUD Engagement Measure (Block Grant SAMSHA/DBHDS Requirement) – benchmark increased to 65%. National scores are average and used as a baseline not a benchmark. During our presentation to the Q&O and DMC the SUD engagement benchmark was discussed.**
D. **DLA-20 Measure – revised definition. Measure development for FY26-27. Finalized in conjunction with the CSB/DBHDS Data SME's**

3. **VI. Additional Expectations and Elements Being Monitored**

A.1. Primary Care Screening – revised definition. Measure development for FY26-27. Finalized in conjunction with the CSB/DBHDS Data SME's

A.2. Antipsychotic Metabolic Screening – new required measure - Finalized in conjunction with the CSB/DBHDS Data SME's

B. Outpatient Services - revised measure and benchmark (95%) - Finalized in conjunction with the CSB/DBHDS Data SME's
C. Service Members, Veterans, and Families (SMVF) - revised measures and
D. benchmarks (Training 95% and 90% admissions for MH/SUD services) - Finalized in conjunction with the CSB/DBHDS Data SME's

1.5 **Exhibit C: PHI Data Sharing and Use Agreement -** exhibit C is being repurposed for this amendment that incorporates language into the PC from PC Amendment 2 (P1636.2) that added Exhibit N- PHI Data Sharing and Use Agreement date December 6, 2024 through June 30, 2025 that was regarding sharing confidentiality and security of individually identifiable health information between the Department and the CSBs.

1.6 **Exhibit E: Performance Contract Schedule and Process** – updated to provide the CSB specific due dates for Department required reporting submissions for the performance contract, financial, program related required data submissions for the new data platform, local government audits and Certified Public Accountant (CPA) audits for FY26-27. It also provides specific dates for disbursement of state and federal funds to the CSBs.

1.7 **Exhibit F: Federal Grant Requirements** – revised to reflect the current federal grants and their general and specific terms and conditions. These are required material changes that are not negotiable as a Subrecipient of federal funds. We encourage you to familiarize yourself with this information as a Subrecipient of federal funds

1.8 **Exhibit G: Community Services Boards Master Programs Services Requirements** – this exhibit has been revised to provide terms and conditions for certain programs services that a CSB may provide to reduce the amount of Exhibits D the Department and CSBs will have to review, process, and track. Keep in mind that this is not inclusive of all programs/services a CSB may provide, just those that it may have received on a regular basis for review and execution that have well established baseline requirements, with minimal to no changes, and/or part of ongoing baseline funding received from the Department.

At the request of the CSBs, more program service information has been added as Attachment 1 to provide more details regarding funding information such as appropriation language, where to find

additional requirements that may be in other Exhibits, cost center information and program points of contacts.

1.9 **Exhibit H: Regional Local Inpatient Purchase of Services (LIPOS) Requirements** - revised

to update the reduction of appropriated funding and remove certain CCS3 and taxonomy language.

1.10 **Exhibit K (new attachments - Appendix D, E, F, G, H):** State Hospital Census Management Admission and Discharge Requirements – this Exhibit was revised and reorganize to streamlining and ensuring the inclusion of all populations in the protocols. None of the changes are direct result of the 30-day discharge pilot because those are pilots. DBHDS programs staff did some extensive work regarding this Exhibit with CSB program and state hospitals staff responsible for this work. Please ensure that you take the time to review. Here are some key changes.

Exhibit K - Collaborative Discharge Requirements for Community Services Boards and State Hospitals – revised to clarify: State Hospital Responsibilities and CSB Responsibilities and Time Frames.

New Appendices

1. **Appendix D**- Admission Notifications
2. Individuals to include in admission notification: hospital liaison, liaison supervisor, MH/Clinical Director, ID Director if applicable
3. **Appendix E** - Discharge Dispute Process
4. Discharge Readiness Dispute Process for State Hospitals, CSBs, and DBHDS Central Office
5. **Appendix F**- Clinical Readiness Scale for State Psychiatric Hospitals with Psycho-Legal Considerations
6. **Appendix G**: Discharge Medication Protocol
7. **Appendix H**: Discharge Pilot Protocols for Central State Hospital, Southwestern Virginia Mental Health Institute, Or Southern Virginia Mental Health Institute

1.11 **Exhibit M: Department of Justice Settlement Agreement**: amended as required for DOJ compliance. These are required material changes that are not negotiable. Please review to understand the requirements. Here are some of the revisions:

1. CSB will post a message for individuals with DD and their families related to the DMAS document titled “Help in Any Language” to the CSB website and provide the information through other means, as needed, or requested by individuals with DD and their families who are seeking services.
2. Face-to-Face Visits
    a. CSBs shall refer to Enhanced Case Management Criteria Instructions and Guidance and the Case Management Operational Guidelines issued by the Department.
    b. CSB will document the selected Support Coordinator’s name on the Virginia Informed Choice form to indicate individuals, and as applicable Substitute Decision-Maker's, choice of the assigned SC.
3. Support Coordinator Quality Review

a. Each year, the CSB shall complete the number of Support Coordinator Quality Reviews and provide data to DBHDS as outlined by the process.
b. As requested by DBHDS, the CSB will submit a performance improvement plan (PIP) or Corrective Action Plan (CAP) when two or more indicators ((Item 9ci through x above) are found to be below 60% during any year reviewed.

3. CSB shall notify the community resource consultant (CRC) and regional support team (RST) in the following circumstances using the RST referral form in the waiver management system (WaMS) application to enable the RST to monitor, track, and trend community integration and challenges that require further system development.

1.12 Addendum I Administrative Requirements and Processes and Procedures– Administrative Requirements for Accounts Receivables –

1. **Appendix D - User Acceptance Testing Process –** revised to align with the data modernization requirements
2. **Appendix E - Administrative Requirements for Accounts Receivables -** was repurposed to implement a targeted review process to assess the extent to which CSBs are billing for Medicaid-eligible services they provide, (ii) determine if additional technical assistance and training, in coordination with Medicaid managed care organizations, is needed on appropriate Medicaid billing and claiming practices to relevant CSB staff, and (iii) evaluate the feasibility of a central billing entity, similar to the Federally Qualified Health Centers, that would handle all Medicaid claims for the entire system.
3. **Appendix F** - was repurposed to move Regional Program Operating Principles from the Core Services Taxonomy

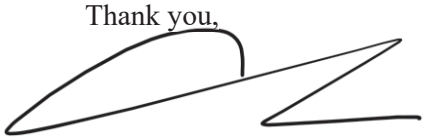
1.13 Addendum III - Sunset Core Services Taxonomy – the contents will sunset except for Regional Program Operating Principles, that was moved to Appendix F of Addendum I-Administrative Requirements and Processes and Procedures of the performance contract. We will keep a placeholder for future repurpose of this section.

The Department would like to thank you all for your service to the community and working with us.

All your hard work and dedication to both your communities and our community services system is much valued and appreciated.

If you need help or have questions, please email performancecontractsupport@dbhds.virginia.gov

Thank you,



Chaye Neal-Jones

Director

Office of Enterprise Management Services

Performance Contract Exhibit	Section	Description of Change
PC-All Exhibits	General	Remove references to CCS, Core Service Taxonomy, CARS; update with references to new data exchange
CSB Master PC	D. Use of Funds; 3. Supplanting	Paragraph added prohibits supplanting state funds with a reduction in funds provided by local governments
CSB Master PC	A. Data Privacy	Updated to conform with current regulations; References new PHI Data Sharing and Use Agreement (Exhibit C)
CSB Master PC	P. Surveys and Additional Data Reporting	Adds responsibility of Department to provide CSBs advance notice; Require Department to communicate at minimum to all CSB EDs and Finance Directors
Exhibit B: Continuous Quality Improvement Process for BH Performance Measures	II. Measure Development	Entire process changed; Did not receive review by Admin Policy Committee; Serious Concerns Noted
Exhibit B: Continuous Quality Improvement Process for BH Performance Measures	V. Performance Measures; B. Same Day Access Measures; 1. ISERV	New measure that has not been fully vetted; Admin policy committee pushed for the wording that indicates DBHDS and CSB will collaborate to determine how to collect in FY26. New guidance indicates this will be required for all CSBs as of Feb. 1, 2026. I strongly oppose any changes until we can implement the data element and process aligned with the CCBHC measure on July 1, 2026. Makes no sense to change to an "interim" solution that we cannot send the data for just to get four months of un-useable data.
Exhibit B: Continuous Quality Improvement Process for BH Performance Measures	V. Performance Measures; D. DLA-20 Measure	Extends application of DLA measure from Outpatient Services only to "STEP-VA" services; How to define denominator still needs to be worked out by DBHDS
Exhibit C: PHI Data Sharing Agreement	General	This agreement was incorporated via an amendment in December 2024; This change just makes it a formal exhibit in the new Performance Contract
Exhibit E: Performance Contract Schedule and Process	General	Remove references to CCS, Core Service Taxonomy, CARS; update with references to new data exchange
Exhibit E: Performance Contract Schedule and Process	General	Adds requirement language for HR Vacancy and Turnover reporting implemented in adhoc manner during the past two years.
Exhibit E: Performance Contract Schedule and Process	General	Adds deadline for request for local match waiver/notification
Exhibit E: Performance Contract Schedule and Process	I. Administrative Performance Requirements; H. Process for Obtaining an Extension of the end of year Fiscal Year Report Due Date	Adds process for obtaining Extensions of fiscal year financial reporting
Exhibit F: Federal Grant Compliance Requirements	II. Defined Terms	Adds definition of De Minimis Rate, Capital Expenditures; Expenditure; Indirect Costs; Modified Total Direct Cost; Notice of Funding Opportunity;
Exhibit F: Federal Grant Compliance Requirements	V. Federal Grant Specific Requirements; A. SAMHSA Grants; 1. SOR/SUD Federal Opioid Response	Adds restriction on expenditure to include making direct payments to individuals to enter treatment/participate in prevention; But may provide $30 non-cash incentive for participation in data collection activities not to exceed $75 in one grant period
Exhibit F: Federal Grant Compliance Requirements	V. Federal Grant Specific Requirements; A. SAMHSA Grants; 1. SOR/SUD Federal Opioid Response	Expenditure Guidelines adds that these funds can only be used to support individuals with opioid or stimulant misues; Also adds that if medications (MOUD) are made available they shall include FDA approved treatments
Exhibit F: Federal Grant Compliance Requirements	V. Federal Grant Specific Requirements; A. SAMHSA Grants; 2. Substance Abust Prevention and Treatment Block Grant (SUD FBG)	Restrictions: Removes any exceptions to the restriction not to provide inpatient hospital services; Clarifies exception to restriction agains providing hypodermic needles or syringes
Exhibit F: Federal Grant Compliance Requirements	General	`Removes the paragraphs in multiple sections which has the subrecipient agreeing to the Hatch Act; Davis Bacon Act
Exhibit F: Federal Grant Compliance Requirements	V. Federal Grant Specific Requirements; A. SAMHSA Grants; 4. Projects for Assistance in Transition from Homelessness (PATH)	Adds Prioritization of eligible veterans; Support training and certification of staff in SSI/SSDI Outreach, Access, and Recovery Model; Adding case management requirement to provide recovery support services such as job training, educational, relevant housing service including use of peer providers; Supportinve and supervisory services in residential settings
Exhibit F: Federal Grant Compliance Requirements	V. Federal Grant Specific Requirements; A. SAMHSA Grants; 6. Strategic Prevention Framework-Partnership for Success Grant	Entire section added
Exhibit G: Community Services Master Programs Services Requirements	10.2: Assertive Community Treatment (ACT) Program Services	Requirement to participate in TMACT review every 12-18 months with final ratings to be used to set DMAS reimbursement rate
Exhibit G: Community Services Master Programs Services Requirements	10.2: Assertive Community Treatment (ACT) Program Services	Adds new requirements for NEW ACT Teams
Exhibit G: Community Services Master Programs Services Requirements	10.2: Assertive Community Treatment (ACT) Program Services	Each new ACT team staff shall successfully complete ACT 101 training within first 120 calendar days of hire
Exhibit G: Community Services Master Programs Services Requirements	10.2: Assertive Community Treatment (ACT) Program Services	Each ACT Team member will receive additional 3 hours of training in area fitting with their area of expertise/role on the team and maintain documentation of this training.
Exhibit G: Community Services Master Programs Services Requirements	10.3 Services to Pregnant Women and Women with Dependent Children	Entire Section added; Admit pregnant women into services within 48 hours of request and provide interim services;
Exhibit G: Community Services Master Programs Services Requirements	10.4 Project Link Program	Adds requirement to provide EBP Nurturing Program for Families in Substance Abuse Treatment and Recovery and a trauma program such as Seeking Safety, Beyond Trauma, Trauma Recovery and empowerment Model, or EMDR

Exhibit G: Community Services Master Programs Services Requirements	10.5 State Opioid Response Program Services (SOR) 3. SOR Treatment and Recovery Services	Adds the following: Increase the number of OTP. Expand MAT for justice-involved; Create pathways for new treatment and recovery providers. Increase treatment for pregnant and post-partum women; Support Peer Support Services in emergency departments.
Exhibit G: Community Services Master Programs Services Requirements	10.5 State Opioid Response Program Services (SOR) 3. SOR Treatment and Recovery Services	Recovery housing supported by funds must be "certified" facilities; Removes implementaton of prevention/education services, training healthcare professionals, peers, first responders in Naloxone; Provide assistance with treatment costs for uninsured/underinsured inidividauls; address barriers to receiving MAT through telehealth
Exhibit G: Community Services Master Programs Services Requirements	10.6 Regional Suicide Prevention Initiatives	Regional reports shall be submitted quarterly
Exhibit G: Community Services Master Programs Services Requirements	10.8 Substance Use Prevention, Treatment, and Recovery Block Grant	Adds Requirement: Each CSB shall work collaboratively with the DBHDS Office of Behavioral Health Wellness (OBHW) team and the OMNI Institute technical assistance team to fulfill requirements of the grant. This collaboration includes responding to information requests in a timely fashion, entering data in the Performance Based Prevention System (PBPS), submitting reports by established deadlines.
Exhibit G: Community Services Master Programs Services Requirements	10.8 Substance Use Prevention, Treatment, and Recovery Block Grant	CSBs must enter all report data inot PBPS by the 15th of the month for month prior
Exhibit G: Community Services Master Programs Services Requirements	10.8 Substance Use Prevention, Treatment, and Recovery Block Grant	Reduce from 2 to 1 required ACE Interface Presenter/Master Trainer and reduce number of required trainings from 12 to 6; Submit narrative report quarterly.
Exhibit G: Community Services Master Programs Services Requirements	10.8 Substance Use Prevention, Treatment, and Recovery Block Grant	Added wording to support or lead at least one community coalition
Exhibit G: Community Services Master Programs Services Requirements	10.8 Substance Use Prevention, Treatment, and Recovery Block Grant	Must have at least one staff trained to deliver MHFA; minimum of 3 trainings to catchment area; minimum of 45 community participants are trained
Exhibit G: Community Services Master Programs Services Requirements	10.8 Substance Use Prevention, Treatment, and Recovery Block Grant	Suicide Prevention- Must have at least one staff member trained in at least one suicide prevention training; must provide 3 suicide prevention trainings; Minimum of 45 participants; Report all data in PBPS by 15th of the month for the month prior
Exhibit G: Community Services Master Programs Services Requirements	10.9 Adult Mental Health Block Grant	Entire section is new addition
Exhibit G: Community Services Master Programs Services Requirements	11.2 Children's Mental Health Initiative Funds	The CSB may carry-forward a balance in the MHI fund during the biennium in which the funds were distributed. If the CSB has a balance of 10% or greater, of the current allocation, at the end of the biennium, the CSB shall work with the OCFS to develop a plan to spend the end of the biennium balance. If the CSB is unable to spend the carry-forward balance within an agreed upon timeframe and, continues to have a carry-forward balance greater than 10%, DBHDS may pause payments of the current allocation.
Exhibit G: Community Services Master Programs Services Requirements	11.3 Permanent Supportive Housing	Adds "and/or pregnant or parenting women with SUD" to eligbility. Reserve any current restricted state mental health funds for PSH that remain unspent at the end of the fiscal year to be used only for PSH activities in subsequent fiscal years as authorized by the Department.
Exhibit G: Community Services Master Programs Services Requirements	11.4 Forensic Services	To the greatest extent possible, the CSB will assist the courts in identifying qualified forensic evaluators to perform adult outpatient forensic evaluations, if such assistance is requested by the courts; Upon receipt of a court order pursuant to § 16.1-357, the CSB shall submit the court order to the DBHDS Juvenile Justice Program Supervisor. The Supervisor will determine if the restoration will be provided by DBHDS Juvenile Justice Program or the CSB.
Exhibit G: Community Services Master Programs Services Requirements	11.4 Forensic Services	CSBs to provide or arrange for restoration services in the community where the individual is currently located; and Department of Corrections Facility was newly added.
Exhibit G: Community Services Master Programs Services Requirements	11.4 Forensic Services	The CSB shall provide follow-up care and discharge planning coordination to patients returning from a state facility to local or regional jails or juvenile detention centers . The CSB shall work with jail mental health and correctional staff to assist with reentry planning from the jail back to the community.
Exhibit G: Community Services Master Programs Services Requirements	11.4 Forensic Services	Upon written notification from DBHDS that an individual found Not Guilty by Reason of Insanity has been placed onto outpatient temporary custody status pursuant to § 19.2-182.2, the CSB shall initiate contact with the individual as soon as possible for the purpose of making referrals to CSB services and other providers as needed, as well as to assess and provide feedback to the Department on the individual's progress. The CSB will provide NGRI coordination and supervision while the individual completes the outpatient temporary custody evaluation process and will work jointly with the Department to develop conditional or unconditional release plans as required by Code.
Exhibit G: Community Services Master Programs Services Requirements	11.4 Forensic Services	The CSB will review and sign an NGRI acquittee's Risk Management Plan for Escorted Community, Unescorted Community, Conditional Release, and Unconditional Release in accordance with the timelines outlined in the Department's NGRI Manual: Guidelines for Management of Individuals Acquitted Not Guilty by Reason of Insanity (February 2023) and the Collaborative Discharge Requirements for Community Services Boards and State Hospitals: Adult & Geriatric.
Exhibit G: Community Services Master Programs Services Requirements	11.4 Forensic Services	The CSB shall submit written reports to the court for individuals adjudicated Not Guilty by Reason of Insanity (NGRI), documenting the person's progress and adjustment in the community. Pursuant to § 19.2-182.7 these reports shall be submitted no less frequently than every six months from the date of release and are required for the duration of conditional release. The CSB shall also provide to the Department's Office of Forensic Services written monthly reports on the person's progress and adjustment in the community for their first 12 continuous months in the community following discharge to conditional release.
Exhibit G: Community Services Master Programs Services Requirements	11.5 Adult Competency to Stand Trial Restorations	Entire section added.
Exhibit G: Community Services Master Programs Services Requirements	11.6 Gambling Prevention	Participate in conducting the Young Adult Survey (YAS), a PG Community Readiness Assessment, and Environmental Scan, and ensure a minimum of two different strategies to prevent problem gambling are included in CSB logic model. CSBs receiving funding for a minimum of .5FTE will need to implement at least 3 strategies.

Exhibit G: Community Services Master Programs Services Requirements	11.7 State Regional Discharge Assistance Program	On behalf of the CSBs in the region, the regional manager funded by the Department and employed by a participating CSB shall assure accurate and timely entry and reporting of all relevant IDAPP and expenditure data in the DBHDS DAP Portal; If the CSB has unspent funds they may be utilized subsequent years to support one time IDAPPS. Any other use of funds must be reviewed and approved by DBHDS in accordance with the DAP manual. The regional Manager shall assure accurate and timely data entry of IDAPPS and expenditures monthly into the DAP Portal. Reports on allocation, use and expenditures shall be available to both DBHDS and the Regional offices in the DAP portal at any time.
Exhibit G: Community Services Master Programs Services Requirements	11.12 System Transformation of Excellence and Performance (STEP-VA)	DBHDS has not defined expectations for this. We are at risk of contractually agreeing to something that we don't know requirements/costs/burden which will result. All CSB will establish a quality management program and continuous quality improvement plan to assess the access, quality, efficiency of resources, behavioral healthcare provider training, and patient outcomes of those individuals receiving outpatient services through the CSB. This may include improvement or expansion of existing services, the development of new services, or enhanced coordination and referral process to not directly provided by the CSB.
Exhibit G: Community Services Master Programs Services Requirements	11.12 System Transformation of Excellence and Performance (STEP-VA)	STEP Virginia requires that each CSB offer, at a minimum, the following Evidence Based Practices for psychotherapy: Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI) and the following EBP's for Psychiatry: Medication Management and Long-Acting Injectable Psychotropic Medications.
Exhibit G: Community Services Master Programs Services Requirements	11.12 System Transformation of Excellence and Performance (STEP-VA)	STEP Virginia requires each CSB also utilize at least one EBP which meets the needs identified by the locality's community needs assessment : Acceptance and Commitment Therapy, Collaborative Assessment and Management of Suicidality (CAMS), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Dialectical Behavior Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), Functional Family Therapy (FFT), Hi-Fidelity Wraparound (HFW), Integrated Treatment for Co-Occurring Disorders, Living in Balance, Medication Assisted Treatment (MAT), Moral Resonation Therapy, Motivational Enhancement Therapy, Multi-Systemic Family Therapy (MFT), Parent Child Interaction Therapy (PCIT), Screening, Brief Intervention, and Referral to Treatment (SBIRT), Seeking Safety, Solution Focused Brief Therapy, Trauma Focused CBT (TF-CBT), Effective but underutilized medications for SUD treatment.
Exhibit G: Community Services Master Programs Services Requirements	11.12 System Transformation of Excellence and Performance (STEP-VA)	This has not been fully operationalized yet. New/Alternate way that SDA can be implemented. 1.b) SDA can also provide a mental health and substance use risk screening and triage to individuals at the time the individual first contacts the CSB/BHA for services. The screening and triage may be completed in person, by telephone, or via telehealth, and will include, at a minimum, the presenting need and a screening for risk of harm to self or others, and for risk of accidental overdose. Appointments are not necessary for this initial screening. Individuals determined to be at high risk will be seen for a full assessment within 24 hours; individuals in an active crisis situation will be routed to Emergency Services immediately. Individuals determined to be at low or moderate risk will be seen for assessment within 10 business days. Based on the results of the comprehensive assessment, if the individual is determined to need services offered by the CSB, the individual will receive an appointment for face-to-face or other direct services in the program offered by the CSB within 30 calendar days, sooner if indicated by clinical circumstances.
Exhibit J: Prescreener Qualifications	C. Quality Assurance/Quality Improvement reviews	5% of all preadmissions screenings to be reviewed annually for all prescreeners by a supervisor who is a CPSC. Documentatioin of reviews shall include actions taken to improve. Domains to consider include: critical issues and concerns; does narrative support disposition; was alternative transportation considereed; were required notificationds completed; was safety plan fully articulated; was their sufficient care coordination/linkage; what services were considered by not appropriate are fully documented.
Exhibit J: Prescreener Qualifications	3. Requirements for CPSC Supervisors	Licensed CPSC supervisors are exempt from the requirement to complete a preadmission screening assessment and report annually.
Exhibit K: Collaborative Discharge Requirements for CSBs and State Hospitals	Entire Exhibit	Large scale changes made to entire Exhibit. Please review.
Exhibit K: Collaborative Discharge Requirements for CSBs and State Hospitals	Appendix D. Admission Notification	New Appendix this contract
Exhibit K: Collaborative Discharge Requirements for CSBs and State Hospitals	Appendix E: Dispute Process	New Appendix this contract
Exhibit K: Collaborative Discharge Requirements for CSBs and State Hospitals	Appendix F: Clinical Readiness Scale with Psycho Legal Considerations	New Appendix this contract
Exhibit K: Collaborative Discharge Requirements for CSBs and State Hospitals	Appendix G: Discharge Medication Protocol	Not listed in main exhibit; New Appendix this contract
Exhibit K: Collaborative Discharge Requirements for CSBs and State Hospitals	Appendix H: Discharge Pilots	Not listed in main exhibit; New Appendix this contract
Exhibit M: DOJ Settlement Agreement Requirements	Section 8.	The CSB will document the selected Support Coordinator's name on the Virginia Informed Choice form to indicate individuals, and as applicable Substitute Decision-Maker's, choice of the assigned SC.
Addendum I: Administrative Requirements	Appendix D. User Acceptance Testing Process	Changes requirement for major changes to be limited to once a year to "primarily occur"…And changes "at discretion of DBHDS and DMC" to "at discretion of DBHDS with input from DMC".
Addendum I: Administrative Requirements	Appendix E: Administrative Requirements for Accounts Receivables	Entirely new Appendix: Requires CSB shall report total client receivables, including accounts aged 30 days, 31-60 days, 61-90 days, 91-120, 120 days and over, by payor type, to DBHDS Finance on a quarterly basis within 30 days of the close of the quarter using the established DBHDS report template. CSB shall send the reports to Eric Billings, Deputy Director of Fiscal Services and Grants Management at eric.billings@dbhds.virginia.gov.
Addendum I: Administrative Requirements	Appendix F: Regional Programs Procedures	New Appendix this contract/Moved from Core Services Taxonomy

Addendum III: Sunset Core Services Taxonomy	Entire Addendum Shall be Sunset	Entire Addendum Shall be Sunset

To: Joe Wickens, Executive Director

From: Brandie Williams, Deputy Executive

Director Re: Strategic Plan for Board Approval

Date: August 1, 2025

The Rappahannock Area Community Services Board has developed a strategic plan for the next three years to complement state initiatives and goals in its efforts to respond to the services and support needs of persons with mental health or substance use disorders or developmental disabilities in Planning District 16.

The plan is presented in the following formats:

- Full Strategic Plan document which extensively describes the plan and its evaluation while incorporating the requirements to meet CARF expectations.
- Priority level worksheets- Quick guide by priority to condense key information into a more easily reviewed/consumable feedback
- One page profile- Serves as the document used to report on the implementation of the plan for the first year.

Rappahannock Area Community Services Board

Strategic Plan

July 2025 - June 30, 2028

Introduction

The Rappahannock Area Community Services Board (RACSB) is one of 39 community services boards and one behavioral health authority throughout the Commonwealth of Virginia. Community Services Boards (CSB) are established by local governments and are responsible for delivering community-based mental health, developmental disability, substance use, and prevention services either directly or through contracts with private providers.

CSBs are the single points of entry into publicly funded mental health, developmental disability, and substance use services, with responsibility and authority for assessing individual needs, accessing a strategic array of services and supports, and managing state-controlled funds for community-based services. CSBs focus on providing individualized, effective, and flexible treatment, habilitation, and prevention services in the most accessible and integrated setting possible. CSBs draw upon available community resources along with individuals' natural support systems to decrease the impacts of mental health disabilities, substance use disorders, developmental disabilities; to encourage growth and development; to support recovery and self-determination; and to help individuals reach their fullest potential.

As a partner with the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and other stakeholders, RACSB shares a desire for the system of care to excel in the delivery and continuity of services for individuals and their families. A collaborative strategic planning process helps identify the needs of individuals and guides operational decisions that contribute to effective care.

Mission, vision, and values are essential components of a strategic plan because they provide a clear foundation and direction for an organization's goals and actions. The **mission** defines the organization's purpose and reason for existence, guiding day-to-day operations. The **vision** includes clear and concise guiding principles reflecting a culture applicable to employees, stakeholders, community partners, and individuals served. The **values** represent the core principles and beliefs that shape the organization's culture and decision-making. Together, these elements ensure that strategic initiatives are consistent, focused, and reflective of the organization's identity.

Mission

RACSB is dedicated to education, recovery, treatment, and wellness of Planning District 16 residents affected by mental health, substance use disorders, and developmental disabilities.

Vision

Spark Hope. Support Hope. Spread Hope.

Values

Inclusion. Collaboration. Integrity. Resilience. Excellence and Innovation

Accreditation and Compliance

RACSB behavioral health programs and services have received international accreditation by CARF (Commission on Accreditation of Rehabilitation Facilities) for the past 27 years. The following programs have received three-year accreditations on recognized standards of quality in the provision of outcomes driven programs and services:

- Case Management/Services Coordination: Integrated Alcohol and Other Drug (AOD)/Mental Health (MH) (Adults);
- Case Management/Services Coordination: Integrated Alcohol and Other Drug (AOD)/Mental Health (MH) (Children and Adolescents);
- Community Housing Mental Health (Adults);
- Community Integration: Psychosocial Rehabilitation (Adults);
- Drug Court Treatment: Integrated: Alcohol and Other Drug (AOD)/Mental Health (MH)(Adults);
- Drug Court Treatment: Integrated: Alcohol and Other Drug (AOD)/Mental Health (MH) (Children and Adolescents);
- Outpatient Treatment: Integrated Alcohol and Other Drug (AOD)/Mental Health (MH) (Adults);
- Outpatient Treatment: Integrated Alcohol and Other Drug (AOD)/Mental Health (MH) (Children and Adolescents);
- Supported Living: Mental Health (Adults); and
- Crisis Stabilization Program

In addition to achieving compliance with international standards developed by CARF, RACSB consistently maintains compliance with the Virginia Department of Behavioral Health and Developmental Services licensure standards.

Input to Strategic Plan

Cooperation with other service providers, community agencies, and statewide organizations ensures a comprehensive response to the community's behavioral health and developmental disability needs. Therefore, RACSB sought input through a variety of methods, including an online survey which was posted on the agency website, promoted via social media, and sent by email to community partners and leaders. This survey garnered 162 responses.
Additionally, the strategic plan workgroup reviewed survey responses from the H-3 Employee Survey which identified areas of strengths and weakness in the area of employee engagement. Finally, the workgroup reviewed the responses to the most recent point-in-time survey, which provides individuals served an opportunity to provide feedback on the services they have received.

In addition to survey responses, the workgroup reviewed the Rappahannock Area Health District (RAHD) and Mary Washington Healthcare's Community Health Assessment and Community Health Improvement Plan (CHIP) which identifies mental health and access to healthcare as two of top three priorities for the region. This assessment occurred from 2024 to 2025 and a plan was developed to last from July 2025 through June 2028. The workgroup also reviewed DBHDS' strategic plan and key performance initiatives as well as KFF's Mental Health and Substance Use State Fact sheet for Virginia.

Community

Based on the estimated 2024 data from the Weldon Cooper Center (WCC), the population for the areas served by RACSB is 407,412. This is a 6.5% total increase from 2020, compared to a 1.9% increase for Virginia. Caroline County had the highest percentage of growth with 9.3%, followed by Spotsylvania County with 7.1%. The WCC projects that the population for areas served by RACSB will grow to 431,060 by 2030. During FY24, RACSB provided 14,672 individuals with mental health services, 1,193 individuals with substance use services, and 3,828 individuals with developmental disability services. Additionally, the agency reached more than 36,096 community members through prevention trainings.

Strategic Plan Priorities, Goals, and Key Performance Initiatives

RACSB has identified four priority areas to address during the next three years. These ambitious goals indicate organizational priorities and directly support the agency's mission. Each respective goal includes strategies to support successful implementation.

Priority 1: Access to Services

Vision and Mission Alignment:

- To ensure equitable, timely, and comprehensive access to services for all individuals in our community.
- To reduce wait times and increase the capacity to serve more clients across programs.
- To simplify and streamline access to services.
- To increase awareness and reduce stigma around behavioral health and remove barriers that prevent clients from engaging in services.

Strengths/Weaknesses/Opportunities/Threats:

Strengths	Weaknesses	Opportunities	Threats
Serving populations not served elsewhere (SMI, underinsured, financially disadvantaged); going beyond code-mandated services to intentionally address gaps in our community; having facilities in each locality of PD16	Silos—demographic, financial, and bureaucratic; community presence, education, partnership, and awareness; knowledge of services; community engagement; need for more efficiency of processes; services aligned to need; lack of crisis services across continuum; dual-diagnosis; child-specific services; feedback from individuals/identification of support needs; lack of access to services; lack of appointment times; long waits for services; transportation barriers; plethora of programs and services and not having the resources for all of them	CRC funding; OAA (Opioid Abatement Authority) funding; new programs coming; additional waivers for individuals in our community; MH employment services funding through DMAS/DARS; community outreach, (schools, counselors, church groups, elders); innovative/non-traditional collaborations (higher learning institutes; private partners; high schools; SDOH Partners); communication (internal and external); Increasing need for our services; future data gathering and analysis; re-evaluation of organizational structure and maximizing organizational efficiencies	DBHDS/DMAS-data, reporting, administrative, documentation requirements; transportation; inconsistent and insufficient funding that does not cover and/or match rates of inflation, unanticipated future expenses, or increased cost of living; rising need for services due to population increase, waiver population, economic impacts on behavioral health, and increased prevalence of behavioral health needs; political and regulatory issues and hurdles at the federal, state, and local levels; economic uncertainty at the federal, state, and local levels.

Strategic Goals:

By FY28, increase the total number of individuals served by 5%. Percentage of increase will be reviewed and adjusted annually to reflect the met/unmet need.

By the end of FY26, 100% of programs will establish a metric to measure access to services using the model below, establishes a benchmark, and a percentage for improvement.

By FY28, 100% of programs will demonstrate improvement on their specific access measure. By the end of FY28, increase individuals' access to services as measured by _____ by ___% from baseline established during FY26.

Key Performance Initiatives by Fiscal Year:

Priority 1: Access To Services
Year 1: July 2025-June 2026
Strategy 1: By June 2026, 50% of individuals receive first service within 10 days of request for service and receive their next two services within 30 days.

Strategy 2: By June 2026, RACSB will secure a facility and begin construction/renovation for re-located Adult CSU, new Adult CRC, Child CSU, and Child CRC. Staffing plan, operational budget, and draft policies and procedures manual will be developed for each of the three new services.
Strategy 3: By June 2026, 80% of individuals assigned a waiver will have a service plan developed and active within 90 days of waiver allocation.
Strategy 4: By June 2026, a plan will be developed to expand access to I/DD Community Engagement day support services. A metric and a benchmark will be developed to measure progress for the next two years of the plan.
Strategy 5: By June 2026, RACSB will partner with four additional middle schools to provide substance use prevention education.

Year 2: July 2026-June 2027
Strategy 1: By FY2028, 60% of individuals receive first service within 10 days of request for service and receive their next two services within 30 days.
Strategy 2: By June 2027, construction/renovation will be completed for Adult CSU, Adult CRC, Child CSU, and Child CRC. Hiring processes will start. Adult CSU services and CRC services will be provided by August 2027 and Child CSU and CRC services by March 2028. A benchmark of individuals to be served will be established during the final year of the plan.
Strategy 3: By June 2027, 80% of individuals assigned a waiver will have a service plan developed and active within 60 days of waiver allocation.
Strategy 4: The plan to expand access to I/DD Community Engagement day support services will be monitored using the metric and benchmark established in Year 1.
Strategy 5: By June 30, 2027, RACSB will partner with six additional middle schools to provide substance use prevention education.

Year 3: July 2027-June 2028
Strategy 1: By June FY2028, 70% of individuals receive 1st service within 10 days of request for service and receive their next two services within 30 days.
Strategy 2: By June 2028, a minimum number of individuals will be served in each of the four crisis services as established in Year 2.
Strategy 3: By June 2028, 90% of individuals assigned a waiver will have a service plan developed and active within 60 days of waiver allocation.
Strategy 4: The plan to expand access to I/DD Community Engagement day support services will be monitored using the metric and benchmark established in Year 1.
By June 30, 2028, 15% of middle school students within Planning District 16 will receive prevention education on the topics of alcohol, tobacco/vaping, and other drugs.

Priority 2: Effective and Quality Services

Vision and Mission Alignment:

- To be a trusted leader in delivering accessible, person-centered, and evidence-based care that improves the lives of individuals and strengthens communities.
- To provide high-quality, inclusive, and culturally responsive programs and services that empower individuals and families to achieve emotional wellness and recovery.
- To empower individuals to live fulfilling, inclusive lives through access to high-quality, person-centered programs and services in a supportive community.
- To deliver and advocate for comprehensive, individualized, and community-integrated supports that enhance the well-being, independence, and inclusion of individuals served.

Strengths/Weaknesses/Opportunities/Threats:

Strengths	Weaknesses	Opportunities	Threats
Best practices/compliance; RACSB goes beyond code-mandated services to intentionally address gaps in our community; community-based training	Plethora of programs and services and not having the resources for all of them; need for more efficiency of processes; Services aligned to need; lack of crisis services across continuum; dual-diagnosis; children-specific services; feedback from individuals/Identification of support needs; insufficient technology.	CRC funding; OAA (Opioid Abatement Authority) funding; new programs coming; additional waivers for individuals in our community; MH Employment services funding through DMAS/DARS; innovative/non-traditional collaborations (higher learning institutes; private partners; high schools; SDOH Partners); communications (internal and external); future data gathering and analysis; re-evaluation of organizational structure and maximizing organizational efficiencies	DBHDS/DMAS-data, reporting, administrative, documentation requirements; inconsistent and insufficient funding that does not cover and/or match rates of inflation, unanticipated future expenses, or increased cost of living; increased need for services due to population increase, waiver population, economic impacts on behavioral health, higher levels of the prevalence of behavioral health needs; political and regulatory issues and hurdles at the federal, state, and local levels; economic uncertainty at the federal, state, and local levels

Strategic Goals:

By the end of FY2026, 100% of programs will establish a metric to measure effectiveness using the model below, establishes a benchmark, and a percentage for improvement. By FY2028, 100% of programs will demonstrate improvement on their specific access measure.

By the end of FY2028, increase the percent of individuals demonstrating improvement and sustainability as measured by _____ by ___% from baseline established during FY____.

Key Performance Initiatives by Fiscal Year:

Priority 2: Effective and Quality Services
Year 1: July 2025-June 2026
Strategy 1: By June 2026, RACSB will complete a gap assessment to identify actions needed to move towards CCBHC.
Strategy 2: By June 2026, RACSB will establish a consumer-based net promoter score process and set performance benchmarks for the next two years.
Strategy 3: By June 2026, RACSB will identify collaborative partnerships and begin to formalize with MOUs. RACSB will identify community engagement events and track attendance. Benchmarks will be set for next two year to increase formalized MOUs for partnerships and to monitor community engagement events attended by RACSB.
Strategy 4: By June 2026, RACSB will complete a gap assessment to identify actions needed to move towards offering primary care services.

Year 2: July 2026-June 2027
Strategy 1: By August 2026, RACSB will create and start the implementation of a work plan to address CCBHC gaps and move the agency towards meeting required criteria.
Strategy 2: By June 2027, net consumer promoter score will meet the benchmark established in year one as measured quarterly.
Strategy 3: By June 2027, RACSB will meet the benchmarks to increase formalized MOUs for partnerships and meet benchmarks for community engagement events attended by RACSB as defined in Year 1.
Strategy 4: By June 2027, complete construction/renovation for co-located primary care services and finalize staffing model and program policies/procedures.

Year 3: July 2027-June 2028
Strategy 1: By June 2028, RACSB will meet all criteria in the CCBHC certification checklist and obtain CARF CCBHC accreditation during the next survey Fall 2028.
Strategy 2: By June 2028, net consumer promoter score will meet the benchmark established in year one as measured quarterly.
Strategy 3: By June 2028, RACSB will meet the benchmarks to increase formalized MOUs for partnerships and meet benchmarks for community engagement events attended by RACSB as defined in Year 1.
Strategy 4: By December 2027, RACSB will begin to deliver co-located primary care services.

Priority 3: Staff Retention, Workforce Support, and Talent Development

Vision and Mission Alignment:

- To enhance employee retention and engagement to support a resilient and high-performing workforce aligned with RACSB′s mission that delivers equitable and high-quality care to the community.

- To recruit, develop, and retain a competent and compassionate workforce through training, leadership development, and employee well-being initiatives while building a positive culture of service.

Strengths/Weaknesses/Opportunities/Threats:

Strengths	Opportunities	Weaknesses	Threats
Quality and competent staff; resilience during uncertain times; Board of Directors; recruiting and training; access to training and resources; competitive benefits to include strong compensation package	Professional and personal growth with educational reimbursement; innovative/non-traditional collaborations (higher learning institutes; private partners; high schools; SDOH partners); communications (internal and external); future data gathering and analysis; re-evaluation of organizational structure and maximizing organizational efficiencies	Gap in decision making and communication (staff survey); lack of recognition and praise of staff, lack of flexible work schedule/work life balance; staff burnout/workload maintenance; feedback from staff/identification of employees' support needs; silos—demographic, financial, and bureaucratic; need for middle management training; cross-training overall; need for more efficiency of processes	DBHDS/DMAS-data, reporting, administrative, documentation requirements; inconsistent and insufficient funding that does not cover and/or match rates of inflation, unanticipated future expenses, or increased cost of living; political and regulatory issues and hurdles at the federal, state, and local levels; economic uncertainty at the federal, state, and local levels

Strategic Goals:

By the end of FY2028, increase employee retention as demonstrated by annual turnover rate of 15% or less and achieve a staff engagement score of at least 80% on the annual engagement survey.

Key Performance Initiatives by Fiscal Year:

Priority 3: Staff retention, workforce support, and talent development
Year 1: July 2025-June 2026
Strategy 1: By December 2025, RACSB will design and implement an employee engagement survey and use results to establish a benchmark for measuring key engagement areas for the next two years.

Strategy 2: By June 2026, RACSB will offer exit interviews and surveys to 100% of employees who voluntarily resign. RACSB will develop a structured stay interview process and survey and conduct them with 50% of staff with the goal of 100% of staff within the three-year period.
Strategy 3: By June 2026, RACSB will conduct a needs analysis around employee leadership development needs and create a curriculum and a plan to define and grow leadership program.

Year 2: July 2026-June 2027
Strategy 1: By October 2026, RACSB will meet the established benchmarks for key engagement areas on the employee engagement survey.
Strategy 2: By June 2027, RACSB will offer exit interviews and surveys to 100% of employees who voluntarily resign. RACSB conduct stay interview process with 75% of staff with the goal of 100% of staff within the three-year period.
Strategy 3: By June 2027, ____ number of employees will engage in the leadership program, per the benchmark established in Year 1.

Year 3: July 2027-June 2028
Strategy 1: By October 2027, RACSB will meet the established benchmarks for key engagement areas on the employee engagement survey.
Strategy 2: By June 2028, RACSB will offer exit interviews and surveys to 100% of employees who voluntarily resign. RACSB conduct stay interview process with 100% of staff within the three-year period.
Strategy 3: By June 2028, ____ number of employees will engage in the leadership program, per benchmark established in Year 1.

Priority 4: Fiscal and Operational Excellence

Vision and Mission Alignment:

- To optimize resource use, streamline processes, and embrace data-driven decision-making to ensure that services remain sustainable, responsive, and high quality.
- To enable RACSB to extend its reach, reduce barriers to care, and invest more deeply in innovative, evidence-based practices—advancing both the impact in the communities served and financial stewardship.
- To provide timely, effective, and accessible service provision by streamlining operations and maximizing resources.

Strategic Goals:
By the end of FY2028, increase year-end positive variance to 1%.
Create a sustainability plan to reaching towards a balance budget within 3 years for each program within X time frame
Strengths/Weaknesses/Opportunities/Threats:

Strengths	Opportunities	Weaknesses	Threats
Robust reserve funds	CRC funding; OAA (Opioid Abatement Authority) funding; new programs coming; additional waivers; MH Employment services funding through DMAS/DARS; increasing need for services; future data gathering and analysis; re-evaluation of organizational structure and maximizing organizational efficiencies	Silos—demographic, financial, and bureaucratic; need for more efficiency of processes; lack of consistency in funding resources; Insufficient technology; plethora of programs and services without having the resources for all of them	DBHDS/DMAS-data, reporting, administrative, documentation requirements; inconsistent and insufficient funding that does not cover and/or match rates of inflation, unanticipated future expenses, or increased cost of living; political and regulatory issues and hurdles at the federal, state, and local levels, economic uncertainty at the federal, state, and local levels

Strategic Goals:
By the end of FY2028, increase year-end positive variance to 1%.
Create a sustainability plan to reaching towards a balance budget within three years for each program.

Key Performance Initiatives by Fiscal Year:

Priority 4: Fiscal and Operational
Year 1: July 2025-June 2026
Strategy 1: By June 2026, each program will develop a sustainability, staffing, and succession plan.
Strategy 2: By June 2026, RACSB will collect data, establish consistent measurement metrics, and establish benchmarks to monitor time from service to documentation completion.

Strategy 3: By June 2026, 100% of programs audited will have a minimum comparative score of 75 on audits.
Strategy 4: By June 2026, RACSB will complete costing engagement through MTM Consulting and present results to Board of Directors.
Strategy 5: By June 2026, RACSB staff will complete a workflow and documentation map process for five programs. Any data element or documentation not currently required will be removed and data entry fields will be reduced.

Year 2: July 2026-June 2027
Strategy 1: By June 2027, RACSB will complete RFP and procurement process to update financial systems, to include at minimum the general ledger system.
Strategy 2: By June 2027, RACSB will meet the Year 1 benchmarks on established performance metrics for time from service to documentation completion.
Strategy 3: By June 2027, 100% of programs audited will have a minimum comparative score of 80 on audits.
Strategy 4: By June 2027, RACSB will develop cost reporting dashboard using the information from the MTM engagement.
Strategy 5: By June 2027, RACSB staff will complete a workflow and documentation map process for five additional programs. Any data element or documentation not currently required will be removed and data entry fields will be reduced.

Year 3: July 2027-June 2028
Strategy 1: By June 2028, RACSB will have applied for a minimum of 15 grant opportunities during the three-year plan period.
Strategy 2: By June 2028, RACSB will meet the Year 2 benchmarks on established performance metrics for time from service to documentation completion.
Strategy 3: By June 2028, 100% of programs audited will have a minimum comparative score of 90 on audits.
Strategy 4: By June 2028, RACSB staff will complete a workflow and documentation map process for five additional programs. Any data element or documentation not currently required will be removed and data entry fields will be reduced.

Evaluation and Continuous Quality Improvement

RACSB Executive Leadership Team in partnership with the Board of Directors will be responsible for consistent evaluation and continuous quality improvement of this strategic plan. In quarterly reviews held during Board of Directors' meetings, the group will monitor progress on goals and adjust strategies as needed. The RACSB strategic plan is intended to be a living document and will be adjusted based on performance feedback no less than annually. The plan establishes consistent staff, community and stakeholder feedback loops which will be used to guide improvement.

Governance and Accountability

RACSB Executive Leadership Team in partnership with the Board of Directors will be responsible for the governance of the plan. A workgroup of executive leadership and Board of Directors, or the Strategic

Plan Steering Committee, was created to guide the development and implement the plan. This group will meet as needed to refine and update the plan. Project leads have been established for each strategic goal and initiative. The position identified as project lead will be accountable for implementing and reporting progress for each of the assigned goals/initiatives.

Priority 1: Access to Services

Vision and Mission Alignment:

- To ensure equitable, timely, and comprehensive access to services for all individuals in our community.
- Reduce wait times and increase the capacity to serve more clients across programs.
- Simplify and streamline access points to services.
- Increase awareness and reduce stigma around behavioral health. Remove barriers that prevent clients from engaging in services.

Strategic Goals:

- By FY2028, increase the total number of individuals served by 5%. Percentage of increase will be reviewed and adjusted annually to reflect the met/unmet need.
- By the end of FY2026, 100% of programs will establish a metric to measure access to services using the model below, establishes a benchmark, and a percentage for improvement.
- By FY2028, 100% of programs will demonstrate improvement on their specific access measure.
- By the end of FY2028, increase individuals' access to services as measured by _____ by ___% from baseline established during FY____.

Strengths/Weaknesses/Opportunities/Threats:

Strengths	Weaknesses	Opportunities	Threats
Serving populations not served elsewhere (SMI, underinsured, financially disadvantaged); RACSB goes beyond code mandated services to intentionally address gaps in our community; having facilities in each locality of PD16	Silos—demographic, financial, bureaucratic; community presence, education, partnerships, and awareness; knowledge of services; community engagement; need for more efficiency of processes; services aligned to need; lack of crisis services across continuum; dual-diagnosis; child-specific services; feedback from individuals/identification of support needs; lack of access to services; lack of appointment times; long waits for services; transportation barriers; plethora of programs and services and not having the resources for all of them	CRC funding; OAA (Opioid Abatement Authority) funding; new programs coming; additional waivers for individuals in our community; MH Employment services funding through DMAS/DARS; community outreach (schools, counselors, church groups, elders); innovative/non-traditional collaborations higher learning institutes, private partners, high schools, SDOH partners); communications (internal and external); increasing need for our services; future data gathering and analysis; re-evaluation of organizational structure and maximizing organizational efficiencies	DBHDS/DMAS-data, reporting, administrative, documentation requirements; transportation; inconsistent and insufficient funding that does not cover and/or match rates of inflation, unanticipated future expenses, or increased cost of living; increased need for services due to population increase, waiver population, economic impacts on behavioral health, higher levels of the prevalence of behavioral health needs; political and regulatory issues and hurdles at the federal, state, and local levels; economic uncertainty at the federal, state, and local levels

Priority 1: Access To Services
Year 1: July 2025-June 2026
Strategy 1: By June 2026 50% of individuals receive first service within 10 days of request for service and receive their next two services within 30 days.
Strategy 2: By June 2026, RACSB will secure a facility and begin construction/renovation for re-located Adult CSU, new Adult CRC, Child CSU, and Child CRC. Staffing plan, operational budget, and draft policies and procedures manual will be developed for each of the three new services.
Strategy 3: By June 2026, 80% of individuals assigned a waiver will have a service plan developed and active within 90 days of waiver allocation.
Strategy 4: By June 2026, a plan will be developed to expand access to I/DD Community Engagement day support services. A metric and benchmark will be established to measure progress for final two years of the plan.
Strategy 5: By June 2026, RACSB will partner with four additional middle schools to provide substance use prevention education.

Year 2: July 2026-June 2027
Strategy 1: By FY2028, 60% of individuals will receive first service within 10 days of request for service and receive their next two services within 30 days.
Strategy 2: By June 2027, construction/renovation will be completed for re-located Adult CSU, new Adult CRC, Child CSU, and Child CRC. Hiring processes will start. Adult CSU services and CRC services will be provided by August 2027. Child CSU and CRC services will be provided by March 2028. A benchmark number of individuals to be served will be established during the final year of the plan.
Strategy 3: By June 2027, 80% of individuals assigned a waiver will have a service plan developed and active within 60 days of waiver allocation.
Strategy 4: The plan to expand access to I/DD Community Engagement day support services will be monitored using the metric and benchmark established in Year 1.
Strategy 5: By June 30, 2027, RACSB partner with six additional middle schools to provide substance use prevention education.

Year 3: July 2027-June 2028
Strategy 1: By June FY2028, 70% of individuals receive 1st service within 10 days of request for service and receive their next two services within 30 days.
Strategy 2: By June 2028, a minimum number of individuals will be served in each of the four crisis services as established in Year 2.
Strategy 3: By June 2028, 90% of individuals assigned a waiver will have a service plan developed and active within 60 days of waiver allocation.
Strategy 4: The plan to expand access to I/DD Community Engagement day support services will be monitored using the metric and benchmark established in Year 1.
Strategy 5: By June 2028, 15% of middle school students within Planning District 16 will receive prevention education on the topics of alcohol, tobacco/vaping, and other drugs.

Priority 2: Effective and Quality Services

Vision and Mission Alignment:

- To be a trusted leader in delivering accessible, person-centered, and evidence-based care that improves the lives of individuals and strengthens communities.
- To provide high-quality, inclusive, and culturally responsive programs and services that empower individuals and families to achieve emotional wellness and recovery.
- To empower individuals to live fulfilling, inclusive lives through access to high-quality, person-centered programs and services in a supportive community.
- To deliver and advocate for comprehensive, individualized, and community-integrated supports that enhance the well-being, independence, and inclusion of individuals served.

Strengths/Weaknesses/Opportunities/Threats:

Strengths	Weaknesses	Opportunities	Threats
Best practices/compliance; RACSB goes beyond code-mandated services to intentionally address gaps in our community; community-based training	Plethora of programs and services and not having the resources for all of them; need for more efficiency of processes; services aligned to need; lack of crisis services across continuum; dual-diagnosis; child-specific services; feedback from individuals/Identification of support needs; insufficient technology.	CRC funding; OAA (Opioid Abatement Authority) funding; new programs coming; additional waivers for individuals in our community; MH Employment services funding through DMAS/DARS; innovative/non-traditional collaborations (Higher learning institutes, private partners, high schools; SDOH Partners); communications (internal and external); future data gathering and analysis; re-evaluation of organizational structure and maximizing organizational efficiencies	DBHDS/DMAS-data, reporting, administrative, documentation requirements; inconsistent and insufficient funding that does not cover and/or match rates of inflation, unanticipated future expenses, or increased cost of living; increased need for services due to population increase, waiver increase, economic impacts on behavioral health, higher levels of the prevalence of behavioral health needs; political and regulatory issues and hurdles at the federal, state, and local levels; economic uncertainty at the federal, state, and local levels

Strategic Goals:

By the end of FY2026, 100% of programs will establish a metric to measure effectiveness using the model below and will establish a benchmark and a target percentage for improvement. By FY2028, 100% of programs will demonstrate improvement on their specific access measure.

By the end of FY2028, increase the percent of individuals demonstrating improvement and sustainability as measured by _____ by ___% from baseline established during FY____.

Key Performance Initiatives by Fiscal Year:

Priority 2: Effective and Quality Services
Year 1: July 2025-June 2026
Strategy 1: By June 2026, RACSB will complete a gap assessment to identify actions needed to move toward CCBHC.
Strategy 2: By June 2026, RACSB will establish a consumer-based net promoter score process and set performance benchmarks for the next two years.
Strategy 3: By June 2026, RACSB will identify collaborative partnerships and begin to formalize with MOUs. RACSB will identify community engagement events and track attendance. Benchmarks and metrics will be set for next two year to increase formalized MOUs for partnerships and to monitor community engagement events attended by RACSB.
Strategy 4: By June 2026, RACSB will complete a gap assessment to identify actions needed to move toward offering primary care services.

Year 2: July 2026-June 2027
Strategy 1: By August 2026, RACSB will create and start the implementation of a work plan to address CCBHC gaps and move the agency towards meeting all required criteria.
Strategy 2: By June 2027, the net consumer promoter score will meet the benchmark established in year one as measured quarterly.
Strategy 3: By June 2027, RACSB will meet the benchmarks to increase formalized MOUs for partnerships and meet benchmarks for community engagement events attended by RACSB as defined in Year 1.
Strategy 4: By June 2027, construction/renovation will be completed for co-located primary care services and finalize staffing model and program policies/procedures.

Year 3: July 2027-June 2028
Strategy 1: By June 2028, RACSB will meet all criteria in the CCBHC certification checklist and obtain CARF CCBHC accreditation during the next survey in 2028.
Strategy 2: By June 2028, the net consumer promoter score will meet the benchmark established in year one as measured quarterly.
Strategy 3: By June 2028, RACSB will meet the benchmarks to increase formalized MOUs for partnerships and meet benchmarks for community engagement events attended by RACSB as defined in Year 1.
Strategy 4: By December 2027, RACSB will begin to deliver co-located primary care services.

Priority 3: Staff retention, workforce support, and talent development

Vision and Mission Alignment:

- To enhance employee retention and engagement to support a resilient and high-performing workforce aligned with RACSB's mission that delivers equitable and high-quality care to the community.
- To recruit, develop, and retain a competent and compassionate workforce through training, leadership development, and employee well-being initiatives while building a positive culture of service.

Strategic Goals:

By the end of FY2028, increase employee retention as demonstrated by annual turnover rate of 15% or less and achieve a staff engagement score of at least 80% on the annual engagement survey.

Strengths/Weaknesses/Opportunities/Threats:

Strengths	Opportunities	Weaknesses	Threats
Quality and competent staff; resilience during uncertain times; Board of Directors; recruiting and training; access to training and resources; competitive benefits package to include strong compensation package	Professional and personal growth with educational reimbursement; innovative/non-traditional collaborations (higher learning institutes, private partners, high schools, SDOH partners); communications (internal and external); future data gathering and analysis; re-evaluation of organizational structure and maximizing organizational efficiencies	Gap in decision making and communication (staff survey); lack of recognition and praise of staff; lack of flexible work schedule/work life balance; staff burnout/workload maintenance, feedback from staff/identification of support needs; silos—demographic, financial, bureaucratic; need for middle management training; cross-training overall; need for more efficiency of processes	DBHDS/DMAS-data, reporting, administrative, documentation requirements; inconsistent and insufficient funding that does not cover and/or match rates of inflation, unanticipated future expenses, or increased cost of living; political and regulatory issues and hurdles at the federal, state, and local levels; economic uncertainty at the federal, state, and local levels

Priority 3: Staff retention, workforce support, and talent development
Year 1: July 2025-June 2026
Strategy 1: By December 2025, RACSB will design and implement an employee engagement survey and use results to establish a benchmark for measuring key engagement areas for the next two years.
Strategy 2: By June 2026, RACSB will offer exit interviews and surveys to 100% of employees who voluntarily resign. RACSB will develop a structured stay interview process and survey and conduct them with 50% of staff with the goal of 100% of staff within the three-year period.
Strategy 3: By June 2026, RACSB will conduct a needs analysis around employee leadership development needs and develop a curriculum and plan to define and increase development of leadership program.

Year 2: July 2026-June 2027
Strategy 1: By October 2026, RACSB will meet the established benchmarks for key engagement areas on the employee engagement survey.
Strategy 2: By June 2027, RACSB will offer exit interviews and surveys to 100% of employees who voluntarily resign. RACSB conduct stay interview process with 75% of staff with the goal of 100% of staff within the three-year period.
Strategy 3: By June 2027, ____ number of employees will engage in the leadership program, per benchmark established in Year 1.

Year 3: July 2027-June 2028
Strategy 1: By October 2027, RACSB will meet the established benchmarks measured key engagement areas on the employee engagement survey.
Strategy 2: By June 2028, RACSB will offer exit interviews and surveys to 100% of employees who voluntarily resign. RACSB conduct stay interview process with 100% of staff within the three-year period.
Strategy 3: By June 2028, ____ number of employees will engage in the leadership program, per benchmark established in Year 1.

Priority 4: Fiscal and Operational

Vision and Mission Alignment:

- To optimize resource use, streamline processes, and embrace data-driven decision-making to ensure that services remain sustainable, responsive, and high quality.
- To enable RACSB to extend its reach, reduce barriers to care, and invest more deeply in innovative, evidence-based practices—advancing both the impact in the communities served and financial stewardship.
- To provide timely, effective, and accessible service provision by streamlining operations and maximizing resources.

Strengths/Weaknesses/Opportunities/Threats:

Strengths	Opportunities	Weaknesses	Threats
Robust reserve funds	CRC funding; OAA (Opioid Abatement Authority) funding, new programs coming; additional waivers; MH Employment services funding through DMAS/DARS; increasing need for services; future data gathering and analysis; re-evaluation of organizational structure and maximizing organizational efficiencies	Silos—demographic, financial, bureaucratic; need for more efficiency of processes; lack of consistency in funding resources; insufficient technology; plethora of programs and services and not having the resources for all of them	DBHDS/DMAS-data, reporting, administrative, documentation requirements; inconsistent and insufficient funding that does not cover and/or match rates of inflation, unanticipated future expenses, or increased costs of living; political and regulatory issues and hurdles at the federal, state, and local levels, economic uncertainty at the federal, state, and local levels

Strategic Goals:

By the end of FY2028, increase year-end positive variance to 1%.

A sustainability plan will be created to move toward a balance budget within three years for each program within X time frame

Priority 4: Fiscal and Operational
Year 1: July 2025-June 2026
Strategy 1: By June 2026, each program will develop a sustainability, staffing, and succession plan.
Strategy 2: By June 2026, RACSB will collect data, establish consistent measurement, and establish benchmarks to monitor time from service to documentation completion.
Strategy 3: By June 2026, 100% of programs audited will have a minimum comparative score of 75 on audits.
Strategy 4: By June 2026, RACSB will complete costing engagement through MTM Consulting and present results to Board of Directors.
Strategy 5: By June 2026, RACSB staff will complete a workflow and documentation map process for five programs. Any data element or documentation not currently required will be removed and data entry fields will be reduced.

Year 2: July 2026-June 2027
Strategy 1: By June 2027, RACSB will complete RFP and procurement process to update financial systems, to include at minimum the general ledger system.
Strategy 2: By June 2027, RACSB will meet the Year 1 benchmarks on established performance metrics for time from service to documentation completion.
Strategy 3: By June 2027, 100% of programs audited will have a minimum comparative score of 80 on audits.
Strategy 4: By June 2027, RACSB will develop cost reporting dashboard using the information from the MTM engagement.
Strategy 5: By June 2027, RACSB staff will complete a workflow and documentation map process for five additional programs. Any data element or documentation not currently required will be removed and data entry fields will be reduced.

Year 3: July 2027-June 2028
Strategy 1: By June 2028, RACSB will have applied for a minimum of 15 grant opportunities during the three-year plan period.
Strategy 2: By June 2028, RACSB will meet the Year 2 benchmarks established on performance metrics for time from service to documentation completion.
Strategy 3: By June 2028, 100% of programs audited will have a minimum comparative score of 90 on audits.
Strategy 4: By June 2028, RACSB staff will complete a workflow and documentation map process for five additional programs. Any data element or documentation not currently required will be removed and data entry fields will be reduced.

Rappahannock Area Community Services Board Strategic Plan
Year-One Profile

Mission: RACSB is dedicated to education, recovery, treatment, and wellness of Planning District 16 residents affected by mental health, substance use disorders and developmental disabilities.

Vision
Spark Hope. Support Hope. Spread Hope.

Values
Inclusion. Collaboration. Integrity. Resilience. Excellence and Innovation

Priority 1: Access To Services	Q1	Q2	Q3	Q4
By FY2028, increase total number of individuals served by 5%				
By June 2026, 100% of programs will develop a metric to measure access to services, establish a benchmark, and adopt a target percentage.				
Strategy 1: By June 2026, 50% of individuals receive first service within 10 days of initial request and receive their next two services within 30 days.				
Strategy 2: By June 2026, RACSB will secure a facility and begin construction/renovation for Adult CSU, Adult CRC, Child CSU, and Child CRC. Staffing plan, operational budget, and draft policies and procedures manual will be developed for each of the three new services.				
Strategy 3: By June 2026, 80% of individuals assigned a waiver will have a service plan developed and active within 90 days of waiver allocation.				
Strategy 4: By June 2026, a plan will be developed to expand access to I/DD Community Engagement day support services. A metric and benchmark will be established to measure progress for the next two years of the plan.				
Strategy 5: By June 2026, RACSB will partner with four additional middle schools to provide substance use prevention education.				
Priority 2: Effective and Quality Services	**Q1**	**Q2**	**Q3**	**Q4**
By June 2026, 100% of programs will develop a metric to measure effectiveness, establish a benchmark, and adopt a target percentage for improvement.				
Strategy 1: By June 2026, RACSB will complete a gap assessment to identify actions needed to move toward CCBHC.				
Strategy 2: By June 2026, RACSB will establish a consumer-based net promoter score process and set performance benchmarks for the next two years.				
Strategy 3: By June 2026, RACSB will identify collaborative partnerships and begin to formalize with MOUs. RACSB will identify community engagement events and track attendance. Benchmarks and metrics will be set for two years to increase formalized MOUs for partnerships and to monitor community engagement events attended by RACSB.				
Strategy 4: By June 2026, RACSB will complete a gap assessment to identify actions needed to move toward offering Primary Care Services.				
Priority 3: Staff retention, workforce support, and talent development	**Q1**	**Q2**	**Q3**	**Q4**
By the end of FY2028, increased employee retention will be demonstrated by annual turnover rate of 15% or less and achieve a staff engagement score of at least 80% on the annual engagement survey.				
Strategy 1: By December 2025, RACSB will design and implement an employee engagement survey and use results to establish a benchmark for measuring key engagement areas for the next two years.				
Strategy 2: By June 2026, RACSB will offer exit interviews and surveys to 100% of employees who voluntarily resign. RACSB will develop a structured stay interview process and survey and conduct them with 50% of staff with the goal of 100% of staff within the three-year period.				
Strategy 3: By June 2026, RACSB will conduct a needs analysis around employee leadership development and create a curriculum and a plan to define and grow leadership program.				
Priority 4: Fiscal and Operational	**Q1**	**Q2**	**Q3**	**Q4**
By the end of FY2028, increase year-end positive variance to 1%.				
Create a sustainability, staffing, and succession plan aiming for a balanced budget within three years for each program				
Strategy 1: By June 2026, each program will develop a sustainability, staffing, and succession plan.				
Strategy 2: By June 2026, RACSB will collect data, establish consistent measurement metrics, and establish benchmarks to monitor time from service to documentation completion.				
Strategy 3: By June 2026, 100% of programs audited will have a minimum comparative score of 85 on audits.				
Strategy 4: By June 2026, RACSB will complete costing engagement through MTM Consulting and present results to Board of Directors.				
Strategy 5: By June 2026, RACSB staff will complete a workflow and documentation map process for five programs. Any data element or documentation not currently required will be removed and data entry fields will be reduced.				

Community Support Services Program Updates

August 2025

Assertive Community Treatment (ACT) - Sarah McClelland

The ACT North Team was informed that our first TMACT Review will be conducted by the UNC Institute of Best Practice in August. ACT North continues to prepare for that review which is designed to analyze and assess how faithful we are to the ACT Fidelity Model. The review also provides feedback to us as a program with regards to our strengths as well as areas for growth and improvement. ACT teams that adhere closely to the ACT Fidelity Model have better client outcomes and the ACT program at RACSB wants to be the best. For that reason, we are working hard on preparing for the review, as well as always taking a look at what we can be doing better to serve our clients.

Our ACT Peers continue to plan enjoyable activities for our clients to increase their socialization opportunities and foster personal interests. On 6/17/25, ACT Peer Specialists Dianna Sloat and Javonne Kirby planned and executed a spectacular cookout at Brooks Park. All the ACT staff coordinated the many logistical details regarding transportation to pick up, drive, and return home all 28 ACT client participants. It was a fun day for clients and staff alike. One client participated by grilling the hamburgers and hotdogs. Clients had a chance to mingle with one another and socialize. There was karaoke which one client in particular really enjoyed. Some clients enjoyed playing cornhole, while others simply chatted with staff. All in all, it was a great success and our ACT peer specialists that planned and coordinated the event went above and beyond. We are all looking forward to the next cookout!

July was another great month for ACT activities. Our peers have taken our clients to Lake Anna for a day of fun as well as The Air and Space Museum in Chantilly, Virginia. ACT continues to expand with offering groups. Our South Team Peer, Dianna Sloat, is holding an Advanced Planning for Prevention and Recovery group which is very similar to a WRAP group. Clients have a workbook that they are collaboratively and individually working through. In the first group held two weeks ago, clients wrote down their goals and dreams.

ACT has also re-structured our daily team meetings to better capture client goals as well as staff intervention. We have added a Transition Readiness Assessment for clients who are preparing for discharge. ACT South has one such client with a planned discharge date next

week. Meanwhile, we continue to hold in-service meetings with various referral sources such as Snowden case management and RACSB outpatient mental health department to discuss our program and admission criteria for referral.

DD Day Support Rappahannock Adult Activities, Inc. (RAAI) - Lacey Fisher

RAAI is currently supporting 119 individuals across 7 teams. We have separated out a new team of Specialized Services that consists of those in our Community Engagement Only groups based out of the YCMAs and our individuals receiving 1:1 customized rate through DBHDS. This will allow for better training, closer budget oversight and targeted services where the greatest need is. We have also separated out our Horticulture program in the budget to better assess the revenue and expenses when not subsidized by waiver funds. Assessments continue from the waitlist at sites that have the capacity to support new admission with current staffing ratios only. Additional growth is identified for the Community Engagement Only groups. RAAI annual Inservice is scheduled for Sept 12th 2025; this will consist of mainly staff trainings that have needed to be scaled back throughout the year due to eliminated positions. Planting will begin soon for our fall plant sale. Be on the lookout for more information and fall workshops.

Developmental Disabilities (DD) Residential Services - Stephen Curtis

All DD Residential Policies and Procedures have now been reformatted and uploaded into the online Policy Pro System.

An individual moved into Stonewall on July 21st, thereby filling the last of the bed vacancies at that home.

Igo Road underwent a DBHDS desk audit re-review for Home and Community Services (HCBS) in July and received a letter of compliance for providing evidence of HCBS standards for privacy, autonomy, and community access.

We are moving forward with setting move in dates for 4 individuals for August and September. 1 individual has chosen Ross ICF, 2 have chosen Igo, and 1 has chosen Galveston. Additionally, we are moving forward with plans to begin accepting/moving individuals into vacancies at Myers once our service is licensed for the flex group home/respite beds.

Year to date, DD Residential has been able to offer emergent assistance to 3 individuals, two of whom chose us to be their permanent service provider. The one who did not choose our services (group home) found a private Sponsored Placement provider match that she bonded well with.

Developmental Disabilities Support Services - Jen Acors

The Developmental Services support coordination team continues to be very busy with the addition of new waivers in June. Approximately 30 people were awarded waivers that we are in the process of opening. There are approximately another 40 slots being awarded at the end of August.

Mental Health (MH) Residential Services - Nancy Price

MH Residential did not have any new admissions or transitions this month. There is currently one transitional referral that is being considered for our one transitional vacancy at Lafayette; however, the individual is at WSH and was found NGRI, so she is not eligible for community passes until early fall. There are two community referrals that we received and are assessing for vacant community beds at Lafayette and Home Road that we expect to be available in August. Two individuals are awaiting approval from CVHC to move to new units at River Place and Home Road. These transitions will create a community vacancy at Home Road and at Lafayette for the current referrals.

PSH currently has 79 individuals enrolled, 70 of which are housed with PSH. Cybil Usual, PSH Housing Locator, has diligently been working to secure housing for the remaining 9 individuals who have significant barriers to housing.

Congratulations to Anne Martin, PSH Peer Specialist! Anne was selected as the Hopestarter Employee of the Quarter. Anne was nominated by a PSH Case Manager that recognizes the hard work, passion and commitment that Anne brings to PSH every single day. This award was well deserved!

Jessica Vaz Williams accepted the position of Community Outreach Case Manager, a position that is fully funded by the City of Fredericksburg. This position will be focused on providing supports and resources to those in the city who are experiencing homelessness. Jessica will work in collaboration with the Fredericksburg PD, the CoC and local businesses to be

present in the community, offer support to business owners, be a familiar face to those in need of resources and help minimize the involvement of Fredericksburg PD. Jessica begins new employee orientation on August 4 and will be supervised by Nancy Price.

Psychosocial Rehabilitation: Kenmore Club - Anna Loftis

Our Art Sale in July was very successful. The majority of the members sold at least one thing and we made a total of about $300 that was either given directly to the members for their work or to club for our future activities. We had the Fire Department do an in-service on summer safety and went on more trips to the local pool.

Sunshine Lady House (Crisis Stabilization) - Latroy Coleman

SLH received 36 prescreens in the month of June 2025 of which four were not accepted. Two of the four did not admit because they did not medically clear. In July, SLH saw an increase in referrals. The program received 83 prescreens. The program accepted all but 14 of the prescreens. Of the 14, 11 were not accepted because they did not medically clear. SLH reached capacity on more than one occasion in the month of July. July proved to be busy with staff shortages due to illness and a vacancy, along with the rise in referrals. Our CSAC resigned due to relocating out of the area. Consequently, this presented an opportunity for promotion for one of our mental health residential specialists. SLH also added another intern. We look forward to watching our staff grow with experience.

Memorandum

To: Amy Jindra, CSS Director

From: Lacey Fisher, RAAI Coordinator

Date: 7/29/25

Re: Kovar Grant Submission

RAAI has submitted a grant to Knights of Columbus of Virginia (KOVAR) for the maximum amount of $20,000 for our King George location. This is to replace the original upholstered furniture, tables and chairs in the main activity room, as well as the dining area. We also are planning to work with the Property Coordinator to remove the existing receptionist area in the front as we have no need for it. This would create another activity area and free up more space currently shared for Clinic use. We have requested funds for additional upholstered furniture for that area. As we look at the number of individuals receiving new waivers, we want to be able to meet the need for desired services. This additional area will serve as a place for individuals who are in the community most of the day receiving Community Engagement services, a place to start and end their day, leaving other space for those on site receiving traditional Group Day services.

"Rappahannock Adult Activities, Inc. (RAAI) provides vital support services to adults with a wide range of intellectual and developmental disabilities. The requested funds will be used to replace heavily used furniture that has reached the end of its functional lifespan. Upgrading this furniture will ensure a safer, more comfortable, and dignified environment for the individuals that we serve. We are requesting funds to purchase upholstered furniture; sofa, chairs, and loveseats; as well as new tables and chairs. The individuals that are supported at RAAI utilize the furniture daily and over time begin to show signs of wear, tear, and can become non-functional. These pieces are original to the site opening over 15 years ago. Upgrading these pieces of furniture will provide the individuals with comfortable places to sit and gather together while participating in recreational activities onsite.

Due to RAAI's current budget, if we do not receive the amount requested, then we will be unable to purchase the furniture that will be used to replace the worn furniture. Continuous use of the worn furniture will eventually render the furniture unusable, thus resulting in a loss of seating for the individuals. If a portion of the grant is funded, then we would have to adjust the number of seating & furniture pieces to reflect the amount received.

The Rappahannock Adult Activities, Inc. (RAAI), RACSB's day support programs, have been in operation since 1976 and was created to allow adults with developmental disabilities a chance to pursue their passions, learn new skills, and develop friendships. RAAI offers services for individuals in integrated community settings as well as within our Day Support buildings. With increased programming and growth comes expenses for new items to help continue the efforts to serve RAAI participants with the best support possible, a goal that both RAAI and RACSB have always strived for. We have overcome the staffing crisis by increasing pay for all Direct Support Professionals who work tirelessly to provide the individuals we serve with a life that they desire. We have had to be cautious and frugal with our budget as we continue to work to balance it. Due to frugality, furnishings are not replaced at the same rate at which they are used.

RAAI supports individuals in the City of Fredericksburg and the counties of Caroline, King George, Spotsylvania, and Stafford. RAAI currently has a total of 5 Day Support locations, and 2 locations based out of local YMCA's. Currently, we serve a total of 119 individuals, ages varying from 18- 75. All of whom have an intellectual disability and/or a developmental disability. "

Memorandum

To: Joe Wickens, Executive Director

From: Amy Jindra, CSS Director

Date: August 11, 2025

Re: Mental Health and Developmental Disabilities Residential Vacancies

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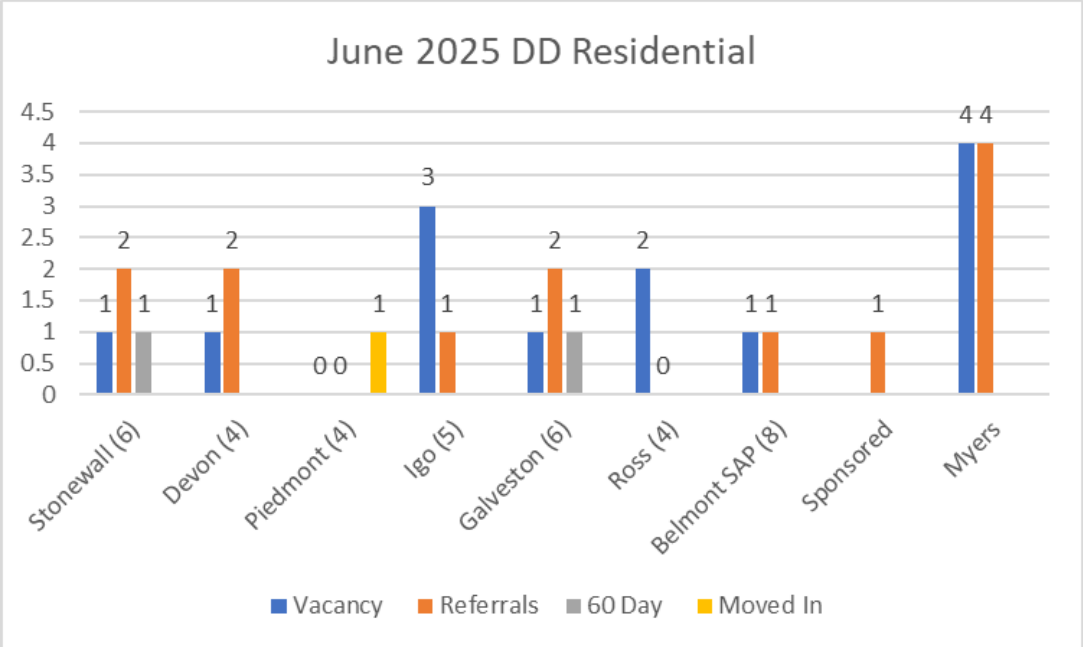
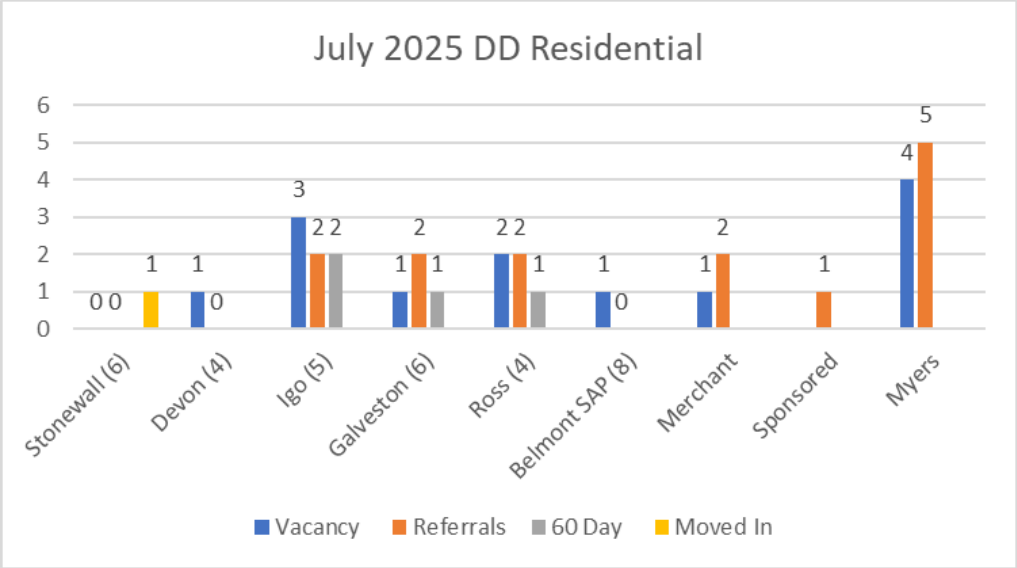
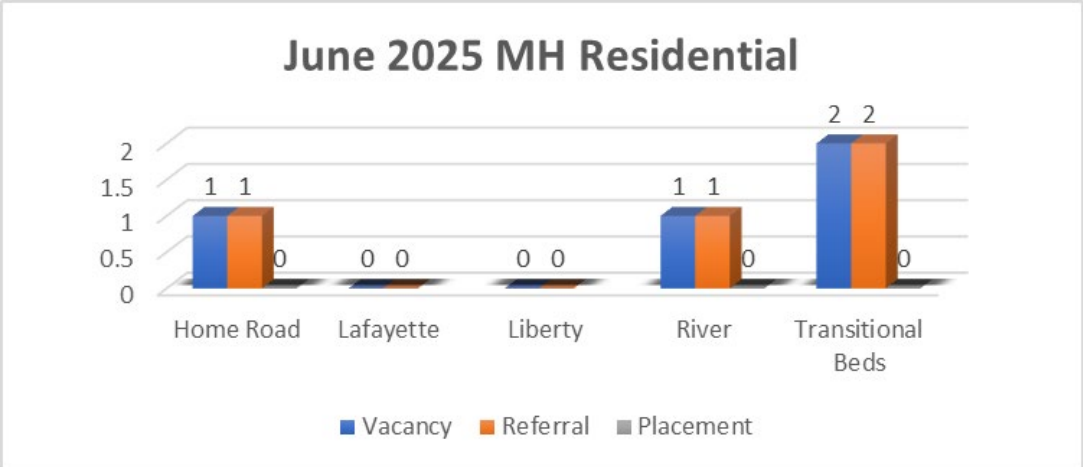
RACSB residential programs continue to provide vital 24-hour care to individuals with intellectual developmental services as well as those individuals with serious mental illness.

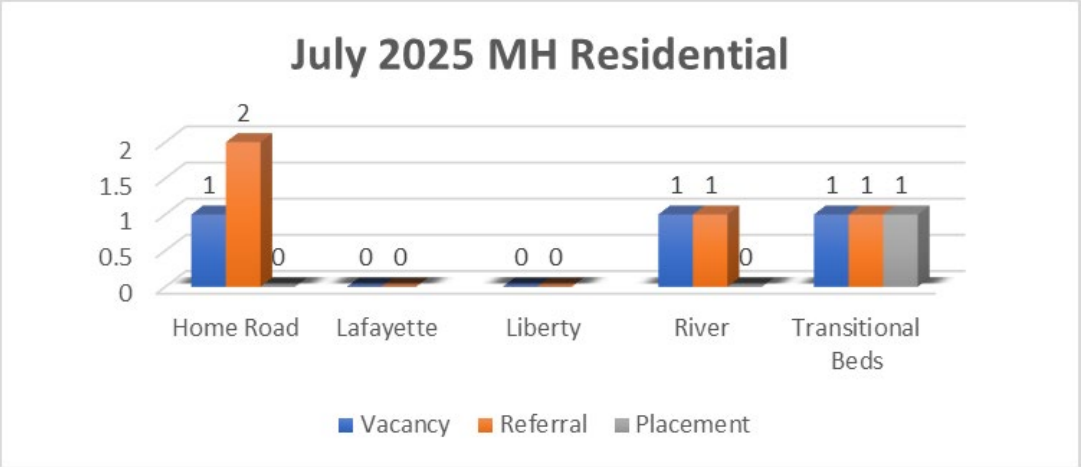
In June and July, DD Residential experienced very positive outcomes as a result of significant efforts by program leadership and staff. In June, Piedmont group home filled its last vacancy. Stonewall and Galveston set move in dates for two other individuals. DD Residential also began the licensing process for creating 4 permanent residential beds at Myers Respite. Immediately, the program began soliciting and receiving referrals for 4 individuals to be the first to move into Myers. Interest in Ross ICF, Galveston, and Devon also increased. June set the stage for an even busier July. DD Residential supported one individual to move into Stonewall, filling the group home's last vacancy. At Igo, 2 individuals have set move in dates for August and September. Merchant had a vacancy open at the same time interest also exists. Ross ICF also experienced an increase in interest with a move in date set for 1 individual. DD Residential is committed to supporting access to individuals for waiver residential services.



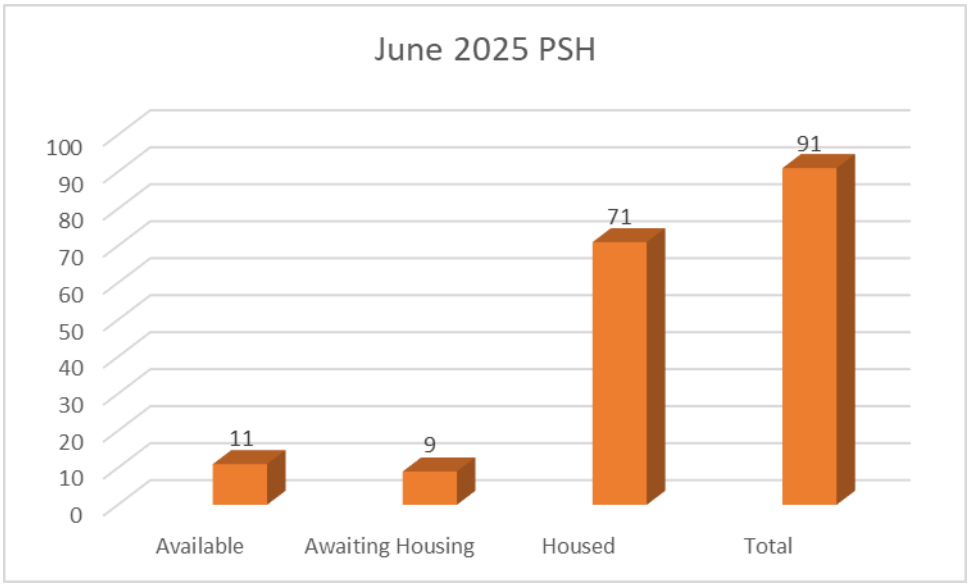


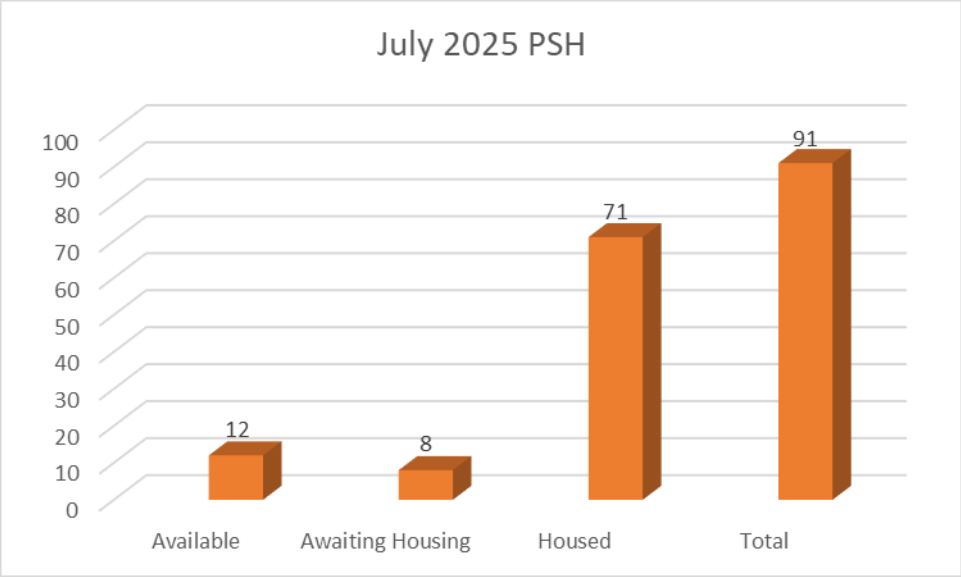
Mental Health Residential supported an individual on June 2 with moving into Liberty Apartments from Lafayette Boarding House. Over the past two months, MH Residential also has worked diligently to provide housing options for adults experiencing serious mental illness. The programs only have 3 remaining vacancies with a placement anticipated for all of the beds. The transitional referral has been accepted into services, but the program is awaiting approval for the discharge from the state hospital due to coordinating a conditional release plan. In addition, River and Home Road has individuals that will be transitioning from higher intensity supports into the lower intensity services at each location. The program leadership and staff continue to support individuals' efforts to gain necessary skills to enhance successful transition into more independent living.





Permanent Supportive Housing (PSH) has 71 individuals currently housed. The program has 8 individuals as of July awaiting placement, 1 less than in June. PSH provides case management to those individuals who are awaiting housing. The program has 12 individuals who are waiting for enrollment into services. Should all 12 individuals enroll, the program will meet its service capacity of 91.




July 2025 PSH
100
90
80
70
60
50
40
30
20
10
0
12
8
71
91
Available
Awaiting Housing
Housed
Total

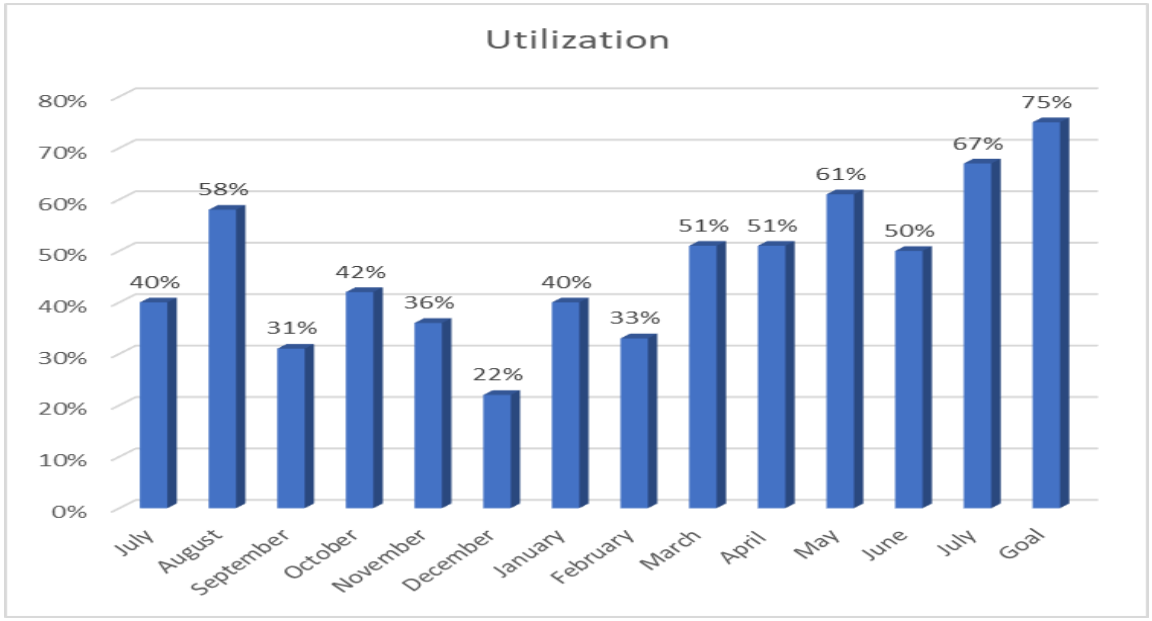
Memorandum

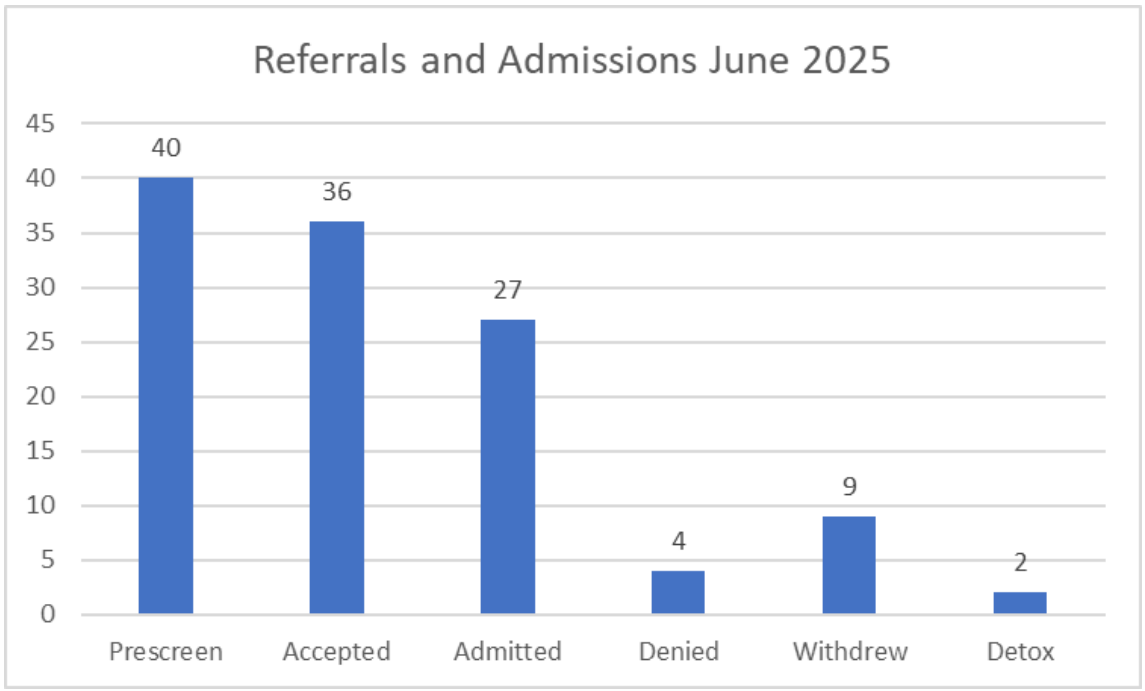
To: Joe Wickens, Executive Director
From: Amy Jindra, CSS Director
Date: August 11, 2025
Re: Sunshine Lady House Utilization

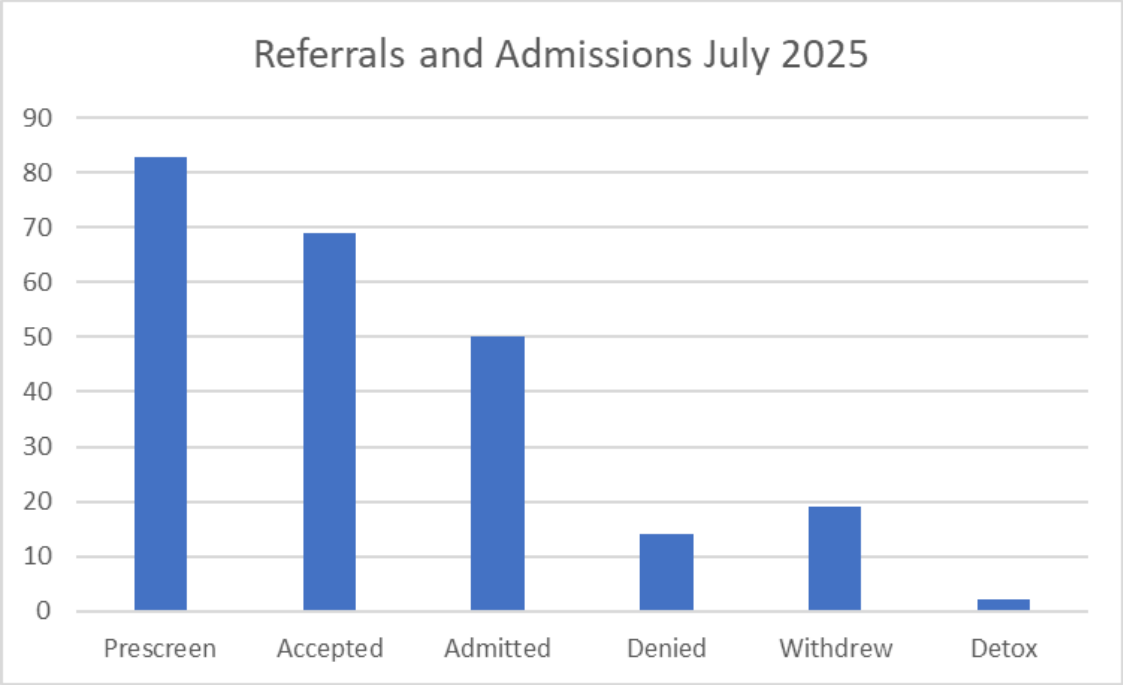
Sunshine Lady House for Wellness and Recovery, is a 12 bed, adult residential crisis stabilization unit. The program provides 24/7 access to services for individuals experiencing a psychiatric crisis. Services include medication management, therapy, peer support, nursing, restorative skill development, crisis interventions, coordination of care, and group support. The program strives to maintain a utilization rate of 75%.

Sunshine received a total of 123 prescreens from June and July. In June the program admitted 27 of the month's 40 referrals with 4 individuals requiring further medical care and 9 individuals declining services. In July, Sunshine admitted 50 of the 83 referrals, with 14 individuals not meeting criteria for service due to recent violent behavior, medical acuity, or not being clinically appropriate for services. The program served 50 of the 83 referrals in July, along with 4 other individuals who were admitted in June. Sunshine provided medically managed detox services for 2 individuals in June and 2 other individuals in July.

Sunshine continues to act as a regional crisis stabilization unit by providing support to individuals outside of RACSB's catchment. The program supported 3 individuals in June and 5 in July from Valley, Region 10, and Encompass Community Services Board along with 1 individual from Richmond Behavioral Health. The program experienced 50% utilization or 150 bed days occupied in June and 67% utilization with 241 beds used in July.


Utilization
80%
70%
60%
50%
40%
30%
20%
10%
0%
40%
58%
31%
42%
36%
22%
40%
33%
51%
51%
61%
50%
67%
75%
July
August
September
October
November
December
January
February
March
April
May
June
July
Goal


Referrals and Admissions June 2025
45
40
35
30
25
20
15
10
5
0
40
36
27
4
9
2
Prescreen
Accepted
Admitted
Denied
Withdrew
Detox


Referrals and Admissions July 2025
90
80
70
60
50
40
30
20
10
0
Prescreen
Accepted
Admitted
Denied
Withdrew
Detox

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

To: Joseph Wickens, Executive Director

From: Jacqueline Kobuchi, Director of Clinical Services

Date: 8/1/25

Re: Clinical Division Program Updates for the August Board Meeting

Outpatient Clinics

Caroline Clinic - Nancy Love, LCSW

Caroline Clinic staff completed 36 intakes in June and 13 were completed during Same Day Access. During the month of July, 44 intakes were completed and 14 were completed the same day the individual called. The intakes seen via Same Day Access decreased during the summer as the clinic remained steady with youth referrals and these intakes were all scheduled. Caroline Clinic began to offer two weekly substance use groups in July. Two clinicians completed advanced Prosper training in June to help assess and treat individuals in crisis. A clinician and clinic coordinator attended Caroline Promise Community Day in July to provide resources about RACSB services to youth and their families.

Fredericksburg and Children's Services Clinic - Megan Hartshorn, LCSW

During the month of June, the Fredericksburg Clinic received 461 calls inquiring about services at RACSB. The Fredericksburg Clinic completed 95 intake assessments for individuals requesting outpatient services. 51 of those assessments took place over ZOOM and 44 took place in person at the Fredericksburg Clinic. Out of the 95 intakes completed, 67 of those intakes were seen the same day they called to schedule. The Children's Services Clinic completed 23 intakes with children and adolescents during the month of June. Additionally in June, the Clinic Coordinator assisted in facilitating a multidisciplinary training as part of the Fredericksburg City's Best Court Practice Team that allowed for attorneys, judges, DSS workers, RACSB, CASA, Court Services Unit, and School Social Workers to discuss recent legislative changes affecting children and families in the Commonwealth. Several clinicians completed training for Multidimensional Grief Therapy to help support children and adolescents experiencing grief.

During the month of July, we received 493 calls inquiring about services at RACSB and completed 88 intakes. Out of the 88 intakes, 28 were in person and 60 were completed over ZOOM. While less intakes were completed in person, telehealth allowed for greater access to Same Day services as evidenced by an increase in SDA intakes (80 intakes during the month of July). The Children's Services Clinic completed 21 intakes during the month of July for children and adolescents.

King George Clinic - Sarah Davis, LPC

The King George Clinic continues to offer two weekly substance use treatment groups. Group topics for June and July have included Stigmas and Myths, Ripple Effect of Addiction, Revive and Narcan Education, Relapse Prevention Plans, Managing Stress, Coping Skills, Understanding the Effects of Cannabis, and Substance Use Recovery. Both groups continue to be well attended. In June, the King George Clinic completed 16 new patient intakes. 14 of these intakes were completed through Same Day Access. In June, the King George Clinic Coordinator participated in a focus group for the King George Department of Social Services to assist in developing their three-year strategic plan.

In July, the King George Clinic completed 30 new patient intakes. 22 of these intakes were completed through Same Day Access. During the month of July, the King George Clinic trained 12 individuals in Narcan and provided 11 Narcan kits.

King George staff would like to highlight a recent client success of an individual who began receiving therapy due to suicidal thoughts and severe depressive episodes following a long term relationship break up. Throughout their journey, this individual has experienced hospitalizations, medication adjustments, and a Bipolar Disorder diagnosis. Through regular treatment and therapy, this individual has developed a better understanding of their mental health. This individual is now working, has not had any recent suicidal thoughts, is engaging in healthy relationships, spending time with friends, and due to progress recently began reducing frequency of therapy. They recently shared feeling "the best that I have in a very long time."

Spotsylvania Clinic - Katie Barnes, LPC

The Spotsylvania Therapists completed 36 intakes in June and 44 intakes in July through Same Day Access. Additional intakes were scheduled in June (13) and July (18) to include child and adolescent assessments. The clinic continues to offer two substance use groups each week.

RACSB continues to employ a Child and Adolescent Therapist who provides Trauma Focused Cognitive Behavioral Therapy to children who have disclosed abuse through Forensic Interviews at Safe Harbor Child Advocacy Center.

The School-Based Therapist provided outpatient therapy to students at the Children's Services Clinic this summer. She will be providing services at Hugh Mercer Elementary and James Monroe High School this year. The School-Based Therapist participated in an interview for the July issue of the Fredericksburg Parent magazine titled "Easing the Back-to-School Transition: Mental Health".

Stafford Clinic - Lindsay Steele, LCSW

During the month of June, the Stafford Clinic met with clients in-person, as well as virtually. The clinic has continued with Same Day Access, which is offered Tuesdays, Wednesdays and Thursdays. Stafford clinicians completed 47 intakes for adults and children, seven of these intakes were completed through Same Day Access. During the month of July, clinicians completed 50 intakes, three of which were completed via Same Day Access. The child/adolescent therapist continues to engage in EMDR training and engaged in Assessment of PTSD and Suicide Risk training. The Mental Health and Substance Abuse therapist has continued facilitating weekly group sessions for adults. The Stafford Clinic has one open position for Mental Health/Substance Abuse therapist, and interviews are being conducted for this. Clinicians have been working hard to continue to provide excellent services to Stafford clients.

Medical Services - Jennifer Hitt, RN

In the month of June, 103 new patient evaluations were completed by MHOP Medical. In the month of July, 108 new patient evaluations were completed by MHOP Medical. Also, in July, the medical team welcomed two full-time psychiatrists, Dr. James Miller and Dr. Paula Gomes.

Case Management - Adult - Patricia Newman

The Adult Mental Health Case Management team is now offering increased supports to individuals as they transition back into the community from the Rappahannock Regional Jail (RRJ). Releasing from the jail after months of incarceration can be very overwhelming but we are trying to make this process just a little easier. Ben Henderson, a Care Coordinator on our team, is working closely with our staff at RRJ to connect with individuals prior to and after their release, in an attempt to connect them with outpatient mental health services as well as benefits and resources in the community. It is hopeful that offering this additional support will help individuals to maintain stability on medications that were started during incarceration as well as link them with necessary resources to establish stability in the community.

Child and Adolescent Support Services - Donna Andrus, MS

In the month of June, the Child and Adolescent Case Management team attended the Fredericksburg Best Practice Court Team training. In attendance were several local Juvenile and Domestic Court Judges, Local Guardian Ad Litems, Attorneys, Court Appointed Special Advocates (CASA), representatives from local Department of Social Services, School Social Workers, Court Services Unit, and Family Assessment and Community Policy Management teams. The Honorable Judge Vance presented on 2025 Legislative Updates that impact children's services, The Director of Virginia's Office of the Children's Ombudsman presented on Parent Child Safety Placement Agreement and there was a local Judge Panel for questions and answer session.

In the month of July, the Child and Adolescent Supervisor received an email from a parent who shared that she was so impressed with the care she received at RACSB that she now has her daughter in services. She wanted to reach out to share that the case manager for her daughter "is the nicest caring person I have ever met. She is extremely helpful extremely supportive extremely informative. And if she doesn't have the answer for me she will find it. I have told her over and over again she's amazing. She deserves a raise. She deserves a month paid vacation. I just wanted to relay the message. My daughter is slowly learning. But I'm not quitting. And our case manager has not shown any signs of wanting to quit. I just wanted to say she's wonderful and I hope you all understand and appreciate what a gem you have in her. Just wanted to let you know that, and thank you for time." It is always great to receive positive feedback about the services and staff at RACSB!

Substance Use Services - Eleni McNeil, LCSW

During the month of June and July, we continued to collect applicants for a nurse practitioner for the mobile office-based opioid treatment (OBOT) clinic. The new nurse for the mobile OBOT clinic began at the start of July and has begun to independently work alongside our prescribers to provide services to those with opioid use disorders.

The SUD Services Coordinator provided training on Substance Use Disorders to the June CIT cohort. Freedom Recovery Centers hosted a lunch 'n' learn for substance use treatment staff to attend to learn of the programs offered. SUD Services Coordinator also met with District 21 Probation and Parole supervisor to review services offered.

Emergency Services - Natasha Randall, LCSW

In July, our Stafford based Co-Response Therapist began working in the field with the Stafford County Sheriff's Department. Both of our Co-Response therapists were able to attend a regional two-day training on de-escalation at the local police academy. Our Emergency Service Coordinator and one of our Co-Response Therapists have started the process of being trained and certified in Collaborative Assessment and Management of Suicidality, otherwise known as

CAMS. Our Child and Adolescent ES Therapist providing community-based crisis stabilization has been at capacity this summer, serving seven children in June and six in July.

Specialty Dockets - Nicole Bassing, LCSW

During the month of June, Specialty Dockets continued to progress, welcome new participants and celebrate lots of graduations. Adult Recovery Court added four new clients and finished the month with 38 active participants. We had our annual formal graduation to celebrate four participants in the program on June 2nd, followed by a reception at the courthouse for participants and their family members. Adult Recovery Court had one termination this month due to non-compliance. Juvenile Recovery Court celebrated one graduation this month and finished the month with one participant. We have two new participants expected to begin the program in July. The Rappahannock Veterans Docket celebrated one graduation this month and welcomed one new participant to finish the month with 15 current participants. Spotsylvania Behavioral Health Docket currently has 11 participants and is expecting two upcoming graduations in July.

On June 13th, we were officially approved by the Supreme Court of Virginia to begin operations for the new Fredericksburg Therapeutic Docket. This docket will service individuals with serious mental illness in the City of Fredericksburg who have been charged with eligible misdemeanor offenses. Approval of this docket has been long awaited since the interdisciplinary team of RACSB and several community partners began the planning process for this in 2023. Eligible participants are being evaluated to begin the program in the upcoming months.

During the month of July, Adult Recovery Court added three new participants this month and celebrated three graduations. We had two terminations this month due to non-compliance. The Juvenile Recovery Court added two new participants this month for a total of three. We have no graduations or terminations in July. The Spotsylvania Behavioral Health Docket added one new participant this month and celebrated one graduation. We finished the month with 11 active participants with The Rappahannock Veterans Docket, and had no new participants, graduations or terminations this month. We currently have 14 participants in the program.

Jail and Detention Services - Portia Bennett

In June, RJC housed 54 residents. In July, the census decreased to 46 residents. There were no residents placed through Central Admission and Placement (CAP) in either month. Individual Bed Placement (IBP) remained steady, with seven residents in both June and July. The Post Dispositional (Post D) program served five residents in June and four in July.

In June, 129 individuals received crisis or therapeutic services at the jail. This increased to 137 individuals in July. In July, 35 individuals received substance use services. A total of 325 individuals were prescribed psychotropic medications in June, decreasing to 288 individuals in July. Bruce Pryor has returned to RRJ as the Substance Abuse Therapist.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Jacque Kobuchi, LCSW, Director of Clinical Services

From: Donna Andrus, Child and Adolescent Support Services Supervisor

Date: August 4, 2025

Re: C&A Case Management Residential Placement Quarterly Report

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The Child and Adolescent Case Management has set the goal of tracking data and outcomes for children placed in out-of-home placements with the goal of reducing the number of children placed in out of home placements and decreasing the length of stay. The Child and Adolescent Case Management team works with each of our localities to provide intensive case management for children placed out of the home through parental agreements and difficult to place foster care cases. When a child is placed out of the home through a parental agreement, the parent maintains custody of the child and enters into an agreement with the locality and RACSB to place the child out of the home for mental health treatment. Children placed in out-of-home placements have not been able to remain safe and have their mental health needs met in a community setting and need a higher level of care through an out-of-home placement for treatment. An out-of-home placement is only considered once community-based services have been exhausted and found to not be successful. We began tracking this data July 1, 2024.

Attached is the data for the 4rd Quarter April 1, 2025 through June 30, 2025 for number of out-of-home placements, number of admissions this quarter, number of discharges this quarter, number of cases per locality and length of stay information.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

April 1, 2025 – June 30,2025

Data on Child and Adolescent Case Management Out of Home Placements

Total out of home placements this quarter: 21

Number of admissions this quarter: 4

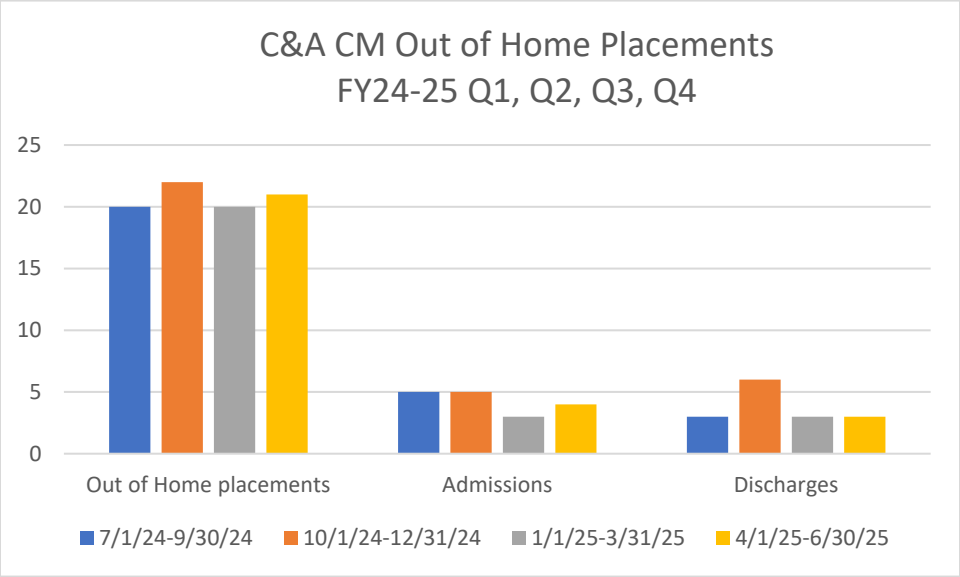
Number of discharges this quarter: 3

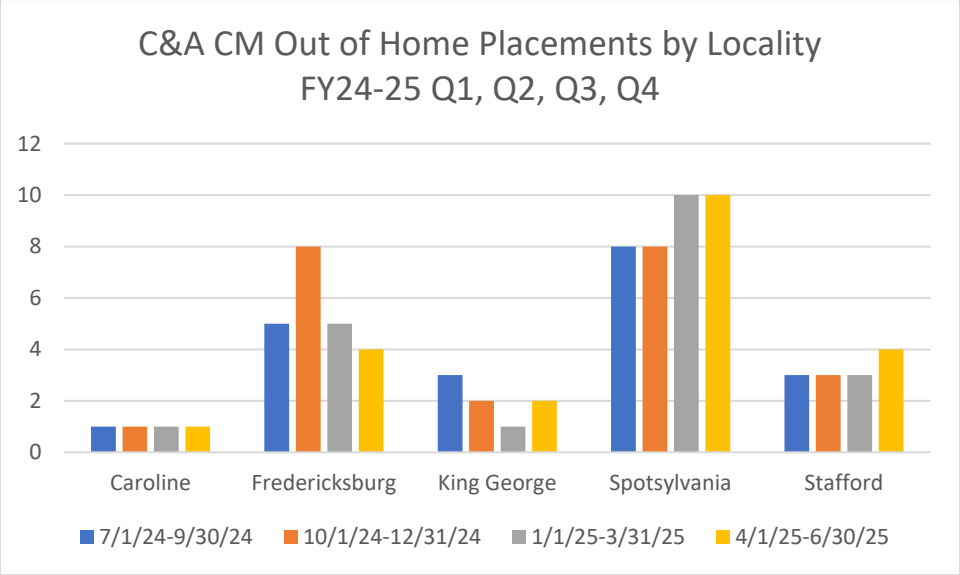
Length of Stays:

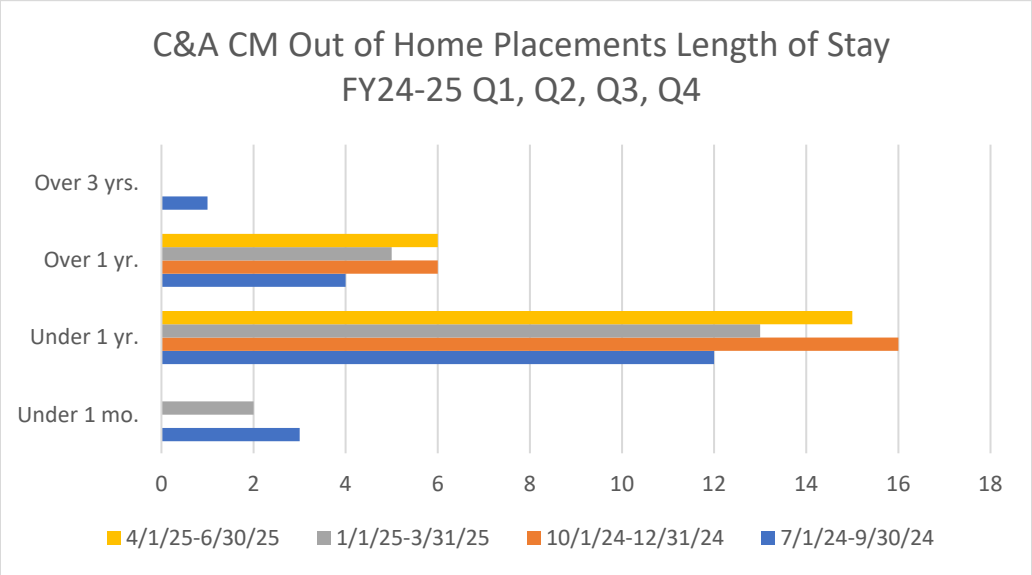
- Over 3 years: 0
- Over 1 year: 6
- Under a year: 15
- One month: 0

Numbers for each locality:

- Caroline County: 1
- King George: 2
- Stafford County: 4
- Fredericksburg City: 4
- Spotsylvania County: 10


C&A CM Out of Home Placements
FY24-25 Q1, Q2, Q3, Q4
25
20
15
10
5
0
Out of Home placements
Admissions
Discharges
7/1/24-9/30/24
10/1/24-12/31/24
1/1/25-3/31/25
4/1/25-6/30/25


C&A CM Out of Home Placements by Locality
FY24-25 Q1, Q2, Q3, Q4
12
10
8
6
4
2
0
Caroline
Fredericksburg
King George
Spotsylvania
Stafford
7/1/24-9/30/24
10/1/24-12/31/24
1/1/25-3/31/25
4/1/25-6/30/25


C&A CM Out of Home Placements Length of Stay
FY24-25 Q1, Q2, Q3, Q4
Over 3 yrs.
Over 1 yr.
Under 1 yr.
Under 1 mo.
0
2
4
6
8
10
12
14
16
18
4/1/25-6/30/25
1/1/25-3/31/25
10/1/24-12/31/24
7/1/24-9/30/24

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
Sarah McClelland - ACT Coordinator
Jennifer Acors – Coordinator Developmental Services Support Coordination

SUBJECT: State Hospital Census Report

DATE: August 19, 2025

June 2025

State Hospital	New	Discharge	Civil	NGRI	Forensic	EBL	Total Census
Catawba Hospital			1				1
Central State Hospital				1	2		3
Eastern State Hospital		1			1		1
Northern Virginia Mental Health Institute							0
Piedmont Geriatric Hospital		1	3		1		4
Southern Virginia Mental Health Institute	1		1		1		2
Southwestern Virginia Mental Health Institute							0
Western State Hospital	4	6	4	9	9	4	22
Totals	5	8	9	10	14	4	33

July 2025

State Hospital	New	Discharge	Civil	NGRI	Forensic	EBL	Total Census
Catawba Hospital			1				1
Central State Hospital		2			1		1
Eastern State Hospital					1		1
Northern Virginia Mental Health Institute							0
Piedmont Geriatric Hospital	3		5		2		7
Southern Virginia Mental Health Institute			1		1		2
Southwestern Virginia Mental Health Institute							0
Western State Hospital	9	9	5	7	11	3	22
Totals	12	11	12	7	16	3	34

Extraordinary Barriers List:

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

Western State Hospital

Individual #1: Was placed on the EBL 12/12/2024. Barriers to discharge include working through the Developmental Disability (DD) Waiver process, identifying and being accepted to a group home as well as working through the guardianship process. This individual previously resided in the community with family but will be best supported in a group home setting at time of discharge. Bridges will be assigned as this individual's public guardian. The guardianship hearing is scheduled for 9/15/2025. This individual will discharge to a group home once the waiver and guardianship is in place and they are accepted to a group home.

Individual #2: Was placed on the EBL 5/18/25. Barriers to discharge include working through the Not Guilty by Reason of Insanity process. This individual has been participating in passes to the community with Gateway Homes, a supervised transitional residential program in Chesterfield, VA. This individual's CRP was approved by the court on 7/25/25 and they will discharge to the community once all follow up care is coordinated with necessary providers.

Individual #3: Was placed on the EBL 7/8/25. Barriers to discharge include identifying and being accepted to a group home. This individual was just recently awarded a Developmental Disability Waiver. They will benefit from the support and supervision of a group home as it has become more challenging for them to be safely supported in their home in the community. At this time, this individual is being referred to multiple group homes. They will discharge once accepted and all necessary waiver paperwork is completed.

Discharged

Individual on July EBL: Was placed on the EBL 4/22/2025. Barriers to discharge include working through the Not Guilty by Reason of Insanity process. This individual had been participating in passes to the community with Region Ten CSB. Their Conditional Release Plan (CRP) was reviewed on 5/29/2025. This individual was on the EBL during the month of July and discharged from the hospital on 7/30/2025.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

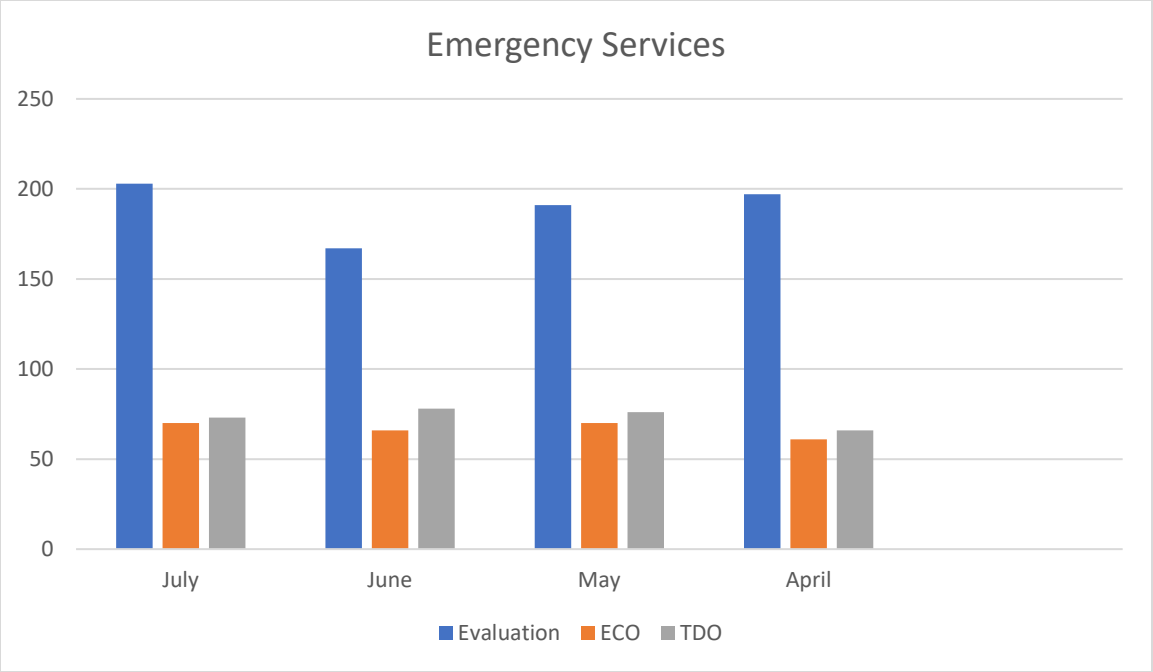
MEMORANDUM

To: Joe Wickens, Executive Director
From: Natasha Randall, Emergency Services Coordinator
Date: August 3, 2025
Re: Emergency Custody Order (ECO)/Temporary Detention Order (TDO) Report – June and July 2025

In June, Emergency Services staff completed 167 emergency evaluations. Sixty-six individuals were assessed under an emergency custody order and 78 total temporary detention orders were served of the 167evaluations. Staff facilitated two admissions to Western State hospital. A total of fifteen individuals were involuntarily hospitalized outside of our catchment area in June.

In July, Emergency Services staff completed 203 emergency services. Seventy individuals were assessed under an emergency custody order and 73 total temporary detention orders were served of the 203 evaluations. Staff facilitated one admission to Northern Virginia Mental Health Institute and two admissions to Western State. A total of four individuals were involuntarily hospitalized outside of our catchment area in July.

Please see the attached data reports.



FY25 CSB/BHA Form (Revised: 07/10/2024)

CSB/BHA	Rappahannock Area Community Services Board	Month	June 2025

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	
167	30	36	66	78	3		75	78	1

FY '25 CSB/BHA Form (Revised: 07/10/2024)

CSB/BHA	Rappahannock Area Community Services	Reporting month	June 2025		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)
6/11/2025	117687	Adolescent with Medical Acuity and ID/DD			No	Western State
6/25/2025	77976	Adult (18-64) with ID or DD			No	Western State

FY26 CSB/BHA Form (Revised: 07/01/2025)

CSB/BHA	Rappahannock Area Community Services Board	Month	July 2025

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	
203	44	26	70	73	2	2	69	73	1

FY '26 CSB/BHA Form (Revised: 07/01/2025)

CSB/BHA	Rappahannock Area Community Services	Reporting month	July 2025		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)
7/9/2025	118998	Adolescent with ID/DD			No	NVMI
7/10/2025	116738	Adult (18-64) with Medical Acuity			No	Western State
7/14/2025	117885	Adult (18-64) with Medical Acuity			No	Western State

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

To: Joe Wickens, Executive Director
From: Natasha Randall, LCSW Emergency Services Coordinator
Date: August 5, 2025
Re: CIT and Co-Response Report

The CIT Assessment Center served 26 individuals in the month of June 2025. The number of persons served by locality were the following: Fredericksburg 5; Caroline 3; King George 0; Spotsylvania 9; Stafford 9; and 0 from other jurisdictions.

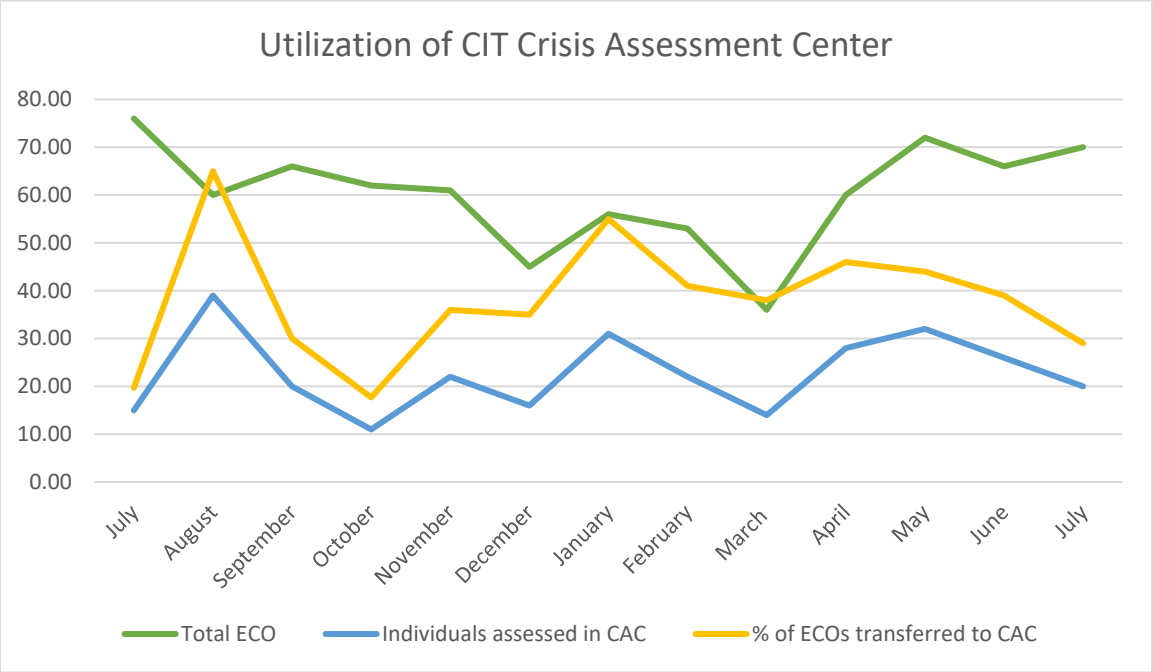
The chart below indicates the number of Emergency Custody orders by locality, those that were able to be transferred into CAC custody, and those who could have use the assessment center if there was additional capacity:

Locality	Total ECO	Custody Transfer to CAC	Appropriate for CAC if Capacity
Caroline	8	3	5
Fredericksburg	20	5	15
King George	0	0	0
Spotsylvania	18	9	9
Stafford	20	9	11
Totals	**66**	**26**	**40**

The CIT Assessment Center served 20 individuals in the month of July 2025. The number of persons served by locality were the following: Fredericksburg 7; Caroline 1; King George 0; Spotsylvania 10; Stafford 2; and 0 from other jurisdictions.

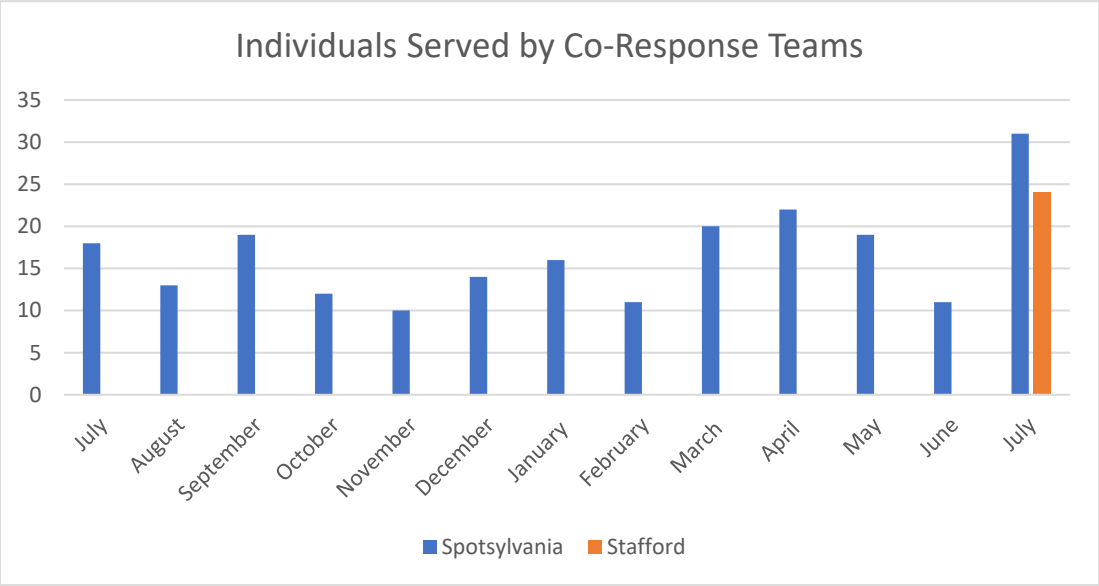
The chart below indicates the number of Emergency Custody orders by locality, those that were able to be transferred into CAC custody, and those who could have use the assessment center if there was additional capacity:

Locality	Total ECO	Custody Transfer to CAC	Appropriate for CAC if Capacity
Caroline	4	1	3
Fredericksburg	17	7	10
King George	1	0	1
Spotsylvania	24	10	14
Stafford	24	2	22
Totals	**70**	**20**	**50**



Co-Response

The Spotsylvania Co-Response Team served 11 individuals in June. In the month of July, the CIRT teams served 31 individuals. The Stafford Co-Response Team served 24 individuals in July. The therapist for the Fredericksburg team remains vacant.



CIT Training

In June 2025 we had a full class for the 40-hour CIT training. In July we had nine new dispatchers trained in CIT.

RAPPAHANNOCK AREA
COMMUNITY SERVICES BOARD

MEMORANDUM

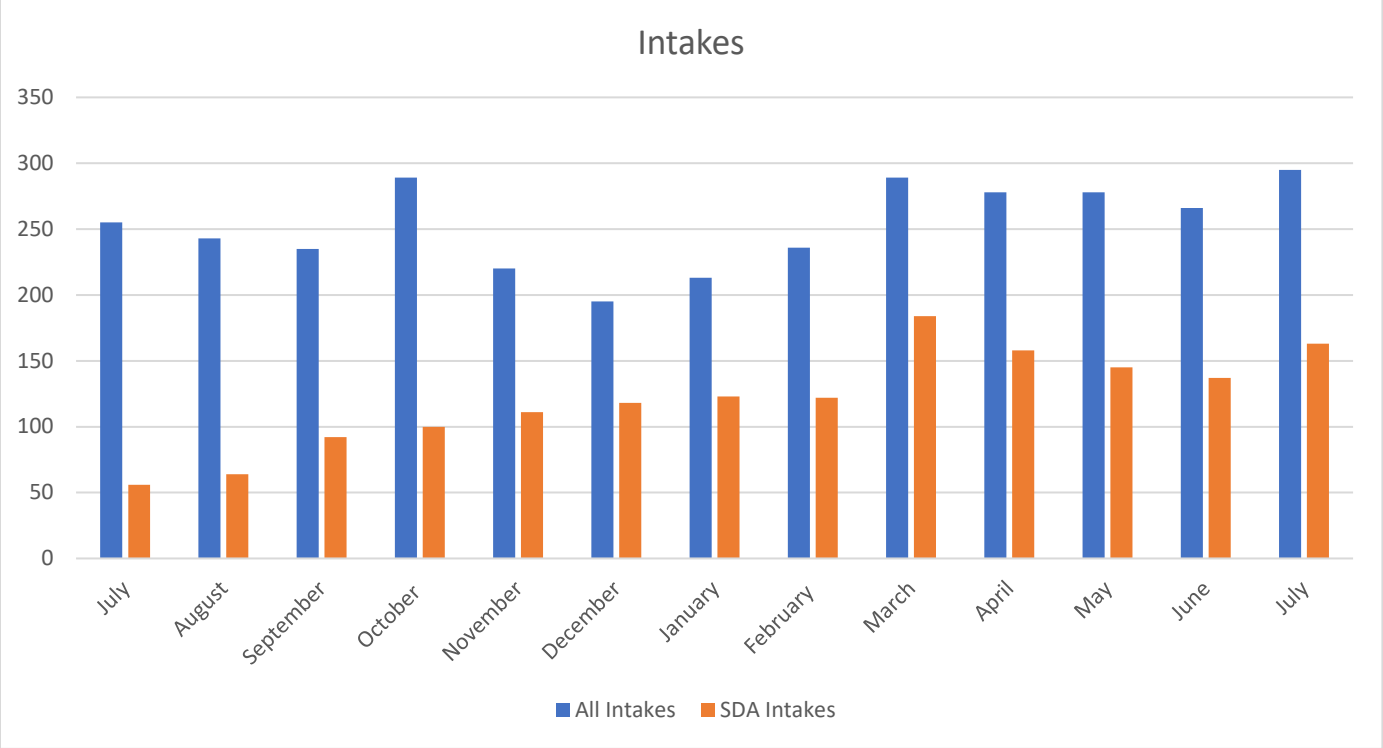
To: Joe Wickens, Executive Director

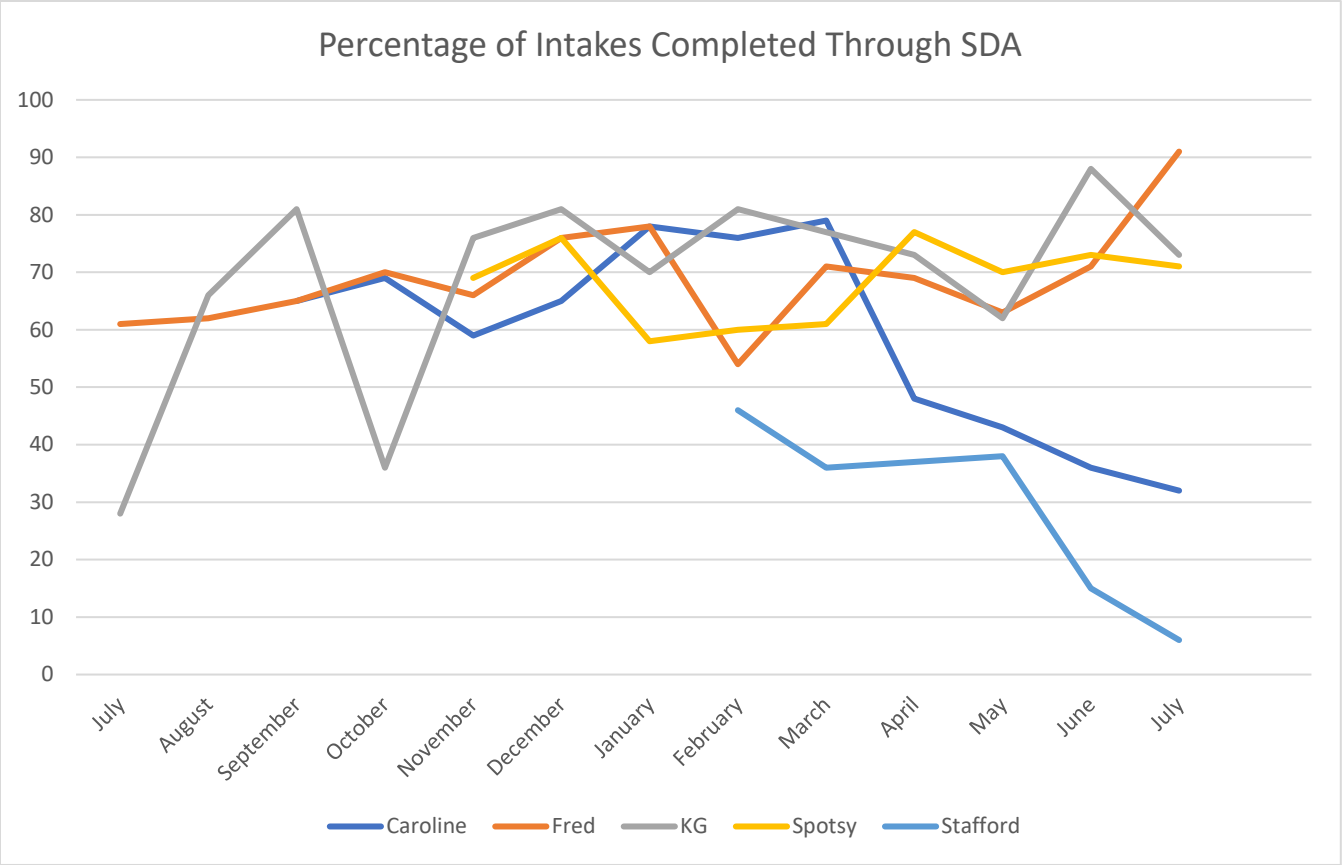
From: Jacqueline Kobuchi, LCSW, Director of Clinical Services

Date: August 7, 2025

Re: Same Day Access

Below is data on the number of intakes completed by clinic, and the percentage of those are completed through Same Day Access.




Percentage of Intakes Completed Through SDA
100
90
80
70
60
50
40
30
20
10
0
July
August
September
October
November
December
January
February
March
April
May
June
July
Caroline
Fred
KG
Spotsy
Stafford

RACSB
Program Update Report
Compliance
July 2025

Incident Reports

- There were 311 Incident Reports entered into the Electronic Incident Report Tracker during the month of July. This is an increase of 16 from the month of June and an increase of 20 from the month of May. All incident reports submitted were triaged by the compliance team.
- The top three categories of reports submitted were Health Concerns (118 reports), Individual Served Injury (45 reports), and Individual Served Safety (31 reports).
- The compliance team entered 40 incident reports into the Department of Behavioral and Developmental Services (DBHDS) electronic incident reporting system (32-Level 2, 8-Level 3) during the month of July; a decrease of two during the month of June (35-Level 2, 7-Level 3); an increase of four during the month of May (27-Level 2, 9-Level 3).
- There were two reports elevated to a care concern by DBHDS related to falls. These are reports that, based on the Office of Licensing's review of current serious incidents as well as a review of other recent incidents related to this individual, the Office of Licensing recommends the provider consider the need to re-evaluate the individual's needs as well as review the current individual support plan. DBHDS recommends provider review the results of root-cause analyses completed on behalf of this individual. In addition, take the opportunity to determine if systemic changes are needed such as revisions to policies or procedures and/or re-evaluating and updating risk management and/or quality improvement plan.
- DBHDS requires the completion of a root cause analysis for selected incident reports. The root cause analysis must be conducted within 30 days of staff's discovery of the incident. The compliance team requested specific programs, based on submitted incident report, to complete the required root cause analysis. A total of 39 root cause analyses were requested in the month of July, a decrease of three requested in the month of June, an increase of nine that were requested in the month of May. A total of six expanded root cause analyses were requested in July.

Human Rights Investigations:

- The compliance team completed 10 Human Rights investigations. Three of the 10 investigations consisted of verbal abuse allegations. Of those three investigations, one was substantiated for verbal abuse and psychological abuse; the second was substantiated for verbal abuse; and the third was substantiated for verbal abuse. Six of the 10 investigations consisted of neglect allegations. Of those six investigations, one investigation was substantiated for physical abuse and neglect, the second investigation was substantiated for neglect; the third investigation was substantiated for neglect, the

fourth investigation was substantiated for neglect; the fifth investigation was substantiated for neglect; and the sixth investigation was unsubstantiated for neglect. Lastly, one of the 10 investigations consisted of an allegation of Restriction of Freedom. This investigation was unsubstantiated for Restriction of Freedom.

Internal Reviewers:

- Compliance team met with Kenmore Club Coordinator regarding audit scores and findings on July 3, 2025.
- Compliance team completed an Exit Audit consisting of 11 charts for Child and Adolescent Case Management on July 23, 2025.
- Compliance team met with the Child and Adolescent Support Services Supervisor regarding audit scores and findings on July 24, 2025.

External Reviewers:

- Compliance team received a phone call from Katherine Rice, Registered Nurse Care Consultant, Office of Integrated Health, regarding a Care Concern from June related to a recent incident report on July 2, 2025.
- Compliance team received and responded to a Proof of Corrective Action request from Artea Ambrose, Senior Human Rights Advocate, Region 1, DBHDS, for a substantiated human rights investigation on July 16, 2025.
- Compliance team received a phone call from Carrie Browder, Registered Nurse Care Consultant, Office of Integrated Health, regarding a Care Concern related to a recent incident report on July 16, 2025.
- Compliance team received and responded to a request of Proof of Corrective Action request from Lequetta Hayes, Senior Human Rights Advocate, Region 1, DBHDS, for a substantiated human rights investigation on July 17, 2025.
- Compliance team received and responded to a request of Proof of Corrective Action request from Lequetta Hayes, Senior Human Rights Advocate, Region 1, DBHDS, for four substantiated human rights investigations on July 23, 2025. In addition, the Compliance team coordinated an A.I.M. 30, (Assess Safety; Initiate Process; Monitor Compliance) meeting on August 5, 2025 to meet with the individuals at day support.
- Compliance team received an email from Bridget Fairman, Registered Nurse Care Consultant, Office of Integrated Health, regarding a Care Concern related to a recent incident report on July 31, 2025.
- Compliance team received 10 phone calls and emails throughout the month of July from Brian Dempsey, DBHDS Incident Management Specialist, regarding serious incident reports.
- Compliance team received and responded to five audit requests from Datavant. A total of 88 individuals medical records/documents were requested.

Complaint Call Synopsis

- Compliance team received four complaints in the month of July. The complaints were categorized as one- Emergency Services, one-ID/DD Support Coordination, one-MH Case Management-Stafford, and one-Crisis Stabilization. Only one of the four calls resulted in a formal investigation and was unsubstantiated.

Special Projects

- Prospective Audits
    - Compliance Specialist reviewed 44 quarterlies and 11 Individual Service Plans (ISPs) for ID/DD Residential Programs during the month of July. Feedback related to any discrepancies was provided to the group home supervisor and assistant coordinator.

Trainings/Meetings

- Compliance team attended the DBHDS Region 1 Local Human Rights Committee Hearing (LHRC) on July 10, 2025.
- Compliance team attended DBHDS Region 3 Nursing Monthly Meeting on July 14, 2025.
- Compliance team provided the Mandated Reporter training to Spotsylvania Rappahannock Adult Activities, Inc. (RAAI) staff on July 15, 2025.

MEMORANDUM

To: Joseph Wickens, Executive Director
From: Stephanie Terrell, Director of Compliance
Date: August 6, 2025
Re: 4th Quarter FY 2025 Incident Report Review

The 4th quarter incident summary report provides an overview of incident reports submitted by Rappahannock Area Community Services Board (RACSB) staff during the months of April 1, 2025 through June 30, 2025. The purpose of the report is to communicate information about trends, remain vigilant for emerging issues, and use data to plan, prioritize and implement preventative and proactive initiatives.

The population covered includes all people receiving services by the RACSB, which includes Mental Health (MH), Substance Use (SU), Developmental/Intellectual Disability (DD), and Prevention Services. RACSB provided services to 7,757 individuals, unduplicated by service area, from April 1, 2025 through June 30, 2025.

Compliance Staff received and triaged 868 Incident Reports from April 1, 2025 through June 30, 2025 (an overall increase of 16 reports from last quarter). Of those 868 incident reports received, 105 incidents were reported to the Department of Behavioral Health and Developmental Services (DBHDS) through the Computerized Human Rights Information System (CHRIS) (83 Level 2, 22 Level 3, 5 Abuse/Neglect/Exploitation (ANE), and 1 Complaint).

Compliance staff triaged all incident reports into one of four categories.

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

DBHDS categories of serious incidents

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

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

4. **Level III**: a serious incident whether or not the incident occurs while in the provision of a service or on the provider's premises and results in:
   1) Any death of an individual;
   2) A sexual assault of an individual;
   3) A serious injury of an individual that results in or likely will result in permanent physical or

psychological impairment;
4) A suicide attempt by an individual admitted for services that results in a hospital admission.

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

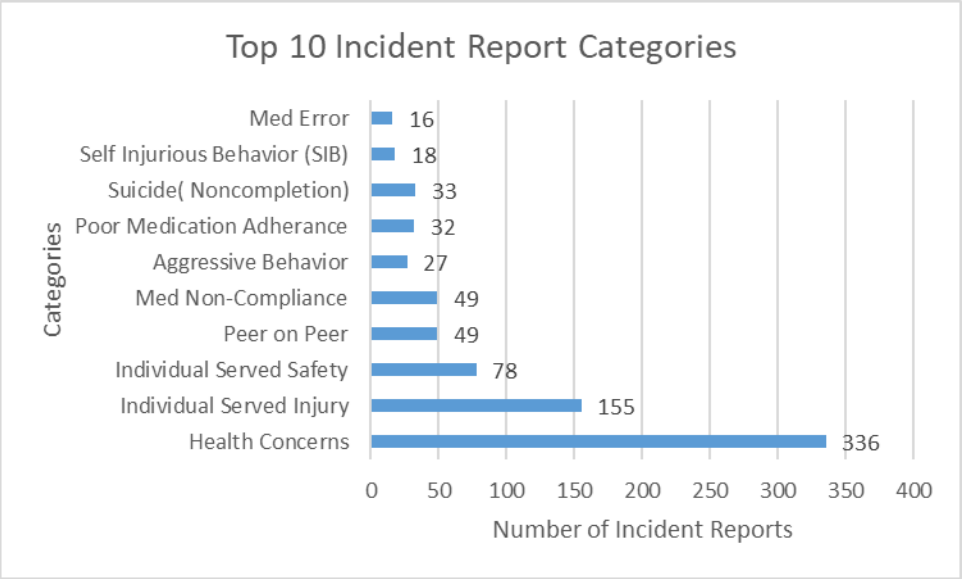
Below is a list of the incident categories and the definition:

- Aggressive Behavior - Physical - hit, slap, push, shove, pull hair, spit, bite, intimidate, demean, threaten, curse etc…
- Aggressive Behavior - Verbal - yelling, screaming, intimidate, demean, threaten, curse etc…
- Individual Safety - situations that may cause a safety risk for individuals served involving physical environment or structures (faulty equipment, smoking.)
- Individual Injury - situations that may cause a safety risk for individuals served involving minor injury such as a scraped knee
- Health Concerns - individual served exhibiting health concerns, i.e. possible seizure activity, sick, sudden weight +/-, etc.
- Elopement/Wandering - unexpectedly leaving program/premises with possible risk to safety
- Biohazardous Accident - needle stick or instance requiring testing of individual served or staff
- Infection Control - lack of infection control and use of universal precautions in relation to risk of non-life-threatening communicable diseases i.e. Flu, Lice… etc…
- Exposure to Communicable Diseases - instance of exposure due to lack of infection control and/or use of universal precautions in relation to risky communicable diseases i.e. TB, HIV/AIDS, HEP A, B, C or MRSA…
- Vehicle Accident - Accident of RACSB or personal vehicle while delivering services. This requires additional paperwork and follow up to protocol contact Human Resources & Supervisor
- Peer-on-Peer - means a physical act, verbal threat, or demeaning expression by an individual against or to another individual that causes physical or emotional harm to that individual. Examples include hitting, kicking, scratching, and other threatening behavior.
- Property Damage - damage to property
- Weapon Use/Possession - Weapons are not allowed in any RACSB facility. Knives, carpet knives, swords, guns etc…
- Staff Injury - injury to staff- ensure proper HR forms are completed
- Use of Seclusion/Restraint - if emergency intervention required to deescalate threatening behavior
- Med Non-Compliance - not following medication regime- staff attempt evident- non-compliance
- Med Error - Staff additionally to complete med error report. error has been made in administering a medication to an individual (wrong - med, individual, route, dose, time)
- Possession of Illicit/Licit Substance - possession of illegal or non-prescribed drug - possible intent of abuse

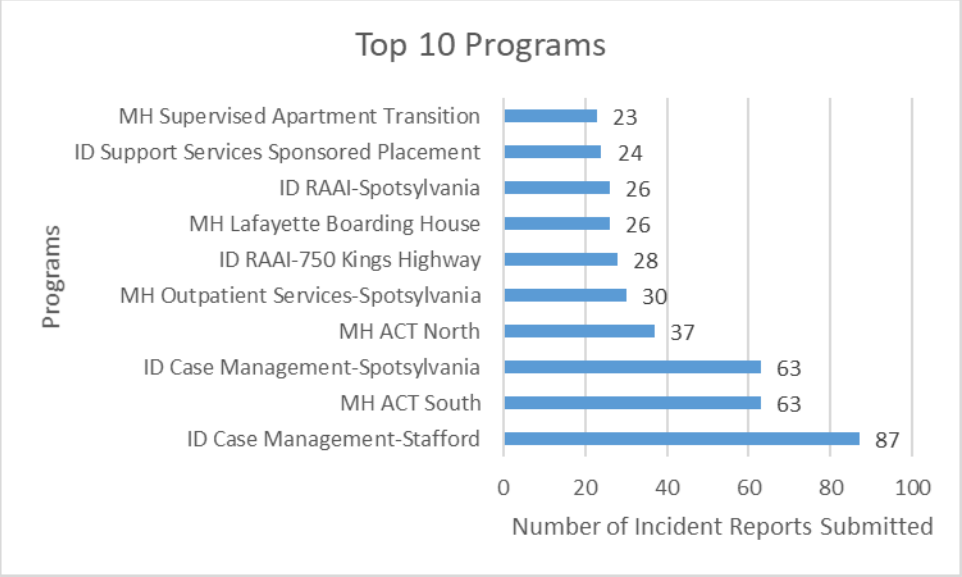
- Sexual Assault - is an act in which a person intentionally sexually touches another person without that person's consent, or coerces or physically forces a person to engage in a sexual act against their will
- Suicide/Suicide Attempt - is the act of intentionally causing one's own death/is the act of intentionally unsuccessfully trying to cause one's own death
- Sentinel Events - An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof - warrants immediate investigation and response
- Other - incident which does not fit into a category above

Incident Report Categories	All RACSB Programs July-September	All RACSB Programs October - December	All RACSB Programs January - March	All RACSB Programs April - June	*All RACSB Residential/24-hour Programs April - June
Accidental Overdose	2	0	0	3	0
Aggressive Behavior - Physical	30	25	18	21	1
Aggressive Behavior - Verbal	5	18	12	11	4
Bio Hazardous Accident	0	0	0	0	0
Elopement/Wandering	15	8	6	5	2
Exposure to Communicable Diseases	2	0	0	0	0
Health Concerns	309	256	390	336	100
Individual Served Injury	106	71	109	155	75
Individual Served Safety	82	89	98	78	6
Infection Control	0	0	0	0	0
Med Error	33	28	28	16	11
Med Non-Compliance	33	17	22	48	31
Medication Non-Adherence	15	15	0	0	0
Medication Poor Adherence	14	14	18	32	0
Missing Person	0	5	5	2	1
Other	33	0	16	17	0
Peer on Peer	2	60	32	51	28
Possession of Illicit/Licit Substances	22	3	0	3	2
Property Damage	9	13	9	6	1
Sentinel Event (death)	3	6	12	11	0
Self-Injurious Behavior (SIB)	4	14	18	18	5
Sexual Assault	6	2	4	1	0
Staff Injury	35	12	10	7	3
Suicide (noncompletion)	1	32	26	33	3
Use of Seclusion/Restraint	10	1	0	0	0
Vehicle Accident	0	25	19	11	2
Weapon Use/Possession	4	0	0	3	0
Total	775	714	852	868	275

The table above depicts the total number of incident reports submitted across all RACSB Locations and submitted across all RACSB Residential/24-hour Programs from July 1, 2025 through June 30, 2025 *All RACSB Residential/24-hour Programs consists of MH Crisis Stabilization, MH Residential, and DD/ID Residential Programs from April 1, 2025 – June 30, 2025.



The chart above depicts the top ten incident categories with the highest occurrences across all RACSB Programs reported April 1, 2025 through June 30, 2025.



The chart above depicts the top ten programs that submitted the highest of number of incident reports across all RACSB programs during the time period of April 1, 2025 through June 30, 2025.

Approximately 38% of all incident reports received noted health concerns. When compared to previous quarters, Health Concerns continues to be the category with the highest number of incidents. This can be contributed to all health-related conditions, such as colds, flu, sepsis, seizures, pneumonia, decubitus ulcer, choking, cellulitis, minor cuts, scratches, scrapes, vomiting, or diarrhea. Within the Health Concerns category, the top three reported subcategories are (253) Other, (21) Seizures, and (15) Urinary Tract Infections.

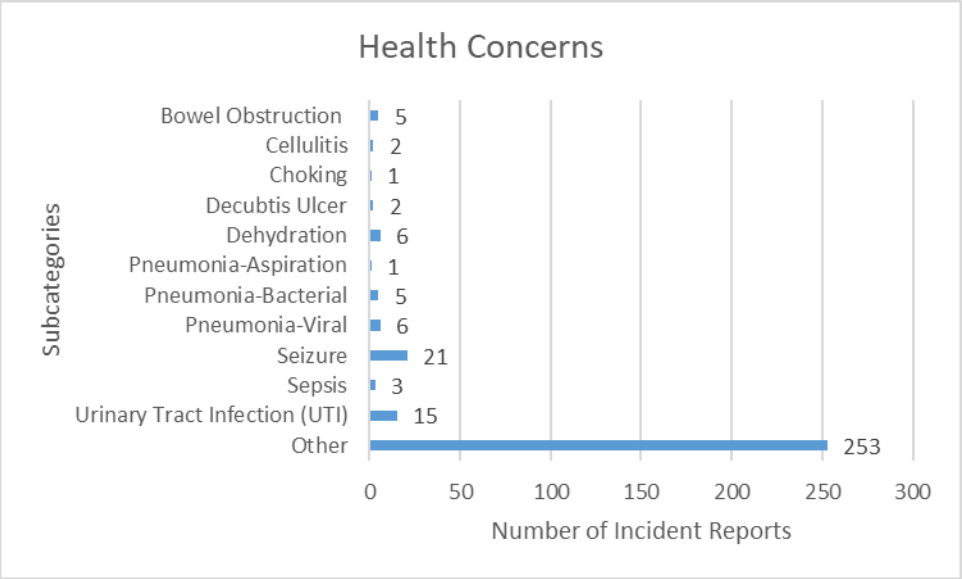
ID/DD Support Coordination submitted 102 of the Health Concern reports; ID/DD Residential Services submitted 68 reports, MH Residential submitted 25 reports; MH ACT submitted 39; ID/DD Support Coordination submitted 15 reports, MH Outpatient submitted 13 reports; MH Case Management submitted 18 reports; ID/DD Day Support submitted 12 reports; Permanent Supportive Housing (PSH) submitted 11 reports, MH Crisis Stabilization submitted seven reports; ID/DD Prevention Early Intervention (PEID) submitted four reports, ID/DD Infant Case Management submitted two reports, Psychosocial Rehabilitation submitted six reports; MH Outpatient Medical submitted five reports, Adult Drug Court submitted four reports, SA Outpatient MAT submitted three reports, SA Case Management Probation and Parole submitted one report, and MH Emergency Services submitted one report.

A review of Health Concern reports showed a decrease of 51 reported Health Concerns in the Other subcategory from the third quarter. ID/DD Support Coordination reported the highest number of Health Concerns in the Other subcategory with a total of 85. All 85 reported incidents did not occur during the provision of services and were reported to the case manager after the incident had occurred. These reports include; but are not limited to, incidents of back pain, stomach pain, skin rashes, upper respiratory infection, GERD, clogged g-tube, urgent care visits and hospital visits.

ID/ID/DD Residential reported the second highest number of incidents in the Health Concerns Other subcategory with a total of 50 reports. There was at total of 24 reported incidents that resulted in needing either minor first aide, urgent care visit, or an assessment by emergency medical services (EMS) due to conditions such as; but not limited to, vomiting, upper respiratory infection, skin break due to picking, jaw pain due to inflammation, TB testing, and congestion. There was a total of 13 reports that resulted in an ER visit due to conditions such as; but not limited to, high blood pressure, urinary tract infection (UTI), ear infection, and upper respiratory infection. There was a total of 12 reports that involved incidents that either occurred out of the provision of services and/or were incidents that did not require first aide or medical attention such as; but not limited to, bruising, skin rashes, wheezing due to upper respiratory infection, TB testing. Lastly, one of the reported Health Concerns Other reported incidents resulted in an unsubstantiated human rights investigation.

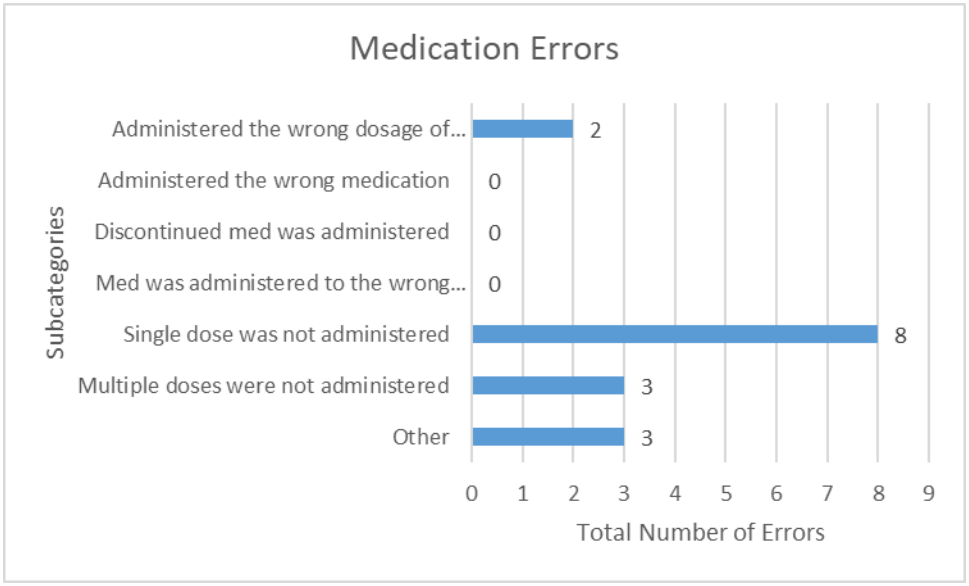
MH ACT reported the third highest number of incidents in the Health Concerns Other subcategory of 36. There was a total of 29 reports that involved incidents that either occurred out of the provision of services and/or were incidents that did not require first aide or medical attention such as; but not limited to, mental health issues that resulted in an ER visit and/or psychiatric admission, vomiting, clinical lab values that were abnormal and elevated during a routine medical visit, and dizziness. There was a total of five reports that resulted in an ER visit due to conditions such as; but not limited to, altered mental status, fall (hit head), and mental health issues. There was a total of two reported incidents that resulted in needing either minor first aide, urgent care visit, or an assessment by emergency medical services (EMS) due to conditions such as; but not limited to, dental pain and medication management.

The remaining Health Concerns Other subcategory incident reports were reported by the following programs: (17) MH Residential; (12) PSH; (10) MH Outpatient Services; (8) ID/DD Day Support; (7) MH Crisis Stabilization; (5) Psychosocial Rehabilitation; (4) MH Adult Case Management; (4) MH Adolescent Case Management; (4) Adult Drug Court; (4) Substance Abuse Outpatient (SAOP); (4) MH Outpatient Medical Services; (3) PEID; (2) Infant Case Management; and (1) MH Emergency Services.



The chart above depicts the number of incidents submitted across all RACSB programs for the subcategories listed under the Health Concerns category during the time period of April 1, 2025 through June 30, 2025.

A total of 16 medication errors occurred during the 4th quarter. Of those 16 medication errors, 10 were reported from ID/DD Residential Services, three from ID/DD Support Coordination, one from ICF Day Support, one from MH Residential Services, and one from MH ACT.



The chart above depicts the number of errors in each medication error subcategory across all RACSB programs during the time period of April 1, 2025 through June 30, 2025.

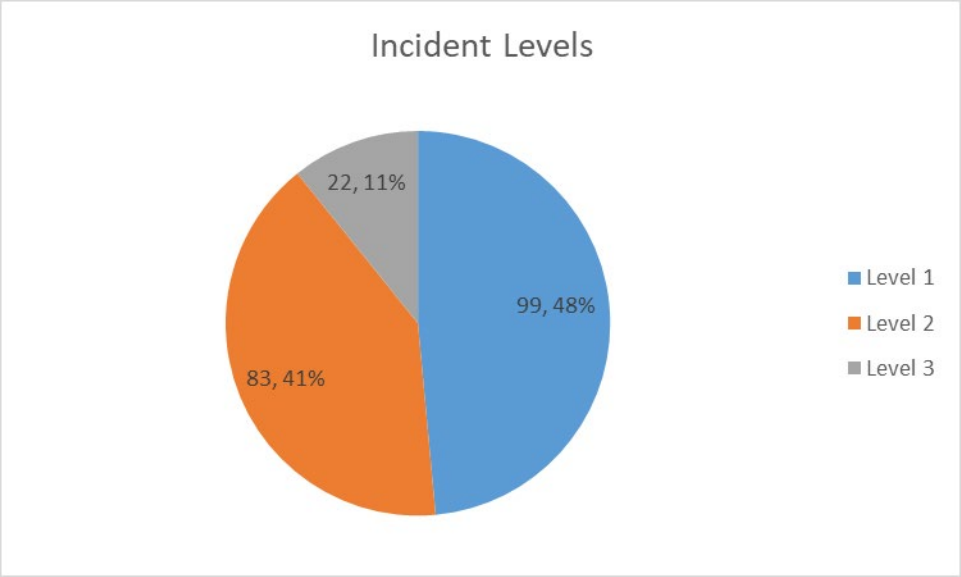
Medication errors occurred in the following programs;

- 1-Wolfe Street ICF Group Home
- 1-Ross Drive ICF Group Home
- 1-Churchill Group Home
- 2-Galveston Group Home
- 2-ID Supervised Apartments - Brittany Commons

- 1-ID Supervised Services Belmont
- 2-ID Highly Intellectual New Home Group Home
- 1-ICF Day Support
- 2-ID/DD Support Coordination-Stafford
- 1-ID/DD Support Coordination - Caroline
- 1- MH Supervised Apartments - Home Roads
- 1-MH ACT North

Review and analysis of medication policy, medication administration area, staffing patterns, and cause of errors took place in an attempt to mitigate future errors.

Overall, there is a significant decrease of 12 medication errors that were noted from the third quarter to the fourth quarter. From the third quarter, there was a decrease of five in subcategory Administered the Wrong Dosage of Medication; a decrease of three in subcategory Administered the Wrong Medication; a decrease of two in subcategory Discontinued Medication was Administered; no change in subcategory Medication was Administered to the Wrong Person; a decrease of five in subcategory Single Dose not Administered; an increase of two in subcategory Multiple Doses Were Not Administered; and an increase of one in subcategory Other. Additionally, MH Supervised Apartments - Home Roads has seen a significant decrease of five reported medication errors from the third quarter.



The chart above depicts the total number of incident reports categorized by Incident Levels 1, 2, and 3 across all RACSB programs during the time period of April 1, 2025 through June 30, 2025.

There was a total of 99 incidents categorized as a level 1. Of the 99 incidents categorized as a level 1, many were the result of minor or superficial cuts, scratches, or bruises, which required first aid. There was a total of 65 reported incidents that were reported from ID/DD Residential Services; 18 reported incidents were from ID/DD Day Support; 10 reported incidents were from MH Residential Services; two reported incidents were from MH ACT Services; one reported incident was from MH Crisis Stabilization; one reported incident was from Psychosocial Rehabilitation; one reported incident was from MH Case Management; and one reported incident was from Emergency Services.

- EMS assessment without transport for excessive exhaustion and falls

- Urgent care visits for:
    - Urinary Tract Infection (UTI)
    - Abdominal pain
    - Choking
    - Abnormal, pain or bruising on feet
    - Infection
    - General feeling of illness
    - Fever
    - Seizure
    - Sinus discomfort
    - Light headed
- First Aid administered for a minor burns, sores, cuts, and scrapes.
- Falls requiring first aide and/or urgent care visits.

Based on review of the level 1 incidents reported, there was a slight increase of five incidents that were reported during the fourth quarter in comparison to the reported incidents in the third quarter. Only one pattern was found involving one individual from ID/DD Residential had a total of six reports related to seizure related falls. It was also noted that seven of 99 Level 1 incidents were reported from ID/DD Residential - Stonewall Estates Group Home, but were unrelated incidents.

There were 83 incidents classified as a Level 2. Root Cause Analyses were conducted for all Level 2 Incidents. Of the 83 Level 2 reports, 32 were from ID/DD Residential Services; eight were from MH Crisis Stabilization; 23 were from MH Residential Services; five were from MH ACT; four were from Psychosocial Rehabilitation; three were from MH Outpatient Services; six were from ID/DD Day Support; one was from MH Case Management; and one was from SAOP.

Fifty-five of the Level 2 were reported as Health Concerns; 22 were from ID/DD Residential Services; 16 were from MH Residential; six were from MH Crisis Stabilization; eight from Psychosocial Rehabilitation; two were from PSH; five were from MH ACT; and one from MH Outpatient Services. Four were reported as Suicide Noncompletion; two were from MH Crisis Stabilization; one was from PSH; and one was from MH Outpatient Services Caroline. Seventeen were reported as Individual Served Injury; nine were from ID/DD Residential; five were from Day Support; two were from MH Residential; and one was from PSH. One was reported as Aggressive Behavior from Psychosocial Rehabilitation. Five were reported as Individual Served Safety; two were from ID/DD Residential; one was from PSH; one was from MH Case Management; and one was from MH Outpatient Services Spotsylvania. Lastly, one was reported as Vehicle accident from Substance Abuse Outpatient.

Level 2 incidents included; but not limited to:

- Fall resulting in stitches
- Abdominal Pain
- Chest Pain
- Fall Fractured finger
- Bleeding from the rectum
- Potential Stroke
- Labored breathing
- Kidney stones
- High blood pressure
- Low blood pressure
- Severe headache

Based on review of the Level 2 incident reports, there was a decrease of 10 reported incidents for the fourth quarter compared to 93 reported in the third quarter.

There was a total of 22 incidents classified as a Level 3. Root Cause Analyses were conducted for all Level 3 Incidents. Of the 22 Level 3 reports, three were from ID/DD Support Coordination; 10 were from MH Emergency Services; six were from MH Outpatient Medical; one was from MH Case Management; one was from MH ACT; and one was from MH Outpatient Services.

Ten of the Level 3 reports were categorized as Death from (3) ID/DD Support Coordination; (5) MH Outpatient Medical; and (2) MH Emergency Services. There were 12 Level 3 reports that were categorized as Suicide (noncompletion) from (8) MH Emergency Services; (1) MH Outpatient Services; (1) MH Outpatient Medical; (1) MH ACT; and (1) MH Case Management.

Based on review of the Level 3 incident reports, there was an increase of three incidents in this fourth quarter compared to the 19 incidents reported in the third quarter.

There were a total 51 incident reports submitted for peer-on-peer incidents. Peer on peer incidents require an incident report be completed for each individual involved if the incident occurs during provision of service or if both/all of individuals involved receive RACSB Case Management/Support Coordination Services. Twenty-eight of the 51 peer on peer incident reports were from ID/DD Residential; (6) Churchill Group Home; (4) Myers Respite Group Home; (2) Galveston Group Home; (2) ID Supported Services Sponsored Placement; (4) ID Igo Road Group Home; (8) Ruffin's Pond Group Home; and (2) Wolfe Street ICF Group Home. Five reports were from ID/DD Day Support; (2) ID/DD Day Support Stafford; and (3) ID/DD Day Support 750 Kings Highway. Three reports were from ICF Day Support. Nine reports were from ID/DD Support Coordination; (4) ID/DD Support Coordination Stafford, (1) ID/DD Support Coordination Spotsylvania, (1) ID/DD Case Management Fredericksburg. Four reports were from Psychosocial Rehabilitation. Lastly, two reports were from MH ACT North.

No serious injuries resulted from the incidents reported. Each reported incident involved an isolated situation. In addition, staff immediately redirected and resolved the concerns.

An increase of peer-on-peer incidents of 19 were reported in the fourth quarter compared to the incidents reported in the third quarter. Only one pattern was found in which one individual was directly involved and reported to be the aggressor in eight of the reported incidents from both ID/DD Residential and ID/DD Day Support Services. Of those eight reported incidents, six incidents involved the same two individuals, one being consistently the aggressor in those reports.

Program actions as a result of Incident Reports

1. Action plans for aggressive behavior included recommendations for behavior plans, assisting the individual in learning and using coping skills during times when they become upset, review and revision of individual's service plan, and continuance of using interventions that are currently in the individual's service plan.
2. Action plans for health concerns varied based on the concern. RACSB staff contact 911 in cases of medical emergencies. Ad-hoc medical appointments will continue to be made by RACSB staff to address health concerns for those individuals residing in RACSB residential programs. In addition, for RACSB non-residential programs staff will continue to assist individuals and family members with health concerns that are identified during program hours.

3. For those incidents which involve individuals that do not reside in RACSB residential programs, Support Coordinators and Case Managers monitor health concerns and document in case notes.
4. Root cause analyses were conducted on all incidents that fell into the Level 2 or Level 3 category. Some incidents required an enhanced root cause analysis due to the number of instances that an individual has experienced or has been observed at the hospital for the same or related event within a specific timeframe. Findings of root cause analysis resulted in programs revising individual service plans, behavior plans, ad-hoc reviews of program files, policy and procedure revisions, staff training, and personnel action.

To: Joseph Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance & Human Rights

Date: June 2025

Re: Quality Assurance Report

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

- Mental Health Residential: Home Road
- Mental Health Residential: Lafayette Boarding House
- Project LINK

Mental Health Residential: Home Road

There was one staff member responsible for the selected charts.

Findings for the nine open charts and one closed chart reviewed for Mental Health Residential: Home Road were as follows:

- Nine charts were reviewed for Assessment compliance:
  - **Discrepancies noted with Assessments:**
    - One chart was missing a current DLA 20.

- Nine charts were reviewed for Individual Service Plan compliance:
  - **Discrepancies noted with Individual Service Plan:**
    - One chart was missing the Individual Service Plan.
    - One chart had an annual Individual Service Plan that was late.
    - Two charts had Individual Service Plans finalized after 30 days from admission.

- Nine charts were reviewed for Quarterly Review compliance:
  - **Discrepancies noted with Quarterly Reviews:**
    - One chart had a Quarterly Review that was missing.
    - Two charts had Quarterly Reviews that were late.

- Nine charts were reviewed for Progress Note compliance:
  - **Discrepancies noted with Progress Notes:**
    - One chart had Progress Notes that were missing.

- Nine charts were reviewed for Medical compliance:
  - **Discrepancies noted with Medical compliance:**
    - Two charts had MARs missing for the month of April.

- Nine charts were reviewed for General Documentation compliance:
  - **Discrepancies noted with General Documentation.**
    - Three charts were missing the Program Agreement.

- One chart were reviewed for Discharge compliance:
    - **Discrepancies noted with Discharge.**
        - One chart had an Individual that should have been discharged but was still open to Services.

Comparative Information:

In comparing the audit reviews of Mental Health Residential: Home Road charts from the previous audits to the current audits, the average score decreased from 91 to 81 on a 100-point scale.

Corrective Action Plan:

- **ISP finalized after plan date:** All residents have been assigned to a QMHP who is responsible for tracking documentation, including ISPs. Documentation dates are also reviewed, updated and sent out monthly by the MH Residential Coordinator or Assistant Coordinator, which is provided to each QMHP. The MH Residential Assistant Coordinator completes internal chart audits each month, which includes at least 2 charts from Home Road, in order to help identify missing documents or errors in a timely manner. The internal chart audits have significantly reduced errors with signatures, timeliness and quality of documentation. MH Residential Coordinators are also in the process of identifying a shared calendar platform that all QMHP's can access, in order to receive reminders about upcoming documentation dates. This will be updated by the program coordinators at least monthly, and can also be updated by other QMHP's, as needed. Current audit process is ongoing, while the shared documentation calendar will be established by 6/30 and all staff will be trained on the calendar by the July program staff meeting.
- **Late ISP-due 4/29, completed 5/14**—During an internal audit of charts on May 14, the program manager found that TW's ISP was not completed on 4/29. The program manager took responsibility for the late documentation and self-reported this to the program coordinators. The plan was completed and submitted on May 14. This chart has been reassigned from the program manager to another QMHP, in order to equally distribute charts among all QMHP's at Home Road.
- **MAR's—backs of MARs are not scanned in; not scanned by 5th of the month:** In the month of May, April MARs were not scanned in by the 5th of the month, therefore, they were not present at the time of audit. In addition, some MARs only had the front scanned. Home Road has designated one QMHP to scan in MARs each month, but she was on vacation during the first part of May. This task was not reassigned during her absence, resulting in MARs being scanned in after the 5th. Moving forward, the program manager will ensure that duties will be reassigned in the absence of the designated staff. MARs that were missing back pages were scanned in on June 13. The scanner has 2 scanning options, one that will scan both sides, and the other that only scans one side. The staff responsible for scanning will be asked to verify that the scan captured both pages before submitting the document in Avatar. This process will be reviewed by program coordinators and manager during the next program staff meeting in July and for new staff during orientation.
- **Program agreement not located:** Missing program agreement was located and scanned into Avatar on 6/13/25. The agreement had been signed as part of the lease agreement last year, but was not scanned into the Agreements section of the EHR. Assigned QMHP is responsible for making sure annual documents are scanned in, and is also monitored during monthly internal chart audits by MH Residential Assistant

Coordinator. This process will be reviewed by program coordinators and manager during the next program staff meeting in July and for new staff during orientation.

- **Quarterly completed 5 days after due date:** QMHP's are aware that quarterlies must be completed by the due date. This expectation will be reviewed by the program coordinators and manager during the July staff meeting and during orientation for new staff. MH Residential Assistant Coordinator will monitor during chart audits. Medicaid allows 15 days from due date to submit quarterly reviews.
- **Preliminary ISP completed 3 days after admission:** KW was open to Home Road episode on 1/31/25, but the LMHP could not complete the CNA in person until 2/3/25, due to the individual having COVID. Although open to the episode on 1/31/25, no billing was submitted for services until 2/3/25, when the CNA and preliminary ISP were completed. CNA's are required to be completed prior to admission, but no later than the day of admission, or admission may need to be delayed. This procedure will be reviewed by the program coordinators and manager during the July staff meeting and with new staff during orientation.

Mental Health Residential: Lafayette Boarding House

There was one staff member responsible for the selected charts.

Findings for the six open charts and one closed chart reviewed for Mental Health Residential: Lafayette Boarding House were as follows:

- Six charts were reviewed for Assessment compliance:
  - **No discrepancies noted with Assessments.**

- Six charts were reviewed for Individual Service Plan compliance:
  - **Discrepancies noted with Individual Service Plans:**
    - One chart was missing the client's signature on Individual Service Plan.
    - One chart was completed by one staff but signed by another staff.

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

- Six charts were reviewed for Progress Note compliance:
  - **Discrepancies noted with Progress Notes:**
    - Six charts contained progress notes that were copied and pasted.

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

- Six charts were reviewed for General Documentation compliance:
  - **No discrepancies noted General Documentation.**

- One chart was reviewed for Discharge compliance:
  - **No discrepancies noted Discharge Documentation.**

Comparative Information:

In comparing the audit reviews of Mental Health Residential: Lafayette Boarding House charts from the previous audits to the current audits, the average score remained the same, 82 on a 100-point scale.

Corrective Action Plan:

- **Notes:** were copied and pasted. It was identified that one staff appeared to have copied and pasted notes, which were similar to other resident notes. The program manager has since discussed this with the responsible staff, and drafted a counseling memo to give to the staff on 6/16/25. This will be discussed during the June staff meeting and during 1:1 supervision with staff that are found to be copying notes. The program manager will also support the responsible staff with identifying multiple ways to write distinctive notes for similar service delivery.
- **ISP not signed**: Service plan dated 8/22/24 was not signed by one individual. During an internal chart review on 12/4/24, the MH Residential Assistant Coordinator discovered that the ISP was not signed and notified the program manager about the missing signature. The program manager spoke with the QMHP and sent her an email on 12/4/24, letting her know that the ISP needed to be printed, signed and scanned in. This was not completed. The program manager has since spoken with the responsible staff and has issued her a counseling memo for not obtaining the signature, as instructed. Moving forward, for any internal audits that require corrections, the program manager must follow up to ensure required corrections were made within the timeframe identified by the MH Residential Coordinators. This will be discussed during the June staff meeting with program staff.
- **ISP indicated that one staff signed the ISP and another staff completed the ISP:** The ISP was completed by the assigned QMHP. The QMHP completed the ISP in Avatar under another staff login, without realizing, so the other staff was listed on the ISP as the staff "completing" the ISP. The program manager has since discussed with staff the importance of logging out of Avatar when finished, as well as making sure staff log in each time. This will also be discussed during the June program staff meeting.

Project LINK

There were two staff members responsible for the selected charts.

Findings for the ten open charts and one closed chart reviewed for Project LINK were as follows:

- Ten charts were reviewed for Assessment compliance:
    - **Discrepancies noted with Assessments:**
        - 9 charts contained late Comprehensive Needs Assessments.
        - 1 chart was missing a Comprehensive Needs Assessments.

- Ten charts were reviewed for Individual Service Plan compliance:
    - **Discrepancies noted with Individual Service Plan:**
        - Seven charts contained late Individual Service Plans.

- Ten charts were reviewed for Quarterly Review compliance:
    - **Discrepancies noted with Quarterly Reviews:**
        - Two charts contained Quarterly Reviews which were completed late.

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

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

- One chart was reviewed for Discharge compliance:
    - **No discrepancies noted with Discharge.**

Comparative Information:

In comparing the audit reviews of Project LINK charts from the previous audits to the current audits, the average score increased from a 40 to 50 on a 100-point scale.

Corrective Action Plan:

- Project LINK case manager and program manager will update the assessments, informed consents, consumer orientations and releases on identified clients.
- Staff will add client alerts to each chart in order to remind clinicians to complete treatment plans and assessments within identified timeframe. Alerts will be set to notify staff 15 days prior to due date.
- All missing documentation will be updated and completed in the next 90 days, no later than 9/30/25.
- Project LINK program manager will conduct audits on random clients charts monthly, auditing a minimum of 5 charts per month.
- Project LINK program manager will review and confirm the corrective action plan, has been implemented.

To: Joseph Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance & Human Rights

Date: July 2025

Re: Quality Assurance Report

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

- Child and Adolescent Case Management
- Psychosocial Rehabilitation

Child and Adolescent Case Management: Spotsylvania

There were five staff members responsible for the selected charts.

Findings for the ten open charts and one closed chart reviewed for Child and Adolescent Case Management: Spotsylvania were as follows:

- Ten charts were reviewed for Assessment compliance:
  - **Discrepancies noted with Assessments:**
    - One chart contained an assessment that was finalized a month later.

- Ten charts were reviewed for Individual Service Plan compliance:
  - **No discrepancies noted with Individual Service Plans.**

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

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

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

- One chart was reviewed for Discharge compliance:
  - **No discrepancies noted with Discharge.**

Comparative Information:

In comparing the audit reviews of Child and Adolescent Case Management: Spotsylvania from the previous audits to the current audits, the average score increased from 94 to 99 on a 100-point scale.

Corrective Action Plan:

Deficiency:

- Assessment was completed on 10/25/24 but not finalized until 11/21/24.
- Assessments are due to be finalized within 24 hours.
- Staff reported the assessment had been done but inadvertently left in draft and staff did not discover it was in draft until the following month during monthly chart reviews.
- A case note was not entered into the chart indicating that the assessment was finalized late due to inadvertently being left in draft.

Corrective action to minimize future deficiencies in this area:

- Staff will be reminded during the 8/1/25 staff meeting that assessments are due to be finalized and submitted within 24 hours and to check for any documents inadvertently left in draft.
- Staff will be advised to enter a case note in the chart if they discover a document was left in draft in error during the 8/1/25 staff meeting.
- Monthly chart audits are completed by child and adolescent case management staff and regular chart reviews.

Staff responsible for overseeing on-going compliance:

- Child and Adolescent Supervisor, Senior Case Managers and Case Managers

Psychosocial Rehabilitation

There were two staff members responsible for the selected charts.

Findings for the ten open charts and one closed chart reviewed for Psychosocial Rehabilitation were as follows:

- Ten charts were reviewed for Assessment compliance:
  - **Discrepancies noted with Assessments:**
    - One chart was missing a six-month assessment.
    - One chart contained a Comprehensive Needs Assessment which was completed late.

- Ten charts were reviewed for Individual Service Plan compliance:
  - **Discrepancies noted with Individual Service Plans:**
    - One chart contained a late Individual Service Plan.

- Ten charts were reviewed for Quarterly Review compliance:
  - **Discrepancies noted with Quarterly Reviews:**
    - One chart contained a late Quarterly Review.

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

- Ten charts were reviewed for General Documentation compliance:
    - **No discrepancies noted General Documentation.**

- One chart was reviewed for Discharge compliance:
    - **No discrepancies noted Discharge Documentation.**

Comparative Information:

In comparing the audit reviews of Psychosocial Rehabilitation charts from the previous audits to the current audits, the average score increased from 88 to a 94 on a 100-point scale.

Corrective Action Plan:

Corrective Action Plan for missing re-assessments:

- Coordinator will work with IT to see if there is a form that can be developed to track assessment dates more efficiently. Anyone enrolled in the program in December will have their treatment plan completed within the same calendar year. All staff will complete the treatment plan as close to enrollment/assessment date as possible to avoid future concerns. Coordinator will be responsible for monitoring assessment dates.
- Coordinator will be responsible for maintaining a spreadsheet of annual and 6-month assessments.

Quarterlies being too early or late:

- All staff will be responsible for tracking their own caseload. During monthly supervision, upcoming documentation dates will be discussed. Assistant Coordinator and Coordinator will develop a new tracking system for all documentation, and specifically for quarterlies, to check behind staff and ensure date accuracy by August 15 2025.

Late Plans:

- Staff will try and plan ahead if a client won't be in attendance and write the plans early, as long as the assessment is completed, and put a future start date. ISPs will be discussed in monthly supervision logs. Staff will make outreach calls to members to encourage them to attend when they have a plan due.

MEMORANDUM

To: Joe Wickens, Executive Director

From: Stephanie Terrell, Director of Compliance

Date: August 1, 2025

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) received four licensing reports. Two reports are related to late reporting of serious incident reports into the DBHDS Computerized Human Rights Information System (CHRIS), (1) Ruffin's Pond Group Home and at (1) Sponsored Residential Home Service for Adults; and two reports are related to human rights allegations at (1) New Hope Church Road Group Home and at (1) Belmont Supervised Apartments.

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

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-08-011**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-01-2025**
Program Type/Facility Name: **08-011 Betsy Street**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-160. D. (2) - The provider shall collect, maintain, and report or make available to the department the following information: 2. Level II and Level III serious incidents shall be reported using the department's web-based reporting application and by telephone or email to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery. Reported information shall include the information specified by the department as required in its web-based reporting application, but at least the following: the date, place, and circumstances of the serious incident. For serious injuries and deaths, the reported information shall also include the nature of the individual's injuries or	N	Betsy Street This regulation was NOT MET as evidenced by: CHRIS Number: 20250201 Date/Time of Discover: 06/11/2025 7:00AM Enter Date/Time: 06/12/2025 3:32PM Reporting Delay: 8:32:00 Location Name: Betsy Street	PR) 07/08/2025 PR: Moving forward, incident reports will be entered into the CHRIS Program withing the 24-hour deadline. To help ensure understanding of expected timelines for incident report submission, the responsible sponsored placement team members will be re-oriented on expected deadlines and sign off on an attestation of understanding at the staff meeting on 7/11/25. An annual e-learning course on incident reporting will continue to be assigned to all residential program staff and Sponsored Providers annually to ensure continued understanding of expected protocols and deadlines for submitting incident reports. Monitoring and oversight of timeliness for incident reporting protocols and timeline expectations will be provided by the group home manager daily. Systematically, RACSB Compliance and the DD Residential Coordination team will monitor for incidents and timeliness of reports on a daily basis for all programs to ensure Level II and Level III incidents are entered in a timely fashion into the CHRIS system. OLR) Accepted 07/18/2025	7/11/2025

License #: **101-08-011**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-01-2025**
Program Type/Facility Name: **08-011 Betsy Street**

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

General Comments / Recommendations:

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

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

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

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

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

Date of Inspection: **06-27-2025**
Program Type/Facility Name: **01-001 Ruffin's Pond Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-105-160. D. (2) - The provider shall collect, maintain, and report or make available to the department the following information: 2. Level II and Level III serious incidents shall be reported using the department's web-based reporting application and by telephone or email to anyone designated by the individual to receive such notice and to the individual's authorized representative within 24 hours of discovery. Reported information shall include the information specified by the department as required in its web-based reporting application, but at least the following: the date, place, and circumstances of the serious incident. For serious injuries and deaths, the reported information shall also include the nature of the individual's injuries or	N	Ruffin's Pond Group Home This regulation was NOT MET as evidenced by: CHRIS Number: 20250193 Date/Time of Discover: 06/06/2025 11:45AM Enter Date/Time: 06/07/2025 2:57PM Reporting Delay: 3:12:00 Location Name: Ruffin's Pond Group Home	PR) 07/08/2025 PR: Moving forward, incident reports will be entered into the CHRIS System within the 24-hour deadline. To help ensure understanding of expected timelines for incident report submission, all Ruffin's Pond staff members will undergo a refresher training on the incident reporting process at the staff meeting on 7/25/25. Staff will sign off on an attestation of their understanding and agreement to abide by these protocols and requirements. An annual e-learning course on incident reporting will continue to be assigned to all residential program staff annually to ensure continued understanding of expected protocols and deadlines for submitting incident reports program and agency wide. Monitoring and oversight of timeliness for incident reporting protocols and timeline expectations will be provided by the group home manager daily. Systematically, RACSB Compliance and the DD Residential Coordination team will monitor for incidents and timeliness of reports on a daily basis for all programs to ensure Level II and Level III incidents are entered in a timely fashion into the CHRIS system. OLR) Accepted 07/18/2025	7/25/2025

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

Date of Inspection: **06-27-2025**
Program Type/Facility Name: **01-001 Ruffin's Pond Group Home**

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

General Comments / Recommendations:

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

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

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

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-07-006**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **06-02-2025**
Program Type/Facility Name: **07-006 Kenmore Ave**

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	Kenmore Ave This regulation was NOT MET as evidenced by: See OHR citation below.		
12VAC35-115-60. B. (8) - The provider's duties. 8. Providers shall ensure that the entries in an individual's services record are at all times authentic, accurate, complete, timely, and pertinent.	N	Kenmore Ave This regulation was NOT MET as evidenced by: During an internal investigation the provider determined the following: • Inconsistencies found during a review of medical documentation for Individual 1 Failure to ensure that the entries in an individual's services record are at all times authentic, accurate, complete, timely, and pertinent is a violation of 12VAC35-115-60(B)(8).	PR) 06/24/2025 Documentation was reviewed with the staff member responsible and the staff member was reminded that all collateral contacts need to be recorded. The staff members documentation not related to this case was reviewed, showing this was an isolated incident. We will conduct a documentation training at the next Emergency Services Staff Meeting. The ES Coordinator will review documentation for the staff member involved for the next six months. The ES Coordinator will document the training in ES meeting minutes. The ES Coordinator will document the documentation review in the staff members supervision notes. OHR/OLR) Accepted 06/25/2025	07/31/2025 00:00:00

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **101-07-006**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **06-02-2025**
Program Type/Facility Name: **07-006 Kenmore Ave**

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

Date of Inspection: **07-08-2025**
Program Type/Facility Name: **01-001 New Hope Church Rd. 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	New Hope Church Rd. Group Home This regulation was NOT MET as evidenced by: See OHR citations below.		7/18/2025
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	New Hope Church Rd. Group Home This regulation was NOT MET as evidenced by: This regulation was NOT MET as evidenced by: CHRIS #20250010 "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. "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	PR) 07/29/2025 PR: The staff member responsible for the incident of abuse and neglect (Employee #1) was immediately put on administrative leave pending the outcome of an internal investigation. Upon substantiation of the abuse and neglect allegation following the investigation procedures, the staff member responsible for the incident was separated from employment by the agency effective 6/25/25. All program staff will be re-trained on the importance of Human Rights specific to all forms of abuse and neglect. Additionally, they will all receive a training refresher on mandated reporting requirements. Staff will sign off attesting to their understanding and agreement to abide by each of these requirements and obligations. All RACSB staff and volunteers will be required	7/18/2025

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

Date of Inspection: **07-08-2025**
Program Type/Facility Name: **01-001 New Hope Church Rd. Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		receiving care or treatment for mental illness, intellectual disability, or substance abuse Provider substantiated verbal, physical and psychological abuse and neglect based on the following: • Upon review of the video footage, Employee #1 was seen being verbally aggressive toward Individual #1 and, at one point, appeared to push Individual #1 into the seat of the van. ◦ Employee #1's comments are consistent with yelling at Individual #1 to get into the van and threatening that if Individual #1 "did not behave", Individual #1 would not be taken to the doctor. ◦ This incident was observed by Individual #2, Individual #3 and Individual #4. This regulation was NOT MET as evidenced by: CHRIS #20250011, # 20250012, 20250013 "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 psychological abuse based on the following:	to undergo an annual Human Rights training, a Mandated Reporter training, and an annual review of the RACSB Employee Code of Ethics to help ensure continued promotion and support of meeting needs of residents. Newly hired staff will be assigned these courses upon hire during the week of their agency orientation. Human Resources will continue to track these annual trainings for compliance by all staff through its electronic training system/database. 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. The Compliance 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. 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).	

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

Date of Inspection: **07-08-2025**
Program Type/Facility Name: **01-001 New Hope Church Rd. Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		◦ Upon review of the video footage, the compliance team observed Individual #2, #3 and #4 present during the verbal abuse of Individual #1. ◦ Observing abuse inflicted upon Individual #1 was deemed by the provider to be psychologically abusive both to the individual and to the individuals who witnessed the abuse. Knowingly, recklessly, or intentionally performing acts that cause or might have caused physical or psychological harm to an individual is a violation of 12VAC35-115-50 (B)(2).	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. Any staff member failing to abide by human rights regulations, or failing to intervene or report instances of human rights violations will receive corrective action measures. OHR/OLR) Accepted 07/30/2025	
12VAC35-115-260. B. (2d) - Providers shall require their employees to: 2. Protect individuals from any form of abuse, neglect, or exploitation by: 2d. Reporting all suspected abuse, neglect, or exploitation to the director;	N	New Hope Church Rd. Group Home This regulation was NOT MET as evidenced by: This regulation was NOT MET as evidenced by: CHRIS #20250010, # 20250011, 20250012 and #20250013 Protect individuals from any form of abuse, neglect or exploitation by reporting all suspected abuse, neglect or exploitation to the director. • Employe #2 and Employee #3 failed to report the allegation of abuse that occurred on June 4, 2025, to the director or designee. Failure to report the incident is a violation of 12VAC260(B)(2)(d).	PR) 07/29/2025 PR: Employee #2 and Employee #3 will receive corrective action for failing to report the allegation of abuse that occurred on June 4th to the DD Residential Coordination team and Compliance Director. All program staff will be re-trained on the importance of Human Rights specific to all forms of abuse and neglect. Additionally, they will all receive a training refresher on mandated reporting requirements. Staff will sign off attesting to their understanding and agreement to abide by each of these requirements and obligations. All RACSB staff and volunteers will be required	7/18/2025

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

Date of Inspection: **07-08-2025**
Program Type/Facility Name: **01-001 New Hope Church Rd. Group Home**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			to undergo an annual Human Rights training, a Mandated Reporter training, and an annual review of the RACSB Employee Code of Ethics to help ensure continued promotion and support of meeting needs of residents. Newly hired staff will be assigned these courses upon hire during the week of their agency orientation. Human Resources will continue to track these annual trainings for compliance by all staff through its electronic training system/database. 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. The Compliance 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. 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).	

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

Date of Inspection: **07-08-2025**
Program Type/Facility Name: **01-001 New Hope Church Rd. 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. Any staff member failing to abide by human rights regulations, or failing to intervene or report instances of human rights violations will receive corrective action measures. OHR/OLR) Accepted 07/30/2025	

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 #: **101-01-011**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-08-2025**
Program Type/Facility Name: **01-011 2526 Carriage Lane Apt #3D**

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	2526 Carriage Lane Apt #3D 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	2526 Carriage Lane Apt #3D This regulation was NOT MET as evidenced by: #20250009 "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 did not received Medication #1 for an extended period of time. ◦ Employee #1 did not report that the legal guardian did not want to pay the $5 (out of pocket) for the medication. ◦ Entity 1 was not consulted regarding	PR) 07/15/2025 PR: Individual #1 began receiving Medication #1 effective 6/27/25 as prescribed. Individual #1 will receive all medications moving forward in accordance with physician orders. Employee #1 was issued corrective action and coaching on 6/26/25 in regards to neglect for Individual #1 not receiving Medication #1 for an extended period of time, not reporting that the legal guardian did not want to pay out of pocket for the medication, and for not consulting Entity #1 regarding removing Medication #1 from Individual #1's medication list. Employee #1 understands steps to take moving forward should a similar issue present. Systematically, all RACSB staff, volunteers, and contractors will be required to undergo an annual Medication Refresher training to help ensure continued understanding of the importance of the	06/27/2025 00:00:00

License #: **101-01-011**
Organization Name: **Rappahannock Area Community Services Board**

Date of Inspection: **07-08-2025**
Program Type/Facility Name: **01-011 2526 Carriage Lane Apt #3D**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
		removing Medication #1 from Individual #1's medication list. Failure to administer medications as prescribed by the physician is a violation of 12VAC35-115-50 (B)(2).	medication management and administration responsibilities. Newly hired staff will be assigned the full medication management course as part of their onboarding. The DD Residential Coordination team and the Compliance team will monitor incident reports regarding medication errors on a daily basis to help ensure systematically that incidents of this nature are identified and mitigated quickly. OHR/OLR) Accepted 07/17/2025	

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

Corporate Responsibility

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

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

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

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

Signature, Executive Director

Signature, Chair, Board of Directors

Date

July 2025

I. Compliance Standards

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

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

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

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

3) Federal laws and regulations regarding substance use confidentiality.

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

5) Applicable regulations through the Health Care Finance Administration.

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

7) Accreditation standards, as issued through CARF.

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

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

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

II. Staff Education

All RACSB employees are expected to comply with all policies, procedures, and applicable laws. At the beginning of employment, all employees review highlighted policies and sign off indicating they have read and understand the Employee Handbook.

The Code of Ethics, grievance procedures, and standards of conduct violations are all outlined in the Employee Handbook.

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

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

Annually, the Board of Directors review Board policies and procedures, as well as make recommendations for changes/clarification.

A. Policy and Procedure manuals

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

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

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

B. Maintenance of records and documentation

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

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

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

State and federal confidentiality laws bind information on services provided at Rappahannock Area Community Services Board. With the exception of information that may need to be shared in cases of emergency, subpoenas, search warrants and court

orders are the other tools through which information may be released without the prior consent of the person receiving services.

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

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

Any written information that is released as a result of a subpoena duces tecum shall be accompanied by a certification indicating the information is being released as ordered.

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

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

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

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

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

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

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

IV. Availability of Legal Counsel

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

V. Monitoring, Auditing and Risk Assessment Activities

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

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

VI. Investigations of Suspected Noncompliance

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

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

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

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

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

VII. Consequences for Non-Compliance

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

VIII. Outside Investigations

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

IX. Corporate Citizenship.

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

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

Hope Starter Communications

Communications Plan FY 26

Things to Note

Starting in FY23, the communications goals switched from a focus on external to internal because of a high number of staff vacancies. In FY24, employee engagement efforts became part of the communication coordinator duties.
Due to an enhanced compensation package, an enlarged human resources team, and efforts to improve employee engagement and internal communications, RACSB has been able to dramatically decrease the number of open positions.
At the same time, the need for external communications has increased. Therefore, in FY26, the focus will return to external communications while still working to ensure robust and effective strategies for internal communications and employee engagement.

The agency website is overdue for a refresh. The site has more than doubled in size since its relaunch in 2017. There have also been dramatic changes both inside RACSB and in the Fredericksburg community, which means that each piece of information on the site needs to be reviewed for relevancy.

Because of changing communications methods and budget priorities, it is also time to re-evaluate many of the communications strategies that RACSB has used for decades.

Last year's goals focused on metrics and numbers. Those are still included as part of the method for measuring success, but this year's goals are more strategic and focus on the message and its delivery.

FY25 Results

Internal Communications

- Expansion of employee recognition: Employee of the Quarter announcements have been added to the lobby slide presentation and Engage; the kudos section of Inside RACSB grew from 1-2 pages to routinely being 4-5 pages (and on a few occasions, 6)
- Fostering a team spirit: Employee and program spotlights were added to Inside RACSB, an employee ambassador program was created, use of Engage increased dramatically, Spark (intranet) use doubled year over year, dramatic increase in employees owning HopeStarter t-shirts, held three merch-making events where employees made more than 60 HopeStarter t-shirts

134

Engage posts created by communications coordinator

62

HopeStarter shirts given to employees through engagement contests and the ambassador program or as rewards for volunteering to represent RACSB at events.

118

HopeStarter shirts purchased through RACSB's Bonfire store

10,487

visits to Spark in the last quarter of FY25, compared to 5,681 in the last quarter of FY24

FY25 Results

External Communications

- Increase awareness of RACSB's work in the community: 11 media releases were disseminated (which is stable compared to prior year), blog posting increased significantly, website traffic and social media followers increased, e-newsletter was created and contact list grown, RACSB had a presence at a wide array of community events

4,449

social media followers at the end of FY25

1,494

social media posts in FY25

69,230

website visitors in FY25

853,526

page views in FY25

34

community events where RACSB's presence was supported by communications coordinator (this is in addition to events where RACSB's presence was coordinated by the prevention team)

$3,106

sold through the website to support RAAI

FY26 Goals

External Communications

- Oversee and maintain agency advertising
- Draft media releases and serve as liason to local media
- Maintain website to keep contact information, events, and program descriptions current
- Redesign/refresh website
- Maintain blog with frequent posts
- Maintain social media presence with frequent posts across at least three platforms
- Create annual report and oversee production and distribution
- Oversee brochure reprints, edits, and revisions
- Grow e-newsletter contact list
- Serve as agency photographer
- Support and coordinate RACSB presence at community events
- Support agency programs with communication needs
- Support program fundraising efforts
- Support recruitment efforts

Tools:

- Website/blog
- Social media
- Media Releases
- E-newsletter
- Community events
- Print collateral
- HopeStarter merchandise
- Annual Report

Tactics:

- Update website navigation to ensure easier use
- Refresh/redesign website
- Keep abreast of current SEO techniques and use them
- Update website regularly
- Include links to RACSB website on social media

- Attend community events and support staff attending community events
- Provide talking points and facts sheets to board members and staff meeting with legislators or other community leaders
- Provide a consistent e-newsletter to community
- Produce an annual report which shows return on investment to community and showcases RACSB's work in our community
- Encourage individuals to share their behavioral health journeys
- Promote Prevention Services activities
- Include blog posts that promote the benefits of receiving care
- Promote peer-led support groups
- Promote messages of hope
- Support behavioral healthcare staff in their outreach efforts
- Educate community on crisis services
- Disseminate media releases about prevention trainings on website and social media
- Include monthly wellness topics in Inside RACSB
- Partner with Rappahannock Health District on a monthly newspaper column that educates the community on physical and behavioral health
- Post wellness tips on social media
- Support community partners working on wellness
- Show agency culture on website and social media
- Highlight RACSB employees as experts in their fields
- Build agency presence on LinkedIn
- Ensure that promotional materials for recruitment include diversity in age, race, gender, job function


FY26 Strategic Communications Plan

RACSB's Strategic Plan priorities that relate to communications:

- Access to Services: Increase awareness and reduce stigma around behavioral health. Remove barriers that prevent clients from engaging in services.
- Effective and quality services: Deliver and advocate for comprehensive, individualized, and community-integrated supports that enhance the well-being, independence, and inclusion of individuals served
- Staff retention, workforce support, and talent development: Enhance employee retention and engagement to support a resilient and high-performing workforce aligned with our mission that delivers equitable and high-quality care to the community
- Staff retention, workforce support, and talent development: Recruit, develop, and retain a compassionate workforce through training, leadership development, and employee well-being initiatives while building a positive culture of service

Target Audiences:

- Community partners
- Community leaders
- Individuals served
- Caretakers/guardians/family of individuals served
- Community members

Community Partners

Communications Goals:

- Community partners know the services we provide and understand how we can partner with them to meet related needs.
- Community partners understand the trainings we provide to the community.
- Community partners have the information they need to help individuals with behavioral health concerns and/or developmental disabilities.
- Community partners feel comfortable with the services we provide and see us as a valued community asset.

Key Messages:

- RACSB provides quality services that improve lives in our community.
- HopeStarters will be at the table to explore and solve community problems.
- HopeStarters have topic expertise and can provide valuable information and knowledge.
- Community trainings provide opportunities for everyone in the community to better understand and respond to suicidal thoughts or opioid overdoses.
- RACSB will provide services and expertise in its service field and will partner to solve problems but will not do all the things for all the people.

Communications Channels:

- Agency website
- Social media, primarily Facebook and Instagram
- E-newsletter
- Community events
- Brochures
- Flyers
- Annual report

Channel Strategies:

- Agency website: improve SEO to increase visitors, consistent blogging on topics of interest to community partners and/or the people they serve, improve navigation, update images, add video, feature community trainings, improve calendar.
- Social media: Share content from community partners, advertise trainings, provide tips about behavioral health and developmental disability, create shareable graphics, post about presence at community events.
- E-newsletter: send monthly, increase subscribers, include trainings, provide helpful content with easily digestible and memorable information, showcase our work to prove the value RACSB adds to community.
- Community events: monitor and track RACSB presence at events and the costs associated, choose carefully which ones we attend, solicit volunteers by providing HopeStarter t-shirt and offering ambassador points, create sign-up list, create clear guidelines on who registers for events and who provides supplies to avoid duplication of efforts, inform employees about procedures for getting events approved, develop budget, create compelling content to provide at events.
- Brochures: Update outdated brochures, create image library, reduce words, provide to clinics and community partners, bring to community events.
- Flyers: Create as needed, create image library, remind employees that all flyers need to be approved by communications coordinator and must include branding.

- Annual report: Develop theme early, collect content throughout the year, create library, make shorter, create digital magazine version and an annual report webpage with interactive elements.

Community Leaders and Elected Officials

Communications Goals:

- Community leaders know the services we provide
- Community leaders know when and where to refer people to our services
- Community leaders understand the crisis process so they can support individuals and families through that.

Key Messages:

- RACSB provides quality services that improve lives in our community
- Behavioral health issues and developmental disabilities can impact anyone
- People impacted by behavioral health concerns and developmental disabilities need support, and it is possible for anyone to learn how to offer that support
- Community trainings provide opportunities for everyone in the community to better understand and respond to suicidal thoughts or opioid overdoses
- Crisis services seem scary; people will not look for information before they need them, so it is important for community leaders to understand the process and to help people through it empathically

Communications Channels:

- Agency website
- Social media, primarily Facebook and Instagram
- E-newsletter
- Brochures
- Media Kit and talking points
- Earned media

Strategies:

- Agency website: improve SEO to increase visitors, improve navigation, create guides that clearly show when, why, and how to access services; create blog posts on topics that reduce stigma, increase awareness, and offer tips on how to support individuals; feature community trainings and support groups.
- Social media: advertise trainings and support groups, provide tips about behavioral health and developmental disability, create shareable graphics, create explainer videos (could also be used on website).
- E-newsletter: send monthly, increase subscribers, include trainings, provide helpful, easily digestible, memorable tips on how to provide support.
- Brochures: distribute to community leaders.

- RACSB Media Kit: Continually update and ensure its availability for leadership and board members when meeting with elected officials or community leaders.

Individuals Served

Communications Goals:

- Individuals understand the services provided and can make informed choices
- Individuals know how to provide feedback.
- Individuals know when there will be agency closings.
- Individuals will learn more about the agency overall and the HopeStarter culture.

Key Messages:

- Services are here to support you.
- Your feedback is valued.
- Changes/closings/updates will be communicated to you in a variety of ways.
- RACSB is a caring organization that provides quality services by people with expertise.

Communications Channels:

- Agency website
- Social media
- Lobby presentations
- Holiday closing signs on doors

Strategies:

- Agency website: improve navigation, assess and monitor accessibility, create blog posts on topics of interest to individuals served, include agency changes on a banner at the top of the site, support groups kept up-to-date on website, feedback form regularly updated.
- Social media: create posts that show RACSB's work, offer tips of use to individuals served, showcase photos of individuals served
- Lobby presentations: update at least monthly and as needed, include any changes to agency or schedules, provide information that individuals need to know to receive services
- Holiday closing signs: make sure they are updated, print for each clinic and facility (except 24-hour programs), send printed signs through interoffice mail and send a PDF to coordinators, create and disseminate a schedule for posting the signs

Caretakers/Guardians/Parents

Communications Goals:

- Caretakers understand the services provided and can make informed choices.
- Caretakers will better understand when to seek certain services.
- Caretakers will better understand their role.
- Caretakers know how to provide feedback.
- Caretakers will learn more about the agency overall and the HopeStarter culture.
- Caretakers will feel comfortable with the choice to use RACSB.
- Caretakers will feel less isolated.
- Caretakers will better understand the waiver and crisis processes.
- Caretakers will receive messages that help them reduce stigma.

Key Messages:

- Services are here to support you and your loved one.
- RACSB is a caring organization that provides quality services by people with expertise.
- You are not alone.
- Waivers may seem confusing, but they are important and we can help you understand them.
- If your loved one is in a crisis, they will receive care from compassionate professionals who can handle emergency situations.
- Behavioral health and developmental challenges can happen to anyone.
- You are not alone on your journey.

Communications Channels:

- Agency website
- Social media
- Brochures
- Waiver booklets
- E-newsletter

Strategies:

- Agency website: improve navigation, create blog posts that offer tips for caretakers, review and update guides to waivers and crisis services; improve descriptions of services.
- Social media: promote blog posts of interest to families, promote family support group, create shareable graphics that breakdown stigma, show RACSB services in action, show individuals being served, create posts with details about and links to waivers and crisis services.
- Brochures: Update crisis services, DD residential and sponsored placement brochures.
- Waiver booklets: update to include new contact information and REACH details; print; bring to community events and provide to support coordinators.

- E-newsletters: send monthly, increase subscribers—promote to family members; include details on services; include family support group; use compelling visuals to showcase the work of RACSB (to help families feel secure in our services and for them to see that they are not alone).

Community Members

Communications Goals:

- Individuals better understand behavioral health concerns and developmental disabilities to reduce stigma.
- Individuals understand the dangers associated with substance abuse, vaping, gambling, etc.
- Individuals know the signs of suicide.

Key Messages:

- Behavioral health concerns are common and not something to be ashamed of.
- Developmental disabilities are not shameful.
- Making healthy choices is important.
- Community trainings provide needed information to help you tackle difficult topics.

Communications Channels:

- Agency website
- Social media
- E-newsletter
- Flyers

Strategies:

- Agency website: improve SEO to increase visitors; improve navigation; create blog posts on topics that reduce stigma, increase awareness, and offer tips on how to support individuals; feature community trainings.
- Social media: advertise trainings, provide tips about behavioral health and developmental disability, create shareable graphics, create explainer videos (could also be used on website).
- E-newsletter: send monthly; increase subscribers; highlight trainings; provide helpful, easily digestible, memorable tips on how to provide support
- Flyers: Disseminate prevention services flyers, create flyers offering mental health tips and/or information about SUD and DD for specific events or to be placed in specific community locations and to be disseminated at community events.
- Community events: Evaluate events to choose the most meaningful opportunities

Priority 2

Deliver and advocate for comprehensive, individualized, and community-integrated supports that enhance the well-being, independence, and inclusion of individuals served.

Communications Goals:

- Community understands the value of inclusion.
- Community knows the importance of integrated supports.

Key Messages:

- Our community is stronger when everyone is included regardless of mental illness, substance use disorder, or developmental disability.
- The right supports can help individuals be part of the community and to achieve their maximum potential.

Communications Channels:

- Agency website
- Social media
- E-newsletter
- Annual report

Strategies:

- Agency website: include photos of individuals served in the community, make it easier to find the right supports.
- Social media, e-newsletter, annual report: highlight photos of individuals served in the community; create database of photos of individuals in each program; meet with coordinators to explore ways to highlight more individuals; accompany programs on community outings to get photos and video.

Priority 3

Enhance employee retention and engagement to support a resilient and high-performing workforce aligned with our mission that delivers equitable and high-quality care to the community.

Target Audiences:
- HopeStarters
- Job-seekers

HopeStarters

Communications Goals:
- HopeStarters know they are valued and appreciated.
- HopeStarters know about what is happening in the agency.
- HopeStarters understand that their feedback is valued and heard.
- HopeStarters understand their role in the agency's mission.
- HopeStarters know about training opportunities.
- HopeStarters understand training deadlines.
- HopeStarters feel encouraged to promote their well-being.
- HopeStarters feel part of a positive culture.

Key Messages:
- RACSB provides quality services that improve lives in our community.
- RACSB is a good employer who will provide meaningful work in a culture that celebrates employees.
- HopeStarters do important work changing lives, no matter what their role.
- HopeStarters are a cohesive team.
- The wellbeing of HopeStarters is key to the agency's success.
- Training is an important part of your job.
- Agency leaders value HopeStarters.
- Leaders will be transparent and can be trusted to lead the agency in a matter consistent with our mission.
- RACSB values training.
- The well-being of HopeStarters is vital to serving our community.
- RACSB cares about employees' well-being.
- HopeStarters are part of a culture that believes in serving our community.

Communications Channels:
- Spark
- Engage
- Inside RACSB

- Agency social media
- Information Friday emails
- Other all-staff emails

Strategies:

- Spark: update information regularly, include photos of employees doing amazing things, include kudos and recognitions—Employee of Quarter, years of service, other awards and celebrations; make the site easily navigable, regularly update employee newsletter and galleries, update documents, include and update training calendars, create monthly wellness posts; update the personal development folder to include more up-to-date opportunities and tips; as leadership program is developed, promote it and educate employees about it.
- Engage: Regularly post, respond to employee posts in a timely manner, monitor posts, Include posts reminding staff of training deadlines, create posts that promote well-being and a positive company culture; foster discussions that break down silos and help employees get to know each other.
- Inside RACSB: include director's message, use compelling photos, celebrate employee accomplishments, solicit kudos and other content, create both print and digital versions, make sure it has any agency changes and information employees need, include training calendars and reminders about training deadlines, showcase company culture, grow the program spotlight and Get to Know a HopeStarter features, include a wellness article in each edition; promote leadership program when developed; provide leadership tips.
- Social media: include regular posts celebrating employees and showing them in action, show the company culture using photos, quotes, and videos.
- Information Friday: distribute regularly, provide updates and events, celebrate employees.
- Other all-staff emails: send as needed.
- Leadership communications: Support executive director when sending messages to staff, create list of employee appreciation days and a guide to employee appreciation and distribute to directors and coordinators, meet with directors and coordinators to explore opportunities for communication and recognition.
- Internal Communications/Engagement Committee: hold regular meetings with clearly defined goals and agendas, lead committee, have standing agenda items devoted to employee wellness and company culture, recognize contributions of committee.
- Engagement events: Plan and implement annual agency employee events, create and/or support opportunities for other engagement events throughout the year, plan and implement spirit days, provide opportunities for recognition at events, explore opportunities for engagement events that focus on wellness.

Job Seekers

Communications Goals:

- Job seekers know that RACSB is a valued employer that offers a strong compensation package and a flourishing culture.

Key Messages:

- RACSB provides quality services that improve lives in our community
- RACSB is a good employer who will provide meaningful work in a culture that celebrates employees
- HopeStarters do important work changing lives, no matter what their role

Communications Channels:

- Social media
- Website
- Community Events

Strategies:

- Social media: include regular posts celebrating employees and showing them in action; show the company culture using photos, quotes, and videos; encourage employees to share their stories and photos; grow LinkedIn presence; create posts featuring job openings
- Website: regularly update employment page; feature photos, videos, and stories of employees; start the Grow Your Own Way blog series; encourage employees to share their stories and photos
- Community Events: Support any career fairs, provide information about job openings when appropriate at community events.

Finance Department
July 2025 Program Updates

Staffing Changes and Opportunities:

There are currently three open positions in the Finance Department: Accounting Coordinator (currently posted), Accounting Specialist (not yet posted) and Financial Analyst (currently on hold/eliminated). We continue to appreciate our financial consultant, Kelly Young Marinoff, who has been working with Sara to help catch up bank reconciliations.

Reimbursement Department:

The Reimbursement Department has completed updating all providers licenses and liability insurance for FY26. They have been actively working with program staff to ensure self-pay agreements are updated across all programs. They are also checking eligibility for clients to ensure accuracy and active authorizations while focusing on collecting on outstanding claims aged over 120 days. Write Offs have increased due to clients not having updated self-pay agreements, which is a trend that will not continue now that new efforts are in place to ensure agreements are on file. Write Offs also increased due to clients that did not meet their spend down requirement in ACT and Residential programs.

Accounting Department:

The Accounting Department has been working on updating allocations and reporting for the new fiscal year. The 2026 Performance Contract report was completed and submitted to DBHDS for review and end of year reporting was submitted to our fiscal agent (Stafford County) for Opioid Abatement Authority (OAA) for review. Year-end FY2025 financial close-out/audit preparation work is under way and expected to continue over the next few months. All LIPOS reimbursement requests have been completed. Work also continues to address outstanding grant reimbursement requests through Web Grants. Investment discussions were also held with our banking partners at Atlantic Union to determine options for our investment future. These will be discussed at the September board meeting.

Summary of Cash Investments

Depository			Rate	Comments
Atlantic Union Bank				
Checking	$	13,963,235	3.25%	
Investment Portfolio				
Cash Equivalents		3,646,139		
Fixed Income		5,505,155		
Total Investment	$	9,151,294		
Total Atlantic Union Bank	$	23,114,530		
Other				
Local Gov. Investment Pool		36,892	4.41%	Avg. Monthly Yield
Total Investments	**$**	**23,151,422**		

Other Post-Employment Benefit (OPEB)

	Cost Basis	Cost Variance From Inception	Market Basis	Market Variance From Inception
Initial Contribution	$ 954,620		$ 954,620	
FY 2024 Year-End Balance	$ 2,131,014	$ 1,176,394	$ 4,489,220	$ 3,534,600
Balance at 09/30/2024	$ 2,132,565	$ 1,177,945	$ 4,358,454	$ 3,403,834
Balance at 10/31/2024	$ 2,131,983	$ 1,177,363	$ 4,270,641	$ 3,316,021
Balance at 11/30/2024	$ 2,131,983	$ 1,177,363	$ 4,403,710	$ 3,449,090
Balance at 12/31/2024	$ 2,131,983	$ 1,177,363	$ 4,334,837	$ 3,380,217
Balance at 1/31/2025	$ 2,131,455	$ 1,176,835	$ 4,392,771	$ 3,438,151
Balance at 2/28/2025	$ 2,131,455	$ 1,176,835	$ 4,374,439	$ 3,419,819
Balance at 3/31/2025	$ 2,131,455	$ 1,176,835	$ 4,272,529	$ 3,317,909
Balance at 4/30/2025	$ 2,130,913	$ 1,176,293	$ 4,264,954	$ 3,310,334
Unrealized Gain/(Loss)			$ 126,623	
Balance at 5/31/2025	$ 2,130,913	$ 1,176,293	$ 4,391,577	$ 3,436,957
Unrealized Gain/(Loss)			$ 135,615	
Balance at 6/30/2025	$ 2,130,913	$ 1,176,293	$ 4,527,191	$ 3,572,571

Health Insurance

FY 2025	Monthly Premiums	Monthly Claims & Fees	Interest	Balance
Beginning Balance				$3,029,016
July	$611,895	$261,724	$1,355	$3,380,542
August	$171,712	$322,228	$1,382	$3,231,408
September	$419,303	$209,940	$1,341	$3,442,111
October	$205,620	$311,924	$1,443	$3,337,250
November	$595,278	$216,548	$1,391	$3,717,371
December	$215,650	$330,102	$1,537	$3,604,456
January	$555,814	$261,380	$1,586	$3,900,475
February	$382,424	$380,808	$1,494	$3,903,585
March	$382,738	$292,163	$1,645	$3,995,804
April	$3,361	$331,179	$1,568	$3,669,553
May	$5,392	$346,780	$1,491	$3,329,656
June	$4,757	$302,391	$1,318	$3,033,340
YTD Total	**$3,553,941**	**$3,567,168**	**$17,550**	**$3,033,340**

FY 2026	Monthly Premiums	Monthly Claims & Fees	Interest	Balance
Beginning Balance				$3,033,340
July	$5,773	$305,482	$1,209	$2,734,840
YTD Total	**$5,773**	**$305,482**	**$1,209**	**$2,734,840**

Historical Data	Average Monthly Claims	Monthly Average Difference from PY	Highest Month
FY 2026	**$305,482**	**$8,218**	**$305,482**
FY 2025	**$297,264**	**$41,811**	**$380,808**
FY 2024	**$255,453**	**$41,076**	**$593,001**
FY 2023	**$214,376**	**($97,137)**	**$284,428**
FY 2022	**$311,513**	**($24,129)**	**$431,613**
FY 2021	**$335,642**	**$14,641**	**$588,906**

Summary of Investments

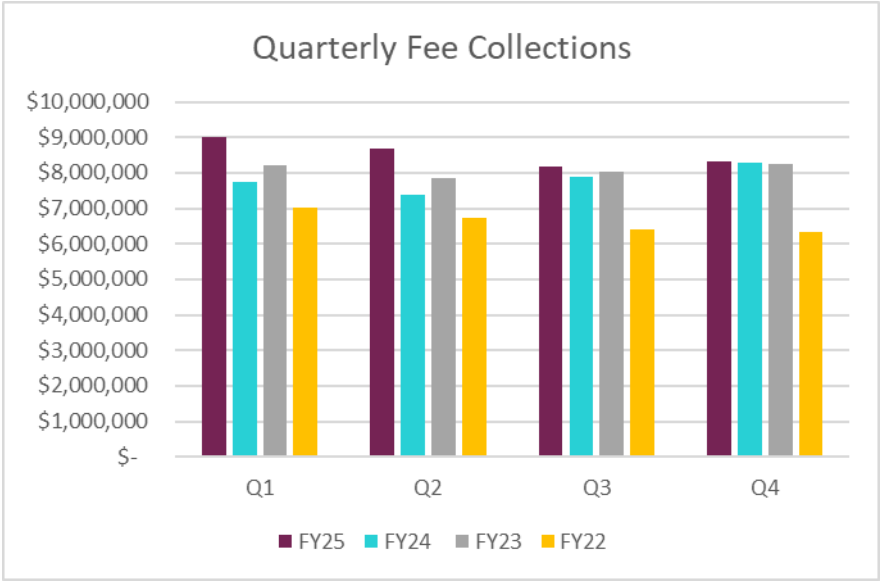
Asset Description	Shares/Face Value	Market Value	Total Cost	Unrealized Gain/Loss	Est. Income	Yield to Maturity	Yield to Cost
Fidelity IMM Gov Class I Fund #57	$ 44,690.57	$ 44,690.57	$ 44,690.57	$ -	$ 1,886.00	4.22%	4.22%
US Treasury Bill (08/07/2025)	$ 500,000.00	$ 483,421.87	$ 483,455.62	$ (33.75)	$ 16,544.38	3.72%	4.00%
US Treasury Bill (11/13/2025)	$ 500,000.00	$ 489,512.91	$ 489,623.47	$ (110.56)	$ 10,376.53	4.25%	4.24%
US Treasury Bill(11/28/2025)	$ 500,000.00	$ 490,925.07	$ 491,040.83	$ (115.76)	$ 8,959.17	4.29%	4.26%
US Treasury Bill(12/26/2025)	$ 500,000.00	$ 486,466.25	$ 487,100.00	$ (633.75)	$ 12,900.00	4.28%	4.00%
US Treasury Bill (01/22/2026)	$ 500,000.00	$ 483,937.08	$ 484,805.21	$ (868.13)	$ 15,194.79	4.09%	3.91%
US Treasury Bill(02/19/2026)	$ 700,000.00	$ 682,145.39	$ 682,488.58	$ (343.19)	$ 17,511.42	3.94%	4.12%
US Treasury Bill(03/19/2026)	$ 500,000.00	$ 485,040.20	$ 485,496.71	$ (456.51)	$ 14,503.29	4.00%	4.05%
Total Cash Equivalents	**$ 3,744,690.57**	**$ 3,646,139.34**	**$ 3,648,700.99**	**$ (2,561.65)**	**$ 97,875.58**		
US Treasury Note (10/15/2025)	$ 1,000,000.00	$ 999,900.00	$ 1,005,781.25	$ (5,881.25)	$ 42,500.00	4.26%	4.06%
US Treasury Note (09/30/2025)	$ 500,000.00	$ 500,465.00	$ 504,570.31	$ (4,105.31)	$ 25,000.00	4.23%	4.50%
US Treasury Note (10/15/2026)	$ 500,000.00	$ 502,960.00	$ 506,738.28	$ (3,778.28)	$ 23,125.00	4.72%	4.15%
US Treasury Note (06/15/2026)	$ 500,000.00	$ 499,690.00	$ 500,810.85	$ (1,120.85)	$ 20,625.00	4.26%	4.00%
US Treasury Note(01/31/2027)	$ 500,000.00	$ 500,570.00	$ 502,623.20	$ (2,053.20)	$ 20,625.00	4.10%	3.79%
US Treasury Note (03/15/2027)	$ 500,000.00	$ 501,915.00	$ 496,308.59	$ 5,606.41	$ 21,250.00	4.60%	4.57%
US Treasury Note (04/30/2026)	$ 500,000.00	$ 502,245.00	$ 499,023.44	$ 3,221.56	$ 24,375.00	4.17%	4.04%
US Treasury Note (08/15/2027)	$ 500,000.00	$ 498,205.00	$ 495,292.97	$ 2,912.03	$ 18,750.00	4.47%	4.15%
US Treasury Note (8/31/2026)	$ 500,000.00	$ 497,865.00	$ 495,195.31	$ 2,669.69	$ 18,750.00	4.31%	4.36%
US Treasury Note (02/29/2028)	$ 500,000.00	$ 501,340.00	$ 499,960.94	$ 1,379.06	$ 20,000.00	4.27%	4.04%
Total Fixed income	**$ 5,500,000.00**	**$ 5,505,155.00**	**$ 5,506,305.14**	**$ (1,150.14)**	**$ 235,000.00**	**4.22%**	**4.19%**
7/31/2025		**$ 9,151,294.34**	**$ 9,155,006.13**	**$ (3,711.79)**	**$ 332,875.58**	**4.24%**	**4.18%**

Fee Revenue Reimbursement- June 30, 2025

RAPPAHANNOCK AREA COMMUNITY SERVICES BOARD
FEE REVENUE REIMBURSEMENT REPORT AS OF June 30, 2025

AGED CLAIMS		Current Month		Prior Month		Prior Year	
Total Claims Outstanding	**Total**	100%	$4,585,936	100%	$6,314,007	100%	$7,227,572
	Consumers	42%	$1,926,985	33%	$2,093,488	49%	$3,520,634
	3rd Party	58%	$2,658,952	67%	$4,220,519	51%	$3,706,938
Claims Aged 0-29 Days	**Total**	51%	$2,336,271	63%	$3,989,326	49%	$3,542,616
	Consumers	1%	$36,084	1%	$58,645	2%	$115,776
	3rd Party	50%	$2,300,187	62%	$3,930,680	47%	$3,426,840
Claims Aged 30-59 Days	**Total**	3%	$155,740	2%	$121,973	2%	$135,937
	Consumers	1%	$41,321	1%	$67,001	0%	$2,317
	3rd Party	2%	$114,419	1%	$54,972	2%	$133,620
Claims Aged 60-89 Days	**Total**	2%	$85,771	2%	$121,310	2%	$141,174
	Consumers	1%	$46,905	1%	$55,677	1%	$104,776
	3rd Party	1%	$38,866	1%	$65,633	1%	$36,397
Claims Aged 90-119 Days	**Total**	2%	$105,851	1%	$85,189	1%	$55,607
	Consumers	1%	$49,594	1%	$47,123	0%	$34,121
	3rd Party	1%	$56,257	1%	$38,066	0%	$21,486
Claims Aged 120+ Days	**Total**	41%	$1,902,304	32%	$1,996,210	46%	$3,352,238
	Consumers	38%	$1,753,082	30%	$1,865,042	45%	$3,263,644
	3rd Party	3%	$149,222	2%	$131,168	1%	$88,594

CLAIM COLLECTIONS	
Current Year To Date Collections	$34,211,327
Prior Year To Date Collections	$31,319,980
$ Change from Prior Year	$2,891,347
% Change from Prior Year	9%



Write-off Report

Month: June 2025		
Write Off Code	Current MTD	Prior MTD
BAD ADDRESS	$ -	$ 19,216
BANKRUPTCY	$ 20	$ 80
DECEASED	$ 5,673	$ 10
NO FINANCIAL AGREEMENT	$ 75,811	$ 9,966
SMALL BALANCE	$ 90	$ 102
UNCOLLECTABLE	$ 270	$ -
FINANCIAL ASSISTANCE	$ 294,988	$ 196,193
NO SHOW	$ 9,068	$ 1,045
MAX UNITS/BENEFITS	$ 64,641	$ 13,894
PROVIDER NOT CREDENTIALED	$ 776	$ 1,233
DIAGNOSIS NOT COVERED	$ 243	$ -
NON-COVERED SERVICE	$ 3,354	$ 2,868
SERVICES NOT AUTHORIZED	$ 9,791	$ 5,744
PAST BILLING DEADLINE	$ 730	$ 160
MCO DENIED AUTH	$ 5,636	$ 900
INCORRECT PAYER	$ 423	$ 935
INVALID MEMBER ID	$ -	$ 195
NO PRIMARY EOB	$ 77	$ -
SPENDDOWN NOT MET	$ 229,895	$ 37,692
TOTAL	**$ 701,487**	**$ 290,232**

Year to Date: July - June 2025		
Write Off Code	Current YTD	Prior YTD
BAD ADDRESS	$ 50,268	$ 278,126
BANKRUPTCY	$ 270	$ 1,921
DECEASED	$ 9,171	$ 1,399
NO FINANCIAL AGREEMENT	$ 165,530	$ 60,350
SMALL BALANCE	$ 1,063	$ 1,599
UNCOLLECTABLE	$ 23,562	$ 2,682
FINANCIAL ASSISTANCE	$ 2,510,170	$ 1,943,951
NO SHOW	$ 22,967	$ 10,656
MAX UNITS/BENEFITS	$ 523,058	$ 194,694
PROVIDER NOT CREDENTIALED	$ 19,971	$ 92,938
ROLL UP BILLING	$ -	$ 56,821
DIAGNOSIS NOT COVERED	$ 7,036	$ 1,750
NON-COVERED SERVICE	$ 63,121	$ 56,122
SERVICES NOT AUTHORIZED	$ 164,035	$ 147,600
PAST BILLING DEADLINE	$ 5,724	$ 18,148
MCO DENIED AUTH	$ 15,625	$ 4,911
INCORRECT PAYER	$ 26,427	$ 37,154
INVALID MEMBER ID	$ -	$ 2,153
INVALID POS/CPT/MODIFIER	$ 100	$ -
NO PRIMARY EOB	$ 3,261	$ 4,800
SPENDDOWN NOT MET	$ 601,410	$ 78,785
STATE FUNDS EXHAUSTED	$ 19,150	$ -
TOTAL	**$ 4,231,919**	**$ 2,996,559**

Payroll Statistics FY2025

Pay Date	Overtime Hours	Overtime Cost	Average Cost per hour-Overtime	2P Hours	2P Cost	Average Cost per hour-2p	Total Hours	Total Costs
7/12/2024	399.5	$16,004.36	$40.06	153.33	$5,252.26	$34.25	552.83	$21,256.62
7/26/2024	377	$15,298.75	$40.58	164.25	$5,893.46	$35.88	541.25	$21,192.21
8/9/2024	475.01	$19,669.66	$41.41	124.5	$4,445.08	$35.70	599.51	$24,114.74
8/23/2024	333.67	$13,727.68	$41.14	210	$6,984.26	$33.26	543.67	$20,711.94
9/6/2024	568	$23,632.36	$41.61	89.5	$3,949.93	$44.13	657.5	$27,582.29
9/20/2024	501.7	$20,914.43	$41.69	112	$3,835.53	$34.25	613.7	$24,749.96
10/4/2024	323.5	$13,263.41	$41.00	130	$4,755.90	$36.58	453.5	$18,019.31
10/18/2024	266.25	$10,848.84	$40.75	131.5	$4,480.69	$34.07	397.75	$15,329.53
11/1/2024	334.25	$14,201.24	$42.49	118	$4,086.40	$34.63	452.25	$18,287.64
11/15/2024	382.5	$14,954.05	$39.10	87.75	$3,095.69	$35.28	470.25	$18,049.74
11/29/2024	369.25	$14,188.19	$38.42	105.75	$3,868.96	$36.59	475	$18,057.15
12/13/2024	227.75	$8,892.61	$39.05	116.5	$4,171.76	$35.81	344.25	$13,064.37
12/27/2024	275.25	$10,882.21	$39.54	136	$4,381.10	$32.21	411.25	$15,263.31
1/10/2025	331.75	$12,638.27	$38.10	115.5	$3,929.20	$34.02	447.25	$16,567.47
1/24/2025	306.25	$13,068.75	$42.67	93.85	$3,515.85	$37.46	400.1	$16,584.60
2/7/2025	130.75	$5,275.67	$40.35	103.25	$3,602.89	$34.89	234	$8,878.56
2/21/2025	210.75	$8,522.45	$40.44	91.07	$3,470.15	$38.10	301.82	$11,992.60
3/7/2025	168	$6,667.80	$39.69	86.25	$3,149.33	$36.51	254.25	$9,817.13
3/21/2025	118.25	$4,991.23	$42.21	59.75	$2,408.30	$40.31	178	$7,399.53
4/4/2025	80.25	$3,493.22	$43.53	93	$3,383.63	$36.38	173.25	$6,876.85
4/18/2025	82.25	$3,298.41	$40.10	39.75	$1,674.56	$42.13	122	$4,972.97
5/2/2025	126.5	$5,179.88	$40.95	53.35	$2,031.05	$38.07	179.85	$7,210.93
5/16/2025	36	$1,523.64	$42.32	39.87	$1,785.63	$44.79	75.87	$3,309.27
5/30/2025	63	$2,700.69	$42.87	35	$1,245.26	$35.58	98	$3,945.95
6/13/2025	38.25	$1,544.57	$40.38	45.5	$1,682.93	$36.99	83.75	$3,227.50
6/27/2025	28.25	$1,189.74	$42.11	35.5	$1,562.19	$44.01	63.75	$2,751.93
Grand Total	**6553.88**	**$266,572.11**	**$40.67**	**2570.72**	**$92,641.99**	**$36.04**	**9124.6**	**$359,214.10**

Payroll Statistics FY2026

Pay Date	Overtime Hours	Overtime Cost	Average Cost per hour-Overtime	2P Hours	2P Cost	Average Cost per hour-2p	Total Hours	Total Costs
7/11/2025	73.5	$2,911.46	$39.61	33.5	$1,421.70	$42.44	107	$4,333.16
7/25/2025	105	$4,242.78	$40.41	62	$2,274.32	$36.68	167	$6,517.10
8/8/2025	113.25	$4,479.56	$39.55	27.5	$1,024.79	$37.27	140.75	$5,504.35
Grand Total	**291.75**	**$11,633.80**	**$39.88**	**123**	**$4,720.81**	**$38.38**	**414.75**	**$16,354.61**

RACSB
FY 2025 FINANCIAL REPORT
Fiscal Year: July 1, 2024 through June 30, 2025
Report Period: July 1, 2024 through May 31, 2025

MENTAL HEALTH

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE	VARIANCE / REVENUE
	BUDGET FY 2025	ACTUAL YTD	%	BUDGET FY 2025	ACTUAL YTD	%		
INPATIENT	0	12,026	0.00%	0	179,150	0.00%	(167,124)	-1390%
OUTPATIENT (FED)	3,194,943	3,445,931	107.86%	3,194,943	3,741,568	117.11%	(295,637)	-9%
MEDICAL OUTPATIENT (R) (FED)	4,910,714	4,013,780	81.74%	4,910,714	4,319,603	87.96%	(305,823)	-8%
ACT NORTH (R)	1,009,186	869,375	86.15%	1,009,186	1,039,883	103.04%	(170,508)	-20%
ACT SOUTH (R)	969,616	1,041,516	107.42%	969,616	982,884	101.37%	58,632	6%
CASE MANAGEMENT ADULT (FED)	1,196,606	1,253,753	104.78%	1,196,606	1,314,161	109.82%	(60,408)	-5%
CASE MANAGEMENT CHILD & ADOLESCENT (FED)	929,321	847,706	91.22%	929,321	1,085,951	116.85%	(238,245)	-28%
PSY REHAB & KENMORE EMP SER (R) (FED)	776,442	765,977	98.65%	776,442	853,673	109.95%	(87,696)	-11%
PERMANENT SUPPORTIVE HOUSING (R)	3,265,491	5,493,931	168.24%	3,265,491	2,568,505	78.66%	2,925,426	53%
CRISIS STABILIZATION (R)	2,789,414	2,289,113	82.06%	2,789,414	2,635,403	94.48%	(346,289)	-15%
SUPERVISED RESIDENTIAL	622,585	666,844	107.11%	622,585	624,913	100.37%	41,930	6%
SUPPORTED RESIDENTIAL	869,009	823,473	94.76%	869,009	1,115,116	128.32%	(291,643)	-35%
JAIL DIVERSION GRANT (R)	94,043	99,854	106.18%	94,043	56,742	60.34%	43,112	43%
JAIL & DETENTION SERVICES	675,354	477,332	70.68%	675,354	681,720	100.94%	(204,388)	-43%
SUB-TOTAL	**21,302,725**	**22,100,610**	**104%**	**21,302,725**	**21,199,271**	**100%**	**901,339**	**4%**

DEVELOPMENTAL SERVICES

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE	VARIANCE / REVENUE
	BUDGET FY 2025	ACTUAL YTD	%	BUDGET FY 2025	ACTUAL YTD	%		
CASE MANAGEMENT	4,204,751	3,572,809	84.97%	4,204,751	4,606,179	109.55%	(1,033,370)	-29%
DAY HEALTH & REHAB *	5,313,080	4,783,004	90.02%	5,313,080	5,798,757	109.14%	(1,015,753)	-21%
GROUP HOMES	6,851,462	6,295,228	91.88%	6,851,462	6,701,554	97.81%	(406,326)	-6%
RESPITE GROUP HOME	653,469	248,564	38.04%	653,469	661,528	101.23%	(412,963)	-166%
INTERMEDIATE CARE FACILITIES	4,788,336	4,806,804	100.39%	4,788,336	5,115,101	106.82%	(308,298)	-6%
SUPERVISED APARTMENTS	1,932,464	2,691,117	139.26%	1,932,464	1,838,982	95.16%	852,136	32%
SPONSORED PLACEMENTS	1,943,190	2,345,953	120.73%	1,943,190	2,153,882	110.84%	192,071	8%
SUB-TOTAL	**25,686,752**	**24,743,480**	**96.33%**	**25,686,752**	**26,875,983**	**104.63%**	**(2,132,503)**	**-9%**

(R) Restricted Funding within program
(FED) Federal Reimbursement process within program

RACSB
FY 2025 FINANCIAL REPORT
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SUBSTANCE ABUSE

PROGRAM	REVENUE			EXPENDITURES				
	BUDGET FY 2025	ACTUAL YTD	%	BUDGET FY 2025	ACTUAL YTD	%	ACTUAL VARIANCE	VARIANCE / REVENUE
SA OUTPATIENT (R) (FED)	1,544,604	1,433,940	92.84%	1,544,604	1,343,981	87.01%	89,959	6%
MAT PROGRAM (R) (FED)	814,953	1,468,425	180.19%	814,953	1,602,531	196.64%	(134,106)	-9%
CASE MANAGEMENT (R) (FED)	239,631	246,367	102.81%	239,631	146,452	61.12%	99,914	41%
RESIDENTIAL (R)	69,049	29,260	42.38%	69,049	98,227	142.26%	(68,967)	-236%
PREVENTION (R) (FED)	634,155	473,539	74.67%	634,155	594,053	93.68%	(120,515)	-25%
LINK (R) (FED)	274,980	255,133	92.78%	274,980	293,494	106.73%	(38,361)	-15%
SUB-TOTAL	**3,577,371**	**3,906,664**	**109%**	**2,032,767**	**4,078,739**	**201%**	**(262,034)**	**-7%**

SERVICES OUTSIDE PROGRAM AREA

PROGRAM	REVENUE			EXPENDITURES				
	BUDGET FY 2025	ACTUAL YTD	%	BUDGET FY 2025	ACTUAL YTD	%	ACTUAL Variance	VARIANCE / REVENUE
EMERGENCY SERVICES (R)	2,012,744	2,290,786	113.81%	2,012,744	1,815,262	90.19%	475,524	21%
CHILD MOBILE CRISIS (R)	376,212	298,455	79.33%	376,212	243,898	64.83%	54,556	18%
CIT ASSESSMENT SITE (R)	391,306	393,428	100.54%	391,306	406,907	103.99%	(13,479)	-3%
CONSUMER MONITORING (R) (FED)	133,656	143,962	107.71%	133,656	417,089	312.06%	(273,127)	-190%
ASSESSMENT AND EVALUATION (R)	448,026	454,422	101.43%	448,026	410,713	91.67%	43,709	10%
SUB-TOTAL	**3,361,944**	**3,581,053**	**106.52%**	**3,361,944**	**3,293,869**	**97.98%**	**287,183**	**8%**

ADMINISTRATION

PROGRAM	REVENUE			EXPENDITURES			
	BUDGET FY 2025	ACTUAL YTD	%	BUDGET FY 2025	ACTUAL YTD	%	ACTUAL VARIANCE
ADMINISTRATION (FED)	470,080	859,665	182.88%	470,080	859,665	182.88%	0
PROGRAM SUPPORT	27,600	23,000	83.33%	27,600	23,000	83.33%	0
SUB-TOTAL	**497,680**	**882,665**	**177.36%**	**497,680**	**882,665**	**177.36%**	**0**
ALLOCATED TO PROGRAMS				4,268,473	3,126,283	73.24%	

(R) Restricted Funding within program
(FED) Federal Reimbursement process within program

RACSB
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FISCAL AGENT AND OTHER PROGRAMS

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE	VARIANCE / REVENUE
	BUDGET FY 2025	ACTUAL YTD	%	BUDGET FY 2025	ACTUAL YTD	%		
INTERAGENCY COORDINATING COUNCIL (R)	1,882,348	1,924,589	102.24%	1,882,348	1,485,407	78.91%	439,182	23%
INFANT CASE MANAGEMENT (R)	998,791	710,179	71.10%	998,791	1,051,385	105.27%	(341,206)	-48%
EARLY INTERVENTION (R)	2,567,207	1,848,334	72.00%	2,567,207	2,878,112	112.11%	(1,029,778)	-56%
TOTAL PART C	**5,448,346**	**4,483,102**	**82.28%**	**5,448,346**	**5,414,905**	**99.39%**	**(931,802)**	**-21%**
HEALTHY FAMILIES (R)	141,386	161,988	114.57%	141,386	58,739	41.55%	103,249	64%
HEALTHY FAMILIES - MIECHV Grant (R) (REIM)	340,846	414,278	121.54%	340,846	411,387	120.70%	2,891	1%
HEALTHY FAMILIES-TANF & CBCAP GRANT (R) (REIM)	528,690	598,825	113.27%	528,690	664,254	125.64%	(65,429)	-11%
TOTAL HEALTHY FAMILY	**1,010,921**	**1,175,091**	**116.24%**	**1,010,921**	**1,134,380**	**112.21%**	**40,711**	**3%**
COMMUNITY OUTREACH	0	37,524	0.00%	0	0	0.00%	37,524	100%
TOTAL COMMUNITY OUTREACH	**1,539,611**	**1,773,916**	**115.22%**	**1,539,611**	**1,798,634**	**116.82%**	**(24,718)**	**-1%**

(R) Restricted Funding within program
(FED) Federal Reimbursement process within program

RACSB
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RECAP FY 2025 BALANCES

	REVENUE	EXPENDITURES	NET	NET / REVENUE
MENTAL HEALTH	22,100,610	21,276,265	824,345	4%
DEVELOPMENTAL SERVICES	24,743,480	26,875,983	(2,132,503)	-9%
SUBSTANCE ABUSE	3,906,664	4,078,739	(172,075)	-4%
SERVICES OUTSIDE PROGRAM AREA	3,581,053	3,293,869	287,183	8%
ADMINISTRATION	882,665	882,665	0	0%
FISCAL AGENT PROGRAMS	5,695,717	6,549,285	(853,567)	-15%
TOTAL	**60,910,189**	**62,956,806**	**(2,046,617)**	**-3%**

RECAP FY 2024 BALANCES

	REVENUE	EXPENDITURES	NET	NET / REVENUE
MENTAL HEALTH	18,099,249	16,644,461	1,454,788	8%
DEVELOPMENTAL SERVICES	21,311,602	20,923,834	387,767	2%
SUBSTANCE ABUSE	2,774,396	3,353,454	(579,058)	-21%
SERVICES OUTSIDE PROGRAM AREA	3,570,039	2,376,535	1,193,505	33%
ADMINISTRATION	468,936	468,936	0	0%
FISCAL AGENT PROGRAMS	5,174,362	5,289,768	(115,406)	-2%
TOTAL	**51,398,585**	**49,056,988**	**2,341,597**	5%

	$ Change	% Change
Change in Revenue from Prior Year	$ 9,511,604	18.51%
Change in Expense from Prior Year	$ 13,899,819	28.33%
Change in Net Income from Prior Year	$ (4,388,214)	-187.40%

*Unaudited Report

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MENTAL HEALTH

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE	VARIANCE / REVENUE
	BUDGET FY 2025	ACTUAL YTD	%	BUDGET FY 2025	ACTUAL YTD	%		
INPATIENT	0	12,026	0.00%	0	180,850	0.00%	(168,824)	-1404%
OUTPATIENT (FED)	3,194,943	3,959,988	123.95%	3,194,943	4,078,595	127.66%	(118,607)	-3%
MEDICAL OUTPATIENT (R) (FED)	4,910,714	4,315,667	87.88%	4,910,714	4,726,098	96.24%	(410,431)	-10%
ACT NORTH (R)	1,009,186	990,796	98.18%	1,009,186	1,126,007	111.58%	(135,211)	-14%
ACT SOUTH (R)	969,616	1,166,602	120.32%	969,616	1,064,121	109.75%	102,481	9%
CASE MANAGEMENT ADULT (FED)	1,196,606	1,373,170	114.76%	1,196,606	1,423,173	118.93%	(50,003)	-4%
CASE MANAGEMENT CHILD & ADOLESCENT (FED)	929,321	913,222	98.27%	929,321	1,180,418	127.02%	(267,196)	-29%
PSY REHAB & KENMORE EMP SER (R) (FED)	776,442	931,065	119.91%	776,442	920,605	118.57%	10,460	1%
PERMANENT SUPPORTIVE HOUSING (R)	3,265,491	5,762,433	176.46%	3,265,491	2,934,273	89.86%	2,828,160	49%
CRISIS STABILIZATION (R)	2,789,414	2,398,122	85.97%	2,789,414	2,880,930	103.28%	(482,808)	-20%
SUPERVISED RESIDENTIAL	622,585	708,792	113.85%	622,585	677,834	108.87%	30,958	4%
SUPPORTED RESIDENTIAL	869,009	865,817	99.63%	869,009	1,198,428	137.91%	(332,611)	-38%
JAIL DIVERSION GRANT (R)	94,043	107,691	114.51%	94,043	57,767	61.43%	49,924	46%
JAIL & DETENTION SERVICES	675,354	522,263	77.33%	675,354	731,574	108.32%	(209,310)	-40%
SUB-TOTAL	**21,302,725**	**24,027,655**	**113%**	**21,302,725**	**23,180,673**	**109%**	**846,982**	**4%**

DEVELOPMENTAL SERVICES

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE	VARIANCE / REVENUE
	BUDGET FY 2025	ACTUAL YTD	%	BUDGET FY 2025	ACTUAL YTD	%		
CASE MANAGEMENT	4,204,751	3,911,702	93.03%	4,204,751	4,990,913	118.70%	(1,079,211)	-28%
DAY HEALTH & REHAB *	5,313,080	5,275,835	99.30%	5,313,080	6,275,768	118.12%	(999,933)	-19%
GROUP HOMES	6,851,462	6,873,740	100.33%	6,851,462	7,270,471	106.12%	(396,731)	-6%
RESPITE GROUP HOME	653,469	266,645	40.80%	653,469	715,806	109.54%	(449,162)	-168%
INTERMEDIATE CARE FACILITIES	4,788,336	5,121,499	106.96%	4,788,336	5,650,008	118.00%	(528,509)	-10%
SUPERVISED APARTMENTS	1,932,464	2,946,783	152.49%	1,932,464	1,990,847	103.02%	955,936	32%
SPONSORED PLACEMENTS	1,943,190	2,557,545	131.62%	1,943,190	2,344,429	120.65%	213,116	8%
SUB-TOTAL	**25,686,752**	**26,953,748**	**104.93%**	**25,686,752**	**29,238,241**	**113.83%**	**(2,284,493)**	**-8%**

(R) Restricted Funding within program
(FED) Federal Reimbursement process within program

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SUBSTANCE ABUSE

PROGRAM	REVENUE			EXPENDITURES				
	BUDGET FY 2025	ACTUAL YTD	%	BUDGET FY 2025	ACTUAL YTD	%	ACTUAL VARIANCE	VARIANCE / REVENUE
SA OUTPATIENT (R) (FED)	1,544,604	1,563,533	101.23%	1,544,604	1,460,431	94.55%	103,102	7%
MAT PROGRAM (R) (FED)	814,953	1,498,368	183.86%	814,953	1,701,855	208.83%	(203,486)	-14%
CASE MANAGEMENT (R) (FED)	239,631	263,696	110.04%	239,631	158,406	66.10%	105,290	40%
RESIDENTIAL (R)	69,049	31,920	46.23%	69,049	123,264	178.52%	(91,344)	-286%
PREVENTION (R) (FED)	634,155	467,248	73.68%	634,155	665,212	104.90%	(197,963)	-42%
LINK (R) (FED)	274,980	292,264	106.29%	274,980	315,653	114.79%	(23,389)	-8%
SUB-TOTAL	**3,577,371**	**4,117,031**	**115%**	**2,032,767**	**4,424,820**	**218%**	**(410,892)**	**-10%**

SERVICES OUTSIDE PROGRAM AREA

PROGRAM	REVENUE			EXPENDITURES				
	BUDGET FY 2025	ACTUAL YTD	%	BUDGET FY 2025	ACTUAL YTD	%	ACTUAL Variance	VARIANCE / REVENUE
EMERGENCY SERVICES (R)	2,012,744	2,486,655	123.55%	2,012,744	2,004,325	99.58%	482,330	19%
CHILD MOBILE CRISIS (R)	376,212	324,562	86.27%	376,212	259,397	68.95%	65,165	20%
CIT ASSESSMENT SITE (R)	391,306	417,816	106.77%	391,306	460,926	117.79%	(43,110)	-10%
CONSUMER MONITORING (R) (FED)	133,656	143,962	107.71%	133,656	445,774	333.52%	(301,812)	-210%
ASSESSMENT AND EVALUATION (R)	448,026	495,090	110.50%	448,026	447,713	99.93%	47,378	10%
SUB-TOTAL	**3,361,944**	**3,868,086**	**115.06%**	**3,361,944**	**3,618,135**	**107.62%**	**249,952**	**6%**

ADMINISTRATION

PROGRAM	REVENUE			EXPENDITURES			
	BUDGET FY 2025	ACTUAL YTD	%	BUDGET FY 2025	ACTUAL YTD	%	ACTUAL VARIANCE
ADMINISTRATION (FED)	470,080	895,732	190.55%	470,080	895,732	190.55%	0
PROGRAM SUPPORT	27,600	40,381	146.31%	27,600	40,381	146.31%	0
SUB-TOTAL	**497,680**	**936,112**	**188.10%**	**497,680**	**936,112**	**188.10%**	**0**
ALLOCATED TO PROGRAMS				4,268,473	3,126,283	73.24%	

(R) Restricted Funding within program
(FED) Federal Reimbursement process within program

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FISCAL AGENT AND OTHER PROGRAMS

PROGRAM	REVENUE			EXPENDITURES			ACTUAL VARIANCE	VARIANCE / REVENUE
	BUDGET FY 2025	ACTUAL YTD	%	BUDGET FY 2025	ACTUAL YTD	%		
INTERAGENCY COORDINATING COUNCIL (R)	1,882,348	2,079,516	110.47%	1,882,348	1,625,441	86.35%	454,075	22%
INFANT CASE MANAGEMENT (R)	998,791	794,527	79.55%	998,791	1,140,096	114.15%	(345,569)	-43%
EARLY INTERVENTION (R)	2,567,207	2,037,441	79.36%	2,567,207	3,115,155	121.34%	(1,077,713)	-53%
TOTAL PART C	**5,448,346**	**4,911,484**	**90.15%**	**5,448,346**	**5,880,691**	**107.94%**	**(969,207)**	**-20%**
HEALTHY FAMILIES (R)	141,386	168,676	119.30%	141,386	70,841	50.11%	97,835	58%
HEALTHY FAMILIES - MIECHV Grant (R) (REIM)	340,846	469,735	137.81%	340,846	438,417	128.63%	31,319	7%
HEALTHY FAMILIES-TANF & CBCAP GRANT (R) (REIM)	528,690	653,649	123.64%	528,690	717,843	135.78%	(64,194)	-10%
TOTAL HEALTHY FAMILY	**1,010,921**	**1,292,061**	**127.81%**	**1,010,921**	**1,227,101**	**121.38%**	**64,960**	**5%**
COMMUNITY OUTREACH	0	56,288	0.00%	0	0	0.00%	56,288	100%
TOTAL COMMUNITY OUTREACH	**0**	**56,288**	**0.00%**	**0**	**0**	**0.00%**	**56,288**	**100%**

(R) Restricted Funding within program
(FED) Federal Reimbursement process within program

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RECAP FY 2025 BALANCES

	REVENUE	EXPENDITURES	NET	NET / REVENUE
MENTAL HEALTH	24,027,655	23,180,673	846,982	4%
DEVELOPMENTAL SERVICES	26,953,748	29,238,241	(2,284,493)	-8%
SUBSTANCE ABUSE	4,117,031	4,424,820	(307,790)	-7%
SERVICES OUTSIDE PROGRAM AREA	3,868,086	3,618,135	249,952	6%
ADMINISTRATION	936,112	936,112	0	0%
FISCAL AGENT PROGRAMS	6,259,833	7,107,792	(847,959)	-14%
TOTAL	**66,162,466**	**68,505,773**	**(2,343,308)**	**-4%**

RECAP FY 2024 BALANCES

	REVENUE	EXPENDITURES	NET	NET / REVENUE
MENTAL HEALTH	17,945,067	18,524,954	(579,887)	-3%
DEVELOPMENTAL SERVICES	23,477,017	23,064,325	412,692	2%
SUBSTANCE ABUSE	3,445,184	3,704,335	(259,151)	-8%
SERVICES OUTSIDE PROGRAM AREA	3,676,006	2,642,886	1,033,121	28%
ADMINISTRATION	903,410	509,170	394,240	44%
FISCAL AGENT PROGRAMS	5,262,405	5,616,304	(353,899)	-7%
TOTAL	**54,709,089**	**54,061,974**	**647,116**	1%

	$ Change	% Change
Change in Revenue from Prior Year	$ 11,453,376	20.94%
Change in Expense from Prior Year	$ 14,443,801	26.72%
Change in Net Income from Prior Year	$ (2,990,424)	-462.12%

*Unaudited Report

HUMAN RESOURCES PROGRAM UPDATE- June - July 2025

The Human Resources team tackled the hot days of summer by completing some projects and starting up some new ones. Here are a few highlights from June and July 2025.

- Onboarded two new Psychiatrists and prepared for the transition of two contract Psychiatrists into full-time employees.
- Implemented all full-time and part-time staff's benefit decisions to the various vendors and started a new plan year effective July 1, 2025.
- Processed all annual performance evaluation scores and paid merit bonuses in the first paycheck in July.
- Completed the DMV continuous monitoring project. This will help reduce risk and protect our individuals and clients whom we transport.
- Completed phase one of the implementation of our new online performance evaluation system. We are on track to have this implemented for mid-year evaluations.
- Implemented an exit interview process with July resignations.
- Trained 204 staff in various in-person trainings.
- Continued to audit HR files for compliance.
- Participated in a DMAS file audit.
- Implemented position control with the new FY26 budget.
- Two HR staff members attended training, one attended Person Centered Thinking training, and another participated in a virtual conference hosted by Relias.

Office of Human Resources

600 Jackson Street ▪ Fredericksburg, VA 22401 ▪ 540-373-3223

RappahannockAreaCSB.org

MEMORANDUM

To: Joe Wickens, Executive Director

From: Derrick Mestler, Human Resources Director

Date: August 7, 2025

Re: Summary – June & July 2025 Applicant and Recruitment Update

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For June 2025, RACSB received 166 applications.

Of the applications received, 23 applicants listed the RACSB applicant portal as their recruitment source, 11 stated employee referrals as their recruitment source, and 132 listed various job boards as their recruitment source.

As of the end of June, eight positions, 6 full-time 2 part-time, were actively being recruited for.

For July 2025, RACSB received 324 applications.

Of the applications received, 35 applicants listed the RACSB applicant portal as their recruitment source, 12 stated employee referrals as their recruitment source, and 277 listed various job boards as their recruitment source.

As of the end of July, 13 positions, 10 full-time 3 part-time, were actively being recruited for

A summary is attached, indicating the number of external applicants hired, internal applicants promoted, and the total number of applicants who applied for positions for June and July 2025.

Vacancy Report June 2025

6/30/2025								
Actively Recruiting to hire								
Original Date Listed	**Days Open**	**Original Job#**	**Job Title**	**RU**	**Division**	**Location (was Department)**	**FT**	**PT**
12/20/2024	192	1383380	Accounting Coordinator (Accounting Manager in ads)	1000	Admin	Fredericksburg City Administrative - Accounting	1	
						1		
6/6/2025	24	1520077	OUTPATIENT CLINIC NURSE, LPN	2200	Clinical	Fredericksburg City Clinical Services - Outpatient Services	1	
2/5/2025	145	1421071	OFFICE ASSOCIATE II	1100	Clinical	Spotsylvania County Clinical Services	1	
2/26/2025	124	1437967	PSYCHIATRIC NURSE PRACTITIONER, OBOT	4261	Clinical	Fredericksburg City Clinical Services - SA Services	1	
						2		
5/27/2025	34	1510219	DIRECT SUPPORT PROFESSIONAL - DAY SUPPORT - KINGS HWY	3652	CSS	Stafford Coumty CSS - Day Health and Rehabilitiation Services		1
6/23/2025	7	1531544	NURSE, RN - CRISIS STABILIZATION	2770	CSS	Fredericksburg City CSS - Crisis Stabilization Program	1	
6/23/2025	7	1531541	NURSE, RN - CRISIS STABILIZATION	2770	CSS	Fredericksburg City CSS - Crisis Stabilization Program		1
5/5/2025	56	1493982	COMMUNITY OUTREACH CASE MANAGER	TBD	CSS	Fredericksburg City CSS - MH Residential Services	1	
						3		
Avg days open	**73.63**						**6**	**2**

Vacancy Report July 2025

8/4/2025									
Actively Recruiting to Hire									
Original Date Listed	Days Open	Original Listing #	Pos Number	Job Title	RU	Division	Location (was Department)	FT	PT
7/29/2025	6	5/5/6167	2	COMPLIANCE COORDINATOR	1000	Admin	Fredericksburg City Administrative - Quality Assurance	1	
12/20/2024	227	1383380	14	Accounting Coordinator (Accounting Manager in ads)	1000	Admin	Fredericksburg City Administrative - Accounting	1	
7/14/2025	21	1546855	554	DIRECTOR, COMMUNITY SUPPORT SERVICES	26800	Admin	Fredericksburg City Administrative - Administration	1	
							1		
6/6/2025	59	1520077	621	OUTPATIENT CLINIC NURSE, LPN	2201	Clinical	Fredericksburg City Clinical Services - Outpatient Services	1	
2/5/2025	180	1421071	44	OFFICE ASSOCIATE II	1100	Clinical	Spotsylvania County Clinical Services	1	
2/26/2025	159	1437967	620	PSYCHIATRIC NURSE PRACTITIONER, OBOT	4261	Clinical	Fredericksburg City Clinical Services - SA Services	1	
7/29/2025	6	1558524	65	ES Therapist, Co-mobile Response	2000	Clinical	Fredericksburg CSS - Emergency Services	1	
7/29/2025	6	1558604	106	Therapist, MH/SA Outpatient	2200	Clinical	Staffford County Clinica Services - Outpatient Services	1	
5/27/2025	69	1510219	305	DIRECT SUPPORT PROFESSIONAL - DAY SUPPORT - KINGS HWY	3652	CSS	Stafford Coumty CSS - Day Health and Rehabilitiation Services		1
7/11/2025	24	1546263	435	ASST GROUP HOME MGR - DD RESIDENTIAL - NEW HOPE	3777	CSS	Stafford County CSS - ID/DD Residential	1	
7/11/2025	24	1546279	338	ASST SITE LEADER - RAAI KING GEORGE/STAFFORD	3553	CSS	Stafford County CSS - Day Health and Rehabilitiation Services	1	
7/11/2025	24	1546268	304	DIRECT SUPPORT PROFESSIONAL - DAY SUPPORT	3652	CSS	Stafford County CSS - Day Health and Rehabilitiation Services		1
6/23/2025	42	1531544	207	NURSE, RN - CRISIS STABILIZATION	2770	CSS	Fredericksburg City CSS - Crisis Stabilization Program	1	
6/23/2025	42	1531541	206	NURSE, RN - CRISIS STABILIZATION	2770	CSS	Fredericksburg City CSS - Crisis Stabilization Program		1
							2		
Avg days open	**67.92**							**10**	**3**
Budgeted Vacant				**Job Title**	**RU**	**Division**		**FT**	**PT**
						Prevention			
			58	ASSISTANT COORDINATOR - EMERGENCY SERVICES	2000	CSS		1	
			623	PEER SUPPORT PROFESSIONAL - PSH	2760	CSS		1	
			624	LICENSED THERAPIST- PSH	2760	CSS		1	
			625	OFFICE ASSOCIATE - PSH	2760	CSS		1	
			195	MH RESIDENTIAL SPECIALIST - CRISIS STABILIZATION	2770	CSS		1	
			225	RESIDENTIAL COUNSELOR I - LAFAYETTE BOARDING	2786	CSS		1	
			235	DEVELOPMENTAL SERVICES SUPPORT COORDINATOR	3300	CSS		1	
			242	DEVELOPMENTAL SERVICES SUPPORT COORDINATOR	3300	CSS		1	
			243	DEVELOPMENTAL SERVICES SUPPORT COORDINATOR	3300	CSS		1	
			631	DEVELOPMENTAL SERVICES SUPPORT COORDINATOR	3300	CSS		1	
			302	DIRECT SUPPORT PROFESSIONAL - KINGS HIGHWAY	3652	CSS			1
			360	DIRECT SUPPORT PROFESSIONAL - RAAI ICF KINGSN HIGHWAY	3656	CSS			1
			513	DIRECT SUPPORT PROFESSIONAL - LUCAS ICF	3793	CSS		1	
			405	DIRECT SUPPORT PROFESSIONAL - DEVON	3774	CSS		1	
			632	DIRECTOR OF CRISIS SERVICES	5009	CSS		1	
			427	ASST GROUP HOME MANAGER - IGO ROAD	3777	CSS		1	
			429	DIRECT SUPPORT PROFESSIONAL - IGO	3777	CSS		1	
			433	DIRECT SUPPORT PROFESSIONAL - IGO	3777	CSS			1
			452	DIRECT SUPPORT PROFESSIONAL - BELMONT	3781	CSS		1	
			456	DIRECT SUPPORT PROFESSIONAL - BELMONT	3781	CSS			1
			482	DIRECT SUPPORT PROFESSIOANL - GALVESTON	3790	CSS			1
			491	DIRECT SUPPORT PROFESSIONAL - CHURCHILL	3791	CSS			1
			500	DIRECT SUPPORT PROFESSIONAL - ROSS ICF	3792	CSS		1	
			525	DIRECT SUPPORT PROFESSIONAL - MYERS RESPITE	3794	CSS		1	
			528	DIRECT SUPPORT PROFESSIONAL - MYERS RESPITE	3794	CSS		1	
			629	DIRECT SUPPORT PROFESSIONAL - MYERS RESPITE	3794	CSS			1
			633	DIRECT SUPPORT PROFESSIONAL - MYERS RESPITE	3794	CSS			1
			74	LICENSED EMERGENCY SERVICES THERAPIST	2070	Clinical		1	
			43	OFFICE ASSOC II - FREDERICKSBURG	2200	Clinical		1	
			118	PSYCHIATRIST	2201	Clinical		1	
			163	STAFFORD CHILD/ADOLESCENT CASE MANAGER	2500	Clinical		1	
			67	UNLICENSED EMERGENCY SERVICES THERAPIST	4000	Clinical		1	
			571	PSYCHIATRIC NURSE PRACTITIONER-OBOT	4261	Clinical		1	
							Totals:	**46**	**14**
							Cumulative:	**60**	

RECRUITMENT REPORT FY 2025

MONTHLY RECRUITMENT	*JULY*	*AUGUST*	*SEPTEMBER*	*OCTOBER*	*NOVEMBER*	*DECEMBER*	*JANUARY*	*FEBRUARY*	*MARCH*	*APRIL*	*MAY*	*JUNE*	*TOTAL YTD*
External Applicants Hired:													
Part-time	3	8	9	2	1	3	8	2	1	0	3	0	40
Full-time	8	14	13	10	6	9	16	10	3	8	0	3	100
Sub Total External Applicants Hired	**11**	**22**	**22**	**12**	**7**	**12**	**24**	**12**	**4**	**8**	**3**	**3**	140
Internal Applicants Moved:													
Part-time to Full-time	0	0	0	0	3	2	2	2	0	0	0	0	9
PRN As Needed to Full-Time	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub Total Internal Applicant Moves	**0**	**0**	**0**	**0**	**3**	**2**	**2**	**2**	**0**	**0**	**0**	**0**	9
Total Positions Filled:	**11**	**22**	**22**	**12**	**10**	**14**	**26**	**14**	**4**	**8**	**3**	**3**	149
Total Applications Received:													
Actual Total of Applicants:	**1227**	**725**	**800**	**869**	**704**	**196**	**562**	**629**	**382**	**199**	**395**	**166**	6854
Total External Offers Made:	**11**	**22**	**22**	**12**	**7**	**12**	**24**	**12**	**4**	**8**	**3**	**3**	140
Total Internal Offers Made:	**0**	**0**	**0**	**0**	**3**	**2**	**2**	**2**	**0**	**0**	**0**	**0**	9

RECRUITMENT REPORT FY 2026

MONTHLY RECRUITMENT	*JULY*	*AUGUST*	*SEPTEMBER*	*OCTOBER*	*NOVEMBER*	*DECEMBER*	*JANUARY*	*FEBRUARY*	*MARCH*	*APRIL*	*MAY*	*JUNE*	*TOTAL YTD*
External Applicants Hired:													
Part-time	0												0
Full-time	4												4
Sub Total External Applicants Hired	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		4
Internal Applicants Moved:													
Part-time to Full-time	0												0
PRN As Needed to Full-Time	0												0
Sub Total Internal Applicant Moves	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		0
Total Positions Filled:	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**		4
Total Applications Received:													
Actual Total of Applicants:	**324**												324
Total External Offers Made:	**4**												4
Total Internal Offers Made:	**0**												0

APPLICANT DATA REPORT

RACSB FY 2025

APPLICANT DATA	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Female	727	338	373	402	340	150	331	341	195	96	257	95
Male	128	93	128	154	106	37	78	99	41	27	43	8
Not Supplied	372	294	299	313	258	119	153	189	146	76	95	63
Total	**1227**	725	800	869	704	306	562	629	382	199	395	166
ETHNICITY												
White	254	140	155	172	128	40	149	177	76	39	124	23
African American	405	193	227	256	226	111	173	180	108	68	111	62
Hispanic	67	26	32	34	25	6	3	0	9	3	12	9
Asian	20	15	16	18	16	6	5	2	0	3	8	1
American Indian	2	2	0	0	4	1	3	1	0	1	1	0
Native Hawaiian	2	1	1	0	1	0	2	0	0	0	2	0
Two or More Races	63	44	51	49	27	16	1	32	13	6	27	65
RECRUITMENT SOURCE												
RACSB Website	192	138	171	130	143	53	79	79	76	42	43	23
Employee Referrals	99	72	91	68	57	39	30	31	42	15	13	11
Indeed.com	861	437	428	567	428	162	412	455	231	118	300	102
Other -	48	53	75	72	57	47	25	55	28	16	31	23
Zip Recruiter	27	25	35	32	19	5	16	9	5	8	8	7
Job Fair												
Total # of Applicants	1227	725	800	869	704	306	562	629	382	199	395	166

APPLICANT DATA REPORT

RACSB FY 2026

APPLICANT DATA	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Female	212											
Male	37											
Not Supplied	75											
Total	**324**											
ETHNICITY												
White	85											
African American	118											
Hispanic	7											
Asian	5											
American Indian	2											
Native Hawaiian	3											
Two or More Races	92											
RECRUITMENT SOURCE												
RACSB Website	35											
Employee Referrals	12											
Indeed.com	232											
Other -	34											
Zip Recruiter	11											
Job Fair	0											
Total # of Applicants	324	0	0	0	0	0	0	0	0	0	0	

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

MEMORANDUM

To: Joe Wickens, Executive Director

From: Derrick Mestler, Human Resources Director

Date: August 7, 2025

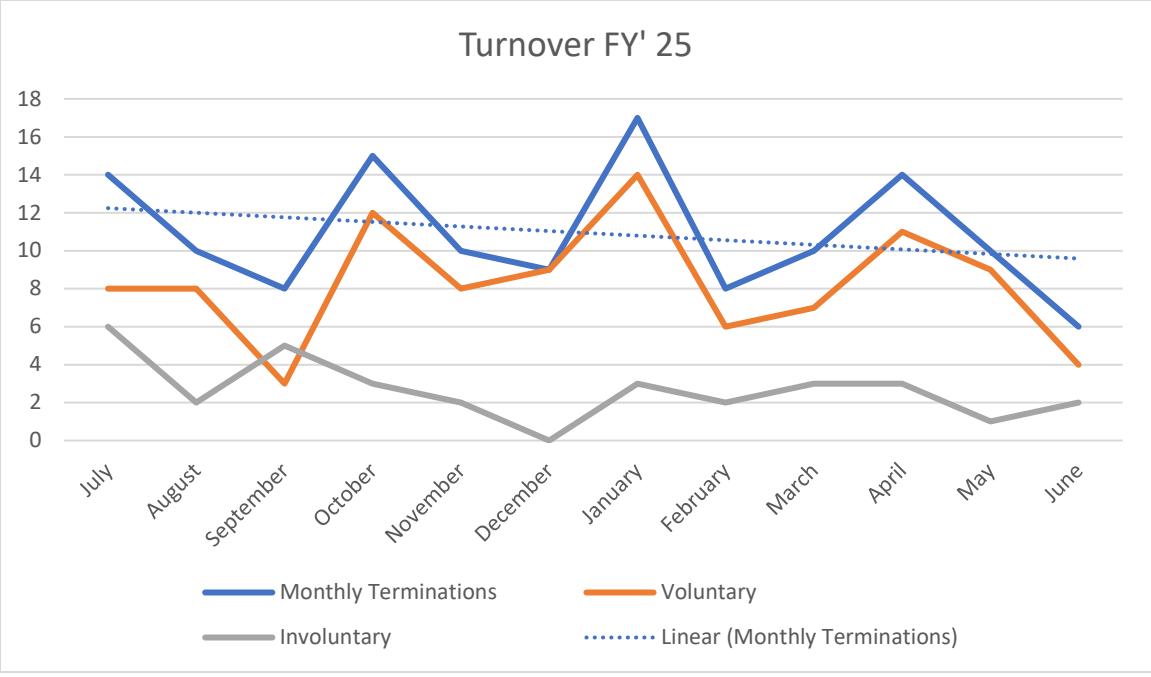
Re: Summary – Turnover Report – June & July 2025

Human Resources processed six (6) employee separations in June 2025. Four (4) were voluntary, and two (2) were involuntary. In July 2025, eight (8) employee separations were processed, all voluntary separations.

Reasons for Separations

Resigned- Vol. – June 2025	4
Involuntary	2

Resigned- Vol. – July 2025	8
Involuntary	0



RACSB Turnover FY '25

Employees	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Average Headcount	572	573	587	586	570	571	579	585	583	576	560	561
Monthly Terminations*	14	10	8	15	10	9	17	8	10	14	10	6
Turnover by Month	2.45%	1.75%	1.36%	2.56%	1.75%	1.58%	2.94%	1.37%	1.72%	2.43%	1.79%	1.07%
Cumulative Turnover YTD	2.45%	4.19%	5.54%	8.11%	9.87%	11.45%	14.39%	15.75%	17.46%	19.89%	21.68%	22.77%
Average % Turnover per Month YTD	2.45%	2.10%	1.85%	2.03%	1.97%	1.91%	2.06%	1.97%	1.94%	1.99%	1.97%	1.90%

***Monthly Terminations, FT, PT, PRN, Do Not Include Interns/Volunteers**

RACSB Turnover FY '26

Employees	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Average Headcount	558											
Monthly Terminations*	8											
Turnover by Month	1.43%											
Cumulative Turnover YTD	1.43%											
Average % Turnover per Month YTD	1.43%											

***Monthly Terminations, FT, PT, PRN, Do Not Include Interns/Volunteers**

RACSB MONTHLY TURNOVER REPORT
Jun-25

ORGANIZATIONAL UNIT	NUMBER OF TERMS	VOLUNTARY	INVOLUNTARY	EXPLANATION
Administrative				
Unit Totals	**0**	**0**	**0**	
Clinical Services		1		Job dissatisfaction
Unit Totals	**1**	**1**	**0**	
Community Support Services		2		Personal
		1		No reason given
			2	
Unit Totals	**5**	**3**	**2**	
Prevention				
Unit Totals	**0**	**0**	**0**	
Grand Totals for the Month	**6**	**4**	**2**	

Total Average Number of Employees	**561**
Retention Rate	**98.93%**
Turnover Rate	**1.07%**

Total Separations	**6**

RACSB MONTHLY TURNOVER REPORT
Jul-25

ORGANIZATIONAL UNIT	NUMBER OF TERMS	VOLUNTARY	INVOLUNTARY	EXPLANATION
Administrative				
Unit Totals	**0**	**0**	**0**	
Clinical Services		1		Resigned - personal
		1		Resignation - other opportunity
Unit Totals	**2**	**2**	**0**	
Community Support Services		2		Resigned no notice - reason unknown
		1		Resignation - relocation
		1		Resignation - personal
		2		Resignation - other opportunity
Unit Totals	**6**	**6**	**0**	
Prevention				
Unit Totals	**0**	**0**	**0**	
Grand Totals for the Month	**8**	**8**	**0**	

Total Average Number of Employees	**558**
Retention Rate	**98.57%**
Turnover Rate	**1.43%**

Total Separations	**8**

To: Joe Wickens, Executive Director

From: Derrick Mestler. Human Resources Director

Re: DBHDS Workforce Reporting Overview

Date: August 7, 2025

The Rappahannock Area Community Services Board is required to submit workforce data to the Department of Behavioral Health and Developmental Services (DBHDS) on a quarterly basis. DBHDS defined certain position categories for the reporting of vacancy rate, turnover rate, and salary information. Please find an overview of the data below for the fourth quarter of FY2025.

	Q1 YTD			Q2 YTD			Q3 YTD			Q4 YTD		
	Vacancy Rate	YTD Vacancy Rate	Turnover Rate	Vacancy Rate	YTD Vacancy Rate	Turnover Rate	Vacancy Rate	YTD Vacancy Rate	Turnover Rate	Vacancy Rate	YTD Vacancy Rate	Turnover Rate
Administrative Support	5.3%	5.3%	3.2%	6.4%	6.1%	5.2%	9.4%	6.8%	12.1%	11.3%	7.6%	15.5%
Case Manager	8.1%	6.8%	1.6%	10.2%	8.2%	4.9%	8.0%	8.1%	8.1%	10.9%	8.8%	8.9%
Clinician	15.0%	16.2%	2.4%	15.0%	15.0%	7.7%	12.5%	14.0%	14.0%	16.5%	15.0%	18.8%
Direct Service Provider	10.1%	11.1%	11.4%	9.5%	10.5%	20.4%	7.8%	9.2%	28.0%	13.1%	9.2%	38.2%
Executive Leadership	0.0%	0.0%	10.0%	0.0%	0.0%	10.3%	0.0%	0.0%	10.2%	0.0%	0.0%	10.2%
Nursing	13.3%	17.4%	11.0%	4.4%	13.0%	15.4%	6.7%	8.7%	19.9%	13.3%	8.7%	32.1%
Other	14.3%	0.0%	0.0%	7.1%	0.0%	0.0%	30.0%	16.7%	51.9%	30.0%	16.7%	57.6%
Peer	7.4%	0.0%	0.0%	17.9%	7.7%	8.3%	3.6%	7.1%	8.1%	10.7%	7.1%	15.9%
Prescriber	34.8%	33.3%	0.0%	43.5%	33.3%	14.0%	43.5%	41.7%	14.4%	43.5%	41.7%	14.6%
Overall	9.8%	9.8%	5.1%	10.4%	10.1%	10.1%	9.6%	9.6%	16.3%	13.2%	10.1%	21.4%

CSB	Vacancy Rate	Turnover Rate
Virginia Beach	27%	1%
Chesapeake	20%	1%
Colonial	11%	29%
Rappahannock Area	10%	5%
Hanover	10%	4%
Prince William	8%	2%
Loudoun County	7%	3%
Goochland-Powhatan	4%	11%
Total	**12%**	**7%**

Position	Vacancy Rate	Turnover Rate
Admin Support	15%	2%
Case Management	10%	5%
Clinician	14%	12%
Direct Services Provider	13%	4%
Executive Leadership	11%	6%
Nursing	12%	3%
Other	16%	1%
Peer	17%	6%
Prescriber	12%	0%
Overall	12%	7%