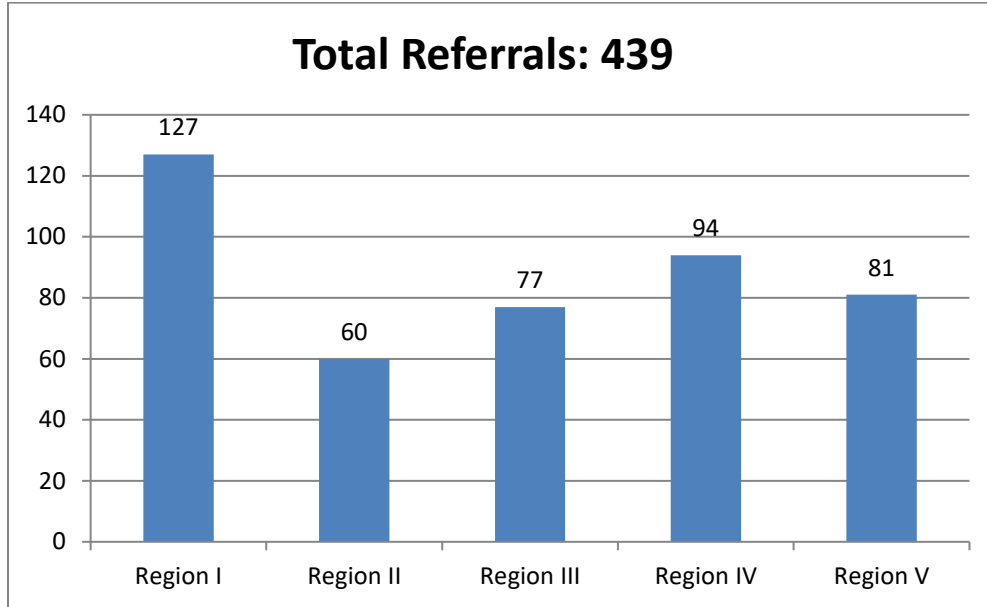


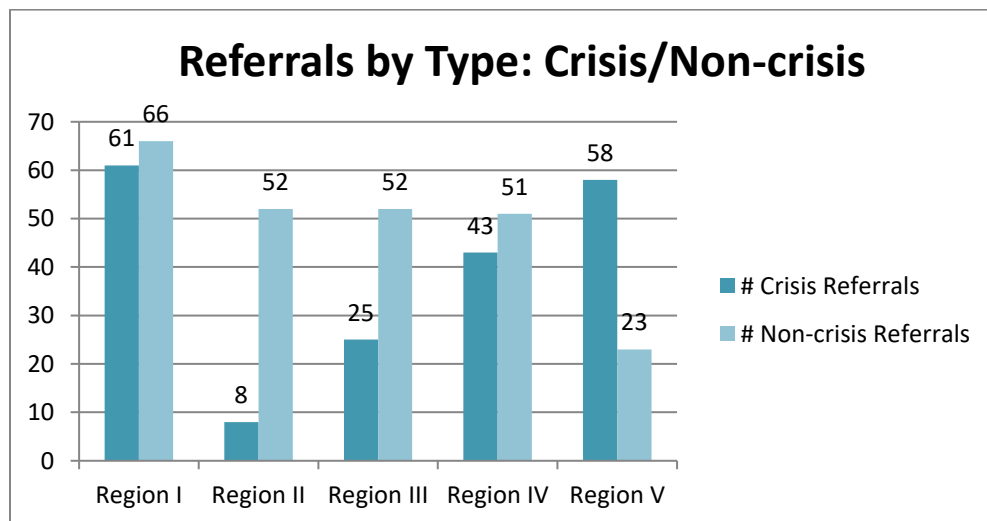
REACH Data Summary Report-Children: II-FY21

This report provides data summarizing the referral activity, service provision, and residential outcomes for children served by the children’s REACH programs during the second quarter of fiscal year 2021 (October 1, 2020-December 30, 2020). Modifications in services due to COVID-19 precautions, such as utilizing telehealth for a crisis response, are also reflected in the data throughout this document.

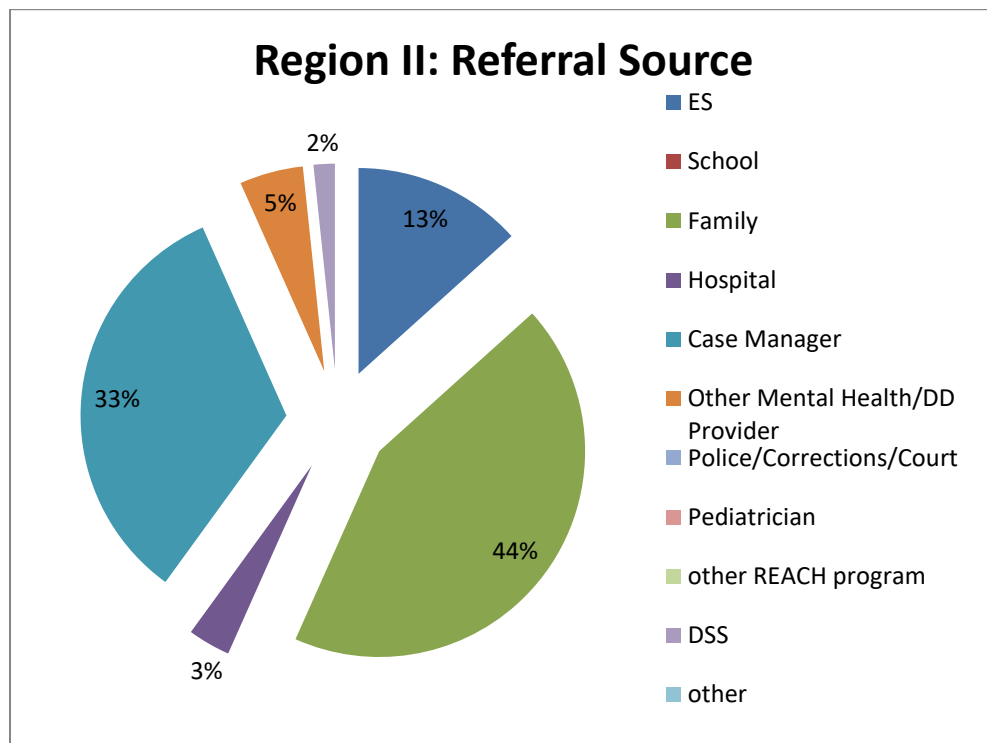
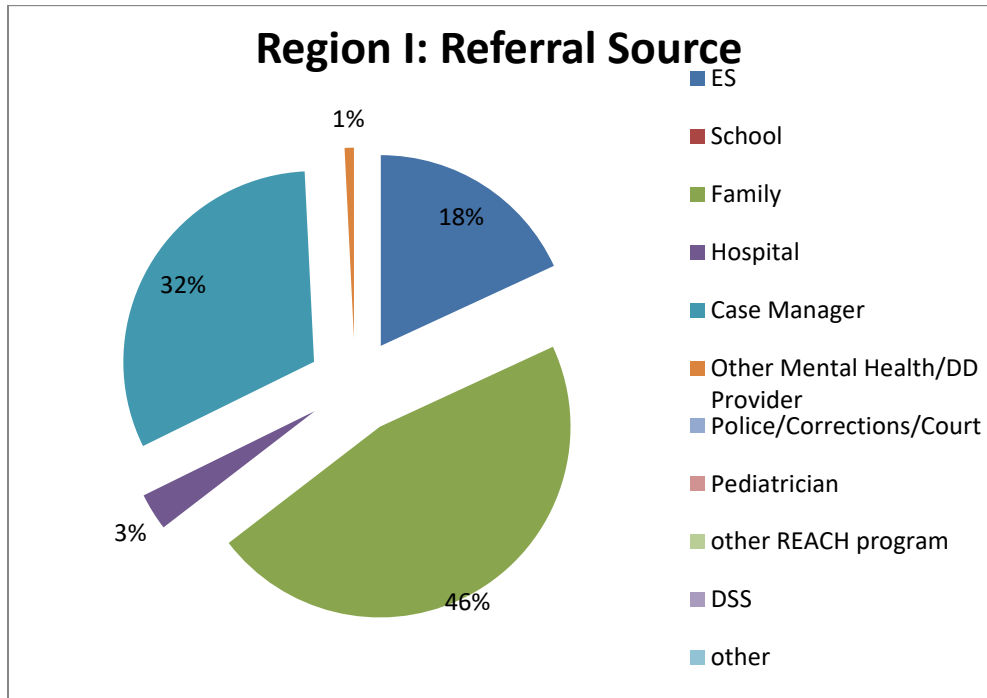
REACH Referral Process

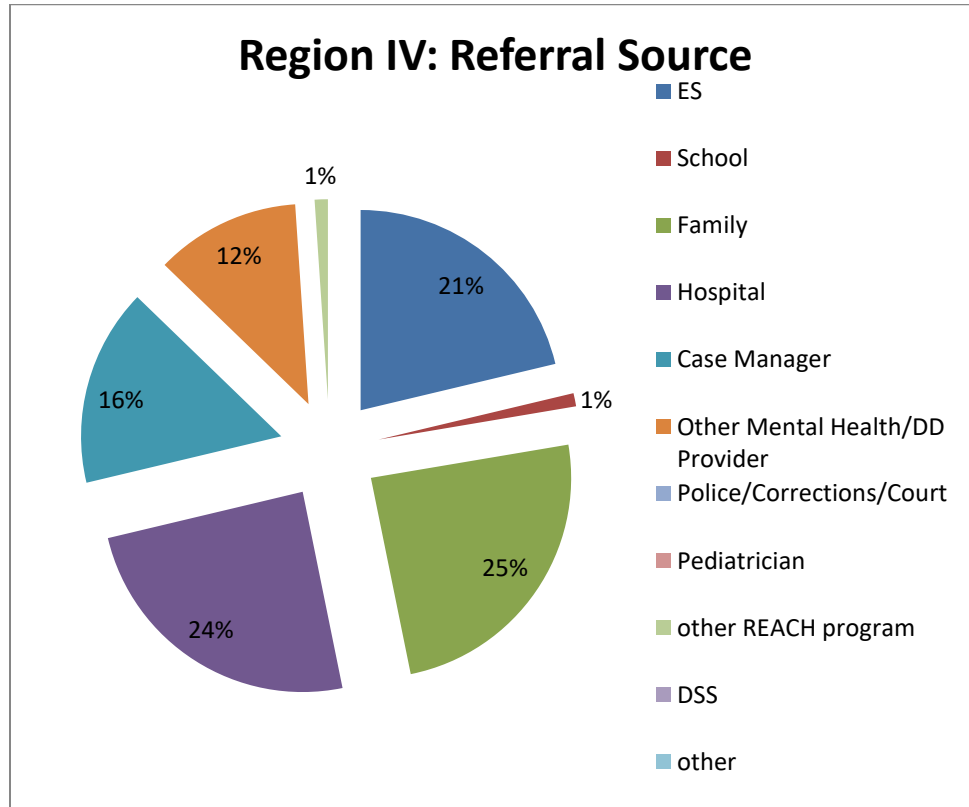
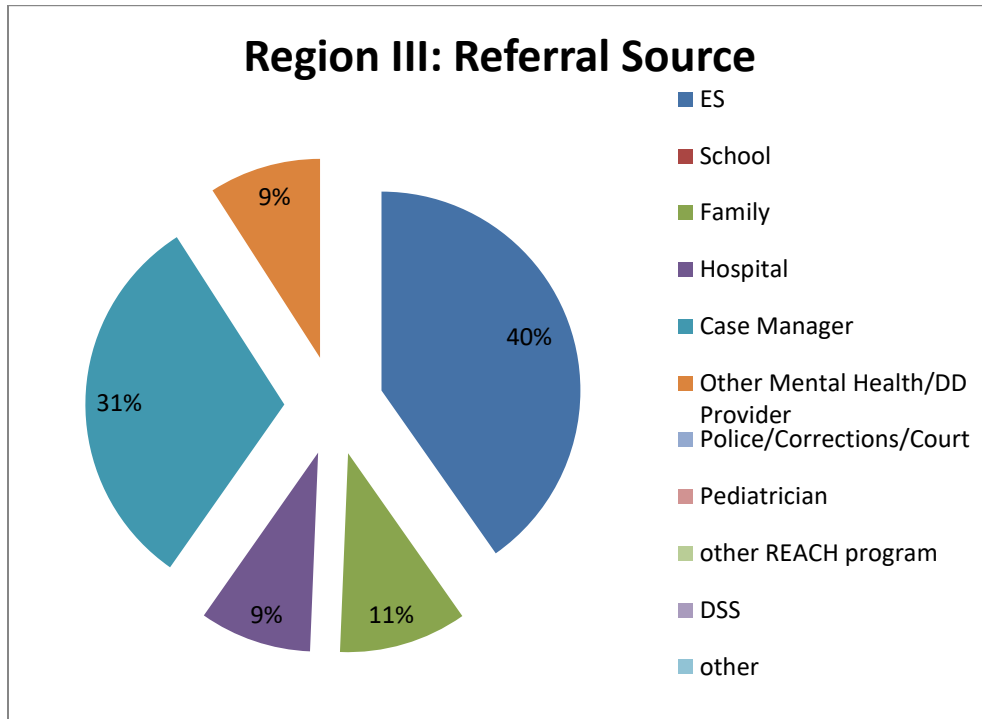


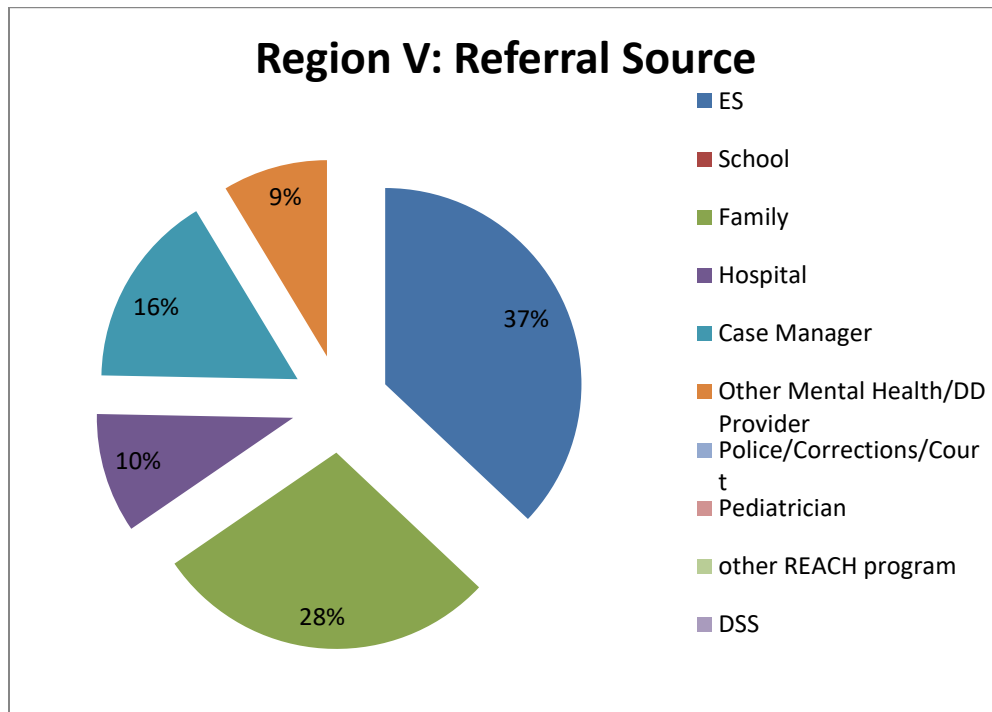
Statewide referrals totaled 439 children and youth for the second quarter of fiscal year 2021 (FY21) for the Children’s REACH programs. This is a significant increase in referrals from the previous quarter (375). The table below segments referrals that were crisis in nature (i.e. need to be seen the same day) and those that were non-crisis or of lesser acuity.



The referral sources provide a perspective on how the programs are establishing themselves within the communities they serve. The five charts below provide a regional breakdown of referral source data. The subsequent tables provide data concerning the day of the week and time of day that referrals are received by the programs.







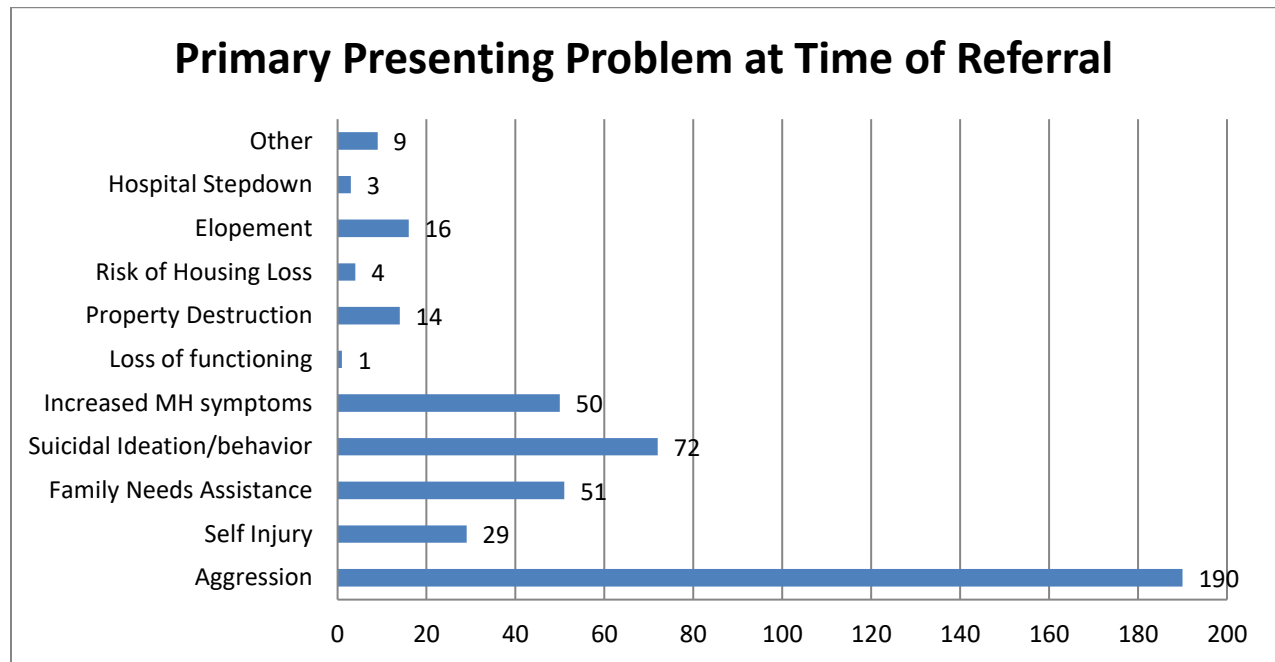
Referral Time	Region I	Region II	Region III	Region IV	Region V	Totals
Monday-Friday	115	53	68	74	67	377
Weekends/Holidays	12	7	9	20	14	62
7am -2:59pm	63	27	43	44	30	207
3pm - 10:59pm	58	29	28	43	42	200
11pm – 6:59am	6	4	6	7	9	32

Also of interest to the Commonwealth is ensuring that the REACH programs serve both the ID and the DD communities. The regions are all reporting that they serve more individuals with only a developmental disability as opposed to both a developmental and intellectual disability. “Unknown” refers to individuals who are still in the referral process at the end of the quarter and documentation of disability is being verified, and “None” references individuals for whom a referral was taken but diagnostic criteria was not substantiated.

Diagnosis	Region I	Region II	Region III	Region IV	Region V	Totals
ID Only	5	3	9	14	17	48
DD Only	109	48	58	63	49	327
ID/DD	10	8	4	13	14	49
None/Unknown	3	1	6	4	1	15
Totals	127	60	77	94	81	439

Aggression continues to be the most common reason for a referral to the REACH program. Aggressive behavior includes physical aggression and verbal threats. The following table summarizes primary presenting problems by region. Note: 1 youth for Region II listed as “other” was referred as stepdown from residential treatment facility; 1 youth from Region III listed as “other” referred for school related issues; 1 youth from Region III listed as “other” referred for sexual behaviors; and 6 youth from Region V listed as “other” referred for Homicidal Ideation.

<i>Presenting Problems</i>	Region I	Region II	Region III	Region IV	Region V	Totals
Aggression	59	29	35	34	33	190
Self-injury	12	2	2	7	6	29
Family Needs Assistance	5	5	15	15	11	51
Suicidal Ideation/behavior	24	8	11	16	13	72
Increased MH symptoms	17	13	5	10	5	50
Loss of functioning	0	0	0	0	1	1
Property Destruction	6	1	3	2	2	14
Risk of Housing Loss	1	0	2	1	0	4
Elopement	3	1	2	6	4	16
Hospital Stepdown	0	0	0	3	0	3
Other	0	1	2	0	6	9
Total	127	60	77	94	81	439

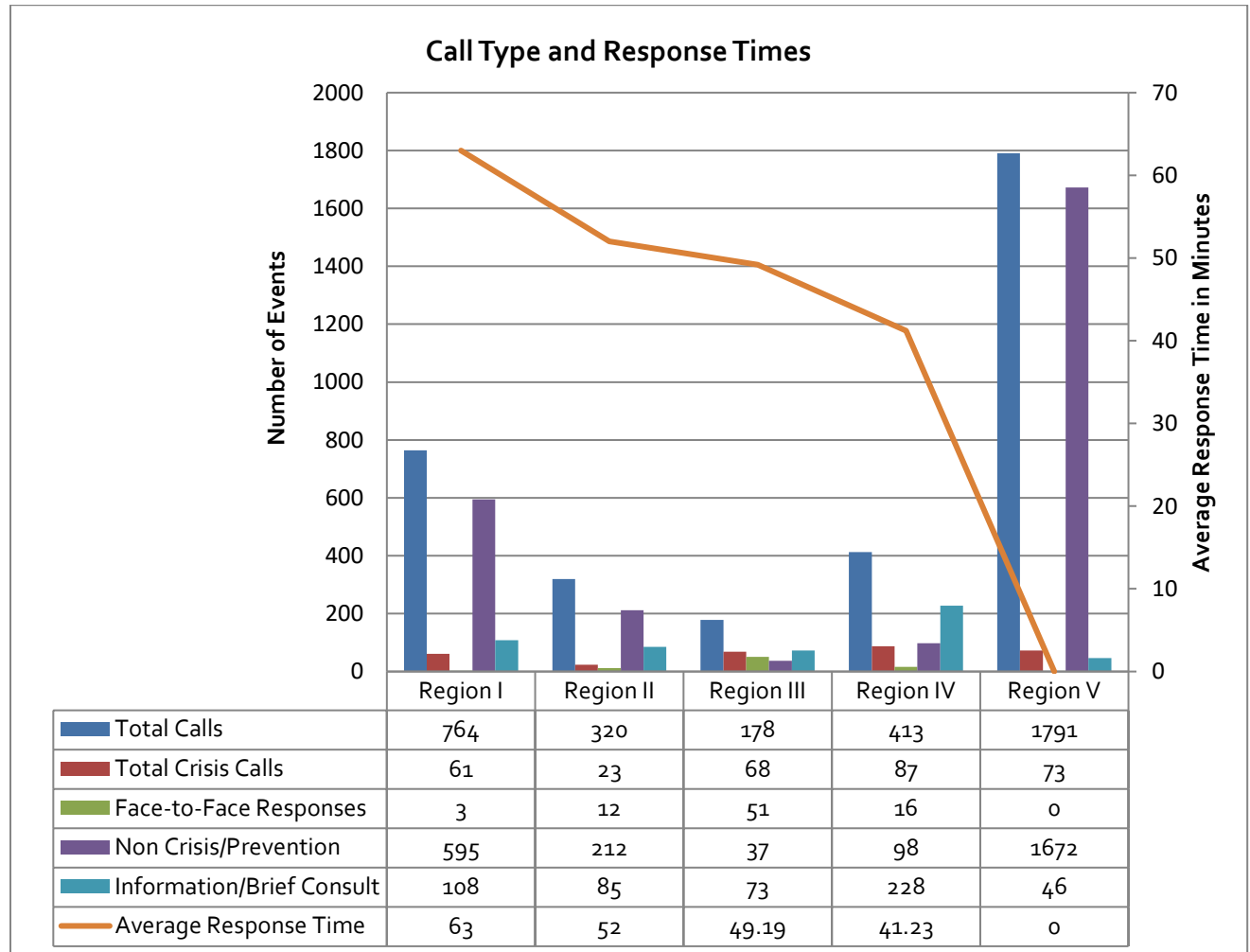


REACH Crisis Response

Each of the five regional REACH programs operates a crisis line 24-hours per day, seven days per week. Calls coming into the crisis lines may be from existing REACH families or from families or care providers in the midst of an escalating situation. Calls are responded to in one of two ways: either by telephone consultation or through an on-site, face-to-face assessment and intervention. As the crisis line allows an individual to access a trained clinician 24/7, it is being used more and more frequently by REACH consumers and their circles of support to maintain stability or to assist the individual in problem solving through a stressful situation. The crisis line is becoming a primary tool of prevention for some of the programs. REACH clinicians are expected to respond in-person to situations that meet the acuity level of a crisis, and this includes partnering with emergency services prescreening staff when a Temporary Detention Order is being considered. Non-crisis calls that are received by the programs are understood to serve a preventive role and may be a prescribed element within a written Crisis Education and Prevention Plan (CEPP). Domains of interest related to crisis line activity include the following:

- Crisis calls
- In-person assessment/intervention
- Telephone intervention
- Prevention
- Total crisis line activity
- Average response time

A summary of information related to crisis calls and responses is depicted in the graph below. Please note that this graph encompasses all calls received on the crisis line during the review cycle. It includes on-site responses to existing REACH consumers, repeat calls from individuals, as well as new referrals who may be contacting REACH for the first time. Therefore, call totals when combined across categories will exceed the total number of referrals for the quarter. As has been noted in previous reports, crisis line activity and referral activity are best understood as separate elements.



The graph on the previous page details calls activity for the programs over the second quarter of FY21. Average response time is graphed on the secondary y-axis as an orange line, both to emphasize it and to allow any variability to be clearly seen. Also noted in the data listed is the impact of COVID-19 in relation to the in-person crisis responses (“face to face response”). Due to precautions related to COVID-19 all programs utilized at least some component of telehealth in order to continue to be a part of the crisis response. There is no average response time for Region V as all calls were responded to via telehealth. The number of responses via telehealth for each region varied across regions, as follows: Region 1, 95%; Region 2, 48%; Region III, 25%; Region IV, 82%; and Region V, 100% via telehealth. The table below offers the reader a more comprehensive view of response time data by breaking it into 30-minute increments. Region I responded to 100% and Region III responded to 98% of their face to face calls within the required 2 hour timeframe for a region designated as rural. Region II responded to 67% of their calls and Region IV responded to 100% of their calls within the 1 hour timeframe for a region designated as “urban”. Region V did not respond to any calls face to face, utilizing telehealth for all crisis calls this quarter.

Region	Region I Rural	Region II Urban	Region III Rural	Region IV Urban	Region V Rural	Totals
0-30 Minutes	0	3	23	4	0	30
31-60 Minutes	2	5	13	12	0	32
61-90 Minutes	1	2	11	0	0	14
91-120 Minutes	0	2	3	0	0	5
121+ Minutes	0	0	1	0	0	1
Totals	3	12	51	16	0	82

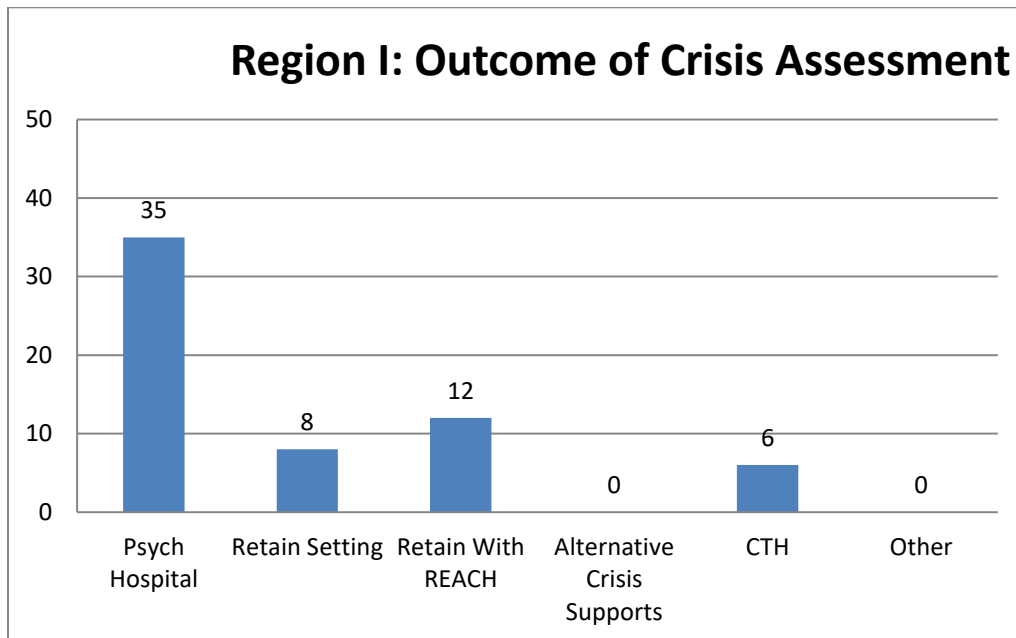
Location of Crisis Assessments

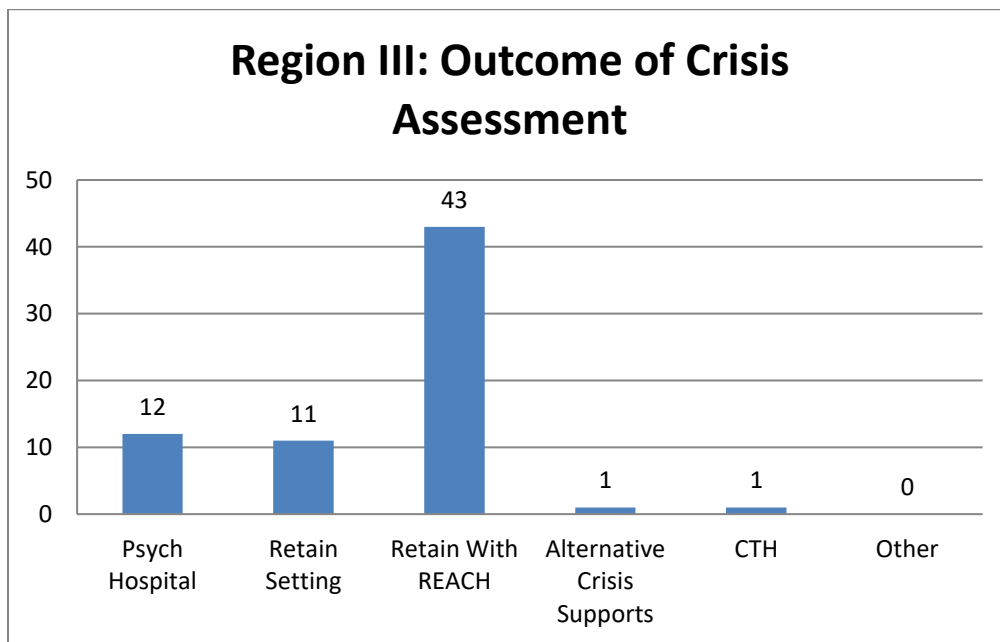
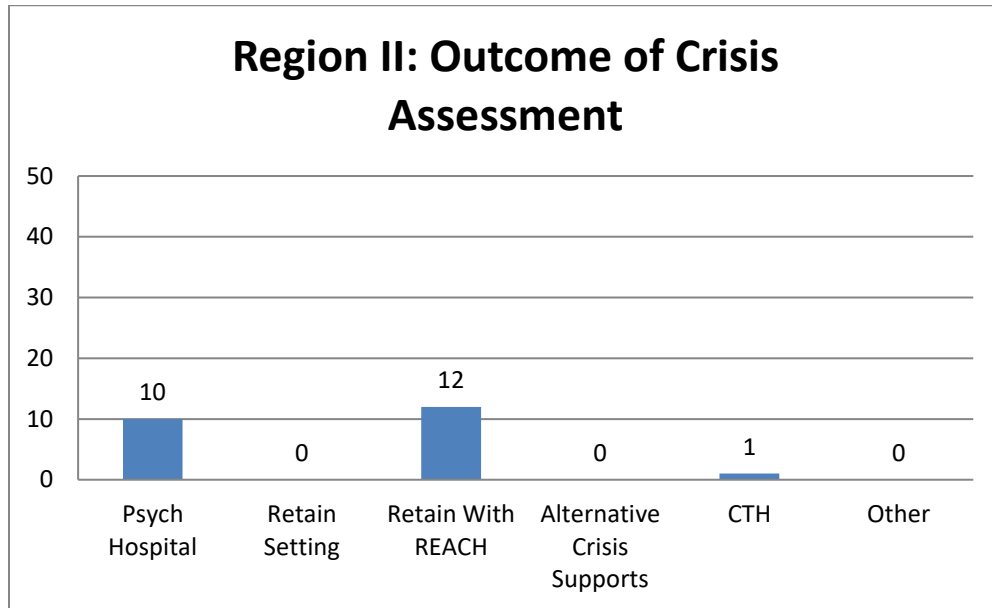
Assessment Location	Region I	Region II	Region III	Region IV	Region V	Totals
Family Home	16	6	42	22	31	117
Hospital/Emergency Room	29	10	22	53	38	151
Emergency Services/CSB	16	7	3	2	3	31
School	0	0	1	1	1	3
Residential Provider	0	0	0	2	0	2
Other	0	0	0	7	0	8
Totals	61	23	68	87	73	312

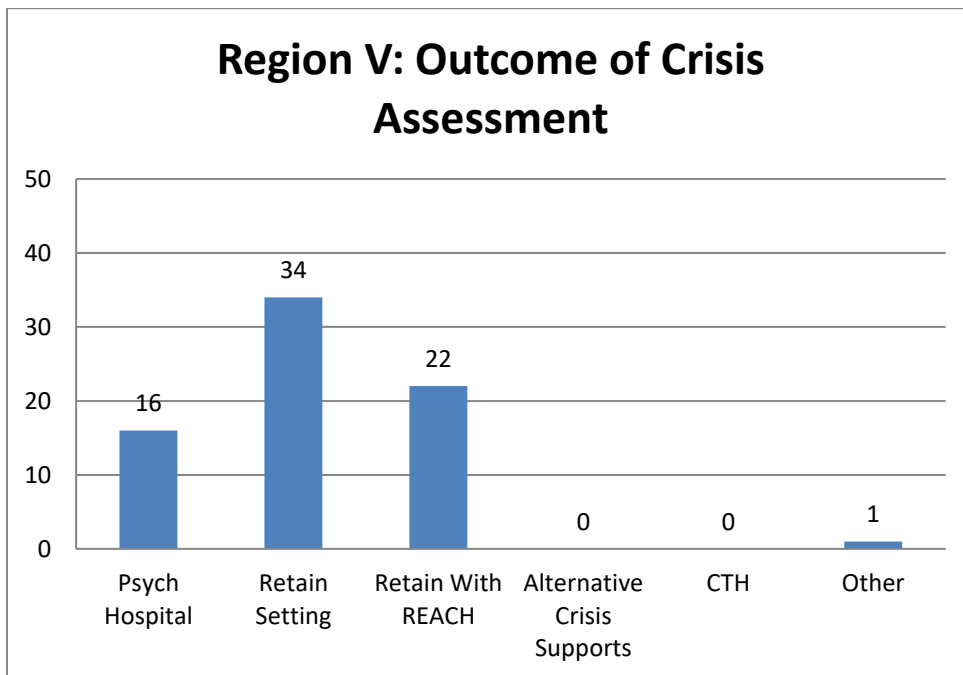
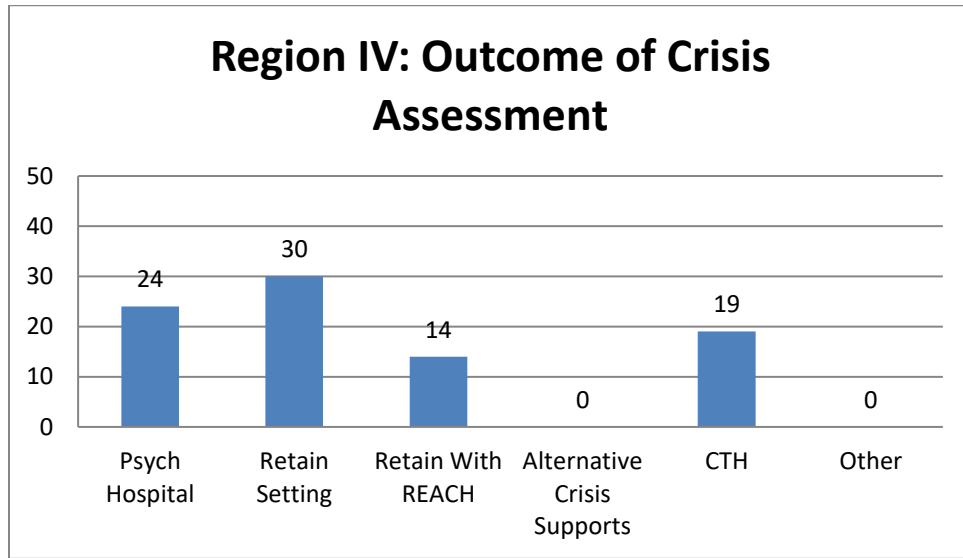
Region IV “other” = 1 community location, 6 at a Hospital Crisis Triage Center

When indicated, the REACH programs are expected to arrive at the physical site of the crisis event, regardless of the nature of the setting. The table above provides a summary of the various locations where mobile crisis assessments took place over the course of the second quarter of FY21. The location of assessments listed in the chart includes both those assessments completed by a REACH staff “in-person” and those completed via telehealth. The location still denotes where the individual was located when the assessment occurred.

Ideally, when a crisis response occurs, it is hoped that the resulting outcome will be that the child will remain in his/her home with family. While this is not always possible, the REACH programs are very often able to intervene in the moment to prevent out-of-home placement. They can do this by providing immediate in-home support to the family, problem solving a safety plan to stabilize the crisis situation until additional help can be accessed, and by following up with community-based crisis stabilization plans. The charts on the following pages offer a picture of the initial outcome after an in-person crisis response has been dispatched by region. In these charts, “Retain with REACH” means an individual retained their setting while receiving community-based REACH services.

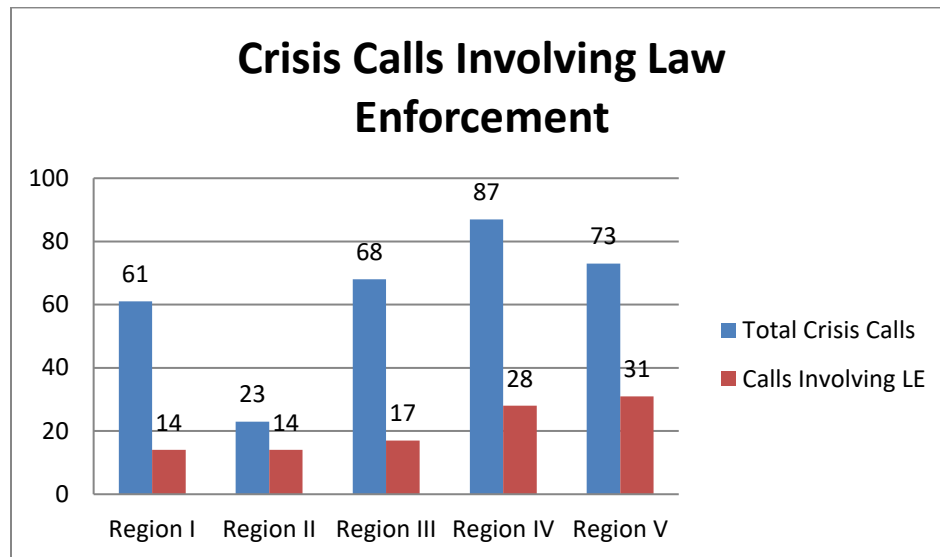






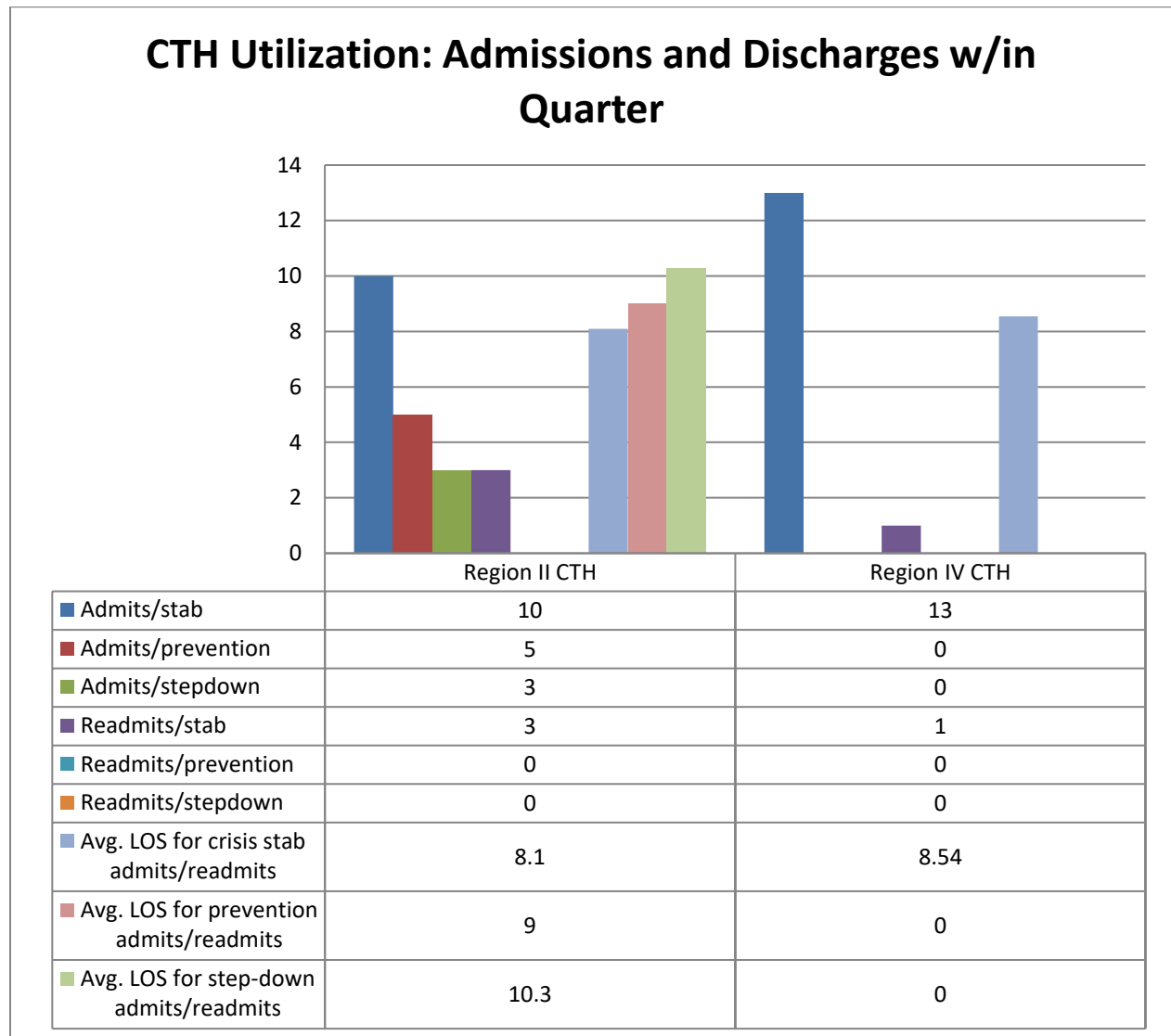
Other = alternative community placement

The table below provides a contrast of the total number of crisis calls to total number of crisis calls which involved law enforcement. Thirty three (33) percent of overall crisis calls received involved law enforcement, which is an increase from the previous quarter (27%).



Crisis Therapeutic Homes

Two of the five REACH programs now operate a Crisis Therapeutic Home (CTH) for children. The homes are located in Culpeper and Chester, and are operated by the Region II and Region IV program operators, respectively. The home that is in Region II serves primarily Regions I and II, while the home in Region IV serves primarily children from Regions III, IV, and V; with that noted, admissions can be accepted into any home from any region of the state. Information such as type of stay, length of stay, readmissions, and waitlists is presented in the graph on the following page. The data presented are displayed by the crisis therapeutic home in which the individual received services, as opposed to by the region where the youth resides. The small table that follows on the next page outlines the region from which the individual was admitted into one of the two child CTHs.

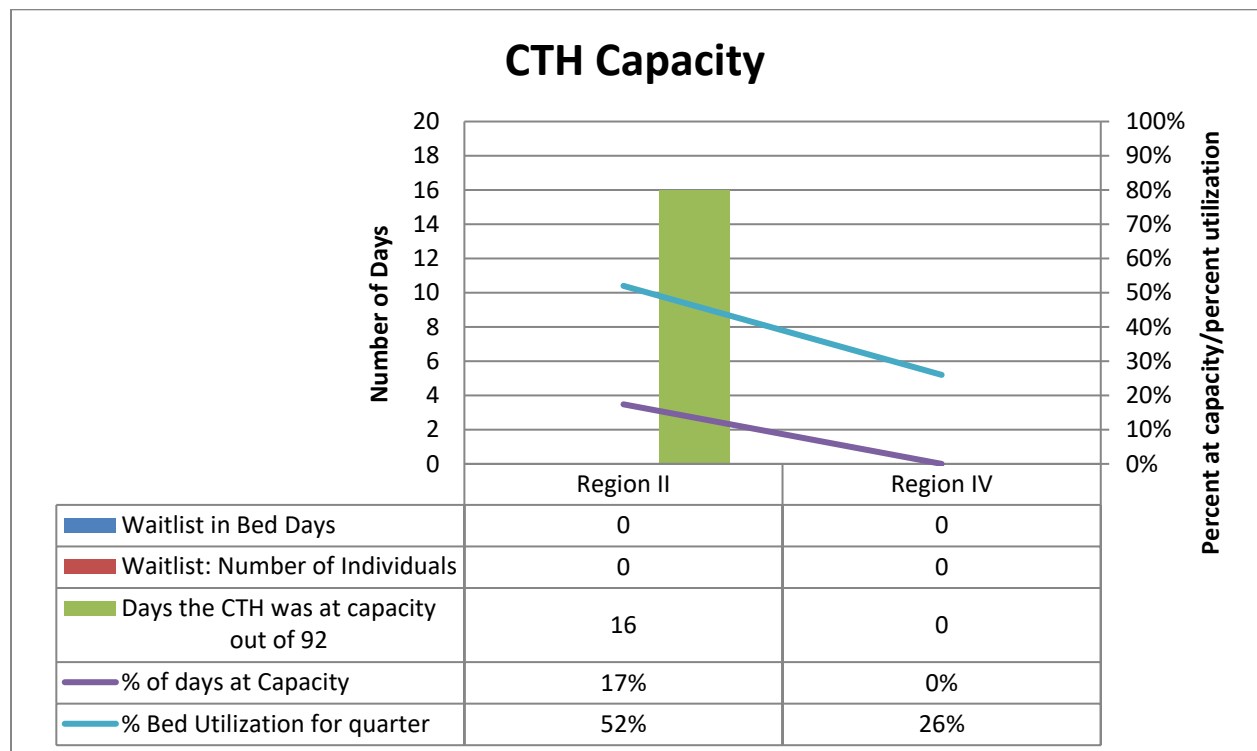


Region	Admits & readmits per region
Region 1	6
Region 2	7
Region 3	3
Region 4	17
Region 5	2

The average length of stay reflected for each type of admission on the above chart (CTH Utilization) is within the expected average length of stay. Across both regions operating a child CTH, there was one individual that admitted in the previous quarter that had a stay that carried over to the current quarter. The table on the next page reflects more specific information for this person regarding length of stay, region, and type of admission.

LOS: Individuals Admitted Previously and Discharged w/in Quarter			
Region	Individual	Type of Admission	Total LOS (Days)
Region 3 admitting region, to Region 4 child CTH	Person 1	Crisis stabilization	10 days

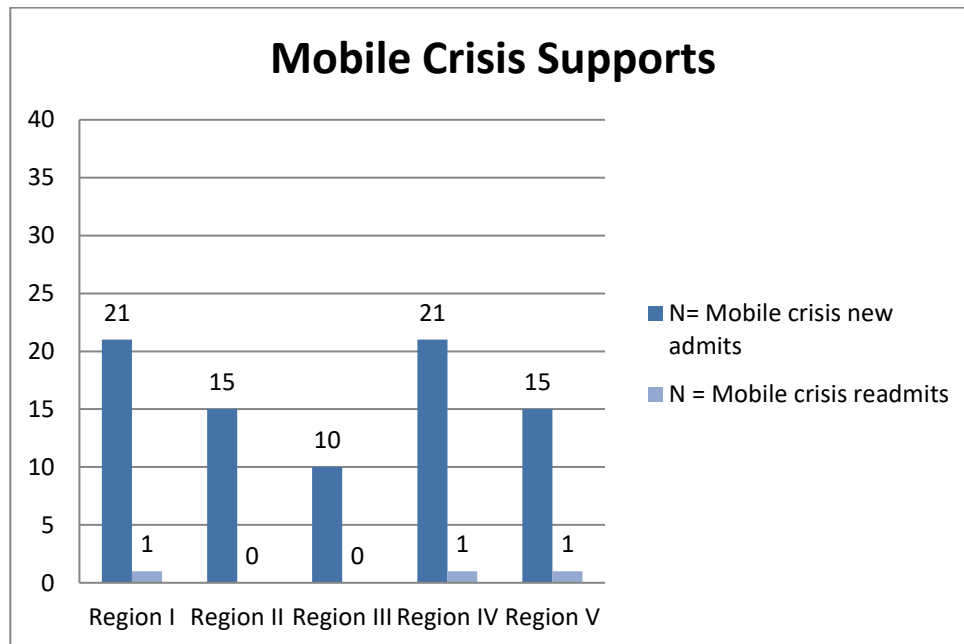
The graph below provides information regarding CTH capacity. Please note that waitlist days are *not* consecutive. This number reflects the cumulative number of days across the quarter when a bed was not available when requested for an *appropriate* admission to the CTH. The information provided in the graph includes both the number of days when the two CTHs were at capacity in the quarter and how many of the beds were utilized. The bed utilization rate for the Crisis Therapeutic Homes ranged from 26% to 52% this quarter. Both homes will be able to serve 6 individuals each upon being fully licensed. It should be noted that during the quarter the home in Region II was licensed for 4 beds. The home in Region IV remains licensed for 6 beds; however, during the quarter, this home had reduced to a 2 bed capacity from 10/1/2020-11/30/2020. Region IV then operated at a 3 bed capacity from 12/1/2020-12/31/2020. The Region IV home experienced significant staffing shortages based on a combination of factors that led to temporary bed reduction in both adult and child CTHs during the quarter.



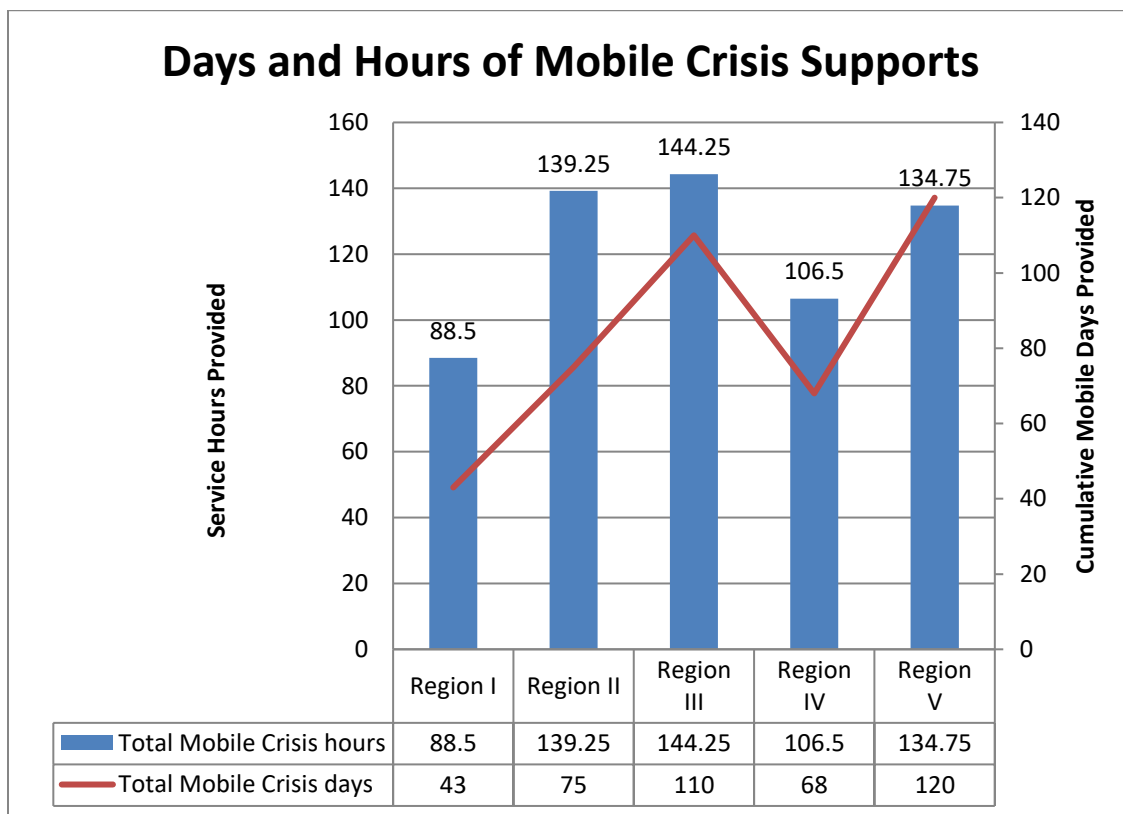
<i>Number of beds used out of beds available</i>	190 out of 368	143 out of 552
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Community Based Mobile Crisis Services

Community-based, mobile crisis supports are one of the key services that the children’s programs provide. These services are provided in the home or community setting as an immediate result of a crisis event. It is especially important to the REACH model because it impacts and benefits not only the child but their immediate support system as well. Generally, these supports are successful in stabilizing the situation and being part of the solution for obviating out-of-home placement. The chart below depicts admissions activity for the community mobile crisis support program.



In addition to collecting information related to the number of admissions into the mobile crisis supports program, data related to service provision is also tabulated. The chart on the following page summarizes both the number of days and hours of crisis intervention and/or stabilization services offered by each region. On the secondary axis, the cumulative number of mobile days provided for families across the quarter is shown.

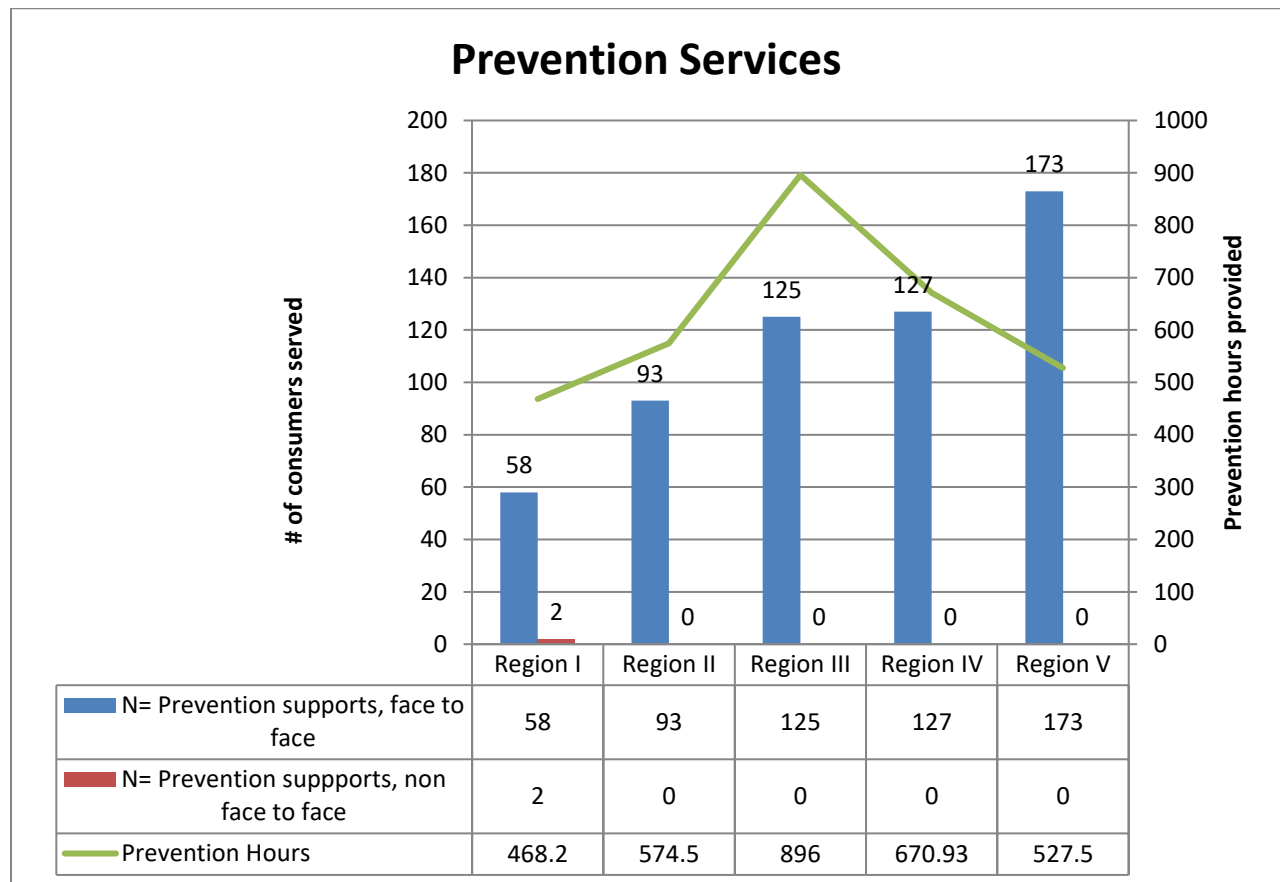


REACH sends clinicians to the homes and schools of individuals to work with them on developing and practicing coping skills. The table below provides information on the range of days across individuals served that mobile crisis supports were in place, the average number of days an individual received mobile crisis supports, and the average number of hours that each individual received per crisis event. All programs met the required average of three days per case, with the exception of Region I which was slightly below at approximately 2 days per individual.

Service Unit	Region I	Region II	Region III	Region IV	Region V
Range of Days	1-6	3-7	4-15	1-5	1-13
Average Days/Case	2.0	5.0	11.0	3.1	7.5
Average Hours/Day	2.1	1.9	1.3	1.6	1.1
Average Hours/Case	4.0	9.3	14.4	4.8	8.4

REACH also provides ongoing community based services to children and their families that is more “preventative” in nature. Mobile prevention services consist of face to face, community based services that target deterring future crisis situations via ongoing education and practice on emerging skills, training on individualized strategies with the support system, and continued

linkages and coordination with other necessary services as needed. In comparison to mobile crisis supports, mobile prevention services are provided at a titrated frequency and do not occur as the immediate result of a crisis situation. More specifically, individuals included in mobile prevention services may be those who stepped down from mobile crisis support or those that were referred to the program in a non-crisis situation. At times, prevention services may include individuals who are offered mobile crisis support immediately following a REACH crisis response but do not elect to access REACH services until sometime after the crisis was stabilized. For this quarter due to COVID-19 precautions, some individuals receiving “face to face” prevention service may have received some or all of these services via telehealth. The data in the section “Prevention Services – face to face” does not delineate between the different services deliveries as individuals may have received a mixture of both in person and telehealth. The graph below depicts the following: 1) the number of youth that accessed face to face mobile prevention services; 2) those that were matriculating out of the REACH program based on ongoing stability and may have received brief non face to face prevention services (e.g. telephonic communication); and 3) the total number of prevention hours provided, across each program. These metrics are displayed via the blue column, red column, and green line, respectively, with the green line corresponding to the secondary y-axis.



Short Term Out of Home Prevention Services

At the time of this report, one provider has commenced providing out of home prevention services for the youth population, while the other provider continues to secure appropriate staffing to be able to accept referrals into service. This service is a short term (targeted length of stay is 7-10 days), out of home service that offers a break from the current family home environment to mitigate a larger crisis situation and avoid the need for longer-term out of home placement. Referrals for the service come directly from the REACH program, with families that enroll their child receiving therapeutic services towards the youth's individual support plan, along with collaboration and support from the REACH crisis program. Though only one service provider is currently operational, referrals can be accepted from across the Commonwealth, with services being delivered in Regions IV and V.

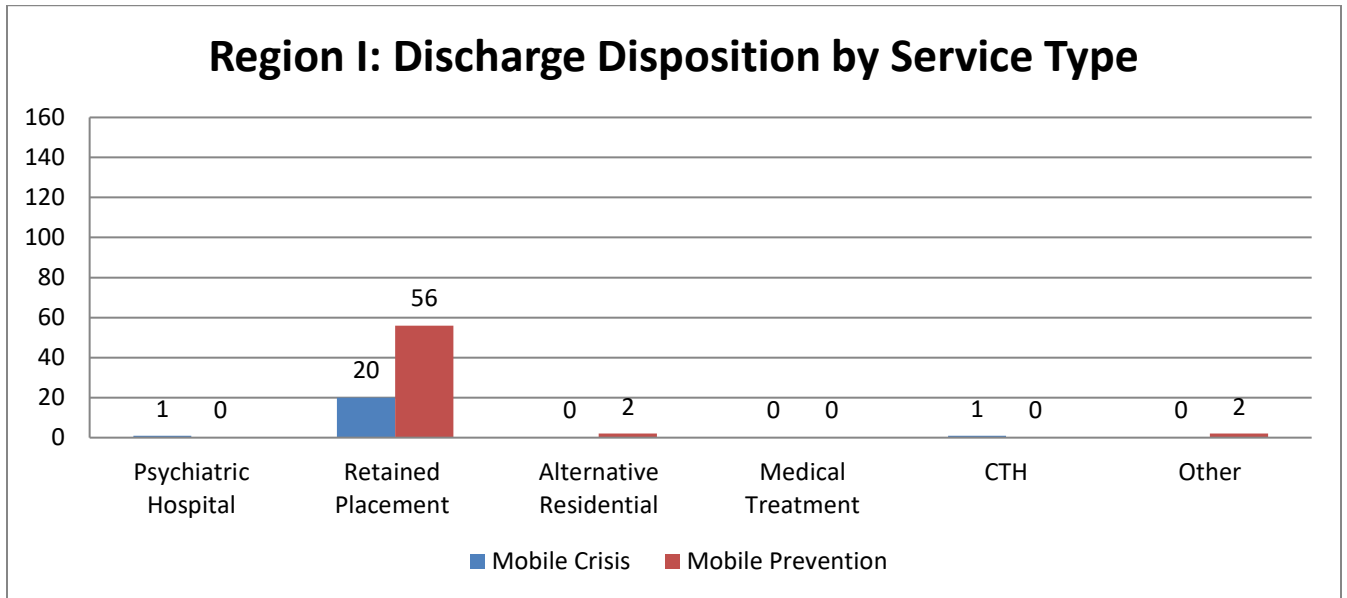
During FY21Q2, there were 6 referrals for service. Two referrals resulted in service delivery, and one individual was a carryover from the previous quarter. Service data for the youth that accessed services are tabled below.

Admitting region	LOS	Service outcome
4	22 days (carryover from FY21Q1)	Retain setting with REACH
4	7 days	Retain setting with REACH
4	6 days	Retain setting

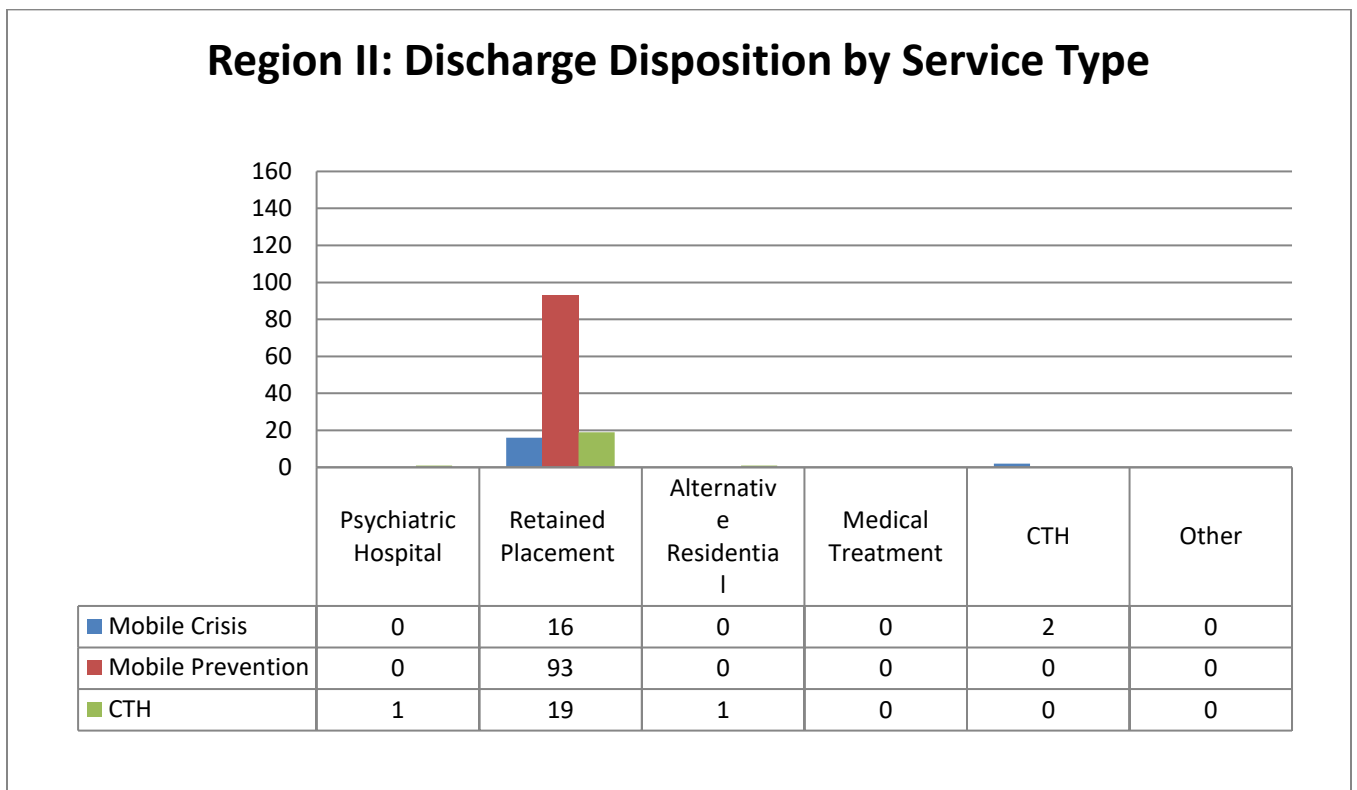
Crisis Service Outcomes/Dispositions

Maintaining residential stability and community integration is one of the primary goals of the REACH programs. The graphs on the following pages provide a summary of outcome data for community mobile crisis and prevention support services. Based upon reported data of the mobile crisis support outcomes for children, 92% of children were able to avoid psychiatric hospitalization with the provision of mobile crisis supports. Based upon reported data of mobile prevention supports, 96% were also able to avoid psychiatric hospitalization (note, additional less than 1%, 1 youth, was legally involved/detention center placement). For CTH services, 94% were able to avoid hospitalization (additionally 1 youth admitted to a residential treatment facility, which accounts for 2% of outcomes). These data suggest that community based REACH supports are overall effective in helping families and their children through times of crisis and in maintaining stabilization post-crisis such that placement in the community can be maintained.

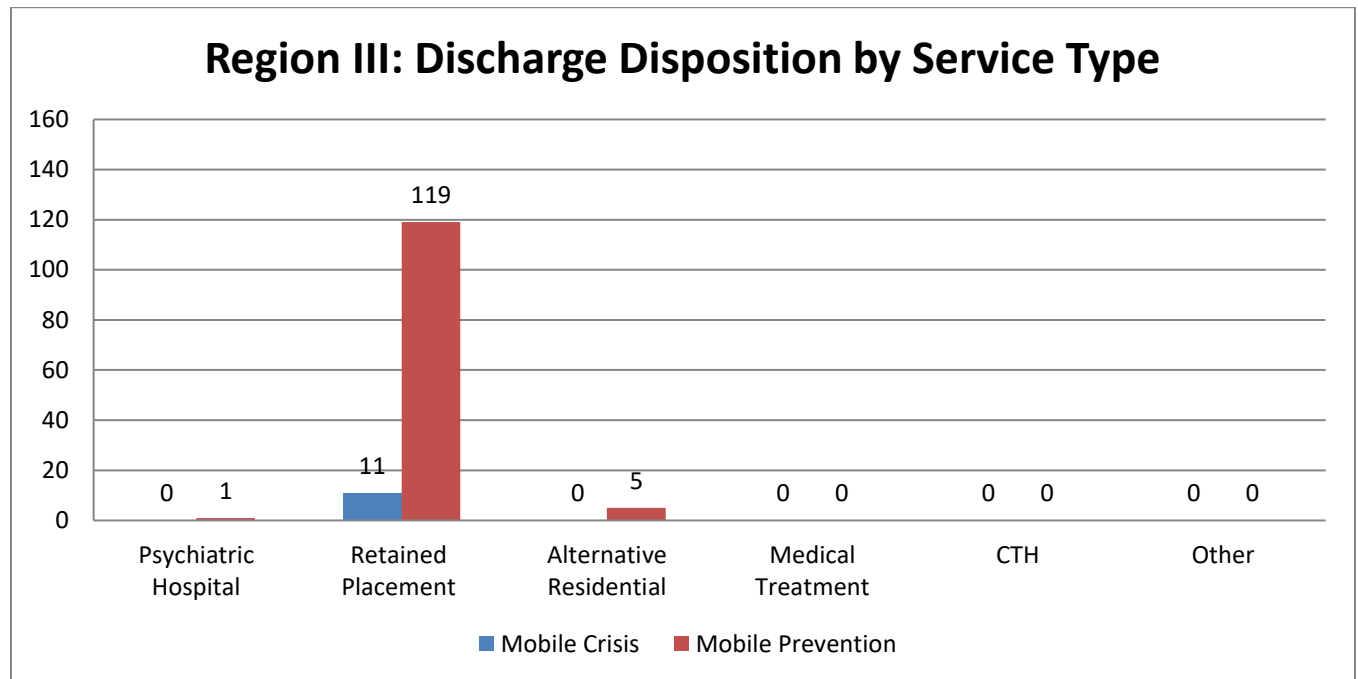
The graphs on the following pages display the outcomes of both mobile crisis and mobile prevention services across each REACH program.



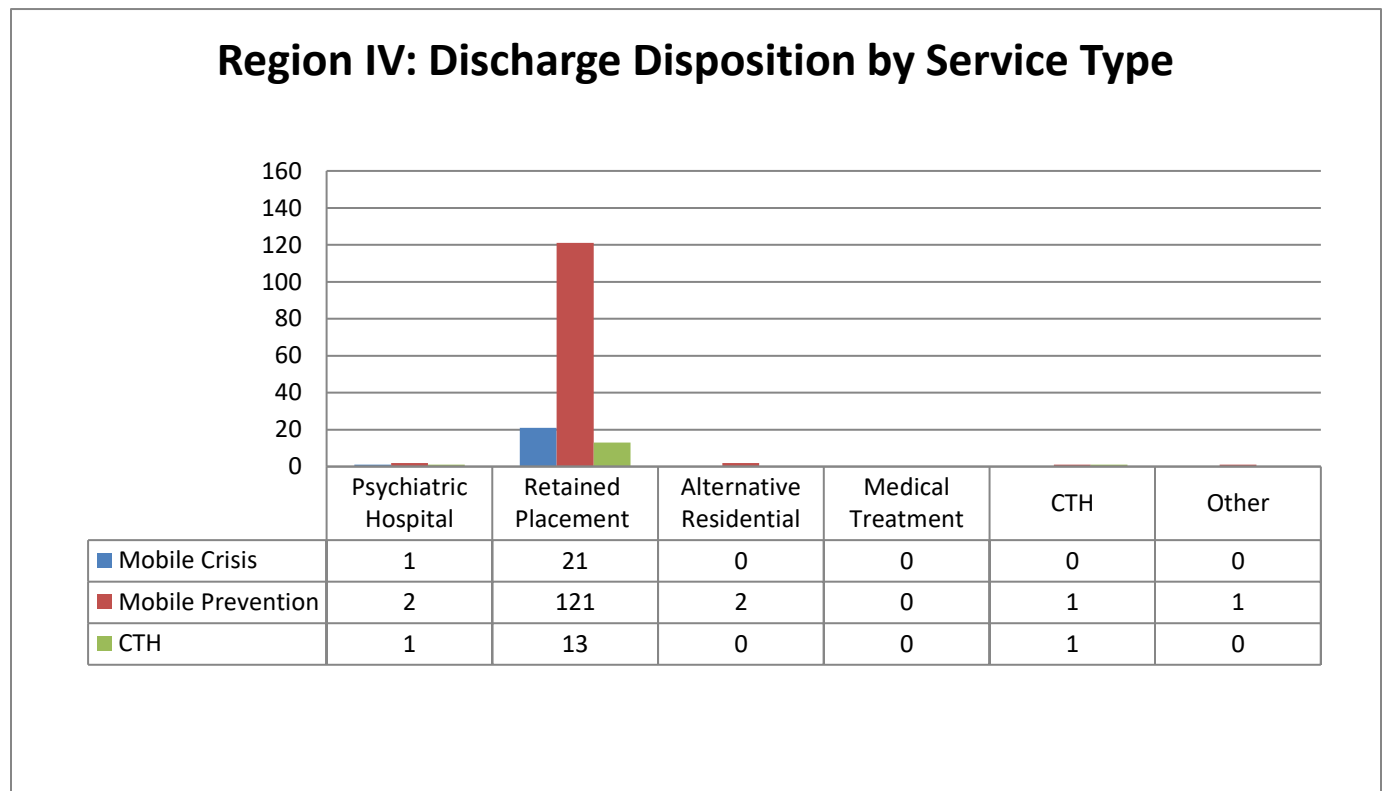
Mobile prevention "other" = transitioned to adult REACH



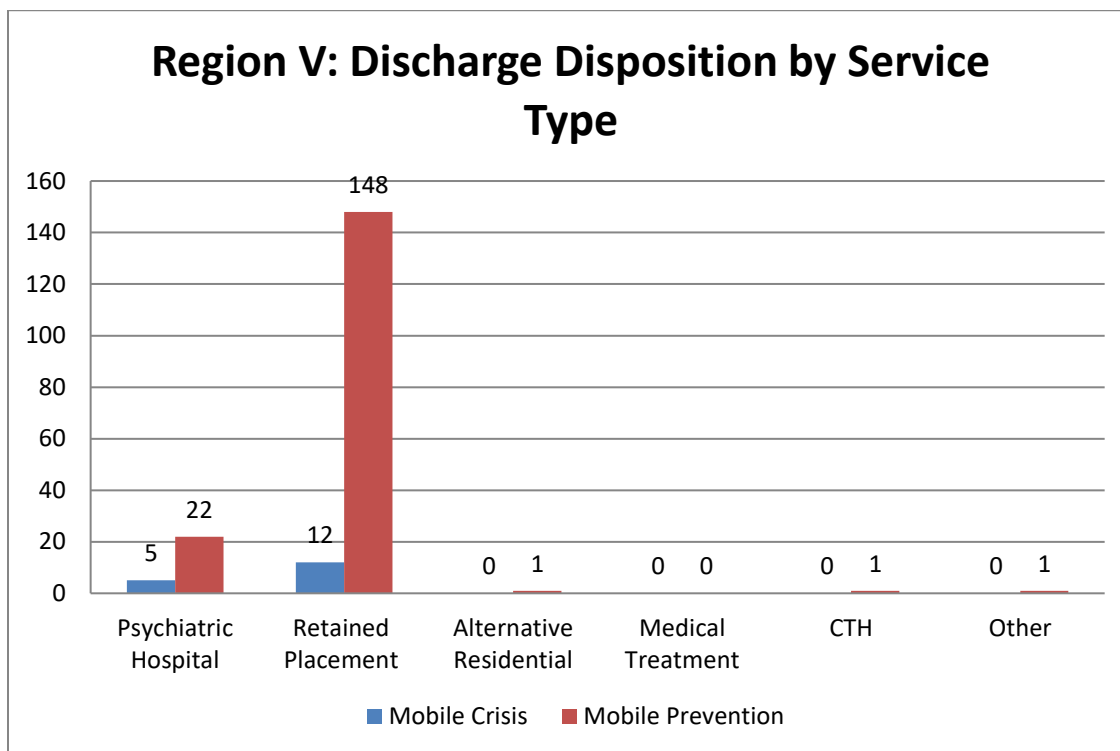
Mobile crisis includes outcome for 3 carryover from FY21Q1



Mobile crisis includes 1 carryover from FY21Q1

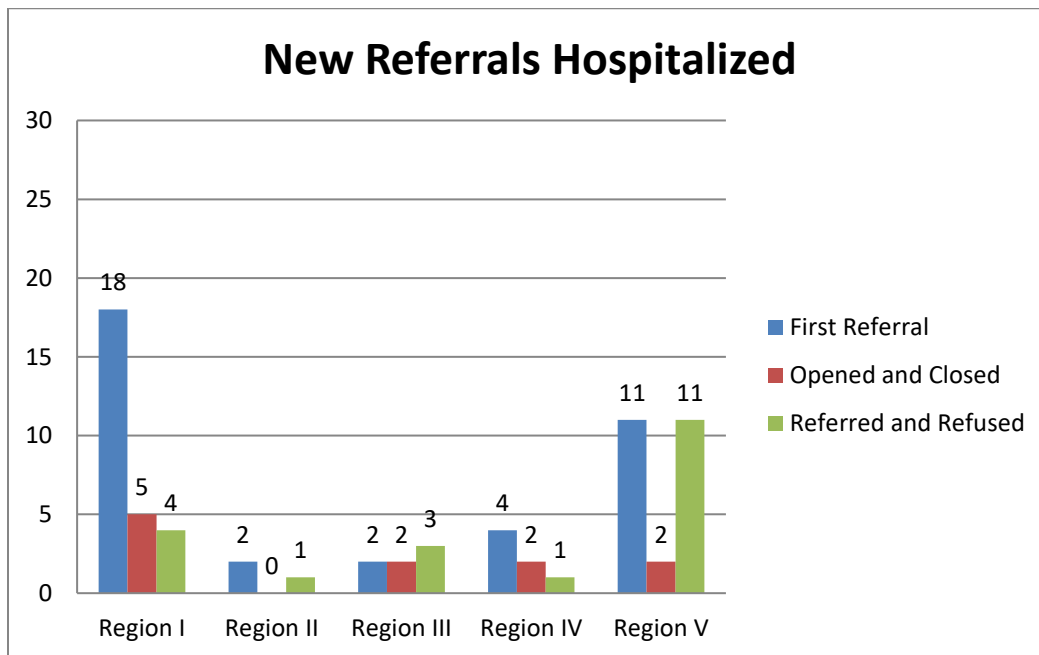
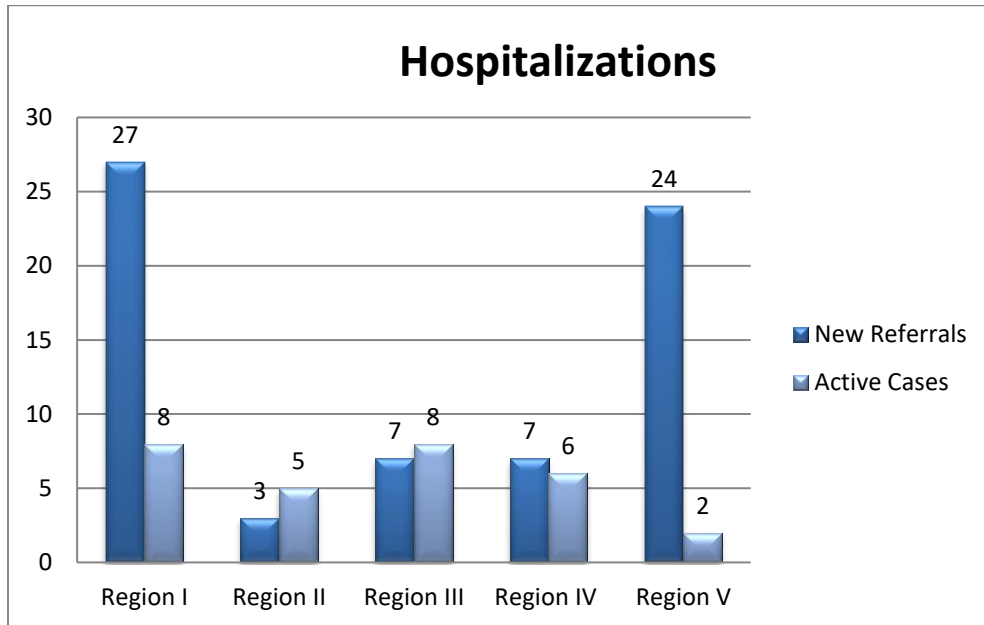


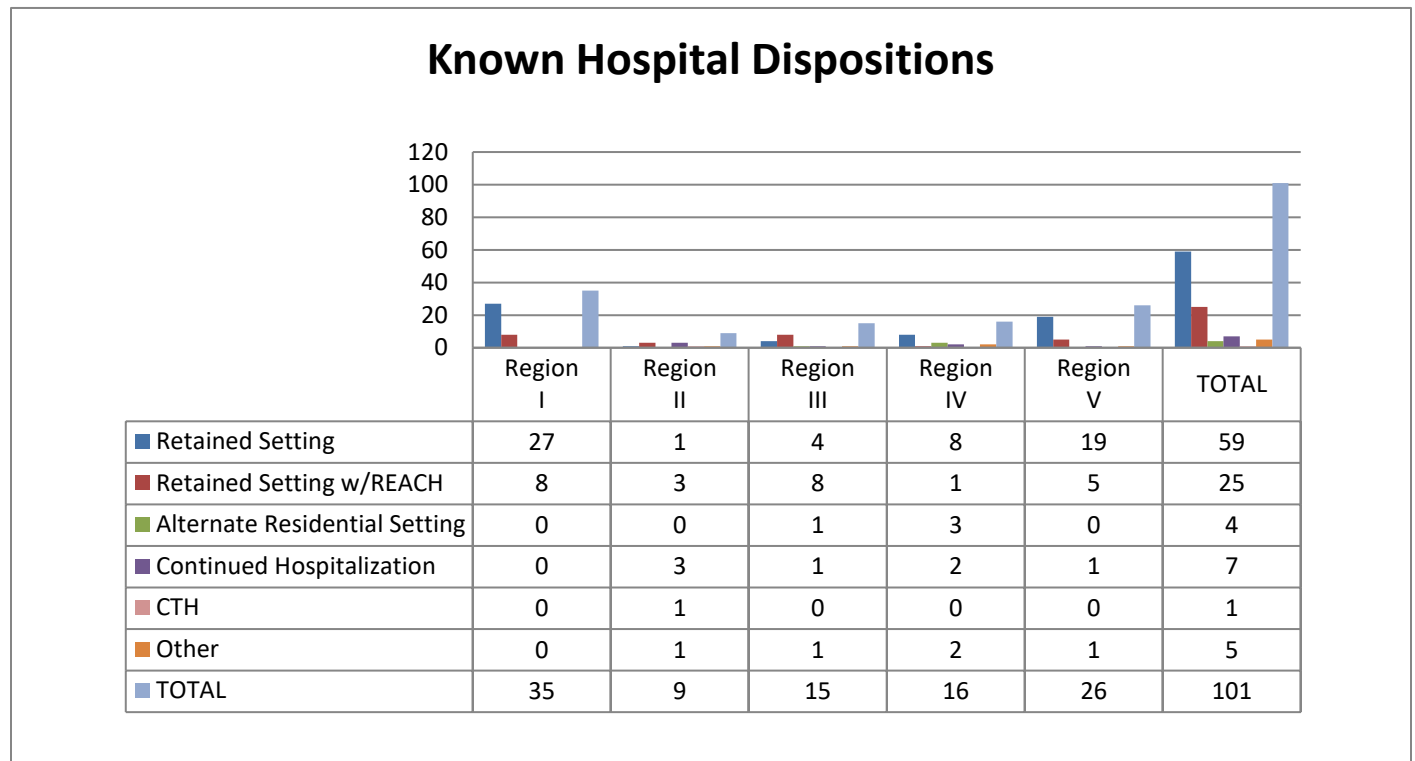
Mobile Prevention "other" = Incarcerated; CTH includes outcome for 1 carryover from FY21Q1



*Mobile prevention "other" = detention facility
Mobile crisis includes outcome for 1 carryover from FY21Q1*

The three graphs that follow display hospitalizations for new referrals and active cases, hospitalizations for new referrals, and known hospitalization dispositions, respectively. While the REACH programs remain actively involved with all hospitalized cases *when they are aware of this disposition and have parental consent to provide service*, they may not always be apprised that a REACH client has been hospitalized or that an individual with DD has entered inpatient treatment. While the Commonwealth Center for Children and Adolescents educates families about the children’s REACH programs, many families elect not to access this service.





Region II “other”=unknown/refused service, 1 person hospitalized twice; Region III “other”= unknown; Region IV “other” = 1 person declined and closed, 1 person incarcerated, 3 people hospitalized twice; Region V “other”= 1 person at a detention center

SERVICE ELEMENTS

Each of the five regional REACH programs provides an array of services to children and families enrolled. These services include prevention and education services, assessment services, and consultation services. A compliance indicator target has been set for mobile crisis services that *86% of families and providers will receive training in implementing CEPPs*. Excluding the CEPPs for readmits during the current quarter, the combined REACH programs trained providers/families on 95% of mobile crisis CEPPs this quarter (note: this is inclusive of training that Region V provided on CEPPs drafted in a previous quarter that were not required to be retrained on). The reasons for not completing the training includes family/provider refusing training, individual being hospitalized during service provision, or inability to contact/schedule the CEPP or the training. The tables that follow summarize the services provided for mobile crisis and CTH services.

Service Type Provided: Mobile Crisis Support					
Service Type	Region I	Region II	Region III	Region IV	Region V
Comprehensive Evaluation	22	15	11	22	15
Consultation	22	15	11	22	15
Crisis Education Prevention Plan	22	13	11	20	14
Family/Provider Training	22	8	11	20	15

Region II: 2 CEPP still being developed as they are still in mobile supports, 4 not trained due to lack of family response, 1 CEPP not trained due to parent hospitalization; Region IV: 1 individual served for 1 day then hospitalized, 1 individual 1st day of service on last day of the month; Region V: 1 CEPP created in the previous quarter

Service Type Provided: Crisis Stabilization (CTH)		
Service Type	Region II	Region IV
Comprehensive Evaluation	13	14
Consultation	13	14
Crisis Education Prevention Plan	13	14
Family/Provider Training	12	14

Region II: 1 CEPP will be trained once Mobile Support completed

Service Type Provided: Planned Prevention (CTH)		
Service Type	Region II	Region IV
Comprehensive Evaluation	5	n/a
Consultation	5	n/a
Crisis Education Prevention Plan	5	n/a
Family/Provider Training	2	n/a

Region II: 1 family not trained due to lack of response, 1 will be trained in early January 2021, 1 was an out of Region admit who never responded to outreach

Service Type Provided: Crisis Step Down (CTH)		
Service Type	Region II	Region IV
Comprehensive Evaluation	3	n/a
Consultation	3	n/a
Crisis Education Prevention Plan	3	n/a
Family/Provider Training	2	n/a

Region II: 1 family not trained due to lack of response once they moved out of region

REACH Training Activities

The Children's REACH programs are working to expand their role as a training resource for the community of support for children and families impacted by developmental disability. The table on the next page provides a summary of attendance numbers for various trainings completed by the Children's REACH programs. These trainings target the information needed by professionals in various work settings to work effectively with individuals with DD.

Training Activity	Region I	Region II	Region III	Region IV	Region V	Totals
CIT/Police: #Trained	15	41	0	0	19	75
Case Manager/Support Coordinator: # Trained	68	18	12	0	0	98
Emergency Service Workers: #Trained	18	39	1	0	12	67
Family: # Trained	0	50	0	1	2	53
Hospital Staff: # Trained	0	0	0	0	0	0
DD Provider: # Trained	10	106	156	16	24	312
Other Community Partners: #Trained	0	15	122	1	0	138
Totals	111	269	291	18	57	743

Note: Regions II, III, IV, and V data are duplicative of adult training data; "Other" includes the following: MH providers, school Staff, and behavior specialists

Summary

This report provides a summary of data for the regional children's REACH programs for the second quarter of fiscal year 2021. The statewide Children's REACH programs are functioning well and are actively serving children and families in crisis. As has been the case throughout the pandemic, the regional programs have continued to face many challenges due to COVID-19. Though there have been regional differences based on the level of outbreaks and percent positivity trends within regions, the programs have worked to maintain in-person responses as much as possible with the implementation of COVID-19 precautions. The children's out of home crisis prevention service had several admissions during the quarter and the Department will continue to partner with REACH and the community provider(s) of this service in the coming quarters. The youth crisis therapeutic home program service faced challenges, with one region having to operate at reduced capacity during the quarter due to staffing shortages.

Overall, the program continues to move forward in support of the mission for a full spectrum of crisis, prevention, and habilitation services to be offered to children in Virginia with a developmental disability. Much has been accomplished within the area of children's crisis services, and the path ahead appears to be clear in terms of defining next steps. The Department remains committed to fulfilling its mission to have a continuum of qualified care for children with developmental disabilities and their families.