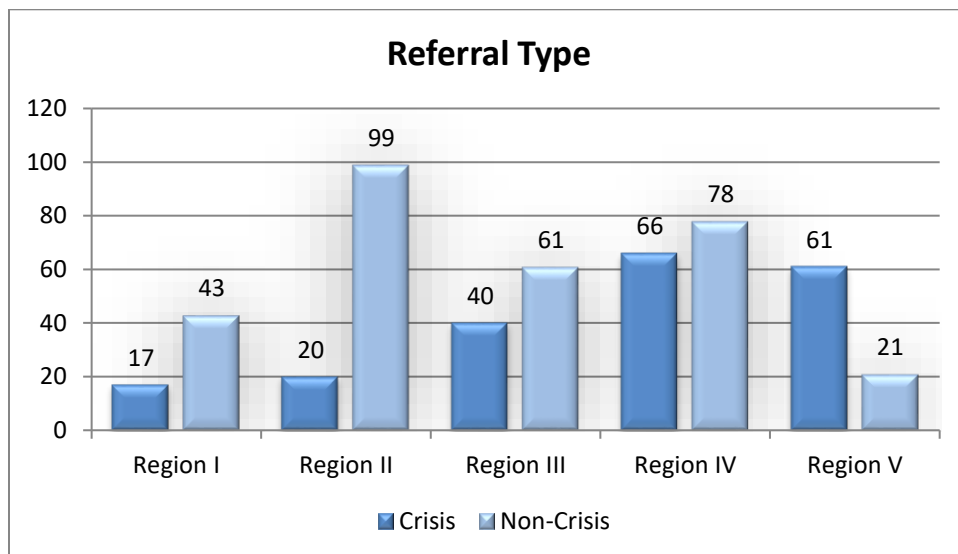
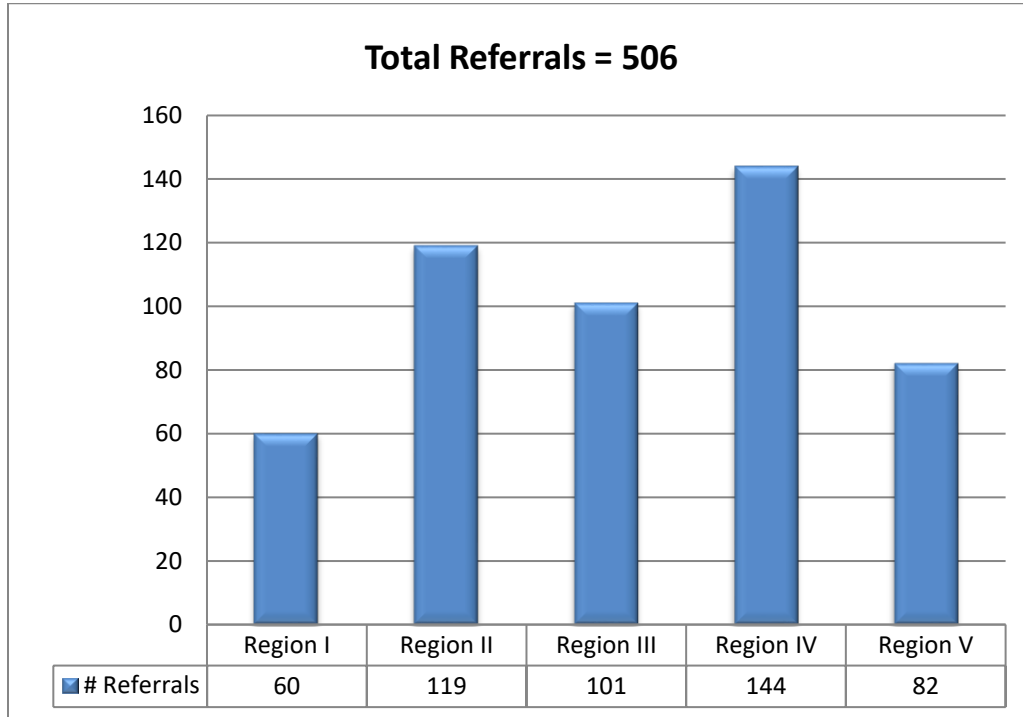


REACH Data Summary Report-Adult: Q4/FY21

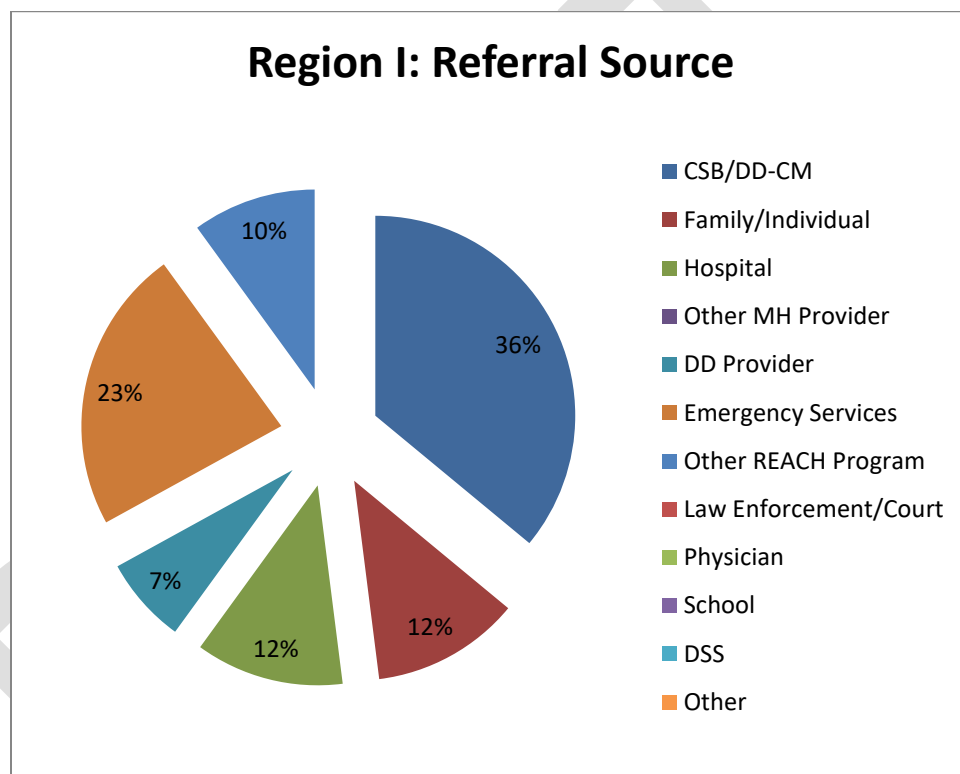
This report provides data summarizing the referral activity, service provision, and residential outcomes for adults served by the REACH programs during the fourth quarter of fiscal year 2021.

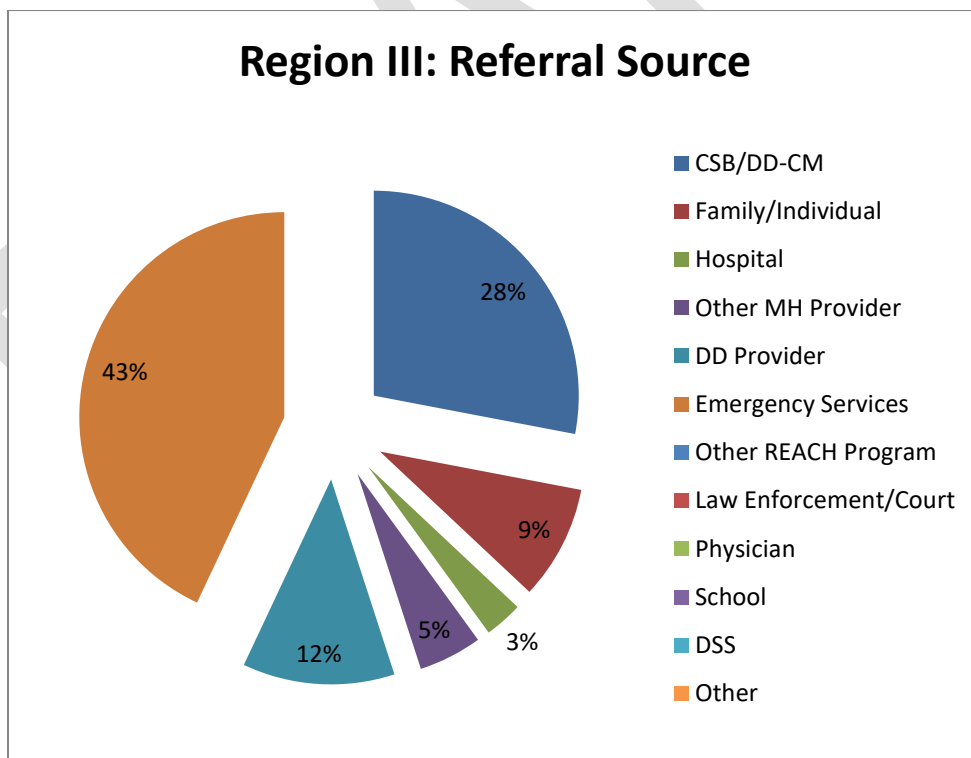
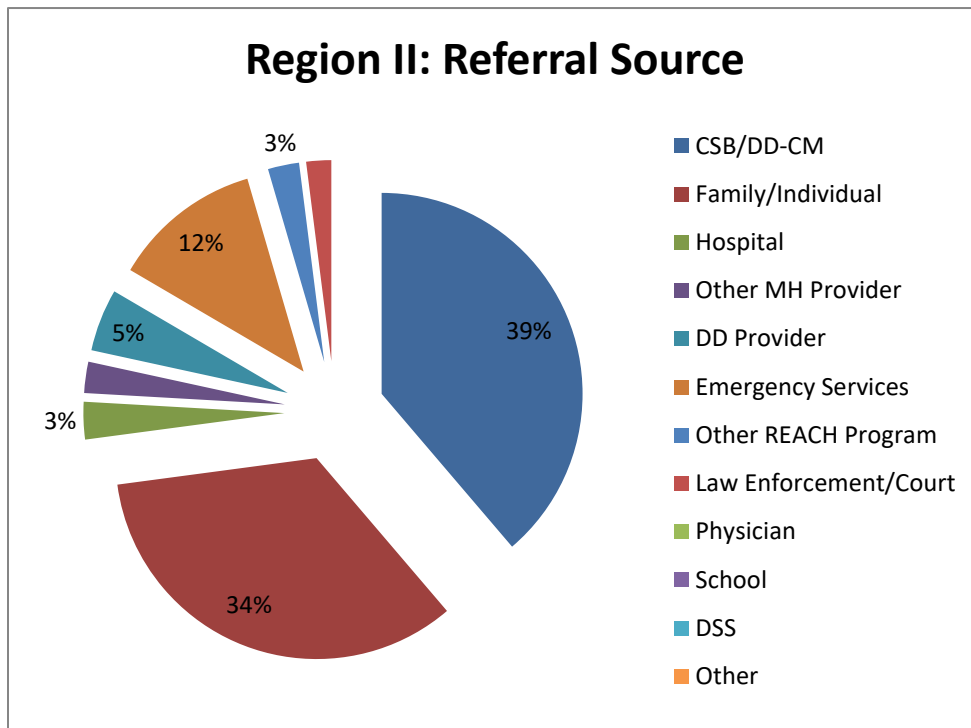
REACH Referral Activity

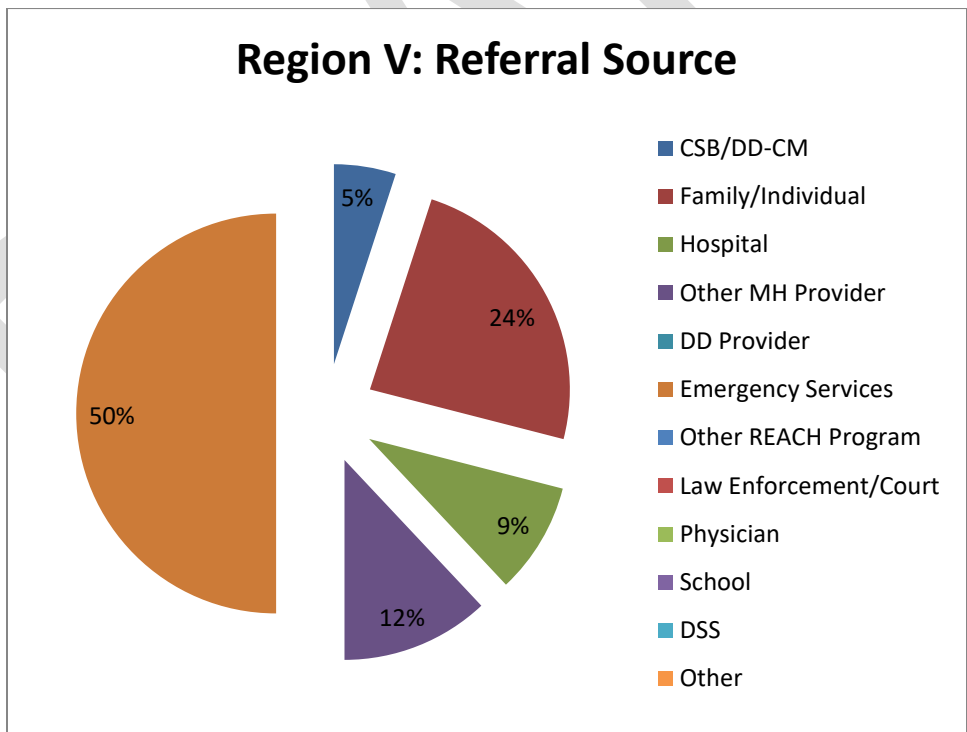
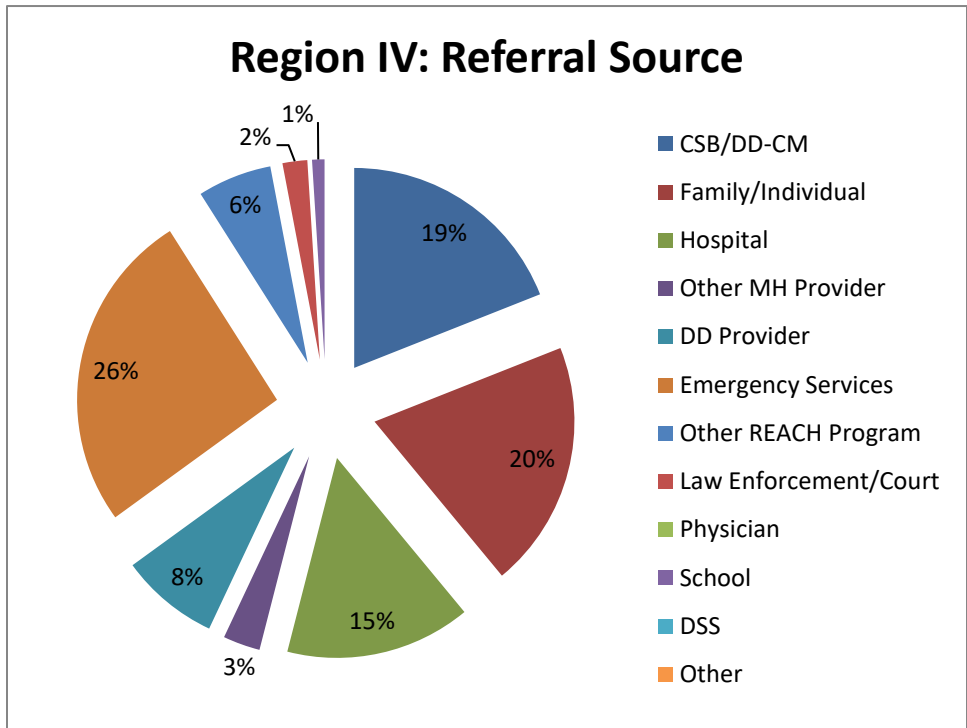


Referral activity for the fourth quarter of fiscal year 2021 is presented in the graphs on the previous page. For FY21 fourth quarter, an increase was noted in total referrals as compared to FY21 quarter three, 454 to 506. The data regarding the breakdown of types of referrals for Regions I through IV denote more non-crisis referrals than crisis referrals; whereas Region V has more crisis referrals. This trend is the same as compared to the previous quarters.

Referral activity is also considered by differentiating the source of the request for service. The following five charts show a breakdown by Region of referral source data. Referral sources cover a broad range of stakeholders when the state is considered as a whole and primary referral sources vary by Regions of the state.







The table below provides a breakdown of referrals by days of the week, ranges of time, and weekends/holidays. Monday through Friday is consistently the prime days for referrals with the 7:00 a.m. to 2:59 p.m. time frame being higher than 3 p.m. to 10:59 p.m. time frame in which most referrals occur.

Referral Time	Region I	Region II	Region III	Region IV	Region V	Total
Monday - Friday	56	110	77	123	70	436
Weekends/Holidays	4	9	24	21	12	70
7am - 2:59pm	33	63	41	55	21	213
3pm - 10:59pm	21	51	53	71	47	243
11pm - 6:59am	6	5	7	18	14	50

Also of interest to the Commonwealth is ensuring that the REACH programs serve the DD community in its entirety and effectively. The table below summarizes the breakdown of individuals referred to REACH with an intellectual disability (ID) only, an intellectual and other developmental disability, developmental disability exclusive of ID, and unknown or no developmental 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 were not substantiated. During this quarter, RIV supported more individuals with “DD only”. Individuals with only the diagnosis of ID continue to be the highest denoted subgroup supported by the Adult REACH programs.

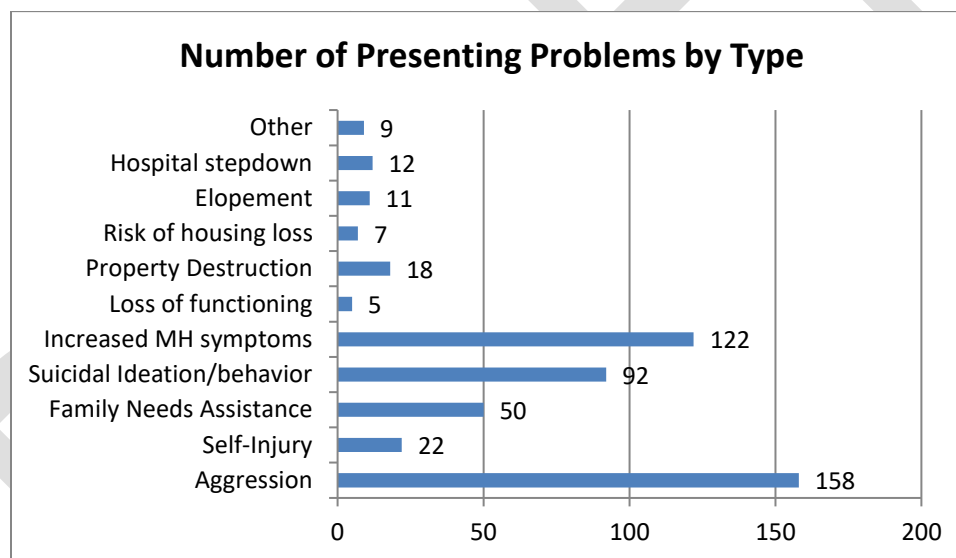
Diagnosis	Region I	Region II	Region III	Region IV	Region V	Total
ID only	31	49	61	72	48	261
DD only	15	41	25	43	28	152
ID/DD	14	25	12	24	6	81
Unknown/None	0	4	3	5	0	12
Total	60	119	101	144	82	506

In terms of what type of clinical issues bring individuals to the REACH programs for support; aggression and increased MH symptoms were the main reasons for referral during the fourth quarter with suicidal ideation moving to the third most common reason for referral. Aggressive behavior includes physical aggression and verbal threats.

Following the summary table below, a graph presents the same information aggregated across all five REACH Regions.

	Region I	Region II	Region III	Region IV	Region V	Total
Aggression	28	32	32	34	32	158
Self-Injury	0	3	5	6	8	22
Family Needs Assistance	2	19	5	21	3	50
Suicidal Ideation/behavior	8	18	20	30	16	92
Increased MH symptoms	14	39	22	31	16	122
Loss of functioning	1	0	1	3	0	5
Property Destruction	0	3	4	7	4	18
Risk of housing loss	1	1	3	1	1	7
Elopement	0	0	2	8	1	11
Hospital stepdown	2	3	3	3	1	12
Other	4	1	4	0	0	9
Total	60	119	101	144	82	506

Other: homicidal ideation; release from jail; unsafe/unpredictable community behavior; transition from another program.



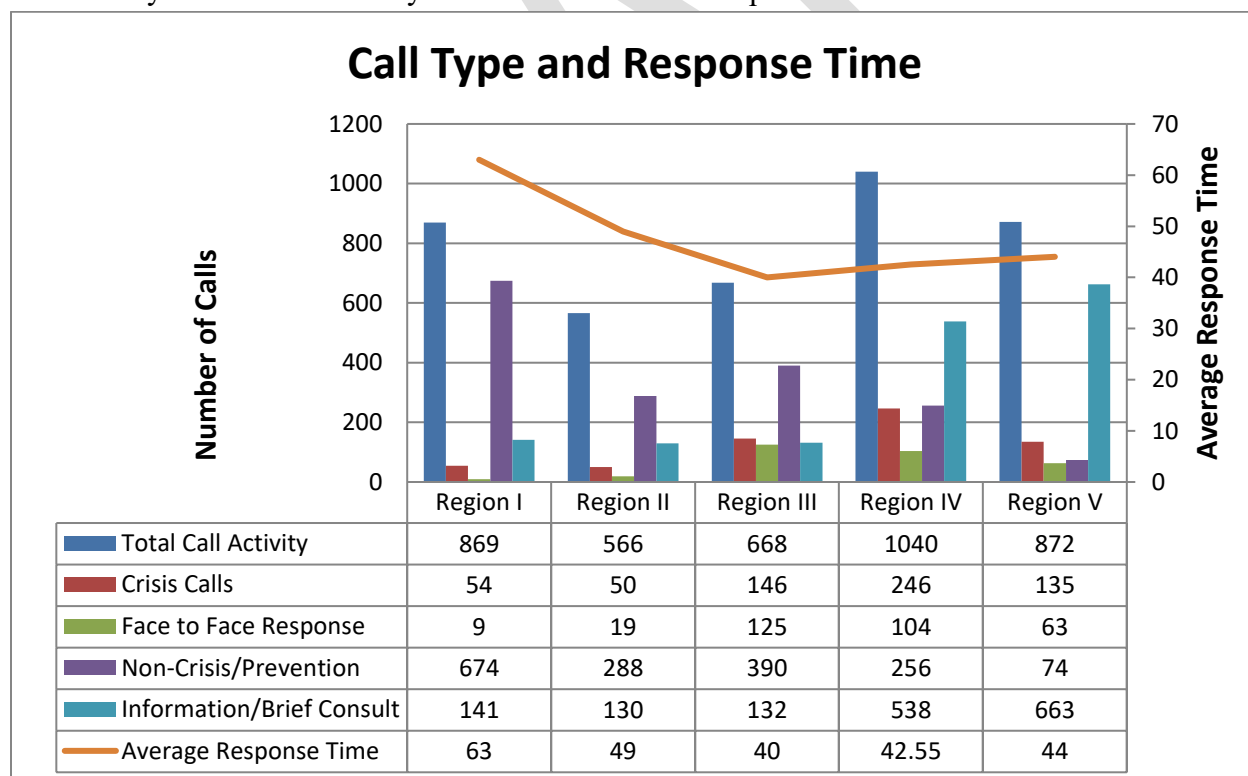
REACH Crisis Response

Each of the five regional REACH programs operates a crisis line 24-hours per day, seven days per week. Arriving calls may be from existing REACH consumers or from systems 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. Because the crisis line allows an individual to access a trained clinician 24/7, it is being used more and more frequently by REACH clients and their circles of support to maintain stability or to assist the individual in problem solving through a stressful situation. The “crisis” line is 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
- Non-crisis/Prevention
- Information/brief consult
- In-person assessment/intervention
- Total crisis line activity
- Average response time

A summary of information related to these elements 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 clients, 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 before, crisis line activity and referral activity are best understood as separate elements.



The average response time is graphed on a secondary axis represented by the orange line. Noted in the data listed above 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 telehealth in order to continue to be a part of the crisis response. The number of responses via telehealth for each region varied with all regions providing increased numbers of face to face response. Overall call activity increased from 3,564 during the third quarter to 4,015 in the fourth quarter. Crisis call activity followed the same trend increasing from 459 calls in the third quarter to 631 call in the fourth quarter. The respective regions experienced the following face to face response to calls during the fourth quarter: RI 17%, RII 38%, RIII 86%, RIV 42%, RV 47%. All five regions met expectations as denoted in the REACH Program Standards regarding average time to respond to the scene of the crisis event. Regions II and IV must have an average response time of within one hour as designated as urban setting and Regions I, III, and V within two hours as designated rural setting. Region I met the response time for 89% of the in-person response while Region II met 79%, Region III met 98%, IV met 96%, and Region V met 95% of their face to face response time. The table on the next page offers a more detailed picture of response time data by breaking it into 30-minute increments. Traffic congestions/distance, and multiple calls were the reasons given for delays in response.

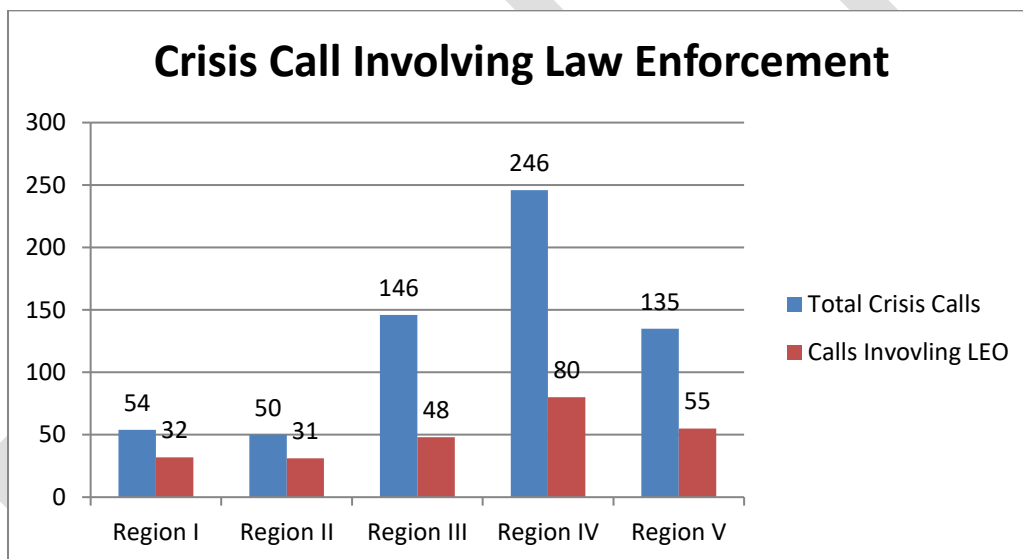
	Region I	Region II	Region III	Region IV	Region V	Total Calls
Response Interval: 0 - 30	2	4	62	21	31	120
Response Interval: 31 - 60	4	11	42	79	16	152
Response Interval: 61 - 90	1	4	16	3	9	33
Response Interval: 91 -120	1	0	3	1	4	9
Response Interval: 120+	1	0	2	0	3	6
Total	9	19	125	104	63	320

Location of Crisis Assessments

Assessment Location	Region I	Region II	Region III	Region IV	Region V	Total
Individual Home/Family Home	5	13	17	26	32	93
Hospital/Emergency Room	44	17	92	144	70	367
Emergency Services/CSB	0	17	9	7	12	45
Residential Provider	3	3	26	51	17	100
Police Station	0	0	1	1	3	5
Day Program	1	0	1	1	1	4
School	0	0	0	0	0	0
Other	1	0	0	16	0	17
Total	54	50	146	246	135	631

Other response settings include: ALF; CSU; Crisis Triage Center, other community locations.

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 fourth 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. During the fourth quarter the number of individuals assessed in family homes was slightly reduced from 98 to 93, emergency room assessments increased from the last quarter from 222 to 367 in the fourth quarter. The area of note is the increase of emergency services/CSB assessment location from 28 to 45, and residential provider location increased from 51 to 100 individuals assessed in the fourth quarter, with 64% of all assessments occurring these 2 locations. The data denotes a slight increase in law enforcement presence for fourth quarter as compared to the previous quarter, 34% to 39%.

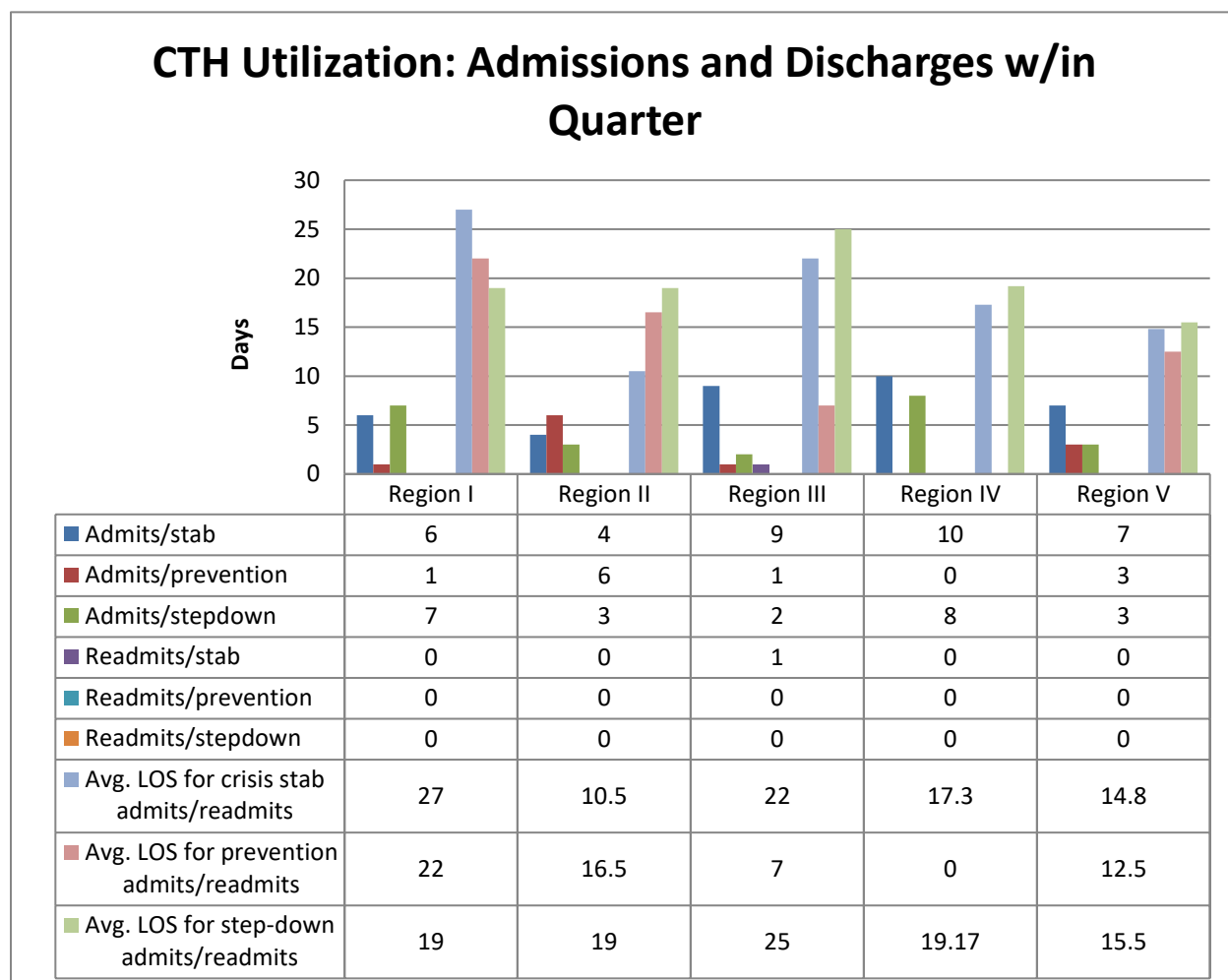


Crisis Therapeutic House

Each of the five REACH programs operates a Crisis Therapeutic Home (CTH) that accepts crisis stabilization admissions, step downs from hospitals and jails, and planned preventive stays. Region specific information such as type of stay, length of stay, readmissions, and waitlists is presented in the graph on the next page. Due to the large variability in average length of stay (LOS) as a result of individuals being admitted with no disposition, the chart depicting CTH utilization was modified in FY20 to reflect only those individuals who were admitted or readmitted and discharged in the quarter. All other individuals who were admitted in previous quarters and discharged in this quarter will have their LOS data reflected in the narrative and table on pages 11

and 12. These particular individuals also will be included in the data on the chart “Dispositions by Service Type” under “CTH”.

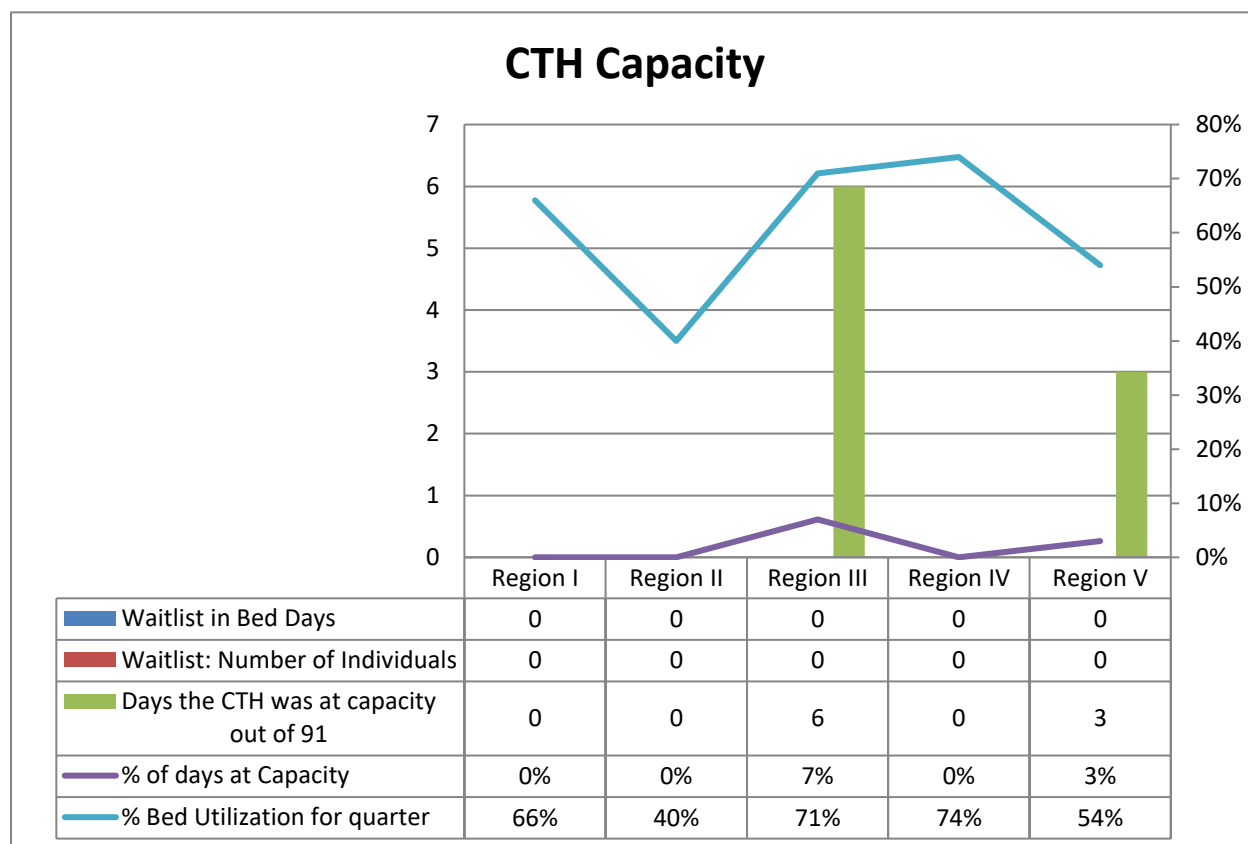
The Commonwealth has been closely monitoring capacity of REACH programs across the Commonwealth. In all instances, the CTH is working with the CSB to ensure the individual is linked to appropriate supports and services. All programs are responsible for working with the Department as well to ensure that the system is working together to ensure an appropriate resolution and placement for the individual being supported. Additionally, the Department is working to address follow-through on services to ensure all parties are working diligently to address the needs of individuals without disposition. The next chart denotes within quarter admissions/readmissions across all Regional programs. During the fourth quarter, there were 36 crisis stabilization admissions, 11 prevention admissions, and 23 step-down admissions with only a slight decrease in step down admissions from 27 in the previous quarter with both crisis and prevention trending up. During the quarter only one crisis stabilization case readmitted, while no prevention or step down admissions readmitted during the fourth quarter.



The average length of stay reflected for each type of admission on the previous chart is within the expected average length of stay with R5 coming back into the expected average length of stay from 40 days in the third quarter to 14.8 in the fourth quarter. Across all Regions for those individuals who were admitted in a previous quarter to the CTH and discharged in this quarter, the data is as follows: 6 crisis stabilization admissions with LOS ranging from 8 – 141 days, 8 step-down admissions with LOS ranging from 8 - 87 days, as well as 1 prevention stay of 10 days. These discharged individuals are in addition to those individuals admitted and discharged within the quarter. The following table reflects more specific information by 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 I	Person 1	Crisis Stab	141
Region II	Person 1	Step Down	8
	Person 2	Prevention	10
	Person 3	Step Down	87
Region III	Person 1	Step Down	22
	Person 2	Crisis Stab	14
Region IV	Person 1	Crisis Stab	8
	Person 2	Crisis Stab	15
	Person 3	Step Down	75
	Person 4	Step down	64
Region V	Person 1	Step Down	20
	Person 2	Crisis Stab	28
	Person 3	Step Down	21
	Person 4	Step Down	23
	Person 5	Crisis Stab	15

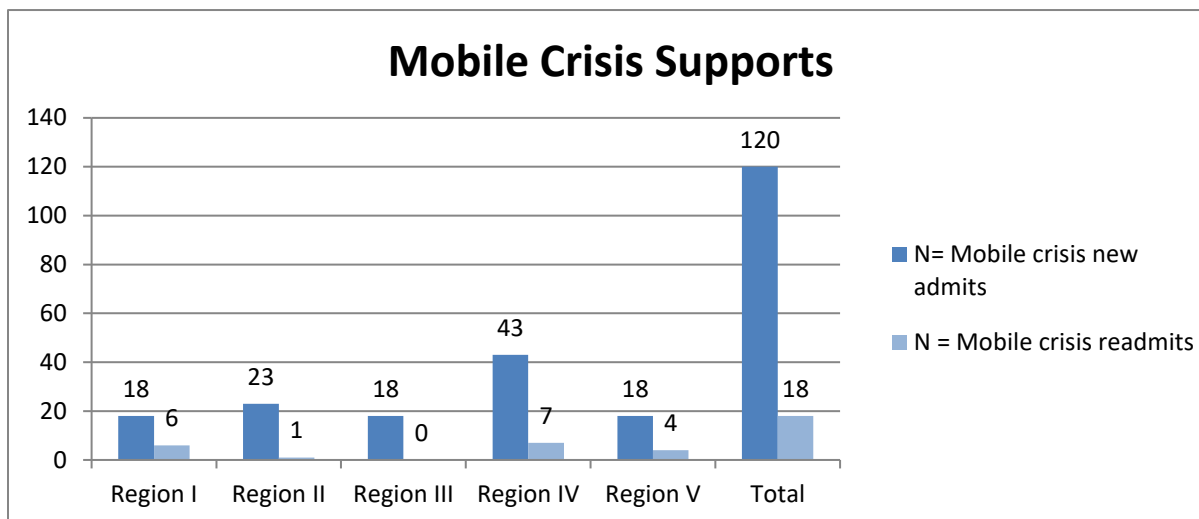
The graph on the next page provides information regarding CTH capacity. Please note that waitlist days are *not* consecutive. This number reflects the cumulative number of days across the quarter when a bed was not available when requested for an *appropriate* admission to the CTH. The information provided in the graph includes both the number of days when each of the five CTHs was at capacity in the quarter and how many of the beds were utilized. The bed utilization rate for the Crisis Therapeutic Homes ranged from 40% to 74% during the fourth quarter. As a result of COVID-19 and staffing impacted by COVID, admissions were interrupted in all Crisis Therapeutic Homes (CTH). All five regional REACH programs experienced the impact of a nationwide staffing shortage which impacted the ability to maintain full occupancy of 6 beds due to client to staff ratio and safety guidelines, occupancy was reduced to ensure ability to support individual's high acuity needs during their admission.



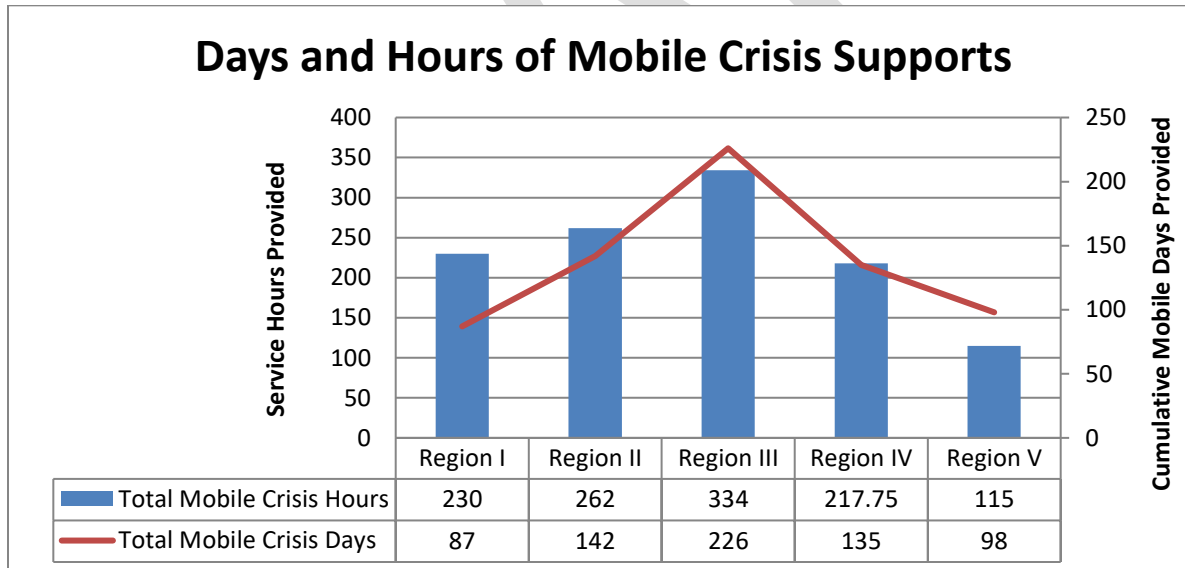
Beds Used Out of 546 Beds Available:	351	219	387	405	294
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Community Mobile Crisis Stabilization

Community-based, mobile crisis supports are one of the key services that the REACH 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 individual 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 on the next page depicts admissions activity for the community mobile crisis supports provided by the regional programs. The total number of new admissions supported through mobile crisis services decreased from 130 in FY21Q3 to 120 in quarter FY21Q4. The total number of readmissions increased from 11 in quarter three to 18 in quarter four.



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



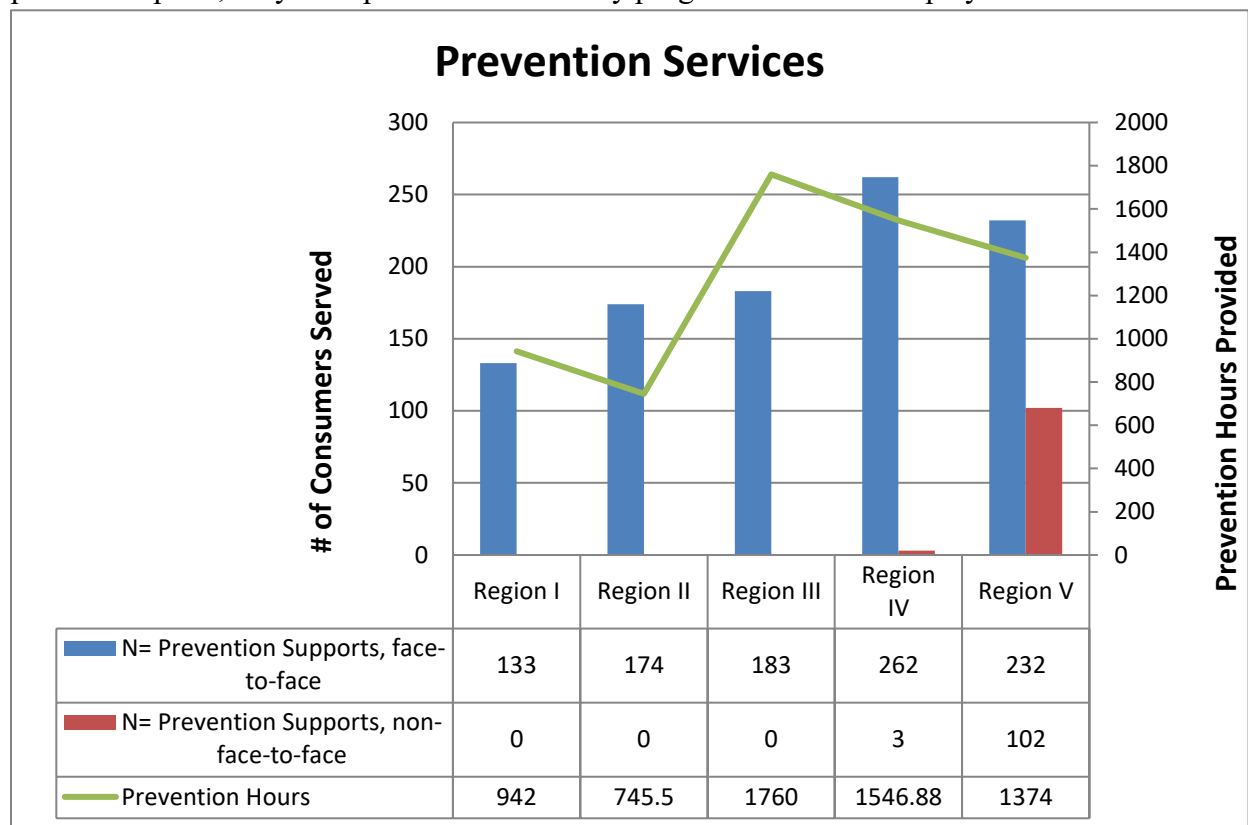
Mobile crisis stabilization services typically involve REACH clinicians going to the homes, day program, work site, or recreational site frequented by the individual to work with them on developing and practicing coping skills, and problem solving situations that arise in the settings where they spend their time. Concurrently, they assist care providers in learning to work

successfully with the people they serve. This may involve helping them to effectively coach the individual through the use of a coping strategy during periods of distress, enhancing their communication skills, or making modifications to the environment or daily routine. Overall, the regional programs provided an increase from 1091 hours in FY21Q3 to 1,158.75 hours in FY21Q4 of mobile crisis supports across 688 days (Q4). Generally, individuals are provided with crisis service for about 3 to 5 days with a targeted average per day of 2 hours. The fourth quarter data shows a range of between 1-15 days of services provided with a range of 1.2 to 2.6 hours per day. All regions continued to provide a mix of in-person and telehealth due to the pandemic. Data for the present quarter regarding the range in crisis service days, as well as the average number of days and hours crisis supports were in place, is as follows:

Service Unit	Region I	Region II	Region III	Region IV	Region V
Range of Days	1-6	1-10	1-15	1-6	1-5
Average Days/ Case	3.6	5.9	12.6	2.7	4.5
Average Hours/Day	2.6	1.8	1.5	1.6	1.2
Average Hours/Case	9.6	10.9	18.6	4.4	5.2

REACH also provides ongoing community based services to the individuals and their support system 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 to 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 services and some received these services via telehealth. The data on the next page 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 adults 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. It should be noted that in previous reports, only total prevention hours by program have been displayed.



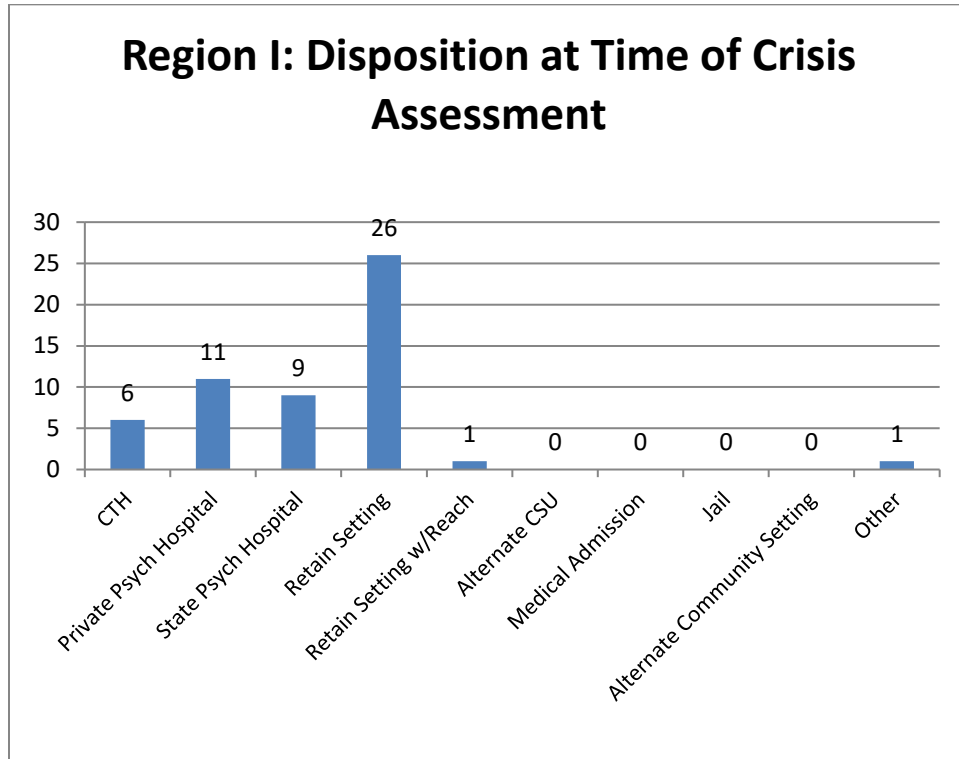
The total number of individuals receiving face-to-face prevention for quarter four was 984. The total number of prevention hours provided by all programs in quarter four was 6,368.

Crisis Service Outcomes/Dispositions

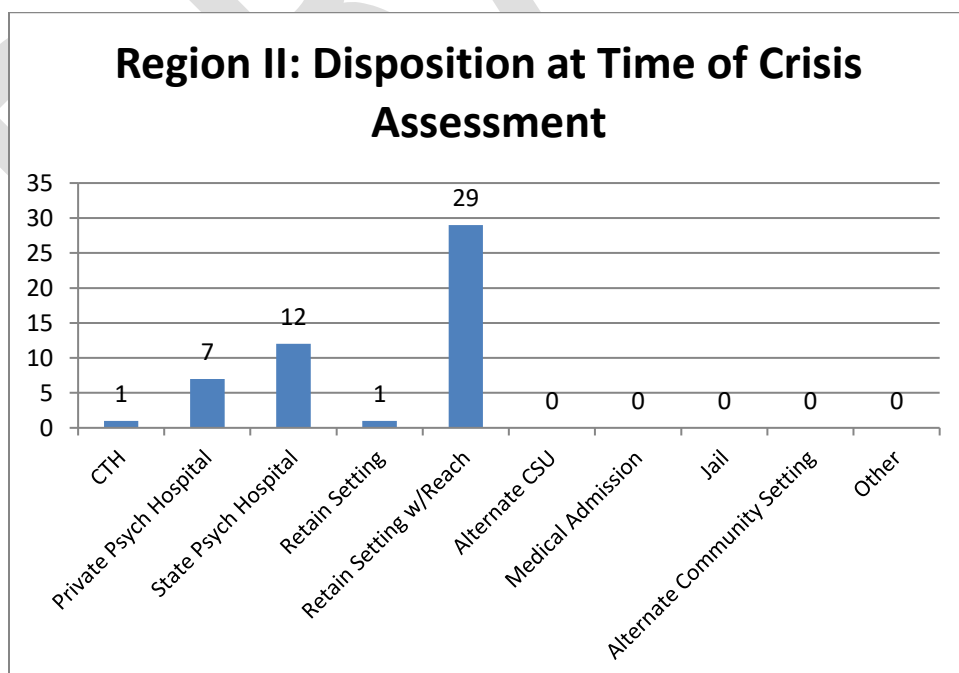
Maintaining residential stability and community integration is one of the primary goals of the REACH programs. Disposition data from three different perspectives are considered in this report. First, what is the outcome when a crisis assessment is needed? Second, what is the outcome when one is admitted to the CTH? Third, what is the outcome when mobile crisis or prevention supports are put in place to stabilize the situation and avoid the need for CTH admission, hospitalization, or some other disposition that involves disrupting the person’s residential setting?

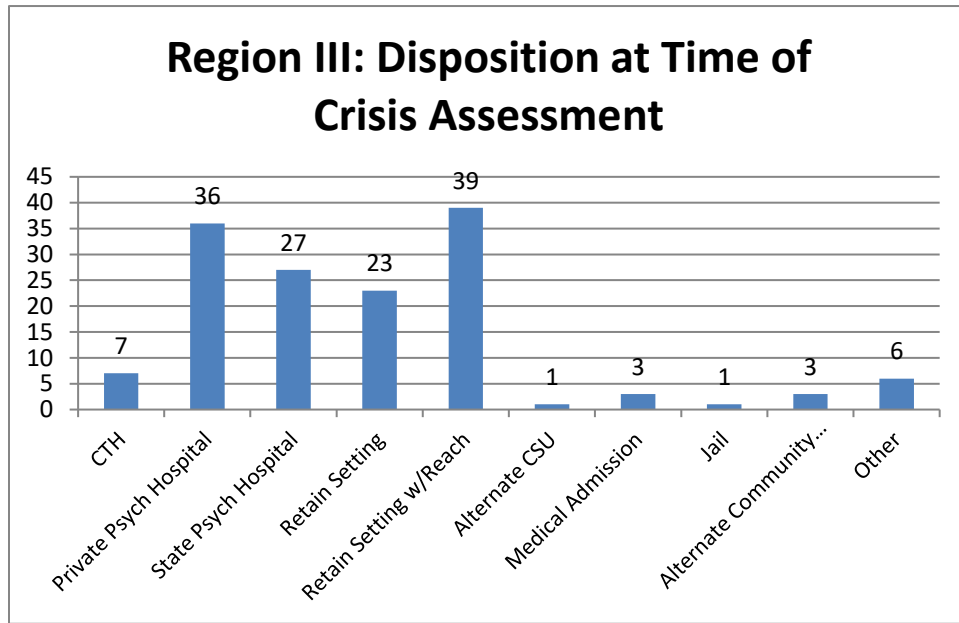
For this quarter, 57% of the individuals receiving a crisis assessment were able to retain their original residential setting, 4% were diverted to a CTH, with another .8% of individuals diverted to an alternate CSU, .5% chose an alternate community setting, and 36% were psychiatrically

hospitalized (22% in private and 14% in state hospitals). The following graphs display the outcomes of the crisis assessments across each regional program.

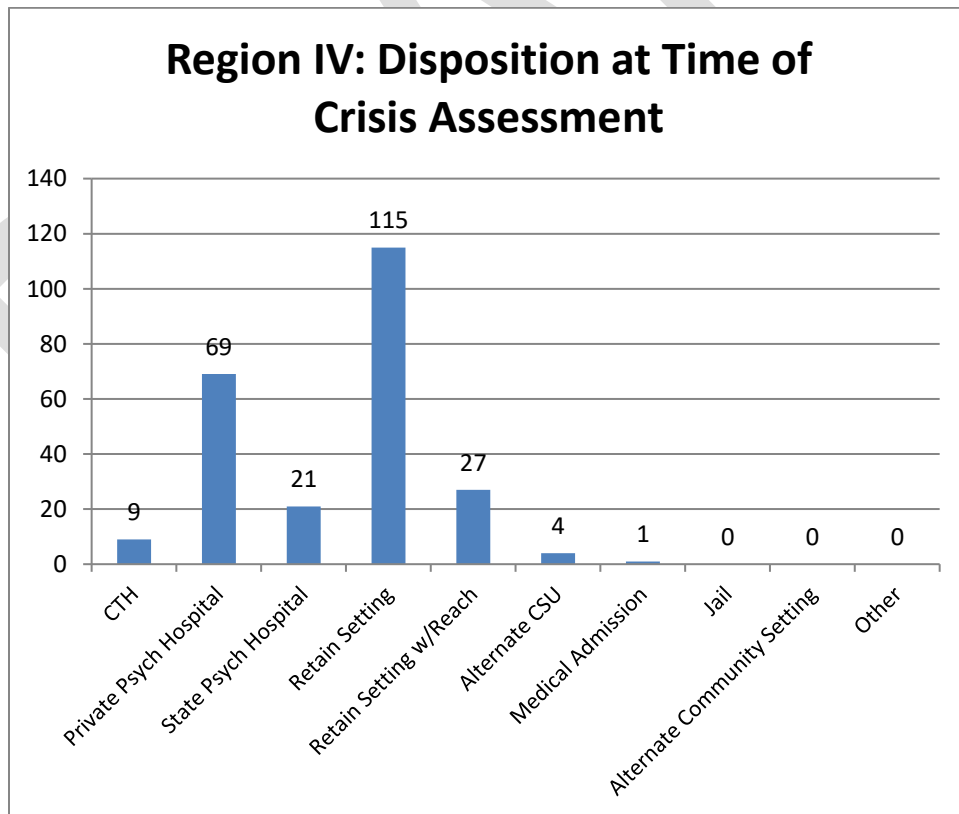


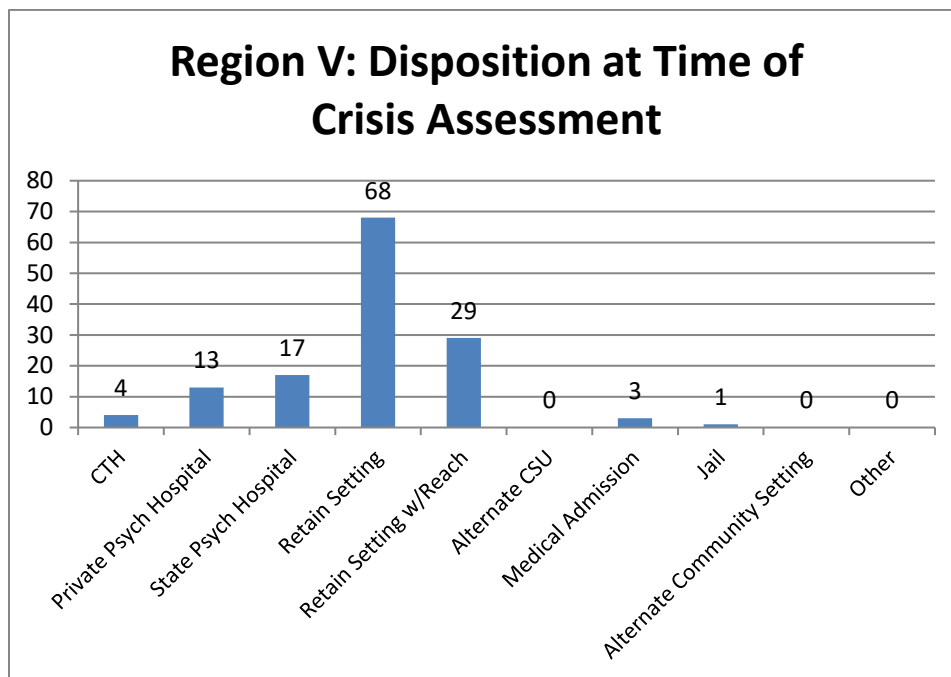
Other: Went to ED after assessment at home.





Other: CTH out of Region, other friend/family, CTAC

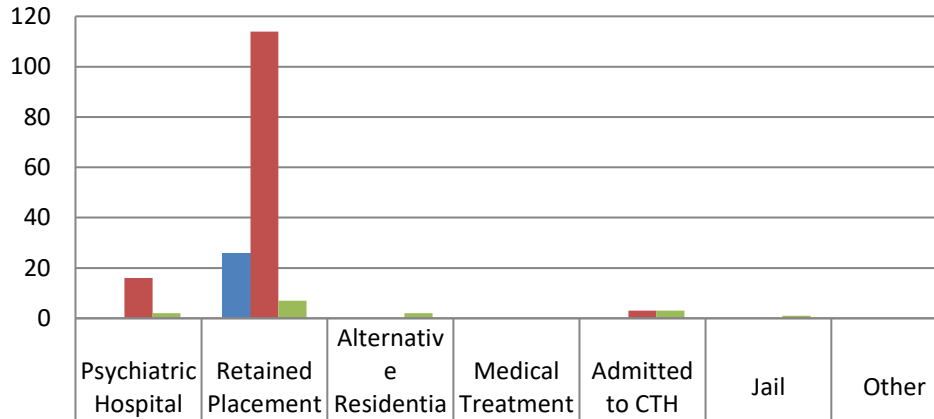




Outcomes that are also of interest are those for individuals that have accessed REACH mobile crisis and mobile prevention services during the quarter in addition to the CTH. Similar to the preceding set of graphs, the following graphs provide a summary of outcome status for adults that accessed ongoing REACH services during the quarter. Of the outcomes for those individuals admitted to the CTH and discharged this quarter and including those admitted previously and discharge, 80% were able to return to their original residence or went to a new residence post discharge. Twelve percent (12%) of outcomes for individuals at the CTH resulted in a psychiatric hospitalization, and the remaining 8% were individuals who had other outcomes (e.g. two people had a medical admission). Eighteen guests remained admitted to all the Regions' CTH at the end of the quarter. For all admissions receiving mobile crisis supports, 90% remained in their residence, 5% were diverted to the CTH, 3% were psychiatrically hospitalized during the course of mobile services, and the remaining 2% had other outcomes. Based on reported data on the outcomes of adults in REACH mobile prevention services, 90% retained their setting or went to an alternative residential community setting, 8% were hospitalized, and 1% were admitted to the CTH and the remaining 1% were comprised of those medically hospitalized, went to jail, or other.

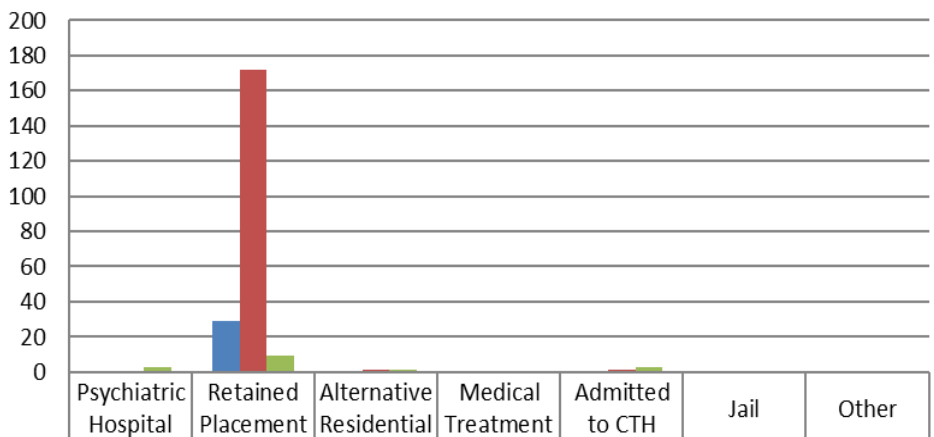
The following graphs display the outcomes of the support services across each regional program. These charts also include outcomes for re-admissions and people carried over and discharged in the quarter.

Region I: Discharge Disposition by Service Type



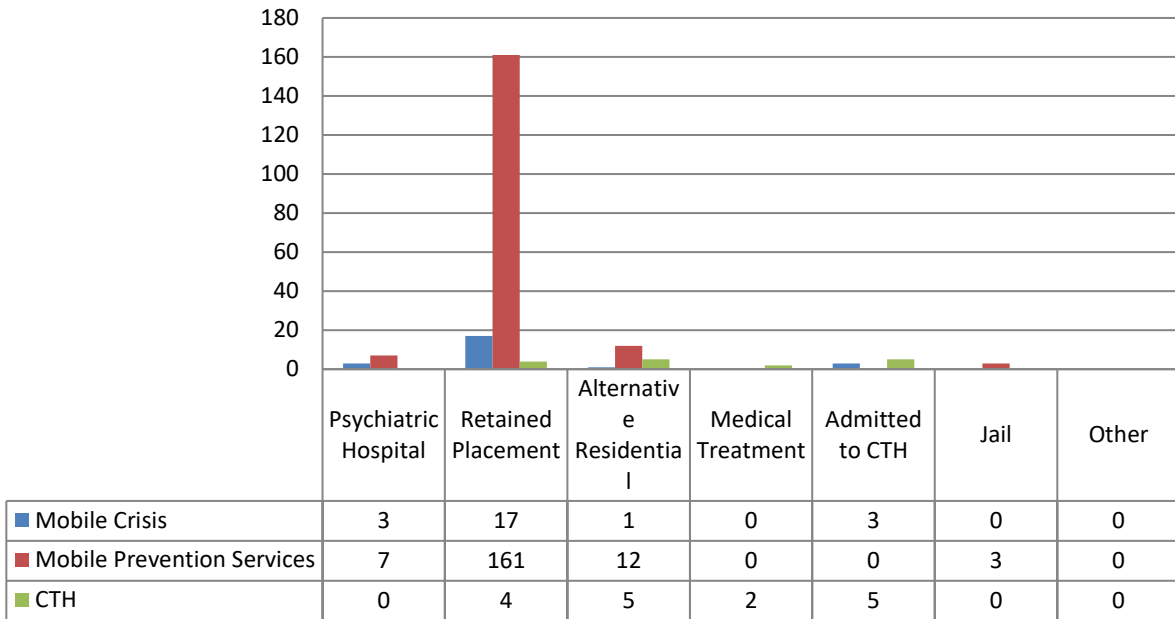
■ Mobile Crisis	0	26	0	0	0	0	0
■ Mobile Prevention Services	16	114	0	0	3	0	0
■ CTH	2	7	2	0	3	1	0

Region II: Discharge Disposition by Service Type

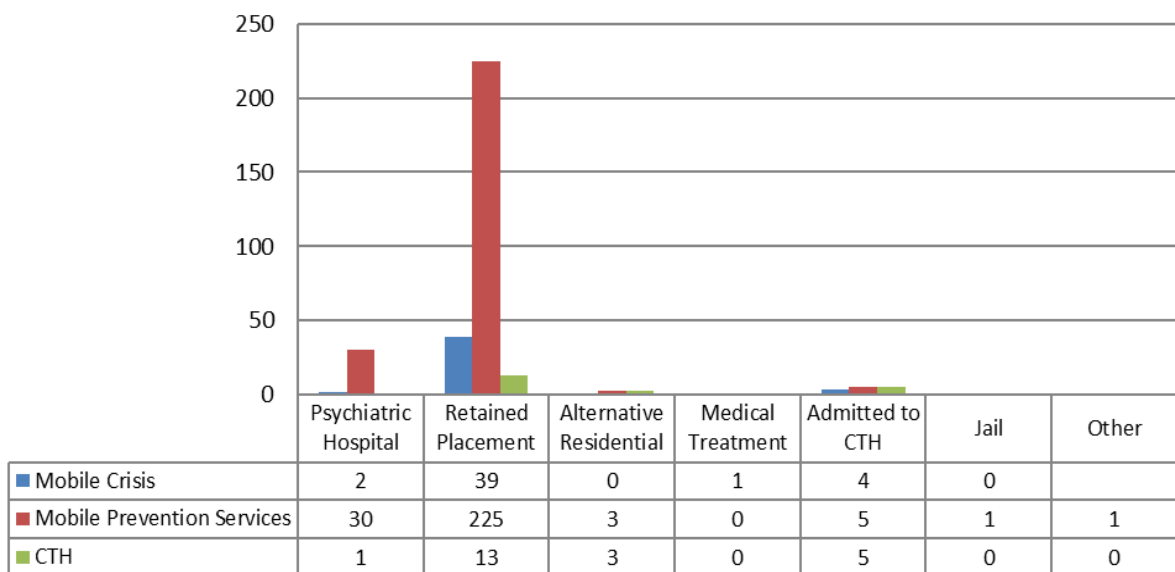


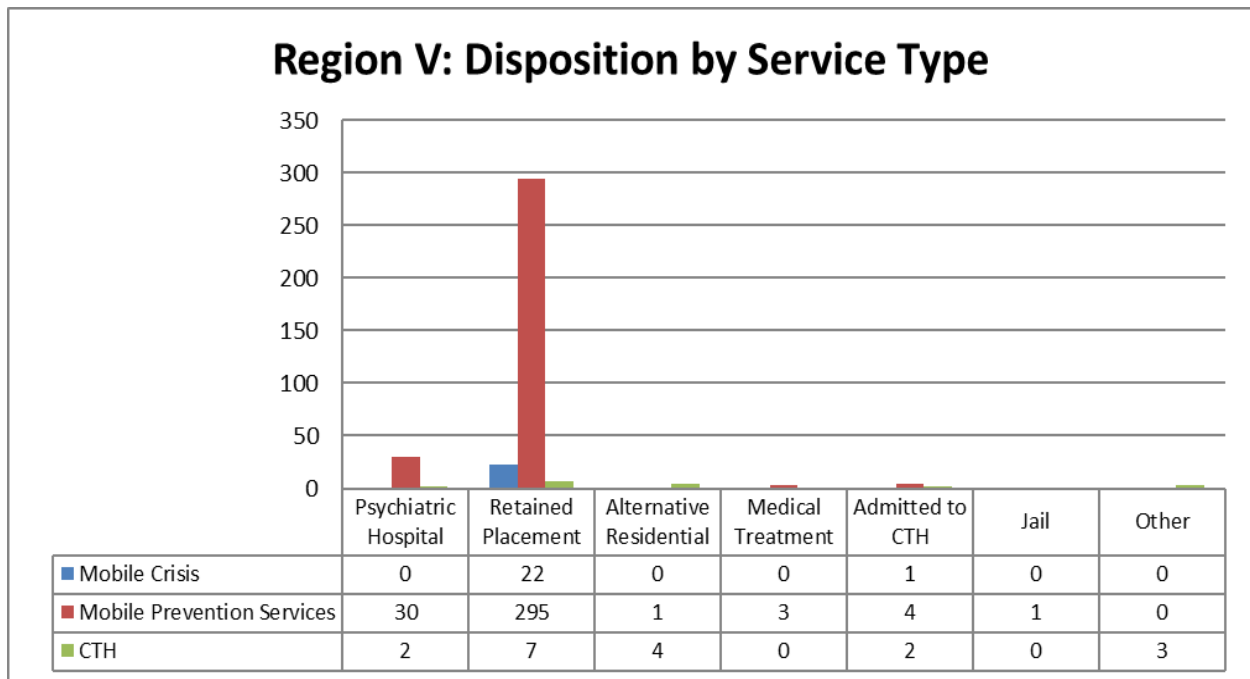
■ Mobile Crisis	0	29	0	0	0	0	0
■ Mobile Prevention Services	0	172	1	0	1	0	0
■ CTH	3	9	1	0	3	0	0

Region III: Discharge Disposition by Service Type



Region IV: Discharge Disposition by Service Type

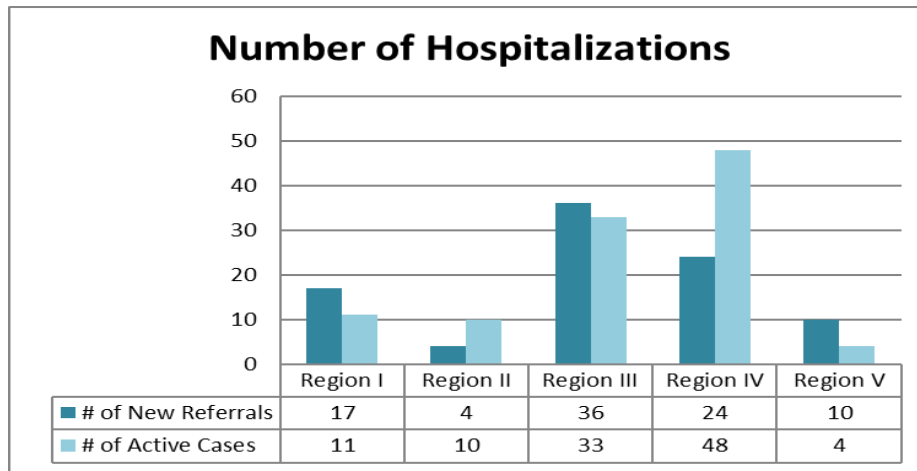




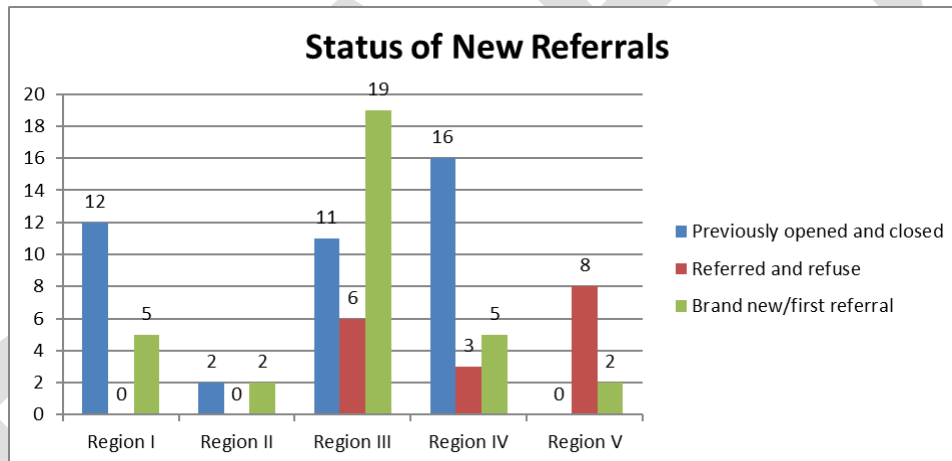
Other: CTH – ATH Admission, left service.

Hospitalizations

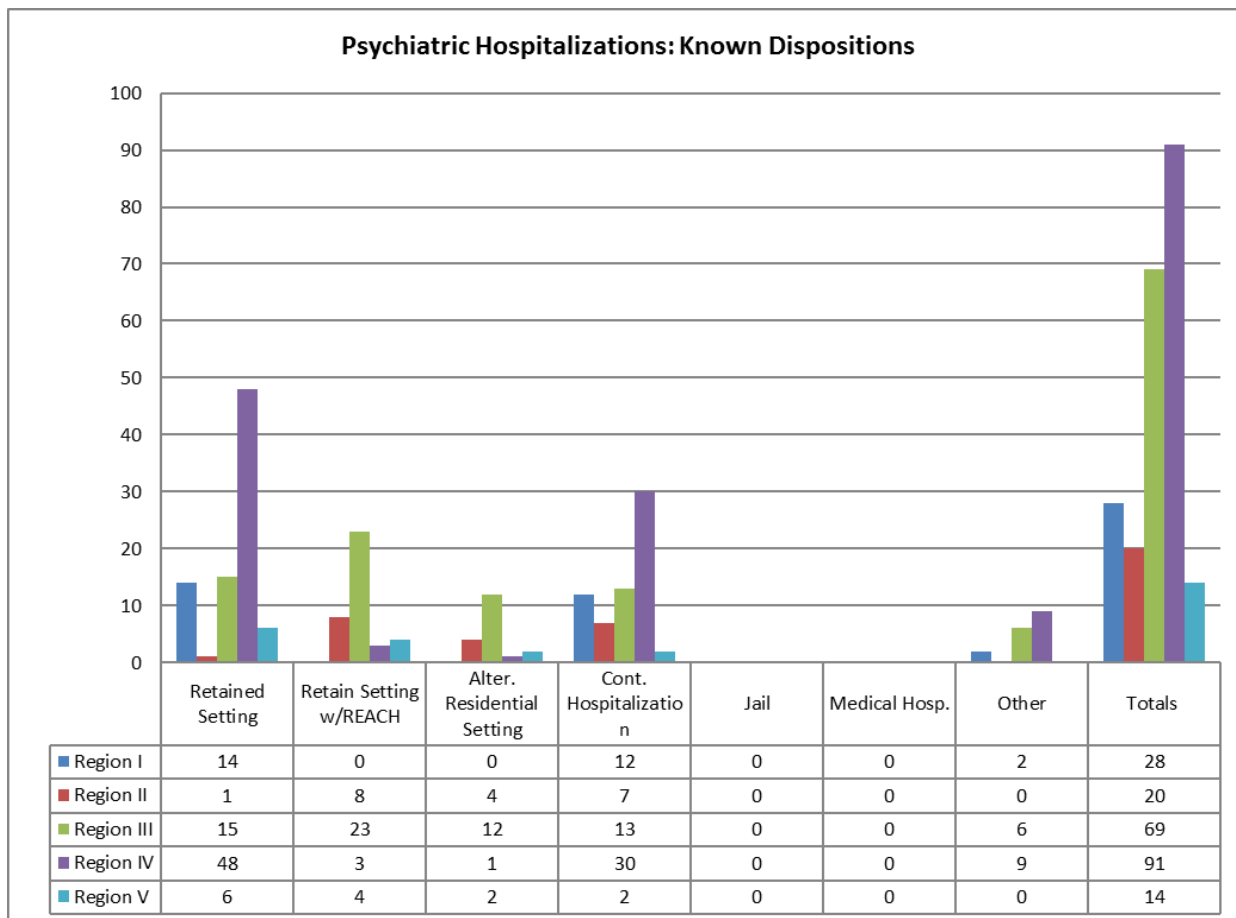
The next graphs provided are intended to supplement the information contained in the larger quarterly report. While the REACH programs remain actively involved with all hospitalized cases *when they are aware of this disposition*, they may not always be apprised that a REACH consumer has been hospitalized or that an individual with DD has entered inpatient treatment as evidenced by the difference in the number of assessments as compared to the number of admissions. While the process of notifying the REACH teams when a prescreening is needed has improved tremendously over the past few years, it remains the case that individuals are sometimes hospitalized without REACH being aware. REACH is active throughout all known psychiatric admissions, including attending commitment hearings, attending treatment team meetings, providing supportive visits, and consultation to the treatment team.



The programs are tracking new referrals according to whether individuals previously received supports through REACH and were closed, were referred but refused follow up services, or were first time referrals.



Forty-six percent (46%) of all hospitalizations were “new referrals” to the REACH program. Of the **new** referrals to REACH that were hospitalized, 36% of the individuals were new to the program, 19% were referred to REACH but refused services, and 45% had been previously discharged (inactive) from REACH services. Of the known dispositions of the people hospitalized and discharged, 77% retained their original community home and 12% went to an alternative community setting. Refer to the chart on the following page for a more detailed breakdown of outcomes.



Includes readmit outcomes. Other: CTH admissions, Unknown, continued hospitalization.

SERVICE ELEMENTS

Each of the five regional REACH programs provides an array of services to individuals enrolled. These services include prevention and education services, assessment services, and consultation services. The REACH staff also provide training to providers/families on the Crisis Education Prevention Plan (CEPP) developed during the guest's stay at the CTH or when receiving mobile crisis services. In some instance the CEPP may not be updated as the plan may be clinically accurate as it may have been recently updated such as in the case of a readmission into service or a transfer of service (mobile to CTH admission) within the quarter. A compliance indicator target has been set related to mobile crisis services of *86% of families and providers will receive training in implementing CEPPs*. Excluding the CEPPs that did not require an update and a subsequent training, the combined REACH programs trained providers/families on 89% of the mobile crisis CEPPs this quarter. Respectively Regions I through V completed the following percentages of the required training for mobile supports: 70%; 95%; 100%; 88%; and 100%. The reasons and related percentage for not completing training this quarter is as follows: 3% ended service; 7% did not

respond to REACH staff communications; and 1% was psychiatrically hospitalized. Region IV completed 3 additional trainings for those individuals who were admitted at the end of quarter 3. Each region makes continuous attempts to schedule training and follow up into the next quarter for those who carry over due to continued admission or admitting late in the quarter.

The tables below summarize the services provided in each of the REACH program components.

Service Type: Crisis Stabilization (CTH)					
Service Type Delivered per Case	Region I	Region II	Region III	Region IV	Region V
Comprehensive Evaluation	6	4	10	10	7
Consultation	6	4	10	10	7
Crisis Education Prevention Plan	6	2	8	9	6
Provider Training	5	0	8	9	3

R1: Training – Not discharged from CTH; R2: CEPPs/Training – 2 ind still admitted CEPP not yet due, 2 CEPPs out of region ind returned to home region training scheduled; R3 – 1 admitted end of qtr, 1 medical hospitalized will complete on discharge; R4:CEPPs and Training – 1 in service only 2 days; R5: CEPP/Training – 3 TDO'd prior to training, 1 CEPP incomplete due to individual leaving treatment.

Service Type Provided: Planned Prevention (CTH)					
Service Type Delivered Per Case	Region I	Region II	Region III	Region IV	Region V
Comprehensive Evaluation	1	6	1	0	3
Consultation	1	6	1	0	3
Crisis Education Prevention Plan	1	5	1	0	3
Provider Training	1	5	1	0	2

R2: Trainings 1 individual remains at CTH CEPP in development not yet due; R5 1 individual training planned

Service Type: Crisis Stepdown (CTH)					
Service Type Delivered per Case	Region I	Region II	Region III	Region IV	Region V
Comprehensive Evaluation	7	3	2	8	3
Consultation	7	3	2	8	3
Crisis Education Prevention Plan	5	3	2	7	3
Provider Training	4	1	2	7	2

R1 training: one not completed due to admit late in quarter, 1 returned to jail, 1 remains admitted training planned at DC; R2: Training 1 ind hospitalized will complete upon discharge, 1 out of region return to home region; R4 – 1 individual left after 1 day; R5 Individual remains admitted to CTH training planned upon dc.

Service Type Provided: Mobile Crisis Support					
Service Type	Region I	Region II	Region III	Region IV	Region V
Comprehensive Evaluation	24	23	18	43	18
Consultation	24	23	18	43	18
Crisis Education Prevention Plan	24	23	17	37	18
Provider Training	16	19	17	37	18

R1: Training – 7 scheduling conflict and 1 moved out of region ; R2 – CEPPs – 1 cancelled, 1 admitted to CTH, and 2 admitted at end of quarter; R3: CEPPs and Training – 1 admitted to CTH after one day; R4: CEPPs and Training: 3 individual separated, 2 individuals hosp., and 1 not due as end of quarter.

REACH Training Activities

In addition to the training REACH programs provide to their staff, REACH continues to expand its role as a training resource for the community of support for those individuals with DD. The REACH programs offered numerous training programs this quarter which enabled 1662 community partners to receive this training.

The table below provides a summary of attendance numbers for various trainings completed by the REACH programs. These trainings target the information needed by professionals in various work settings and are generally tailored to the specific needs of the audience. The training numbers listed in the table is in addition to the training provided to individuals and their respective support system.

Community Training Provided						
Training Activity	Region I	*Region II	*Region III	*Region IV	*Region V	Totals
CIT/Police: #Trained	58	103	1	0	26	188
Case Managers/Support Coordinators	42	109	203	189	10	553
Emergency Service Workers: #Trained	28	34	28	7	0	97
Family Members: #Trained	0	5	0	2	11	18
Hospital Staff: #Trained	0	0	0	0	0	0
DD Provider: #Trained	65	151	71	5	5	297
Other Community Partner: #Trained	155	34	290	29	1	509
Totals	348	436	593	232	53	1662

*Duplicate counts with Children for training in Regions II, III, IV, and V.

Summary

This report provides a summary of data for the regional adult REACH programs for the fourth quarter of fiscal year 2021. In keeping with the DBHDS' vision, all five of the programs continue to focus on mobile crisis and prevention work with adults and outreach with the systems that support these individuals. Additionally, the REACH program management and DBHDS continue to support training to enhance staff clinical skills. The Department's focus on consistency of clinical practice is continuing in addition to the Department's continued work with the programs and related partners to develop consistent processes, training requirements, and documentation across all of the REACH Programs. During the fourth (FY21Q4) quarter the regional programs continue to experience impact due to COVID-19. This impact has been realized through reduction

in access to some in person community settings, family homes, residential providers, medical facilities. REACH programs continue to follow VDH guidelines for health and safety. Positive cases within REACH programs limited admissions during periods of the quarter. A secondary impact the REACH program are attempting to address is the national and statewide shortage of staff for residential and community positions. This shortage resulted in temporary census reductions due to safety of individuals and staff in staffing ratio demands to ensure the needs of high acuity individuals can be met and sustained. The programs have maintained in-person responses as much as possible while maintaining COVID-19 precautions and meeting family/individual's preferences. Telehealth continued to be utilized for crisis calls due to COVID-19 precautions and restrictions during the quarter. The teams have been able to increase CTH census and mobile crisis supports as COVID -19 numbers have fallen in the state. The barriers of staffing continue with programs recruiting for qualified staff.

The Department remains committed to fulfilling its mission to have a continuum of qualified care for adults with developmental disabilities and their families.