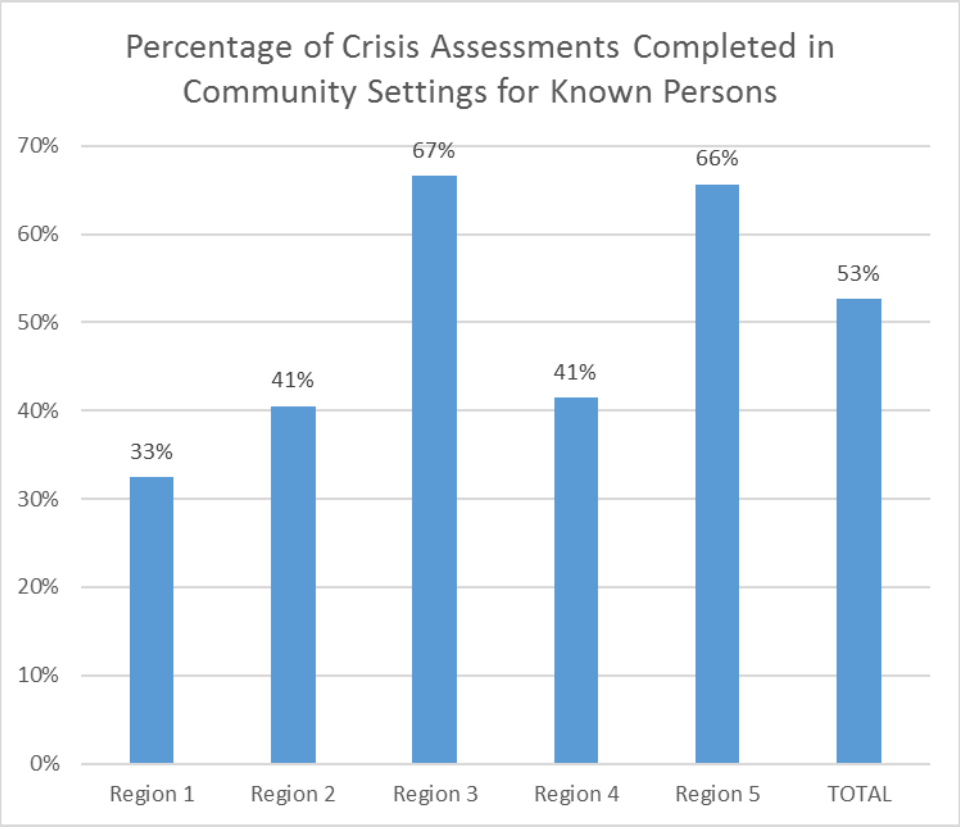
Supplemental Crisis Report: Quarter I-FY21

This report provides supplemental data to the quarterly Adult and Children's REACH Data Summary Reports. The data contained in this report correspond to specific compliance indicators agreed upon between the Commonwealth of Virginia and the United States Department of Justice surrounding crisis services for persons with developmental disabilities in the Commonwealth. The first report of this nature was developed for data collected in and prior to the third quarter of fiscal year 2020 (FY20Q3).

REACH Crisis Assessments in Community Settings

The REACH programs provide crisis assessments to persons with DD that are experiencing a behavioral crisis in various settings. The full array of REACH crisis assessments and their locations is available in both the quarterly Adult and Children's REACH Data Summary Reports. The data provided below speak to the percentage of persons that are known to the system that receive REACH crisis assessments at home, the residential setting, or other community setting, in comparison to crisis assessments completed in emergency rooms/departments or CSB locations. It is most desirable that persons in crisis receive a crisis assessment in the location in which the crisis event occurs, as opposed to being removed from their community setting to be assessed in a different location.



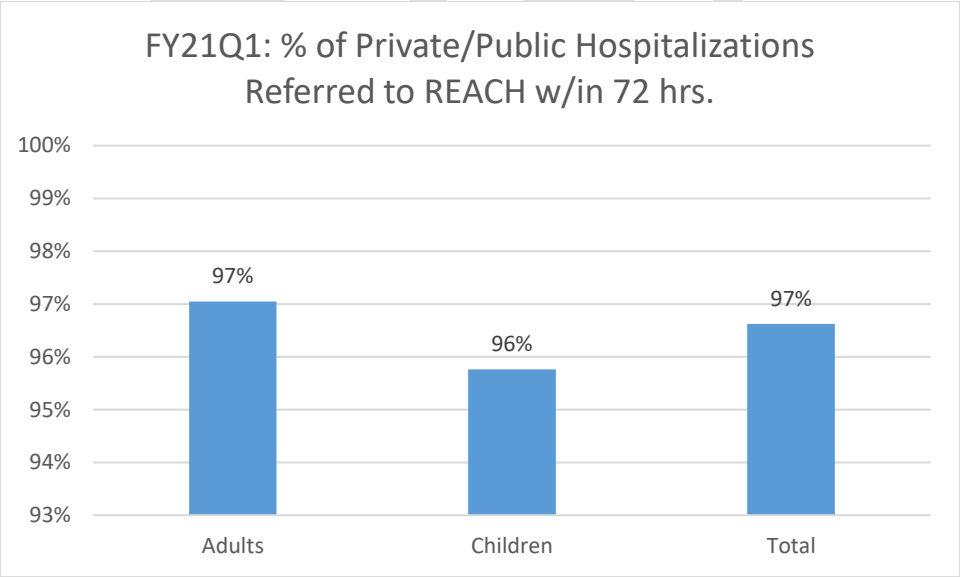
The graph above displays region by region, as well as all regions totaled, the percentage of adults and children combined that are known to the system that received REACH crisis assessments in the home, the residential setting, or other community setting (non-hospital/CSB location). A compliance indicator target has been set of **86% of children and adults who are known to the system will receive REACH crisis assessments at home, the residential setting, or other community setting (non-hospital/CSB location); *filing reference 7.8*.** As displayed above, 53% of persons received REACH crisis assessments

in a community location as opposed to 41% in FY20Q4. This data continues to indicate that the target has not been met for this indicator. These data should not be confused with the crisis assessment data included in the Adult and Children's REACH Data Summary Reports, as those data include all persons receiving a crisis assessment as opposed to just persons known to the system in the previous graphical display.

Hospitalizations

The Commonwealth tracks admissions to state operated psychiatric hospitals, and REACH tracks those to private hospitals as it is made aware. Numerous facets of hospitalization data are analyzed, including but not limited to determining if timely referrals have been made to REACH and examining trends on numbers of persons hospitalized and their associated lengths of stay.

It is critical that persons with a DD diagnosis admitted to psychiatric hospitals are referred promptly to the REACH program. The REACH program can assist hospitals in discharge planning and in offering needed services in the community, such as mobile supports or providing a step down admission to a crisis therapeutic home. The indicator target is that **95% of children and adults admitted to state-operated and private psychiatric hospitals who are known to the CSB will be referred promptly (within 72 hours of admission) to REACH; *filing reference 7.13*.** As displayed below, 97% of adults that were hospitalized during the quarter were referred to REACH within the required 72-hour timeframe; for children, this percentage is 96%. With both populations combined, the percentage is approximately 97% of adults and children known to the CSB that were hospitalized were referred to REACH within 72 hours, which is meeting this compliance indicator. This is the third consecutive quarter that the children's percentage has been at 95% or higher, while this is the first quarter that adults have achieved above 95%.

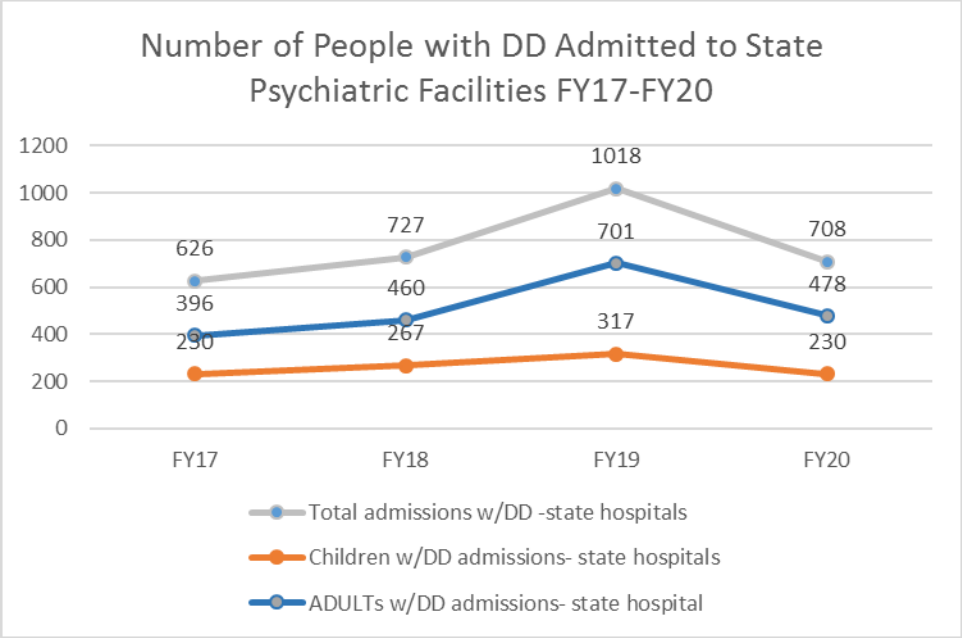


Data on hospitalizations of persons with a developmental disability are examined in several different ways. The Commonwealth has data on persons that are hospitalized in state operated psychiatric facilities such that trends on numbers, average and median length of stays, and percentage of the DD population hospitalized compared to all admissions can be reviewed. There are several compliance indicators surrounding tracking the number of admissions, trends, lengths of stay, and comparisons of DD

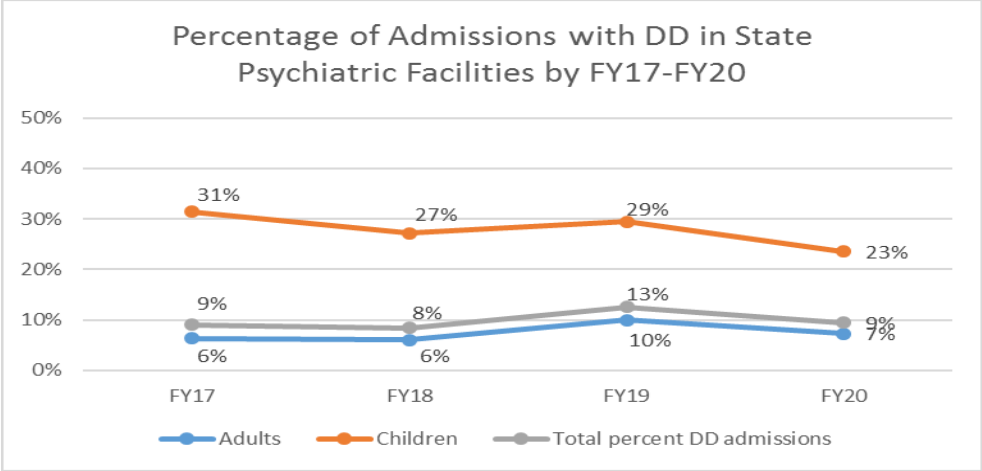
admissions to admissions of the larger, non-DD population. A compliance indicator surrounding hospitalization data requires that **documentation indicates a decreasing trend in the total and percentage of total admissions as compared to population served and lengths of stay of individuals with DD who are admitted to state-operated and known by DBHDS to have been admitted to private psychiatric hospitals; *filing reference 8.6*.** An additional compliance indicator related to the following graphical displays in this "Hospitalizations" section of this report reads as follows (***filing reference 8.7)***:

For individuals with DD who are admitted to state-operated psychiatric hospitals and those known by DBHDS to have been admitted to private psychiatric hospitals, DBHDS will track the lengths of stay in the following categories:
• those previously known to the REACH system and those previously unknown;
• admissions of adults and children with DD to psychiatric hospitals as a percentage of total admissions; and
• median lengths of stay of adults and children with DD in psychiatric hospitals.

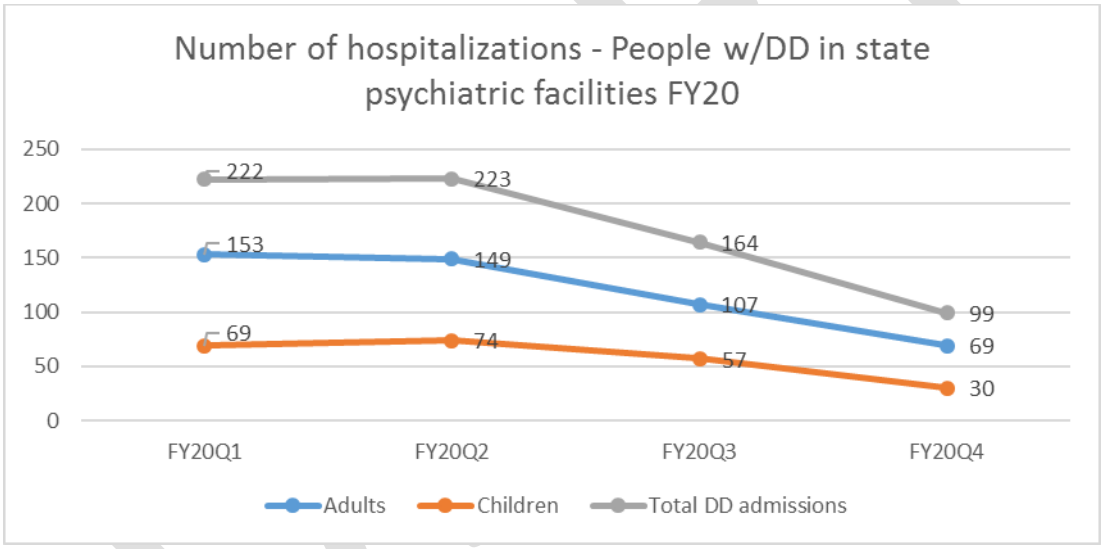
Trend data from fiscal years 2017-2020 on the number of admissions of persons with a developmental disability into a state hospital is available in the graphical display that follows. This is broken down into both age populations (adults and children) and displayed as a total below.



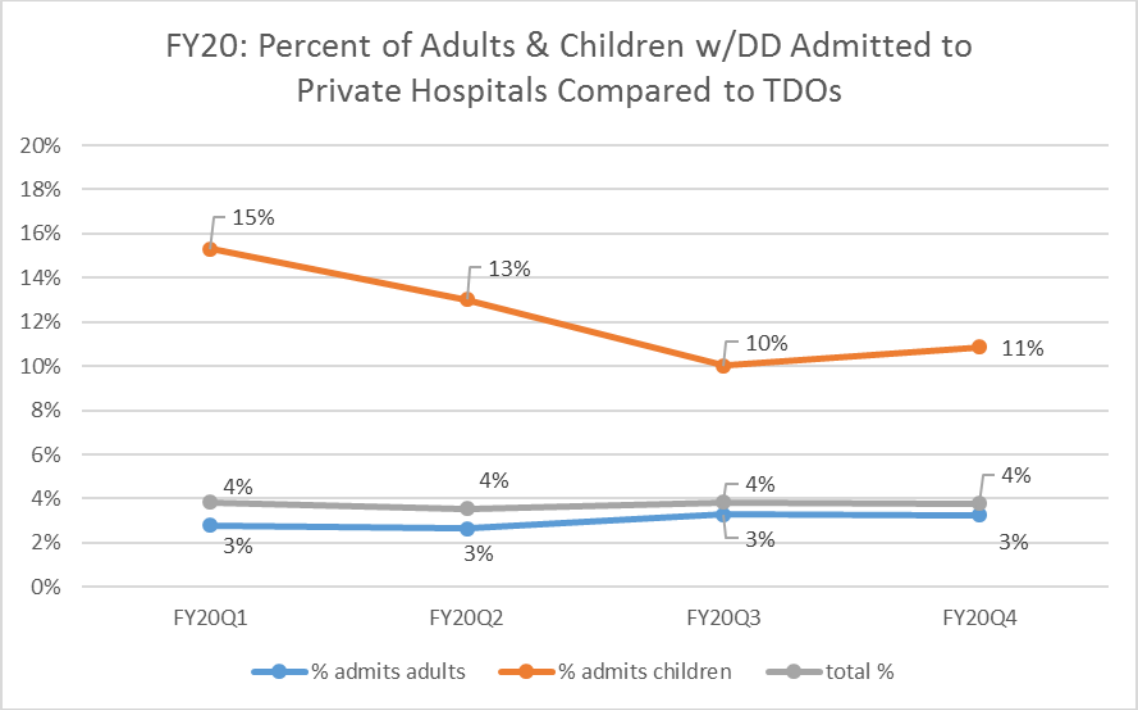
These data are also displayed as a percentage of DD admissions to the entire sum of all individuals that were admitted to a state psychiatric facility in FY17-20 in the graph below.



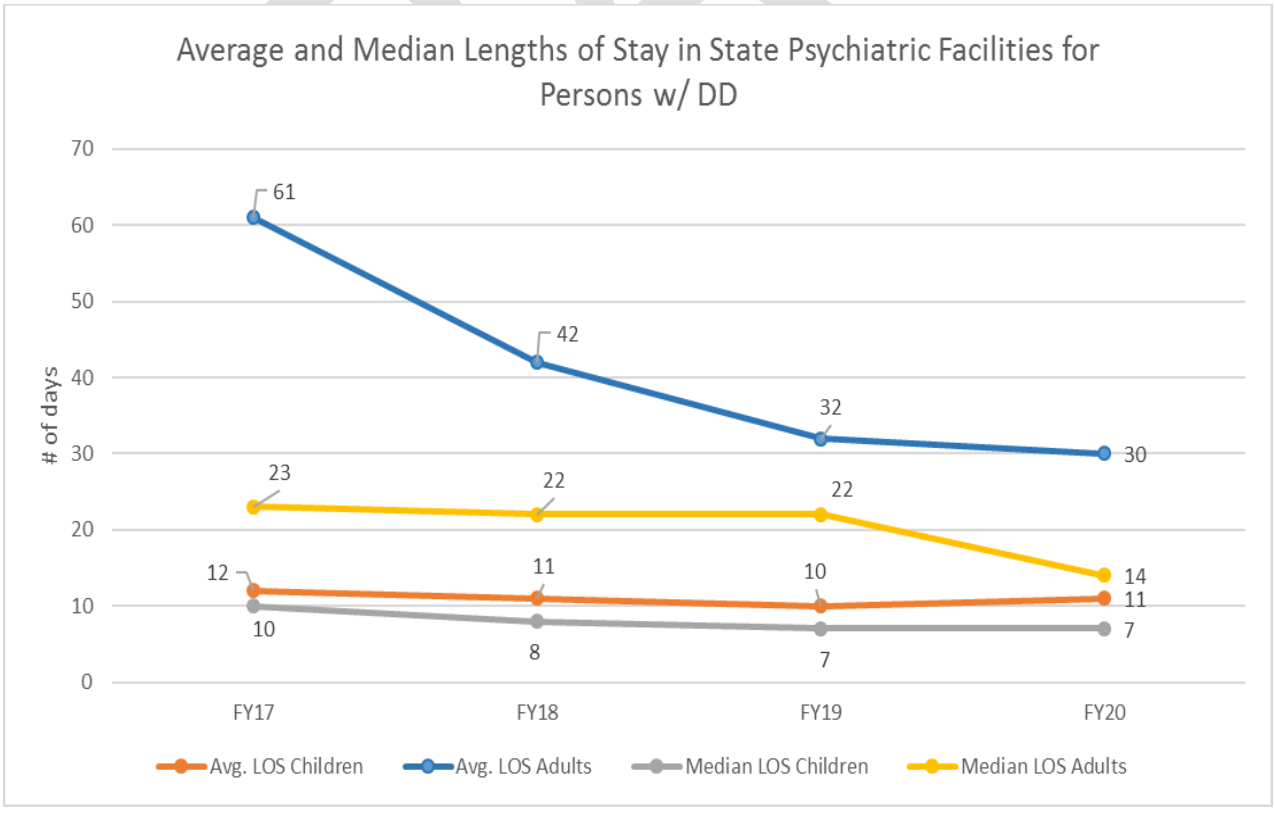
Trend data for quarters 1 through 4 of FY20 on the number of DD hospitalizations for adults and children in state psychiatric facilities are displayed on the graph below.



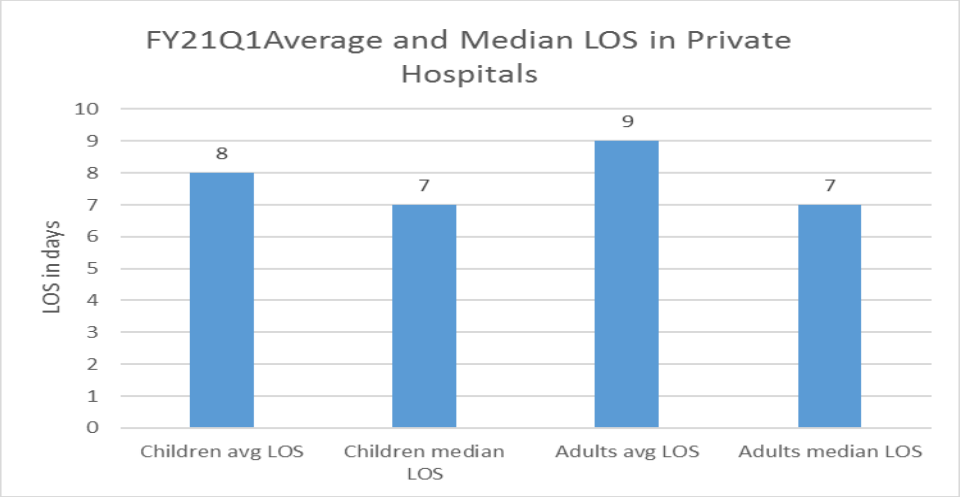
DBDHS is able to provide data on individuals with DD that become known to REACH either through an ES referral or through the private hospital, individual, family member, or other stakeholder referring the individual to REACH. DBHDS also has data available on the number of total Temporary Detention Orders (TDOs) issued each quarter for persons with and without a DD diagnosis. With that noted, individuals can be voluntarily hospitalized in private hospitals that DBHDS and REACH may not become aware of; thus, the data that follows should not be interpreted as including the entire representation of all persons hospitalized in private hospitals. The data on the following page display the percentage of persons with DD that REACH is aware of that are hospitalized in private hospitals compared to private hospitalization TDOs for individuals with DD and without DD (all private hospitalization TDOs).



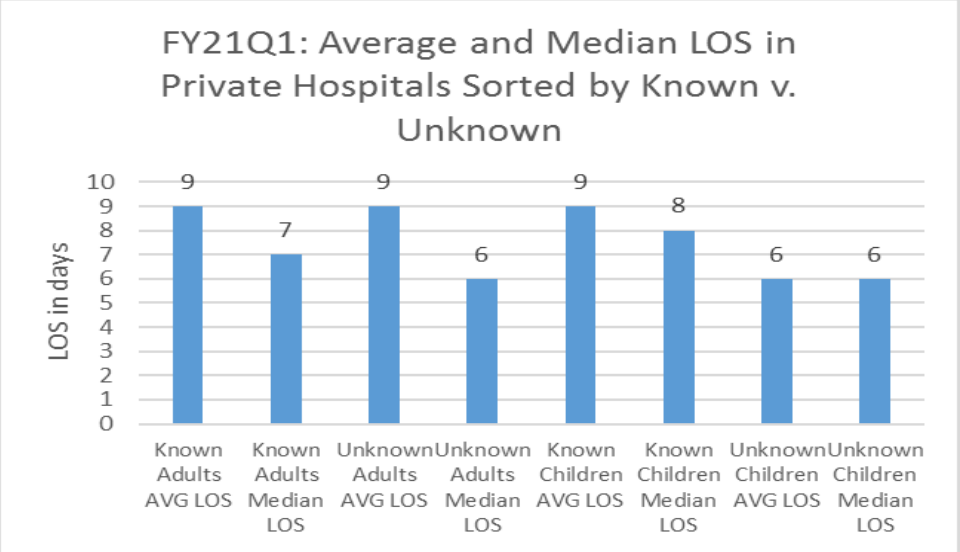
Over the past several fiscal years, the Commonwealth has been tracking information on the average and median lengths of stay for persons admitted to state psychiatric hospitals. The average length of stay and median lengths of stay for both adults and children admitted and discharged in the full fiscal years of FY17-FY20 are displayed below.



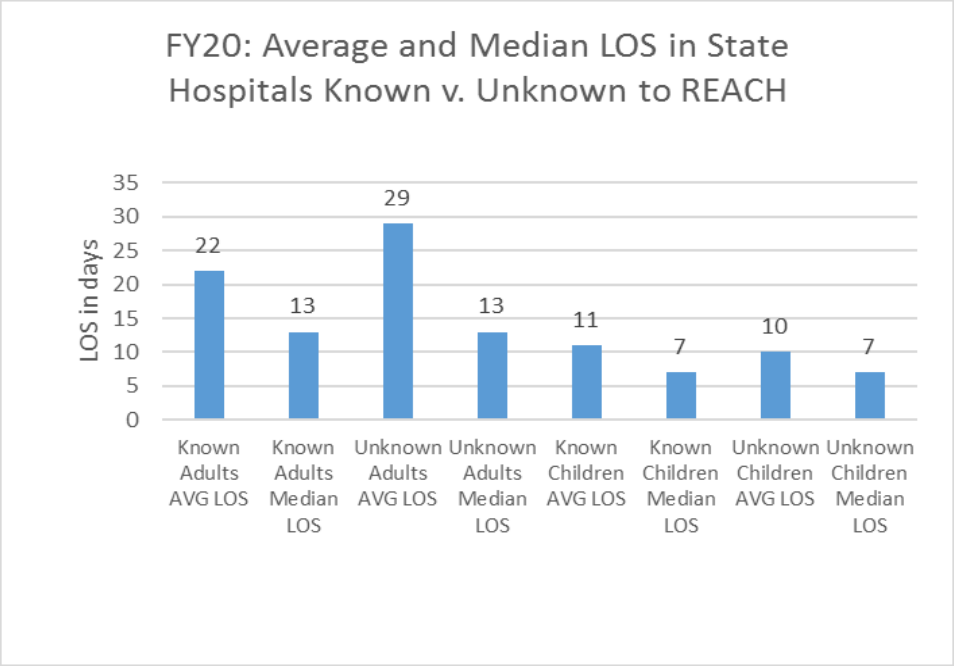
REACH is tracking lengths of stay for persons in a private psychiatric hospital as the REACH programs are made aware of such persons. The median length of stay for both adults and children remain the same in comparing FY20Q3, FY20Q4, and FY21Q1. In comparing the average length of stay from FY20 quarters three and four and FY21 quarter one, the average length of stay was very similar with the adults being 8.6, 9, and 9 days and children 8.5, 8.8 and 8 days, respectively. This information for the current quarter under review is provided below.



REACH is capturing information for hospitalized persons based upon if they are accepting or refusing REACH services surrounding their hospitalization. If the person (or their decision maker, as applicable) accepts REACH services ("known"), REACH can participate in discharge planning and offer mobile supports in the community, or a step down stay at a crisis therapeutic home if indicated. An individual (or their decision maker) may elect to decline REACH services ("unknown") when offered which is outside of the program's control. Length of stay data for private hospitalizations for FY21Q1 are displayed below. In the context of the graphs that follow on average and median lengths of stay, accepting is displayed as "known" and refusing services is displayed as "unknown".

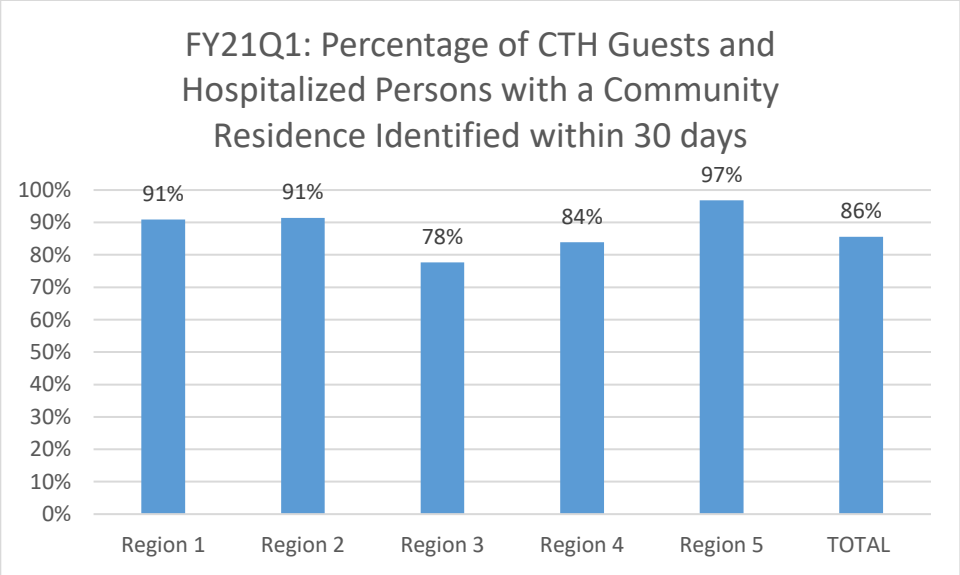


Length of stay data for FY20 are noted below for known versus unknown to REACH persons in state psychiatric facilities.



Identification and Development of Community based Residences

The REACH programs continue to work towards timely and appropriate discharge for persons that are admitted to REACH Crisis Therapeutic Homes (CTH), as well as are partners in discharge planning for persons that accept REACH services while hospitalized. Some individuals become known to the larger public system of developmental services (and REACH) only after they have been hospitalized, or after a hospitalization has been diverted and the person has been admitted to a REACH CTH. For individuals that have never been connected to a CSB and/or to REACH, activating basic services and associated funding stream(s) may take a protracted duration; achieving a discharge timeline of 30 days is highly unusual for persons with such a profile. An indicator has been set outlining that **86% of individuals with a DD waiver and known to the REACH system who are admitted to CTH facilities and psychiatric hospitals will have a community residence identified within 30 days of admission; *filing reference 10.4 (also included in filing reference 11.1)*.** The data on the following page display the percentage of persons admitted with a waiver into a CTH facility, as well as persons admitted into psychiatric hospitals that accepted REACH services, that have a community residence identified within 30 days. The data is calculated within and across all regions.



As demonstrated above, 86% of this group had a community residence identified within 30 days in FY21Q1, which is meeting this indicator for this quarter (as well as being met for the previous quarter, FY20Q4=92%).

In FY18, DBHDS issued a Request for Proposal (RFP) to target the further development of residential providers that can support persons with complicated behavioral needs, as well as persons with co-occurring behavioral health disorders. Via this RFP process, multiple vendors were selected to serve this unique population, which includes persons exiting training centers, persons that have contacted the REACH crisis system, persons that are stepping down from psychiatric hospitalizations, persons in out of state placements, and persons that require complex behavioral/behavioral health services to avoid crisis situations and/or admission to restrictive placements (such as a psychiatric hospital). RFP requirements stipulate person centered and trauma informed care practices, as well as incorporation of appropriate administrative oversight (including nursing, as appropriate, and behavior analysis services). Crisis prevention and stabilization services were also baked-in RFP requirements, as is working in concert with REACH. Based on the population served in these residences, some providers are also incorporating training components through a venerable certification process for individuals with dual diagnoses. There is a related compliance indicator that outlines the following: **DBHDS will increase the number of residential providers with the capacity and competencies to support people with co-occurring conditions using a person-centered/trauma-informed/positive behavioral practices approach to 1) prevent crises and hospitalizations, 2) to provide a permanent home to individuals discharged from CTHs and psychiatric hospitals; *filing reference 10.3*.** As of the date of this report, five homes have been brought online through this RFP process that have been able to open 26 new beds in the Commonwealth to serve this population. The current homes are operational in the northern, western, and eastern regions of the state. At the end of the quarter, 22 of the 26 beds were occupied, with 21 of the 26 beds occupied by individuals who present with significantly complex behavioral needs and/or mental health needs (this is an increase of 1 from the previous reporting period; 1 bed is occupied by an individual that stepped down from CVTC due to closure and does not meet behavior/mental health criteria). There are four remaining beds across two providers to be filled at this time. For the provider offering services in the western part of the state, two beds are targeted to be filled in late October from a state hospital stepdown and a REACH CTH stepdown, and 1 bed is currently vacant with the provider touring individuals (total 3 empty beds for this provider). For the provider offering services in the eastern

region of the state, two persons have been visiting a home on a weekly basis on a transitional status from a state hospital as part of the discharge process (1 empty bed for this provider). This provider has two other homes under or near ready for licensing review that can accommodate the individual that is ready for discharge first, in addition to providing community placement for other persons that fit the target population for these beds. DBHDS continues to work with selected vendors to increase capacity to serve persons with complicated needs and skill repertoires, with progress being made on additional homes being constructed and/or near licensure to accept new residents.

As it relates to resources for individuals that are hospitalized or without disposition at REACH CTHs and need a waiver as a resource for community based services, the emergency waiver slot process remains in use for Community Services Board and Behavioral Health Authorities. There is a compliance indicator which outlines the following: **DBHDS will utilize waiver capacity set aside for emergencies each year to meet the needs of individuals with long term stays in psychiatric hospitals or CTHs; *filing reference 10.2*.** During FY20, 27 out of 68 emergency waiver slots (40%) were provided to support the discharge of people from a psychiatric hospital, REACH CTH, or an Adult Transition Home.

As reported out in the Supplemental Crisis Report from FY20Q4, there were four individuals that had secured a waiver slot near the end of that quarter that had not yet initiated services. The waiver service(s) that those four persons accessed are available in the table below (Table 1).

Table 1: FY20Q4: update on individuals awarded emergency waiver slot to meet needs of individuals discharging from hospital, CTH, or ATH and type of waiver services accessed

Person receiving waiver slot from REACH, ATH, or hospitalization	**Waiver service(s) accessed**
Person 1	Personal assistance, respite services
Person 2	Services not yet initiated
Person 3	In home supports
Person 4	Group home

In FY21Q1, 5 out of 14 emergency waiver slots have been awarded to support persons discharging out of a psychiatric hospital, REACH CTH, or ATH (36%). The waiver services that these individuals have accessed are available in the table below (Table 2).

Table 2: FY21Q1: individuals awarded emergency waiver slot to meet needs of individuals discharging from hospital, CTH, or ATH and type of waiver services accessed

Person receiving waiver slot from REACH, ATH, or hospitalization	**Waiver service(s) accessed**
Person 1	Services not yet initiated
Person 2	Group home
Person 3	Services not yet initiated
Person 4	Group home (ATH)
Person 5	Services not yet initiated

As it relates to avoiding institutionalization for individuals listed as Priority on the waiver waiting list, an associated compliance indicator reads as follows (***filing reference 29.26)***:

The Commonwealth ensures that at least 95% of applicants assigned to Priority 1 of the waiting list are not institutionalized while waiting for services unless the recipient chooses otherwise or enters into a nursing facility for medical rehabilitation or for a stay of 90 days or less. Medical rehabilitation is a non-permanent, prescriber-driven regimen that would afford an individual an opportunity to improve function through the professional supervision and direction of physical, occupational, or speech therapies. Medical rehabilitation is self-limiting and is driven by the progress of the individual in relation to the therapy provided. When no further progress can be documented, individual therapy orders must cease.

During the 4th quarter of FY20, 5 individuals were admitted to an ICF IID. Of these 5 individuals admitted to an ICF IID, none of these individuals were on the priority one waiting list.

Additionally, during the 4th quarter of FY20, there were 87 individuals admitted to private psychiatric hospitals, 7 of whom were on the Priority 1 waitlist. There were 144 individuals admitted to the state psychiatric hospitals, 8 of whom were on the Priority 1 waiting list.

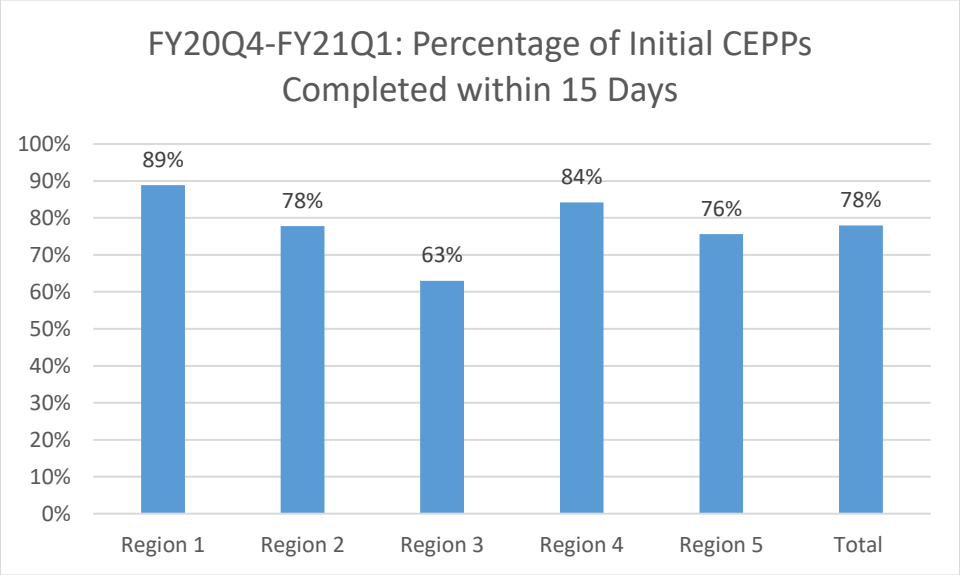
Finally, during the 4th quarter of FY20, there were 3 adults and 0 children admitted to a Nursing facility for long term care, none of whom were on the Priority 1 waiting list.

The total number of people institutionalized from the Priority 1 waiting list was 15. The total number of people on the Priority 1 waiting list as of 6/30/2020 was 3,606. Therefore, DBHDS met the expectation as 99.996% of people on the Priority 1 waiting list were not institutionalized.

Crisis Education and Prevention Plans and REACH Employee Training

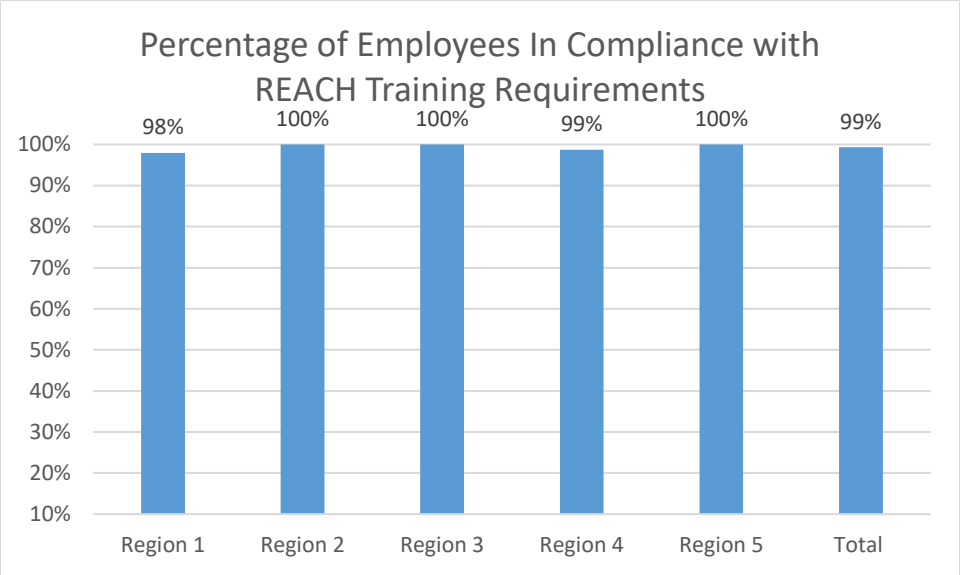
During the course of crisis services, the REACH programs work with the individual and their system of supports to create a Crisis Education and Prevention Plan (CEPP). The CEPP is an individualized, client-specific written document that provides a concise, clear, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist an individual who may be experiencing a behavioral loss of control. The goal of the CEPP is to identify problems that have arisen in the past or are emergent in order to map out strategies that offer tools for the circle of support to assist the individual in addressing and deescalating problems in a healthy way and provide teaching skills that the individual can apply independently. REACH Program Guidelines outline the expectation that an initial CEPP is developed within 15 days of an individual's first full enrollment into the REACH program. The initial CEPP is a working document that provides individualized guidelines for support while additional information is gathered and further interventions and linkages are explored. It should be noted that not every person that accesses REACH services through a call to the REACH hotline, or via mobile crisis supports, will elect to enroll into the program or participate in CEPP development. Additionally, some persons that receive REACH crisis services in the quarter may have had a CEPP created in a previous quarter. A specific compliance indicator related to mobile crisis services has been set which indicates that **86% of initial CEPPs are developed within 15 days of the assessment; *filing reference 8.4*.** The data displayed on the next page offer information on the percentage of CEPPs that were completed within 15 days of full enrollment into the program for individuals enrolled in the quarter under review. These data should not be confused with information that is displayed in table format in the Adult and Child REACH DOJ Quarterly Data Reports that outlines CEPPs completed for mobile supports as those data do not speak to a

specific timeline for completion of a CEPP. The program is shy of the 86% percent requirement, with 78% of initial CEPPs overall completed within the 15 days of mobile crisis enrollments across FY20Q4 and FY21Q1.



REACH Employee Training

All REACH employees that provide any sort of direct or indirect clinical care to persons accessing REACH services are required to complete initial and ongoing employee training requirements. Initial employee training consists of, but is not limited to, completion of required DBHDS competencies, modules and associated competency based assessments on developmental disabilities and related topics, and shadowing/direct observation via seasoned REACH staff. The initial employee training sequence must be completed within 180 days of hire. After the new employee training process, all REACH staff are also required to contact a minimum of 12 hours of continuing education on topics that are pertinent to their ongoing professional development (e.g. developmental disabilities, person centered thinking, behavioral health disorders, positive behavior support, etc.). The graph on the following page displays the percentage of REACH staff region by region, as well as the total, that are in compliance with either new or ongoing training requirements. A specific target indicator has been established that **86% of REACH staff will meet training requirements;** ***filing reference 8.3.*** These data are a representation of employee training compliance from FY20Q4 to FY21Q1 and include both new and veteran REACH employees; data indicate that 99% of REACH employees are meeting training requirements.



Assessing Risk for Crisis/Hospitalization

To foster proactive and preventative referrals to the REACH program, DBHDS initiated the Crisis Risk Assessment Tool (CAT) in FY21Q1. This tool, and associated training, are currently being utilized throughout CSBs/BHA in the Commonwealth. There are several compliance indicators related to the establishment of a "risk of hospitalization" for the DD population, referring to REACH, requirements of training for CSB personnel, and associated provision(s) in the Performance Contract between DBHDS and the CSBs/BHA.

Three compliance indicators are directly linked to language in the Performance Contract. The language of these is as follows:

- **DBHDS will add a provision to the CSB Performance Contract requiring CSBs to identify children and adults who are at risk for crisis through a screening at intake, and if the individual is identified as at risk for crisis needs, refer the individual to REACH to ensure that when needed the initial crisis assessments are conducted in the home; *filing reference 7.2*.**
- **DBHDS will add a provision to the CSB Performance Contract requiring, for individuals who receive ongoing case management, the CSB case manager to assess an individual's risk for crisis during face to face visits and refer to REACH when a need is identified; *filing reference 7.3*.**
- **DBHDS will add a provision to the CSB Performance Contract requiring training on identifying risk of crisis for case managers and intake workers within 6 months of hire; *filing reference 7.6*.**

DBHDS has provided evidence of provisions speaking to these three indicators to the DOJ Expert Reviewer for Crisis Services separate from this report.

Another compliance indicator relates to criteria for the CSBs to determine "risk of hospitalization". The language of this compliance indicator is as follows:

- **DHBDS will establish criteria for use by CSBs to determine "risk of hospitalization" as the basis for making requests for crisis risk assessments; *filing reference 7.4*.**

DBHDS established the Crisis Risk Assessment Tool in consultation with CSB personnel, and also sought out and received feedback on the draft of the tool from the DOJ Expert Reviewer for Crisis Services in May 2020. Feedback from the Expert Reviewer was incorporated directly into the tool and/or the associated training. The Crisis Risk Assessment Tool serves as the vehicle for making a request of REACH to review the individual for enrollment into REACH services.

The following compliance indicator speaks directly to training for CSB personnel on identifying risk for going into crisis for adults and youth:
DBHDS will ensure that all CSB Executive Directors, Developmental Disability Directors, case management supervisors, and case managers receive training on how to identify children and adults receiving active case management who are at risk for going into crisis. Training will also be made available to intake workers at CSBs on how to identify children and adults presenting for intake who are at risk for going into crisis and how to arrange for crisis risk assessments to occur in the home or link them to REACH crisis services; *filing reference 7.5*.

A web-based training on the Crisis Risk Assessment Tool was made available to all target CSB staff through the Commonwealth of Virginia's Learning Center (COVLC) on July 1, 2020. As of October 1, 2020, 2552 individuals have completed this training through the COVLC. This includes 2427 CSB/BHA staff, with training occurring in all CSBs/BHA across the Commonwealth. The additional 125 trainees beyond the CSB/BHA staff include staff from private case management organizations in Virginia, DBHDS sister agencies (e.g. DMAS), local governments, and private providers that have requested enrollment in the training.

Based on year end reporting that CSBs/BHA provided to DBHDS at the conclusion of FY20, there were 719 DD case management/support coordination personnel and 1253 behavioral health case management/support coordination personnel (total 1972). Additionally, each CSB/BHA has 1 Executive Director (40 total) and 1 Developmental Disability Director (40 total). In sum, the target number of listed staff to receive this training (consisting of CSB Executive Directors, Developmental Disability Directors, and case management personnel) was 2052 CSB/BHA. As noted in the previous paragraph, as of 10/1/2020 there were 2427 CSB/BHA staff that have completed training on the Crisis Risk Assessment Tool, which exceeds the 2052 targeted staff required to complete this training (e.g. CSB Executive Directors, Developmental Disability Directors, and case management personnel). Training has also been made available to intake workers at CSBs which likely accounts for the additional 375 CSB/BHA personnel that have completed this training, in addition to position turnover.

Summary

This is the third supplemental quarterly report on specific indicators agreed upon between the Commonwealth and the US Department of Justice surrounding crisis services for persons with developmental disabilities in the Commonwealth. The content of the report will continue to be refined in additional quarters as processes are solidified and associated data become available surrounding additional compliance indicators on crisis services for the DD population. Data will continue to be utilized to guide decision making to meet the overarching goal of Virginians with a developmental

disability that contact the crisis system receiving timely and effective services in the least restrictive setting possible.

ADDENDUM

In the 16th report to the Court, the Independent Reviewer requested several pieces of data through recommendations, of which several DBHDS is able to provide. The data on these recommendations are included below, with the time periods which the data encompasses being noted for each data request. The table on the following page outlines the IR's recommendation, supporting data provided by DBHDS, and the time period that the data reflect for each recommendation.

Table 3: Data on IR requests from 16th review period on crisis services

IR's recommendation	Supporting Data	Time period that data reflect
The number of individuals with IDD who were diverted to stay at a CTH instead of an admission to a psychiatric hospital;	There were 28 individuals admitted as crisis stabilization admissions to CTHs during FY21Q1 for adults; there were 13 individuals admitted as a crisis stabilization admission to CTHs for youth. Total 41 individuals.	July 1, 2020 – September 30, 2020
The number of individuals with IDD who were not diverted to a CTH when a CTH stay would have been appropriate, and were instead admitted to a psychiatric hospital;	There were not any individuals that were not diverted to a CTH stay when one would have been appropriate.	July 1, 2020 – September 30, 2020
The number of individuals with IDD who were discharged by their residential services provider around the same general time of their crises and were either admitted to a CTH or to a psychiatric hospital;	There were 44 hospitalized individuals that REACH is aware of that were discharged by their residential services provider around the same general time of their crisis; there were 10 individuals that were discharged by their residential services provider around the same general time of their crisis that had a stay at a REACH CTH. Total 54 individuals.	July 1, 2020 – September 30, 2020
The number of individuals with IDD in State hospitals who were ready for discharge, but were designated to have "no willing provider" available to deliver community-based residential services;	There were 9 individuals with I/DD in state hospitals that were noted as discharge ready but designated to have "no willing provider".	As of 8/31/2020

The lengths of stays of individuals with IDD in State hospitals who were ready for discharge but who had "no willing provider;" and	The length of stay (LOS) for each person is provided below, as of 8/31/2020. LOS is based on the date the individual was indicated to be "discharge ready". An asterisk (*) indicates the person has not yet discharged as of 8/31/2020. Person 1 LOS = 113 days Person 2 LOS = 180 days* Person 3 LOS = 173 days* Person 4 LOS = 33 days* Person 5 LOS = 49 days* Person 6 LOS = 242 days* Person 7 LOS = 189 days* Person 8 LOS = 606 days* Person 9 LOS = 41 days*	As of 8/31/2020
The utilization data and analysis being maintained by DBHDS for "forever" homes.	Data and analysis are provided earlier in this report; see pages 8-9	Data and analysis cover the entire period of FY21Q1