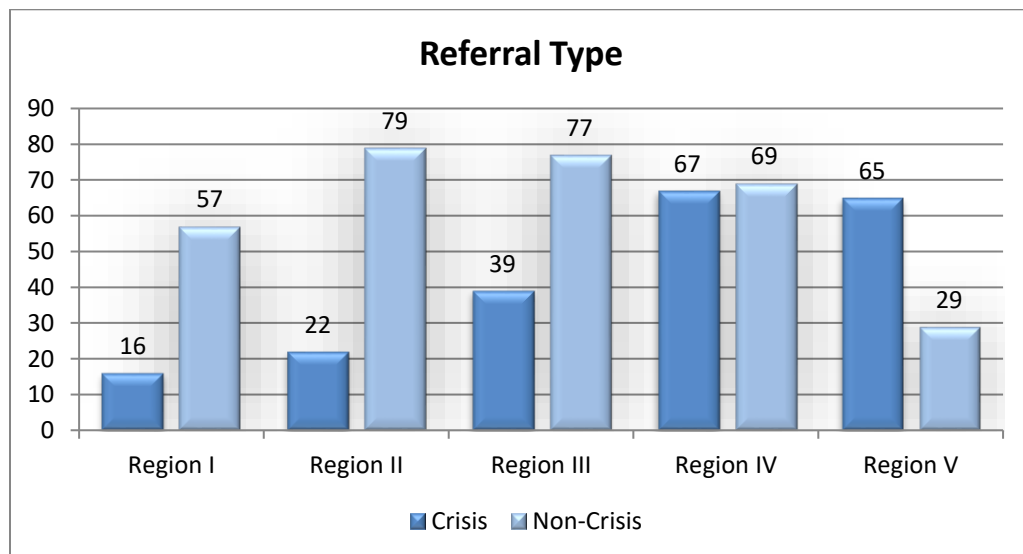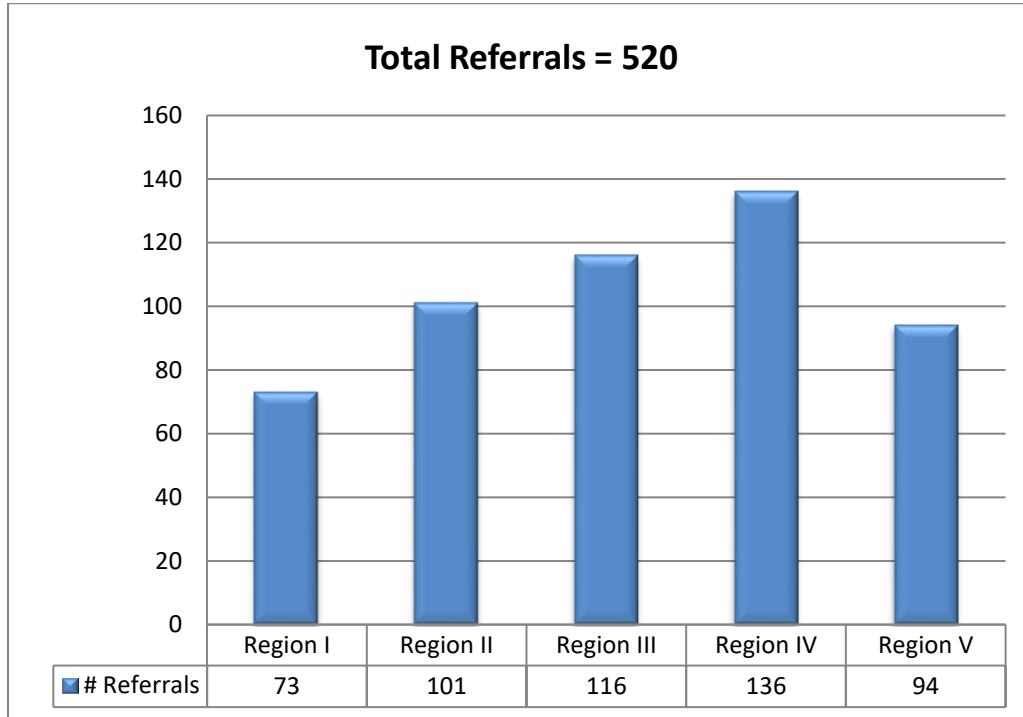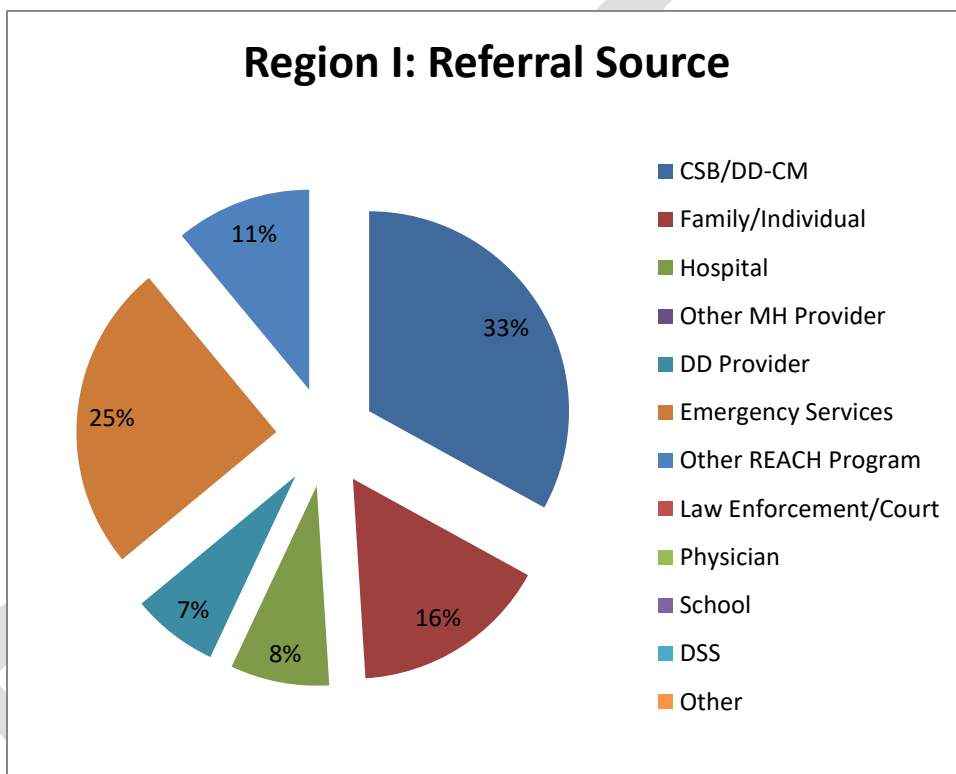# REACH Data Summary Report-Adult: Q1/FY22

This report provides data summarizing the referral activity, service provision, and residential outcomes for adults served by the REACH programs during the first quarter of fiscal year 2022.

REACH Referral Activity

Total Referrals = 520

	Region I	Region II	Region III	Region IV	Region V
# Referrals	73	101	116	136	94

Referral Type

Crisis / Non-Crisis values by region:
- Region I: 16 / 57
- Region II: 22 / 79
- Region III: 39 / 77
- Region IV: 67 / 69
- Region V: 65 / 29
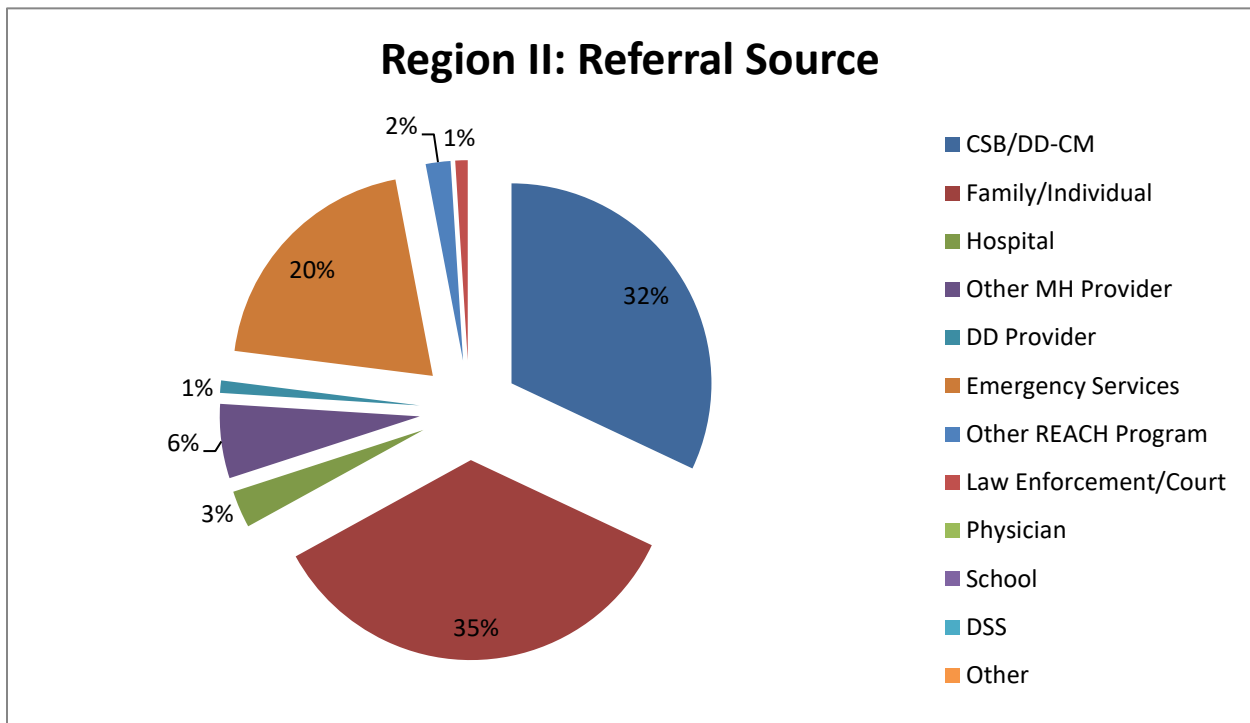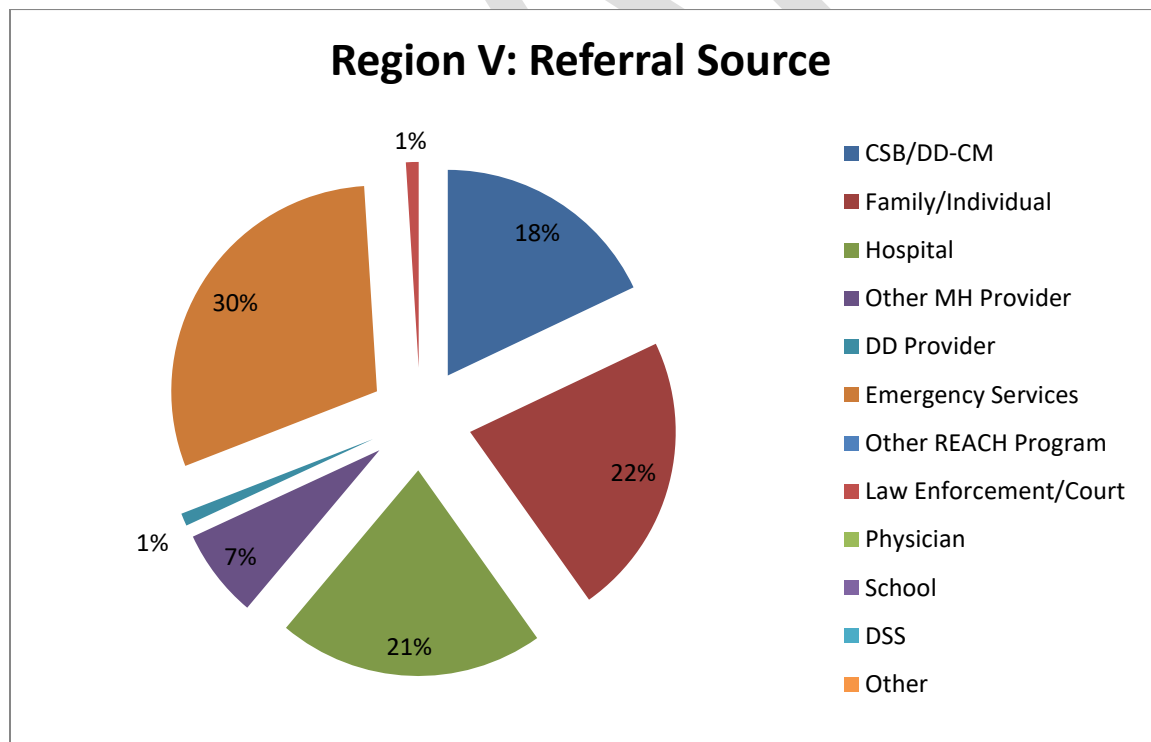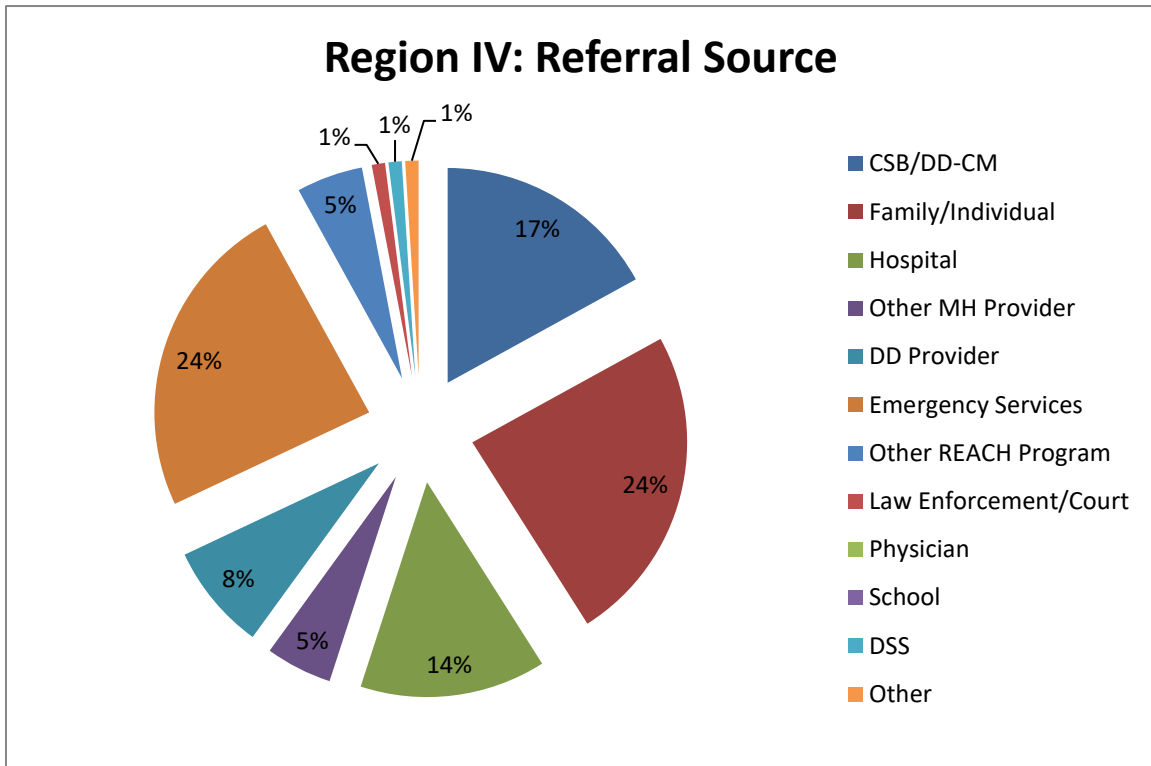
For FY22 first quarter, an increase was noted in total referrals as compared to FY21 quarter four, 506 to 520. The data regarding the breakdown of types of referrals for Regions I through IV denote more non-crisis referrals than crisis referrals; whereas Region V has more crisis referrals. This trend 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.

Region I: Referral Source

- CSB/DD-CM — 33%
- Family/Individual — 16%
- Hospital — 8%
- Other MH Provider
- DD Provider — 7%
- Emergency Services — 25%
- Other REACH Program — 11%
- Law Enforcement/Court
- Physician
- School
- DSS
- Other

Region II: Referral Source

Legend
CSB/DD-CM
Family/Individual
Hospital
Other MH Provider
DD Provider
Emergency Services
Other REACH Program
Law Enforcement/Court
Physician
School
DSS
Other

Region II values: 2%, 1%, 20%, 32%, 1%, 6%, 3%, 35%

Region III: Referral Source

Legend
CSB/DD-CM
Family/Individual
Hospital
Other MH Provider
DD Provider
Emergency Services
Other REACH Program
Law Enforcement/Court
Physician
School
DSS
Other

Region III values: 2%, 36%, 32%, 10%, 4%, 5%, 11%

Region IV: Referral Source

- CSB/DD-CM
- Family/Individual
- Hospital
- Other MH Provider
- DD Provider
- Emergency Services
- Other REACH Program
- Law Enforcement/Court
- Physician
- School
- DSS
- Other

Region V: Referral Source

- CSB/DD-CM
- Family/Individual
- Hospital
- Other MH Provider
- DD Provider
- Emergency Services
- Other REACH Program
- Law Enforcement/Court
- Physician
- School
- DSS
- Other

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	62	87	102	115	81	447
Weekends/Holidays	11	14	14	21	13	73
7am - 2:59pm	45	60	69	52	43	269
3pm - 10:59pm	26	36	35	68	39	204
11pm - 6:59am	2	5	12	16	12	47

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, RII 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	30	21	72	65	47	235
DD only	30	43	32	47	30	182
ID/DD	13	35	10	20	15	93
Unknown/None	0	2	2	4	2	10
Total	73	101	116	136	94	**520**

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 first quarter of FY22 with suicidal ideation as the third most common reason for referral. Aggressive behavior includes physical aggression and verbal threats.

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

Presenting Problems

	Region I	Region II	Region III	Region IV	Region V	Total
Aggression	27	30	29	39	43	168
Self-Injury	3	3	7	3	4	20
Family Needs Assistance	4	17	5	23	6	55
Suicidal Ideation/behavior	5	8	39	30	18	100
Increased MH symptoms	29	34	25	33	21	142
Loss of functioning	0	0	3	1	1	5
Property Destruction	0	0	2	0	0	2
Risk of housing loss	3	2	2	0	0	7
Elopement	1	2	1	3	0	7
Hospital stepdown	0	5	1	4	1	11
Other	1	0	2	0	0	3
	73	101	116	136	94	520

Other: Increased in homicidal ideations, law enforcement involvement. Individual returning to the area.

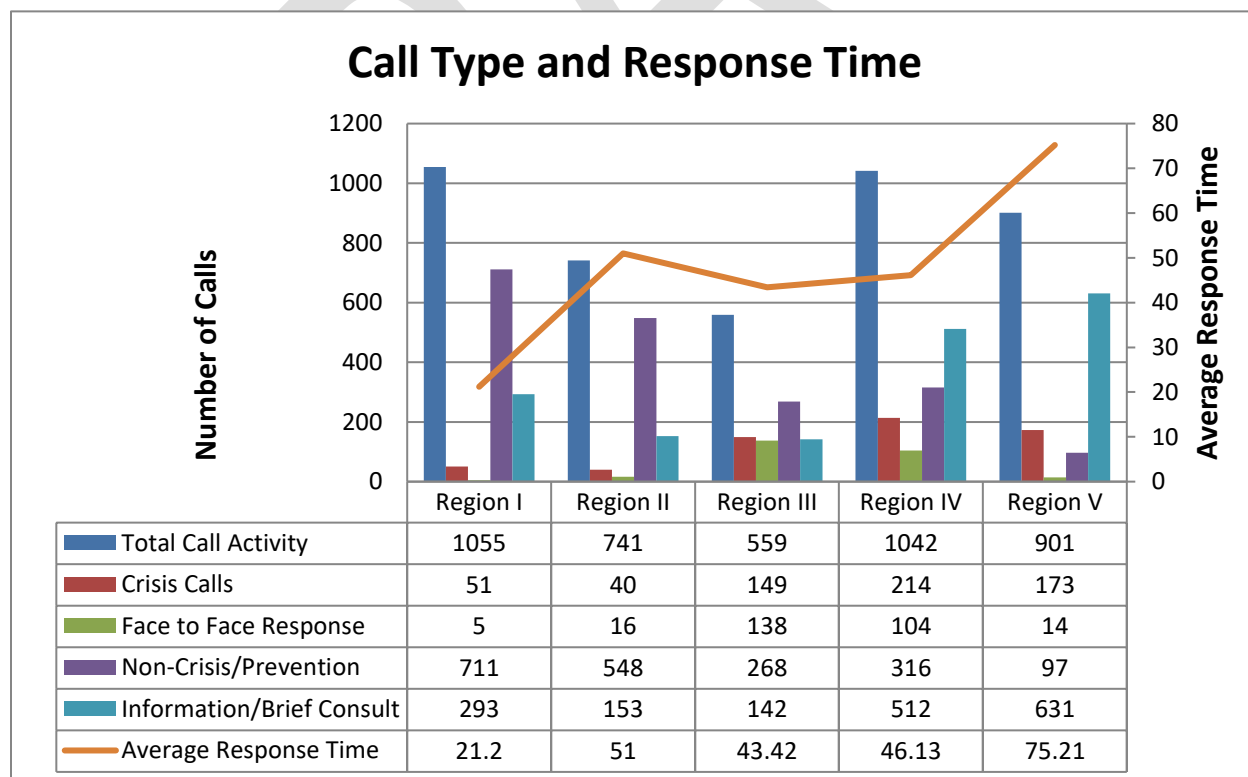**Number of Presenting Problems by Type**
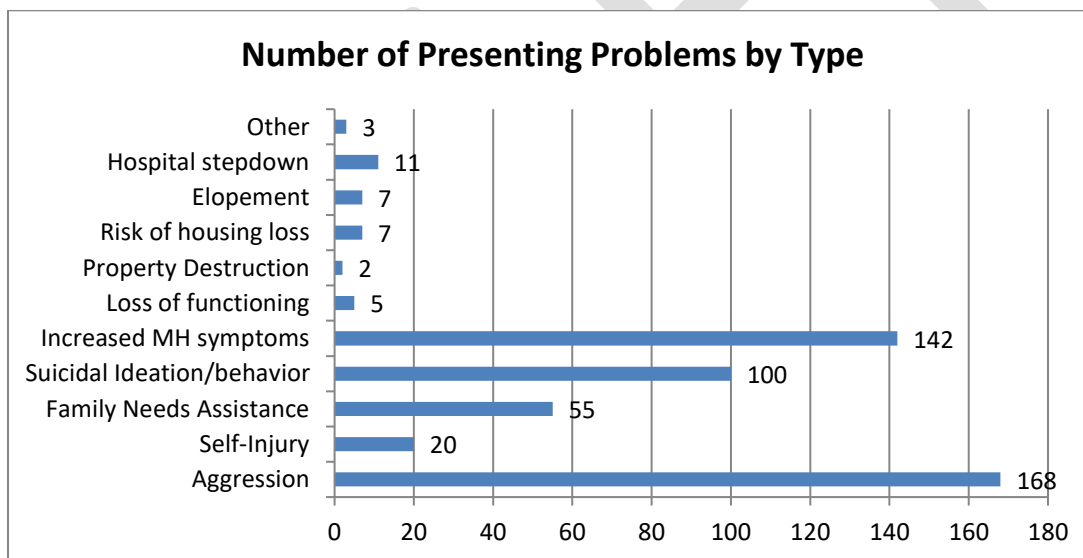
REACH Crisis Response

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.

Call Type and Response Time

	Region I	Region II	Region III	Region IV	Region V
Total Call Activity	1055	741	559	1042	901
Crisis Calls	51	40	149	214	173
Face to Face Response	5	16	138	104	14
Non-Crisis/Prevention	711	548	268	316	97
Information/Brief Consult	293	153	142	512	631
Average Response Time	21.2	51	43.42	46.13	75.21

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 4,015 during the fourth quarter of FY21 to 4,298 in the first quarter of FY22.   Crisis call activity decreased slightly from 631 calls in the fourth quarter to 627 call in the first quarter FY22. The respective regions experienced the following face to face response to calls during the first quarter of FY22: RI 10%, RII 40%, RIII 93%, RIV 49%, RV 8%. All five regions met expectations as denoted in the REACH Program Standards regarding average time to respond to the scene of the crisis event for those responded to face to face. 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 100% of the in-person response while Region II met 88%. Region III met 99%, Region IV met 96%, and Region V met 100% 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.

Response Time

|	Region I	Region II	Region III	Region IV	Region V	Total Calls
Response Interval: 0 - 30	5	4	69	13	1	92
Response Interval: 31 - 60	0	10	36	87	3	136
Response Interval: 61 - 90	0	1	20	4	4	29
Response Interval: 91 -120	0	1	11	0	6	18
Response Interval: 120+	0	0	2	0	0	2
Total	5	16	138	104	14	277

Traffic and receiving multiple calls at same time indicated for 120+

Location of Crisis Assessments

Assessment Location	Region I	Region II	Region III	Region IV	Region V	Total
Individual Home/Family Home	2	11	22	31	50	116
Hospital/Emergency Room	43	9	88	133	70	343
Emergency Services/CSB	2	16	6	1	28	53
Residential Provider	4	2	31	40	24	101
Police Station	0	1	0	1	0	2
Day Program	0	0	1	0	0	1
School	0	1	0	0	0	1
Other	0	0	1	8	1	10
Total	51	40	149	214	173	627

Other response settings include police station, community location, parking lot, 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 first quarter of FY22. 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 denotes where the individual was located when the assessment occurred. During the first quarter of FY22 the number of individuals assessed in family homes increased from 91 to 116, emergency room assessments increased from the last quarter from 297 to 343 in the first quarter. Assessment locations in an emergency services/CSB increased from 45 to 53, and residential provider location increased from 100 to 101 individuals assessed in the first quarter. The data denotes that in the first quarter of FY22 45% of all assessments occurred outside of a hospital emergency departments. he data denotes a decrease in law enforcement presence for first quarter as compared to the previous quarter, 39% to 34%.
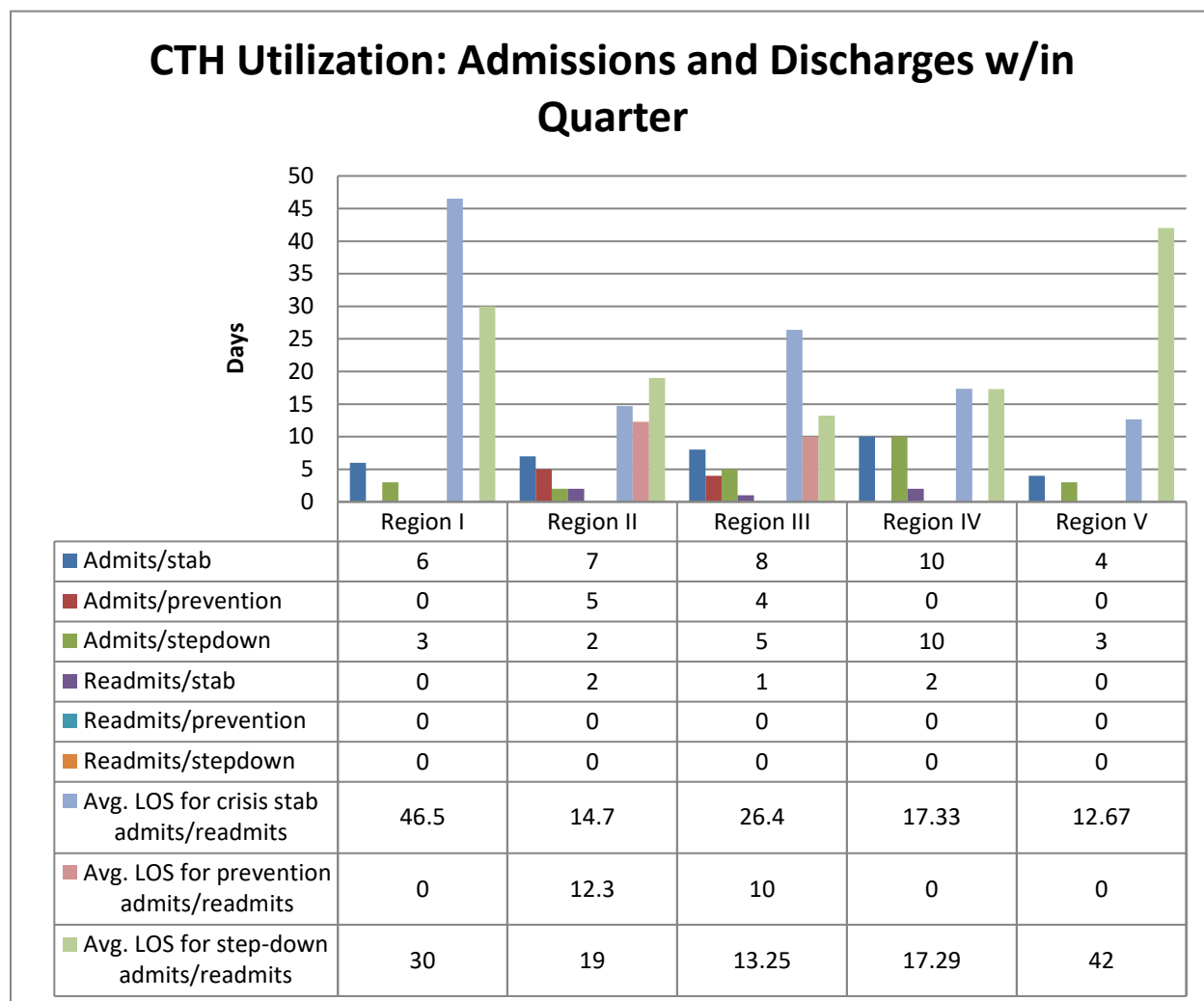
Crisis Call Involving Law Enforcement
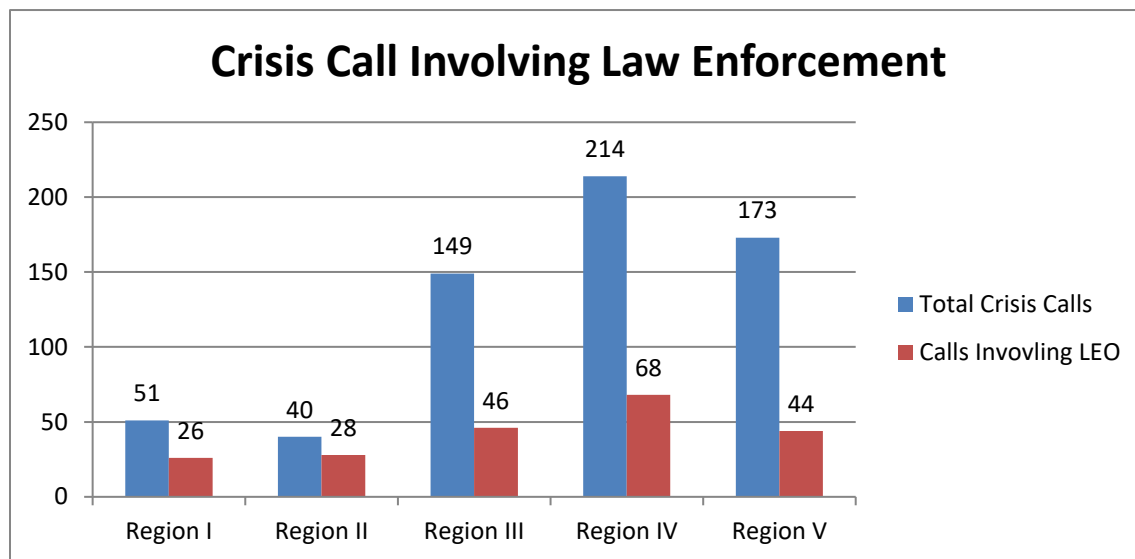
Crisis Therapeutic House

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 the first quarter admissions/readmissions across all Regional programs. During the first quarter, there were 35 crisis stabilization admissions, 9 prevention admissions, and 23 step-down admissions reflecting the same number of step down admissions in the fourth quarter of FY21 (23). Both crisis and prevention admissions saw a slight decrease. During the review period five crisis
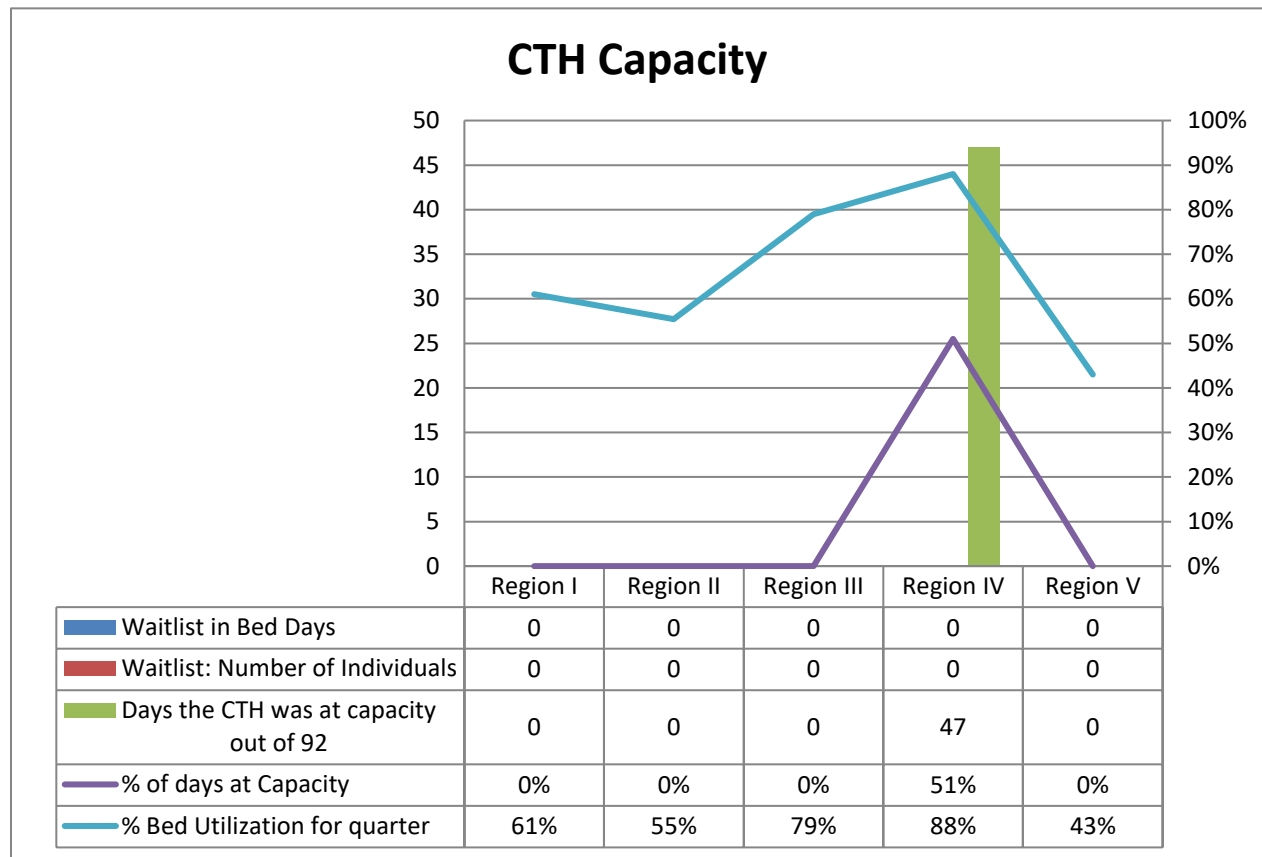
stabilization cases were readmitted, while no prevention or step down admissions readmitted during the first quarter.

CTH Utilization: Admissions and Discharges w/in Quarter

	Region I	Region II	Region III	Region IV	Region V
Admits/stab	6	7	8	10	4
Admits/prevention	0	5	4	0	0
Admits/stepdown	3	2	5	10	3
Readmits/stab	0	2	1	2	0
Readmits/prevention	0	0	0	0	0
Readmits/stepdown	0	0	0	0	0
Avg. LOS for crisis stab admits/readmits	46.5	14.7	26.4	17.33	12.67
Avg. LOS for prevention admits/readmits	0	12.3	10	0	0
Avg. LOS for step-down admits/readmits	30	19	13.25	17.29	42

The average length of stay reflected for each type of admission on the previous chart reflects that Region 11, 11I and IV are within the expected average length of stay with the exception of R1 and R5 at 46.5 and 42 days respectively. 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: 11 crisis stabilization admissions with LOS ranging from 13 to 155 days, 5 step-down admissions with LOS ranging from 18 to 64 days, and 2 prevention stays with 22 and 106 day stays respectively. 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.

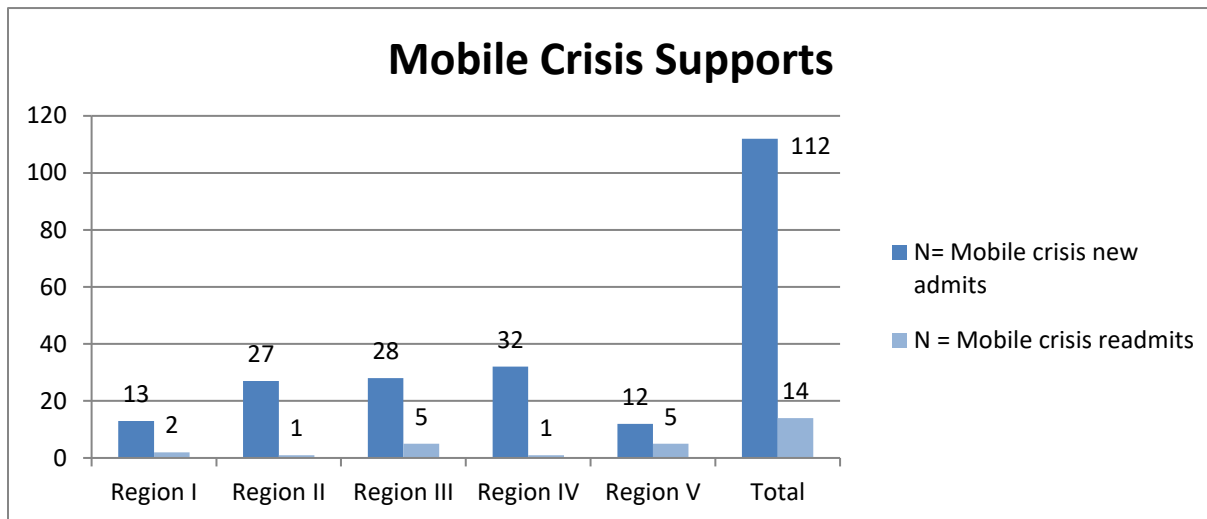| LOS: Individuals Admitted Previously and Discharged w/in Quarter			
Region	*Individual*	*Type of Admission*	*Total LOS (days)*
Region I	Person I	Step down	64
	Person 2	Crisis Stab	118
	Person 3	Crisis Stab	34
Region II	Person1	Crisis Stab	30
	Person 2	Crisis Stab	44
	Person 3	Prevention	22
Region III	Person 1	Step down	35
	Person 2	Crisis Stab	57
	Person 3	Crisis Stab	94
	Person 4	Crisis Stab	155
	Person 5	Crisis Stab	23
Region IV	Person 1	Crisis Stab	23
	Person 2	Crisis Stab	13
	Person 3	Crisis Stab	22
	Person 4	Step down	51
	Person 5	Step down	18
Region V	Person 1	Prevention	106
	Person 2	Step down	61

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 43% to 88% during the first quarter. As a result of COVID-19 and staffing impacted by COVID, admissions were interrupted in all Crisis Therapeutic homes' (CTH). Occupancy this quarter in Regions I though V for bed utilization was 61%, 55%, 79%, 88% and 43%, respectively. 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.
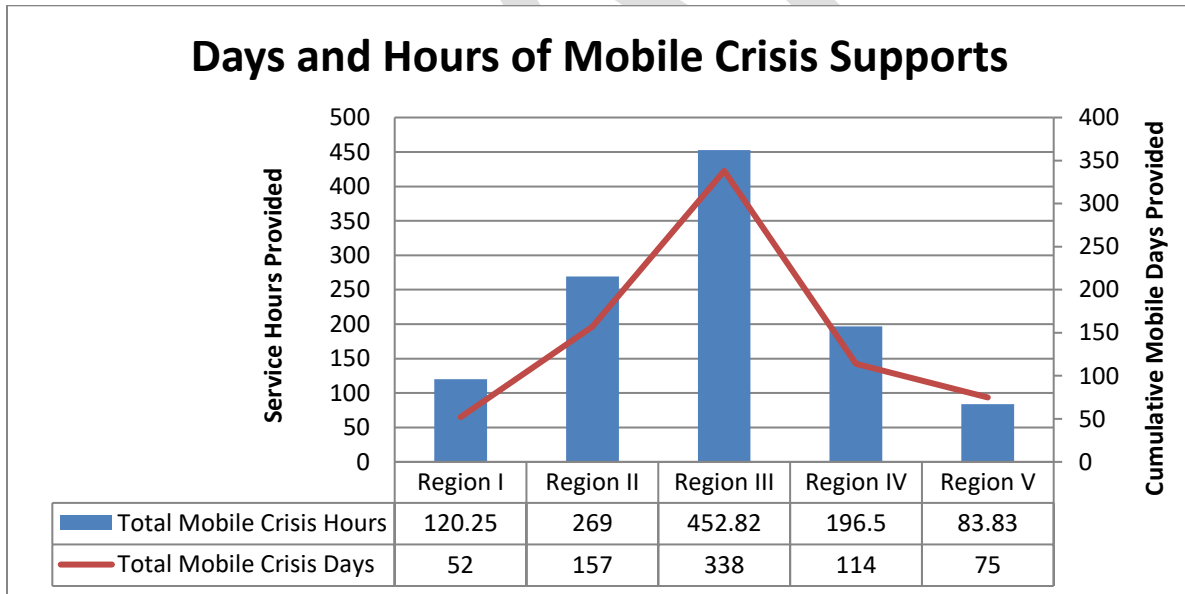
CTH Capacity

	Region I	Region II	Region III	Region IV	Region V
Waitlist in Bed Days	0	0	0	0	0
Waitlist: Number of Individuals	0	0	0	0	0
Days the CTH was at capacity out of 92	0	0	0	47	0
% of days at Capacity	0%	0%	0%	51%	0%
% Bed Utilization for quarter	61%	55%	79%	88%	43%

Beds Used Out of 552 Beds Available:	335	306	434	486	236

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 120 in FY21Q4 to 112 in quarter FY22Q1. The total number of readmissions decreased from 18 in quarter four to 14 in quarter one.

Mobile Crisis Supports

Bar chart showing Mobile crisis new admits (N) and Mobile crisis readmits (N) by region:

	Region I	Region II	Region III	Region IV	Region V	Total
N= Mobile crisis new admits	13	27	28	32	12	112
N = Mobile crisis readmits	2	1	5	1	5	14

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.

Days and Hours of Mobile Crisis Supports

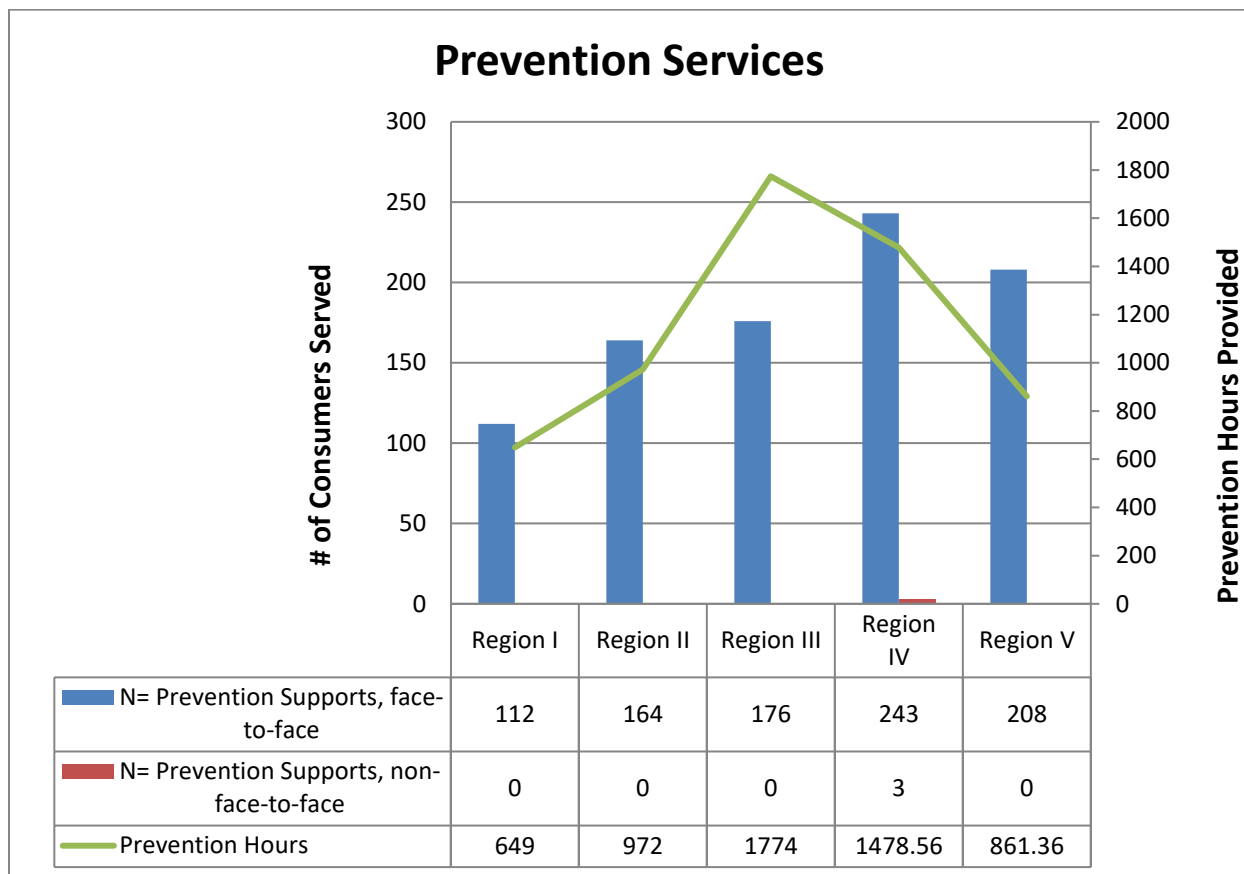|	Region I	Region II	Region III	Region IV	Region V
Total Mobile Crisis Hours	120.25	269	452.82	196.5	83.83
Total Mobile Crisis Days	52	157	338	114	75

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 a slight decrease from 1,158.75 hours in FY21Q4 to 1,122 hours in FY22Q1 of mobile crisis supports across 736 days. Generally, individuals are provided with crisis service for about 3 to 5 days with a targeted average per day of 2 hours. The first quarter data shows a range of between 1-15 days of services provided with a range of 4.9 to 13.7 average hours per case. 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	1-5	1-6	1-15	1-5	1-11
Average Days/ Case	3.5	5.6	10.2	3.5	4.4
Average Hours/Day	2.3	1.7	1.3	1.7	1.1
Average Hours/Case	8.0	9.6	13.7	6.6	4.9

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 hour s by program have been displayed.

Prevention Services

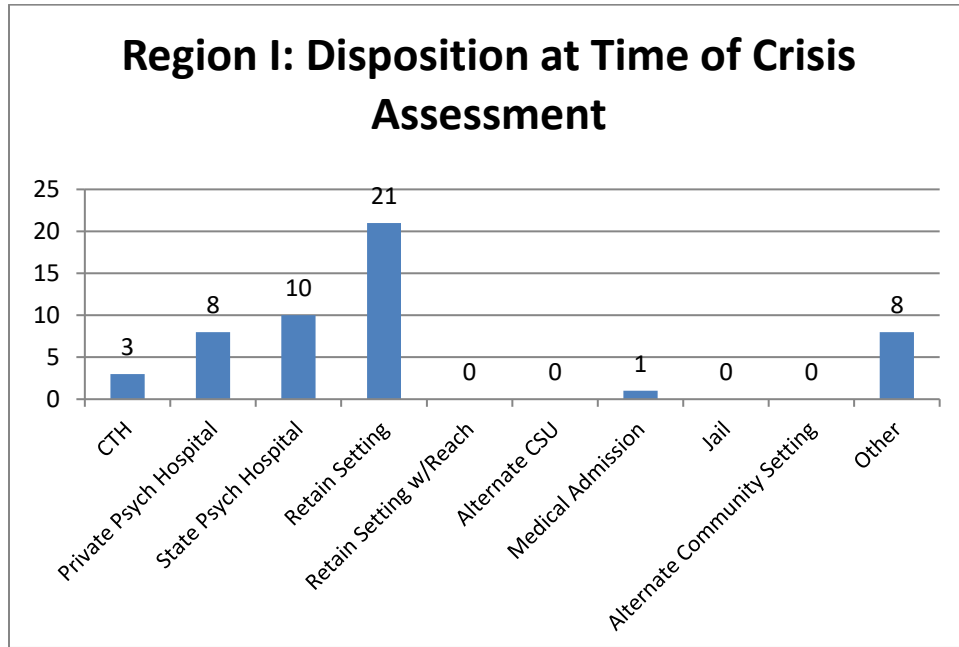|	Region I	Region II	Region III	Region IV	Region V
N= Prevention Supports, face-to-face	112	164	176	243	208
N= Prevention Supports, non-face-to-face	0	0	0	3	0
Prevention Hours	649	972	1774	1478.56	861.36

The total number of individuals receiving face-to-face prevention for quarter one was 903. The total number of prevention hours provided by all programs in quarter four was 5734.92 a slight decrease from FY21Q4.

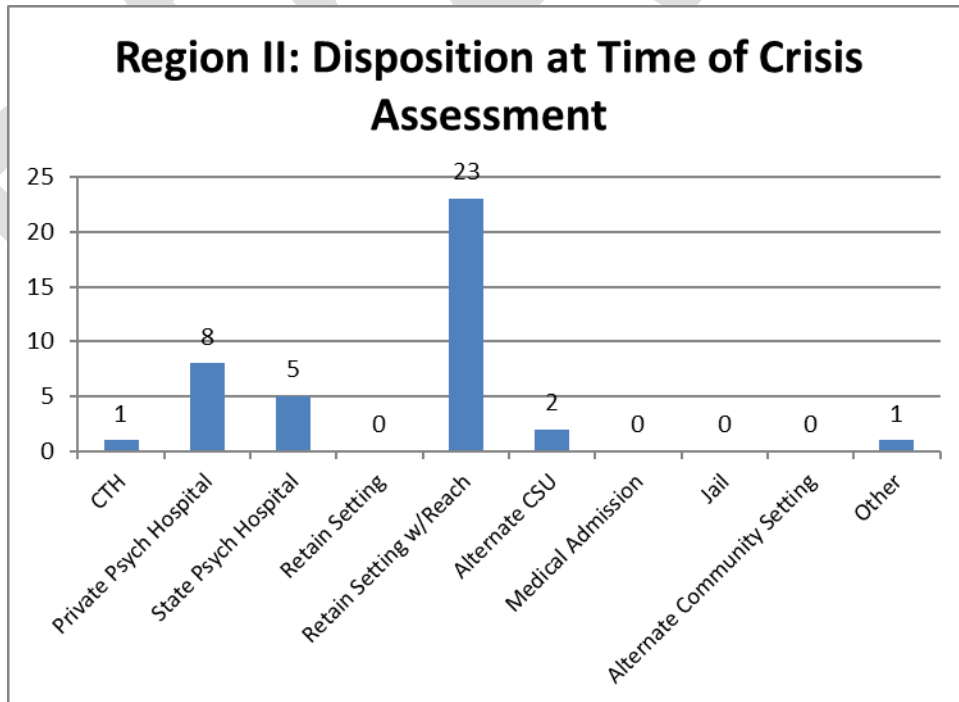## Crisis Service Outcomes/Dispositions

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?
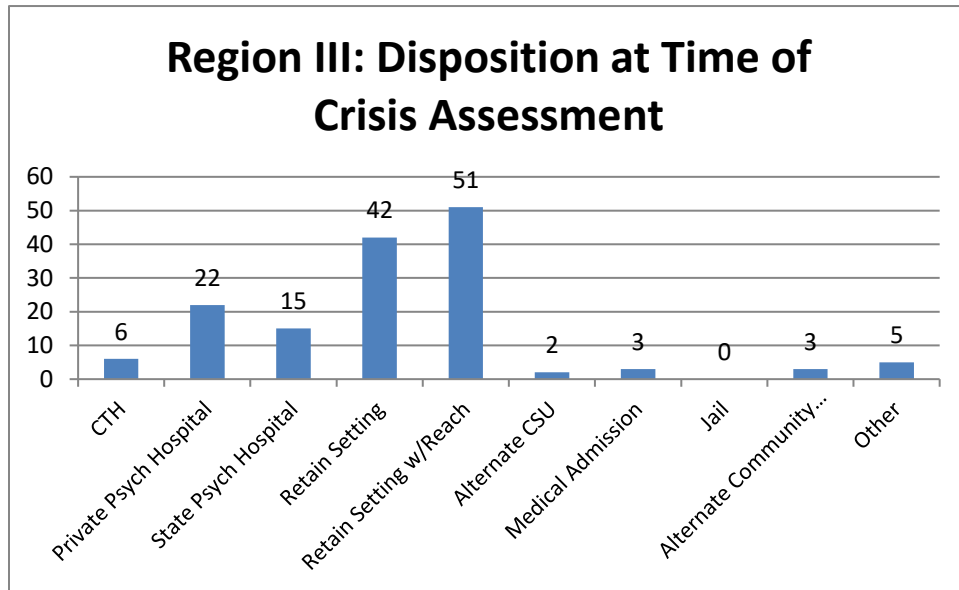
For this quarter, 68% of the individuals receiving a crisis assessment were able to retain their original residential setting, 3.5% were diverted to a CTH, with another .6% of individuals diverted

to an alternate CSU, .6% chose an alternate community setting, and 23.6% were psychiatrically hospitalized (15.4% in private and 8.2% in state hospitals). The following graphs display the outcomes of the crisis assessments across each regional program.

Region I: Disposition at Time of Crisis Assessment

CTH: 3; Private Psych Hospital: 8; State Psych Hospital: 10; Retain Setting: 21; Retain Setting w/Reach: 0; Alternate CSU: 0; Medical Admission: 1; Jail: 0; Alternate Community Setting: 0; Other: 8
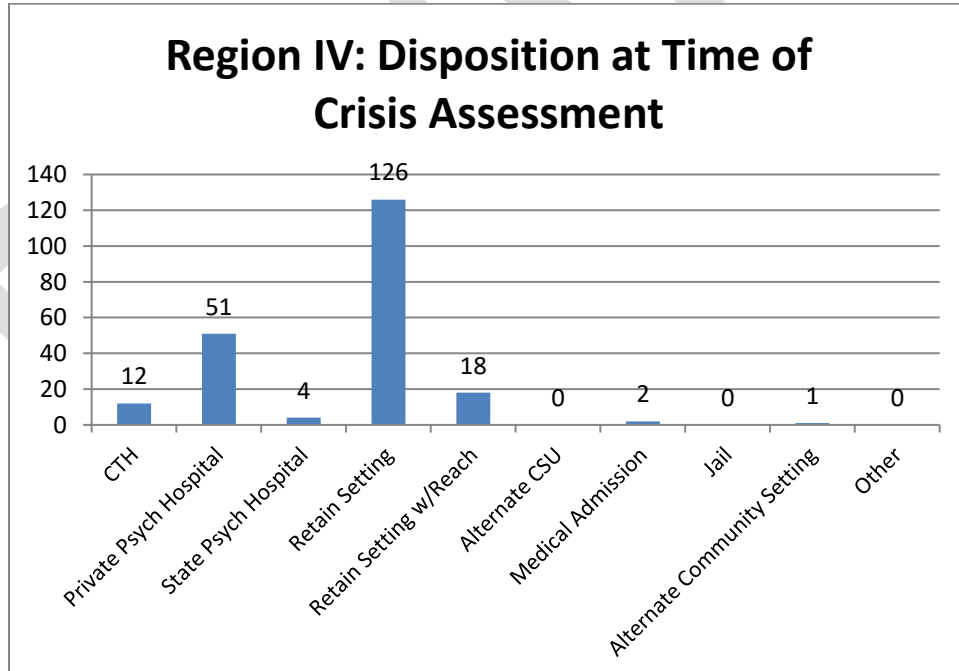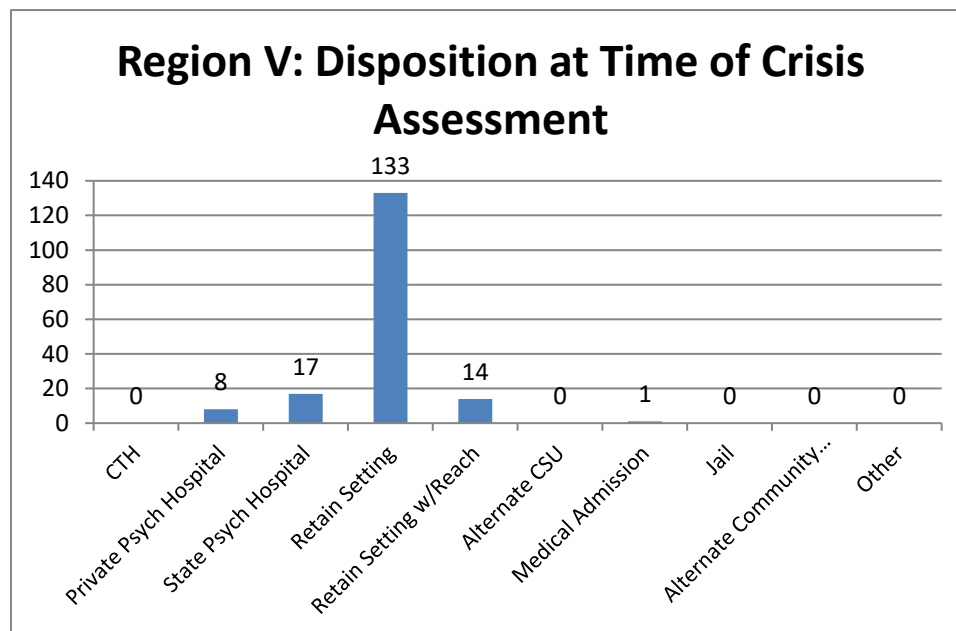
Other: Admitted for "social work admission to medical facility, Remained in ED, Unknown, lives out of state.

Region II: Disposition at Time of Crisis Assessment

CTH: 1; Private Psych Hospital: 8; State Psych Hospital: 5; Retain Setting: 0; Retain Setting w/Reach: 23; Alternate CSU: 2; Medical Admission: 0; Jail: 0; Alternate Community Setting: 0; Other: 1

Region III: Disposition at Time of Crisis Assessment

Values by category:
- CTH: 6
- Private Psych Hospital: 22
- State Psych Hospital: 15
- Retain Setting: 42
- Retain Setting w/Reach: 51
- Alternate CSU: 2
- Medical Admission: 3
- Jail: 0
- Alternate Community...: 3
- Other: 5

Other:ALT crisis support

Region IV: Disposition at Time of Crisis Assessment

Values by category:
- CTH: 12
- Private Psych Hospital: 51
- State Psych Hospital: 4
- Retain Setting: 126
- Retain Setting w/Reach: 18
- Alternate CSU: 0
- Medical Admission: 2
- Jail: 0
- Alternate Community Setting: 1
- Other: 0

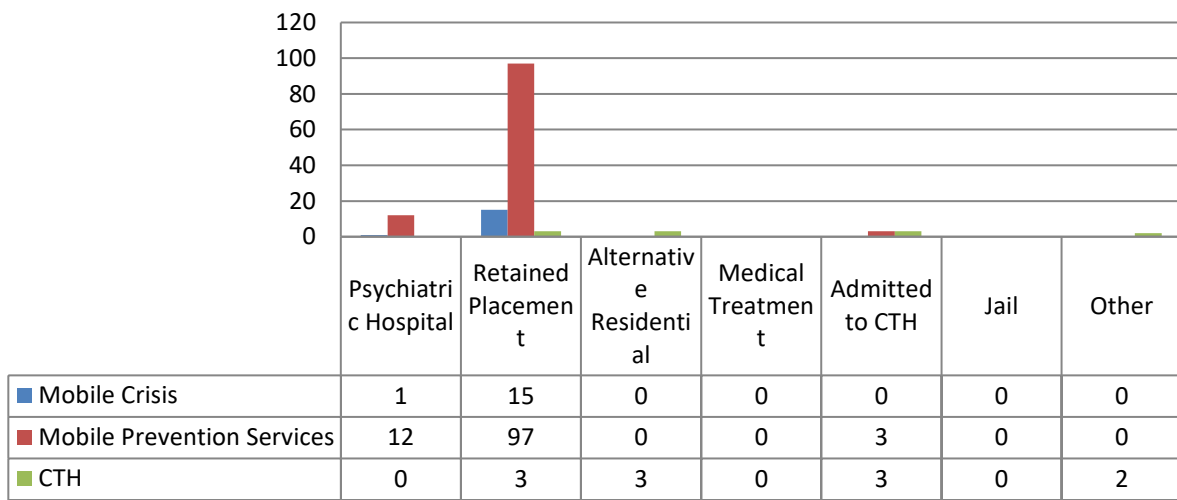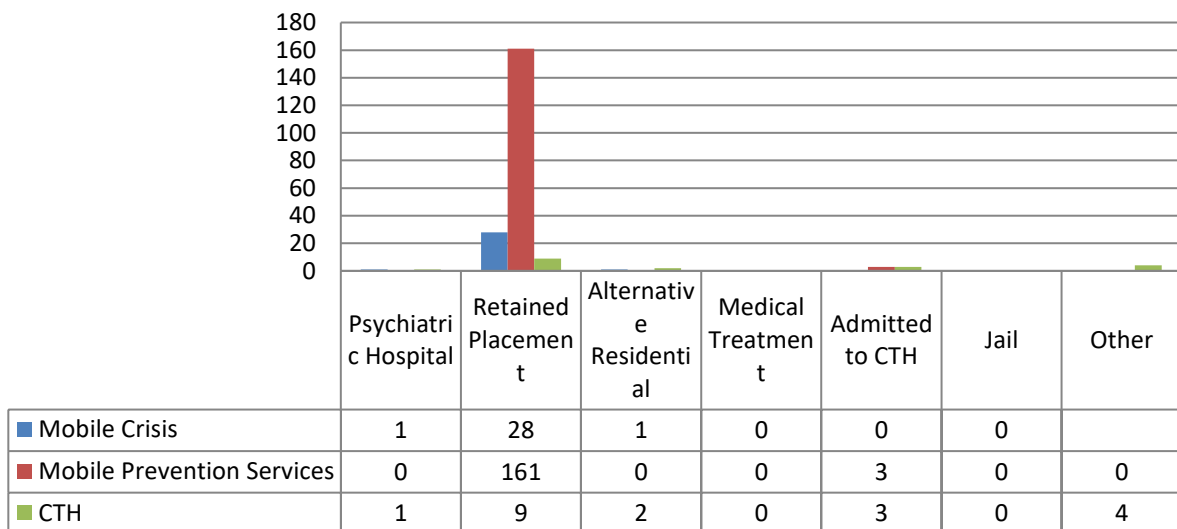## Region V: Disposition at Time of Crisis Assessment

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, 62% were able to return to their original residence or went to a new residence post discharge. Nine percent (8%) of outcomes for individuals at the CTH resulted in a psychiatric hospitalization, and the remaining individuals who had other outcomes include ATH admission, moving out of state. Fourteen guests remained admitted to all the Regions' CTH at the end of the quarter. For all admissions receiving mobile crisis supports, 87% remained in their residence, .8% were diverted to the CTH, 10% were psychiatrically hospitalized during the course of mobile services, and the remaining 2.2% had other outcomes. Based on reported data on the outcomes of adults in REACH mobile prevention services, 80% retained their setting or went to an alternative residential community setting, 5% were hospitalized, and 2.3% were admitted to the CTH and the remain individuals were identified as 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.
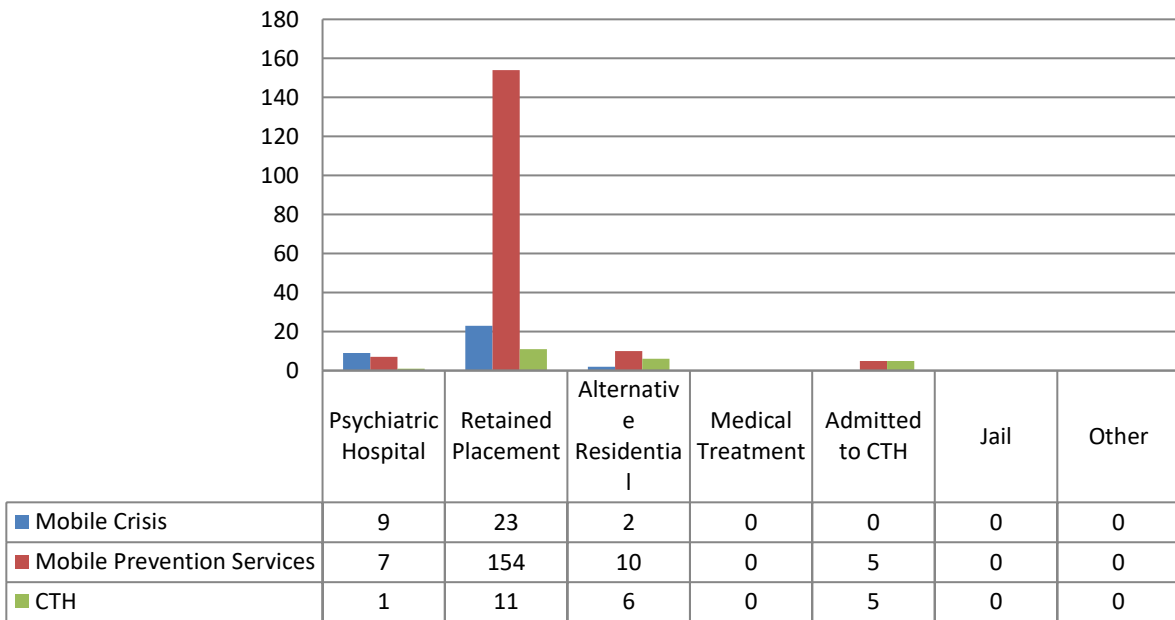
Region I: Discharge Disposition by Service Type

	Psychiatric Hospital	Retained Placement	Alternative Residential	Medical Treatment	Admitted to CTH	Jail	Other
Mobile Crisis	1	15	0	0	0	0	0
Mobile Prevention Services	12	97	0	0	3	0	0
CTH	0	3	3	0	3	0	2

Region II: Discharge Disposition by Service Type

	Psychiatric Hospital	Retained Placement	Alternative Residential	Medical Treatment	Admitted to CTH	Jail	Other
Mobile Crisis	1	28	1	0	0	0	
Mobile Prevention Services	0	161	0	0	3	0	0
CTH	1	9	2	0	3	0	4

Region III: Discharge Disposition by Service Type

	Psychiatric Hospital	Retained Placement	Alternative Residential	Medical Treatment	Admitted to CTH	Jail	Other
Mobile Crisis	9	23	2	0	0	0	0
Mobile Prevention Services	7	154	10	0	5	0	0
CTH	1	11	6	0	5	0	0

Region IV: Discharge Disposition by Service Type

	Psychiatric Hospital	Retained Placement	Alternative Residential	Medical Treatment	Admitted to CTH	Jail	Other
Mobile Crisis	2	27	1	0	0	0	3
Mobile Prevention Services	14	217	3	0	7	1	4
CTH	4	14	2	0	6	0	1

Region V: Disposition by Service Type

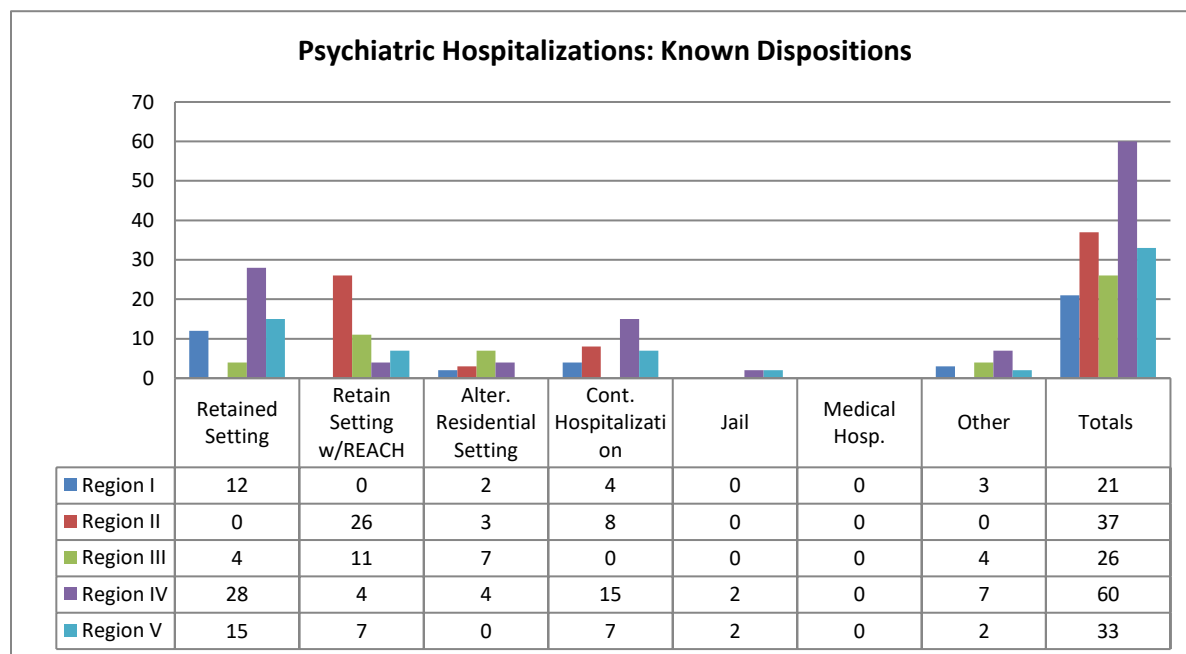|	Psychiatric Hospital	Retained Placement	Alternative Residential	Medical Treatment	Admitted to CTH	Jail	Other
■ Mobile Crisis	0	16	0	0	1	0	0
■ Mobile Prevention Services	14	190	0	1	3	0	0
■ CTH	1	1	4	0	3	0	0
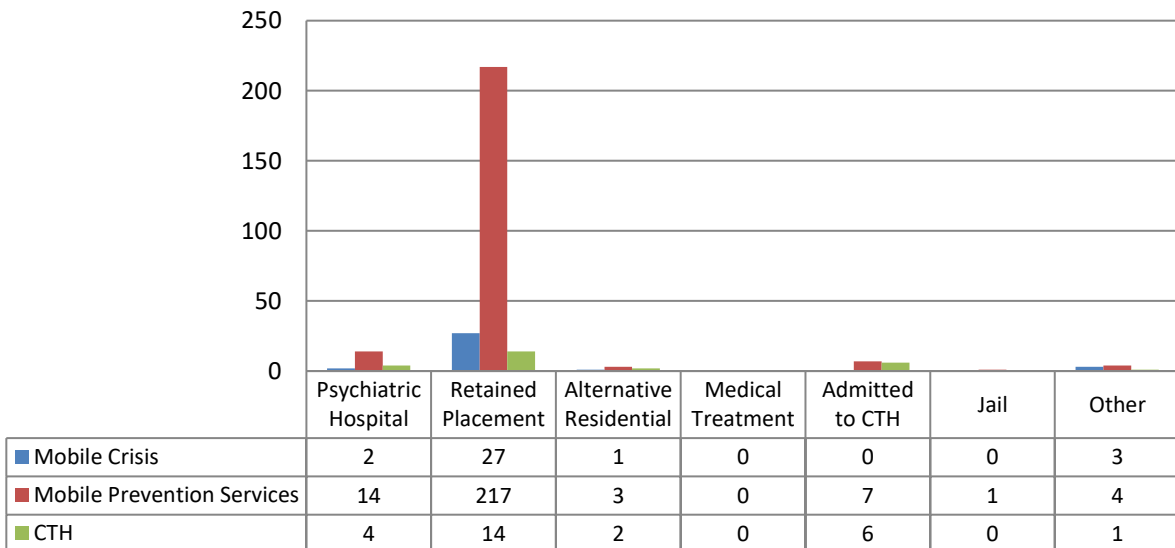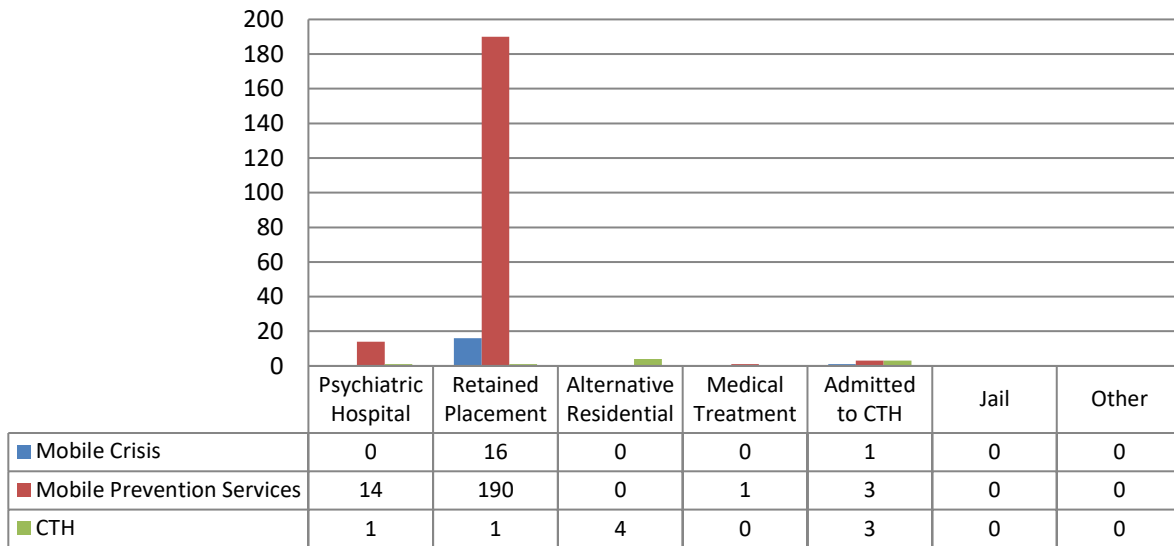
Hospitalizations

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.

Number of Hospitalizations

	Region I	Region II	Region III	Region IV	Region V
# of New Referrals	14	13	16	18	22
# of Active Cases	7	24	20	42	11
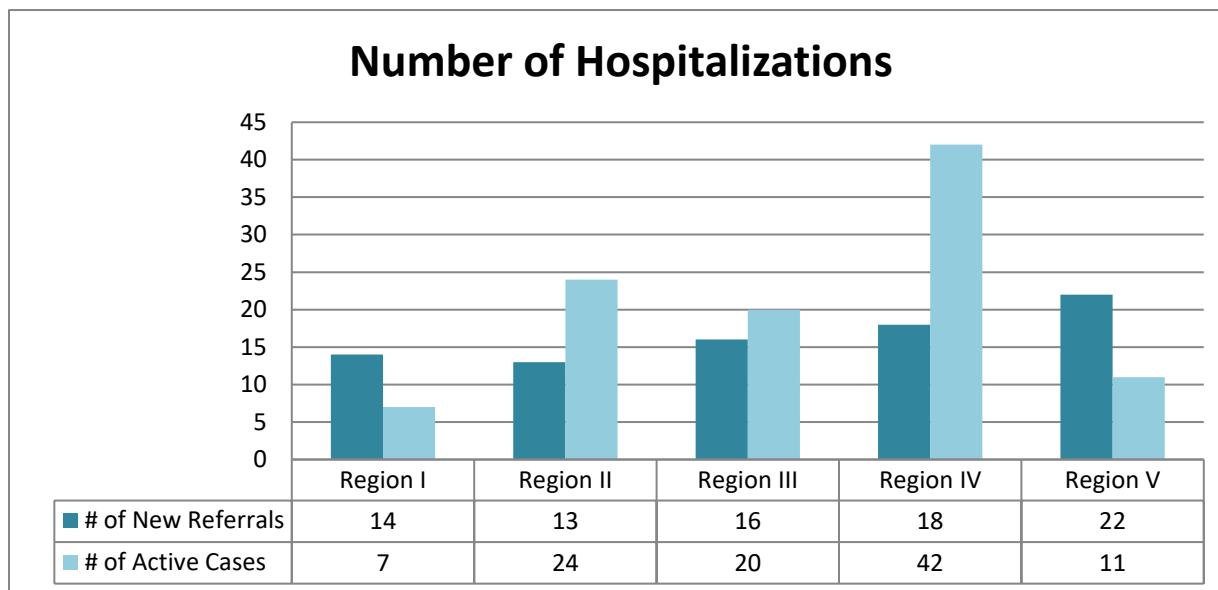
The programs are tracking new referrals according to whether individuals previously received supports through REACH and were closed, were referred but refused follow up services, or were first time referrals.

Status of New Referrals
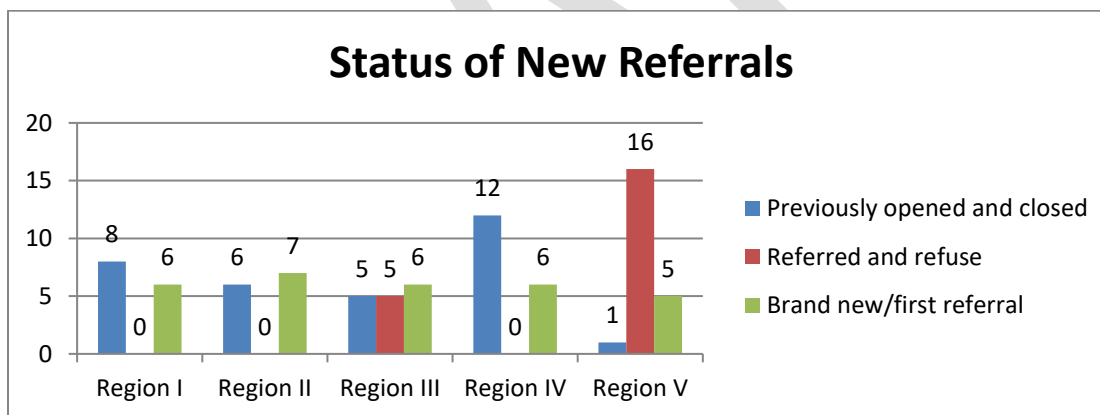
Forty-four percent (44%) of all hospitalizations were "new referrals" to the REACH program. Of the **new** referrals to REACH that were hospitalized, 36% of the individuals were new to the program, 25.3% were referred to REACH but refused services, and 38.5% had been previously discharged (inactive) from REACH services. Of the known dispositions of the people hospitalized and discharged, 59% retained their original community home and 9% went to an alternative community setting. Refer to the chart on the following page for a more detailed breakdown of outcomes.

Psychiatric Hospitalizations: Known Dispositions

	Retained Setting	Retain Setting w/REACH	Alter. Residential Setting	Cont. Hospitalization	Jail	Medical Hosp.	Other	Totals
Region I	12	0	2	4	0	0	3	21
Region II	0	26	3	8	0	0	0	37
Region III	4	11	7	0	0	0	4	26
Region IV	28	4	4	15	2	0	7	60
Region V	15	7	0	7	2	0	2	33

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 84% of the mobile crisis CEPPs this quarter. The data for Mobile crisis supports is as follows: 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. Respectively Regions I through V completed the following percentages of the required training for mobile supports: 36%; 88%; 82%; 100%; and 100%. The reasons and related percentage for not completing training this quarter is as follows: 22% declined service after starting; 17% REACH error; 11% left service; 28% psychiatrically hospitalized; and 22% did not return calls. Regions IV and V each completed one additional training for a person whose service carried over from last quarter; with Region V also

completing 6 additional trainings on CEPPs that were completed in previous quarter (but person was again admitted in this 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	9	8	12	4
Consultation	6	9	8	12	4
Crisis Education Prevention Plan	6	6	7	13	4
Provider Training	4	3	7	13	2

R1 2 have scheduled training. R2 CEPP 2 still admitted to CTH, 1 individual delayed due to TDO, training 2 individuals still admitted, 1 scheduled client no showed, 2 trainings declined, 1 TDO. R3 admission at end of quarter, CEPP and training to be completed. R4 individual carried over, R5 1 individual left service, 1 hospitalized.

Service Type Provided: Planned Prevention (CTH)					
Service Type Delivered Per Case	Region I	Region II	Region III	Region IV	Region V
Comprehensive Evaluation	0	5	4	0	0
Consultation	0	5	4	0	0
Crisis Education Prevention Plan	0	4	2	0	0
Provider Training	0	4	2	0	0

R2 1 CEPP 1 individual still admitted, CEPP and training will be scheduled after discharge. R3 2 admitted end of month CEPP and training to be completed.

Service Type: Crisis Stepdown (CTH)					
Service Type Delivered per Case	Region I	Region II	Region III	Region IV	Region V
Comprehensive Evaluation	3	2	5	10	3
Consultation	3	2	5	10	3
Crisis Education Prevention Plan	3	2	5	10	3
Provider Training	2	1	5	10	1

R1 1 individual still admitted to CTH. R2 1 individual discharged out of region no training requested. R5 2 individual still admitted will train upon discharge.

Service Type Provided: Mobile Crisis Support					
Service Type	Region I	Region II	Region III	Region IV	Region V
Comprehensive Evaluation	15	28	33	33	17
Consultation	15	28	33	33	17
Crisis Education Prevention Plan	12	25	27	34	6
Provider Training	5	22	27	34	13

R1 2 CEPP cases reassigned, 1 in progress still in MC. Training 4 providers did not return communication after services, 2 family declined for training, 1 in progress 3 REACH error. R2 3 CEPP not developed due to continued MS, 2 trainings declined, 1 training delayed individual readmitted to the hospital. R3 4 psych hospital and 2 left service; R4 1 person CEPP and training carried over. R5 6 CEPPS completed in previous admission, 5 readmits had completed CEPPs; 1 training carried over in quarter, 5 readmits did not need training.

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 1066 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	75	104	15	37	40	271
Case Managers/Support Coordinators	13	8	5	0	0	215
Emergency Service Workers: #Trained	9	4	5	2	11	31
Family Members: #Trained	1	0	0	0	19	1
Hospital Staff: #Trained	2	0	15	11	0	28
DD Provider: #Trained	54	94	32	9	9	189
Other Community Partner: #Trained	0	3	54	274	0	331
Totals	154	213	126	333	79	**1066**

*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 first quarter of fiscal year 2022. 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 first (FY22Q1) 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 but equally as impactful on the REACH program is the national and statewide shortage of staff for residential and community positions. This shortage is realized in both recruitment and retention of qualified staffing needs going unmet. This shortage resulted in temporary census reductions due to the health and 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 some level of 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 across the Commonwealth.