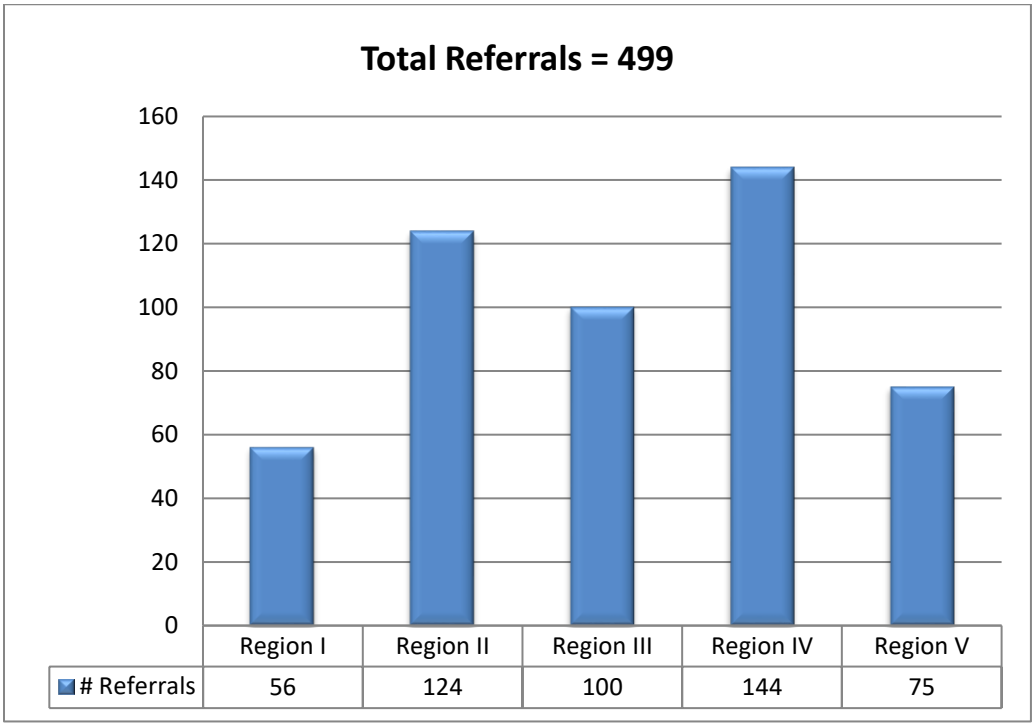
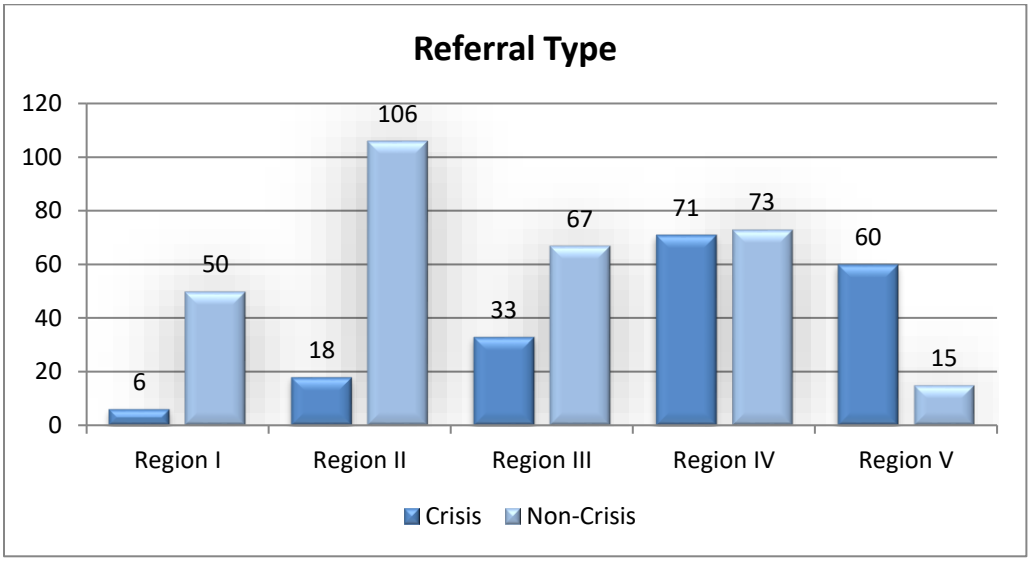
REACH Data Summary Report-Adult: Q3/FY22

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

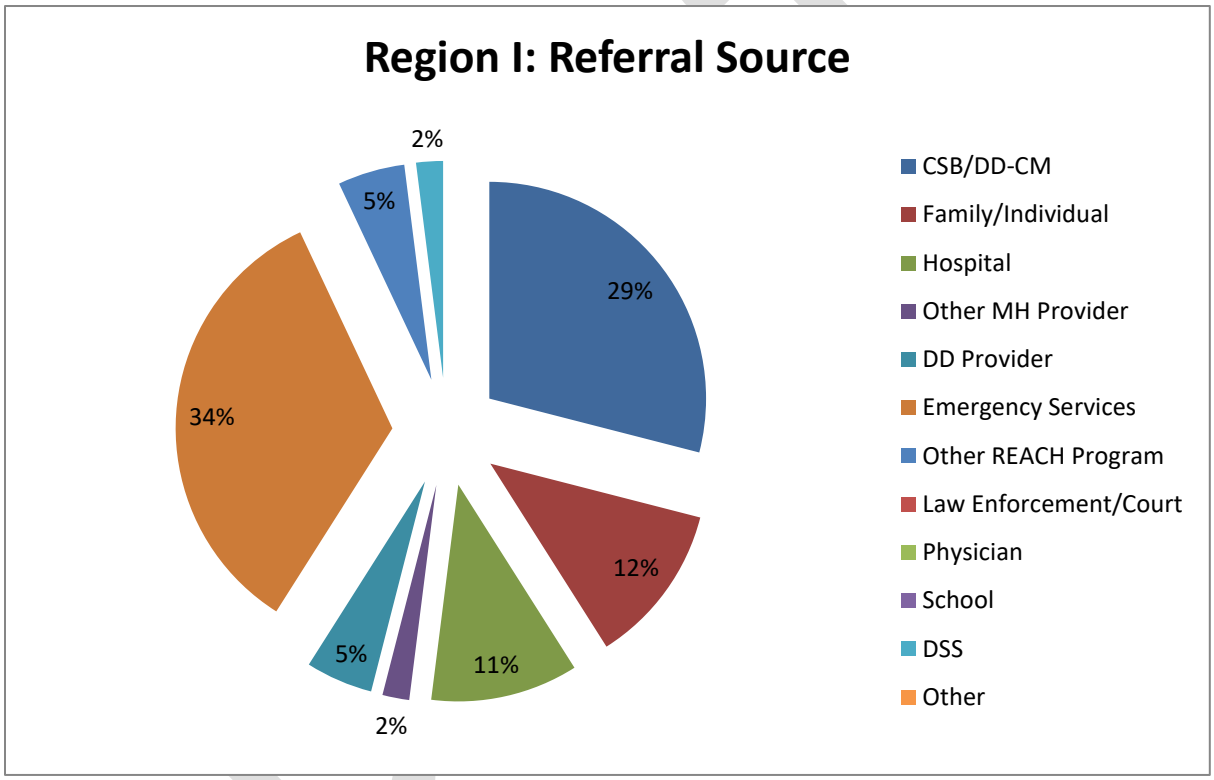
REACH Referral Activity

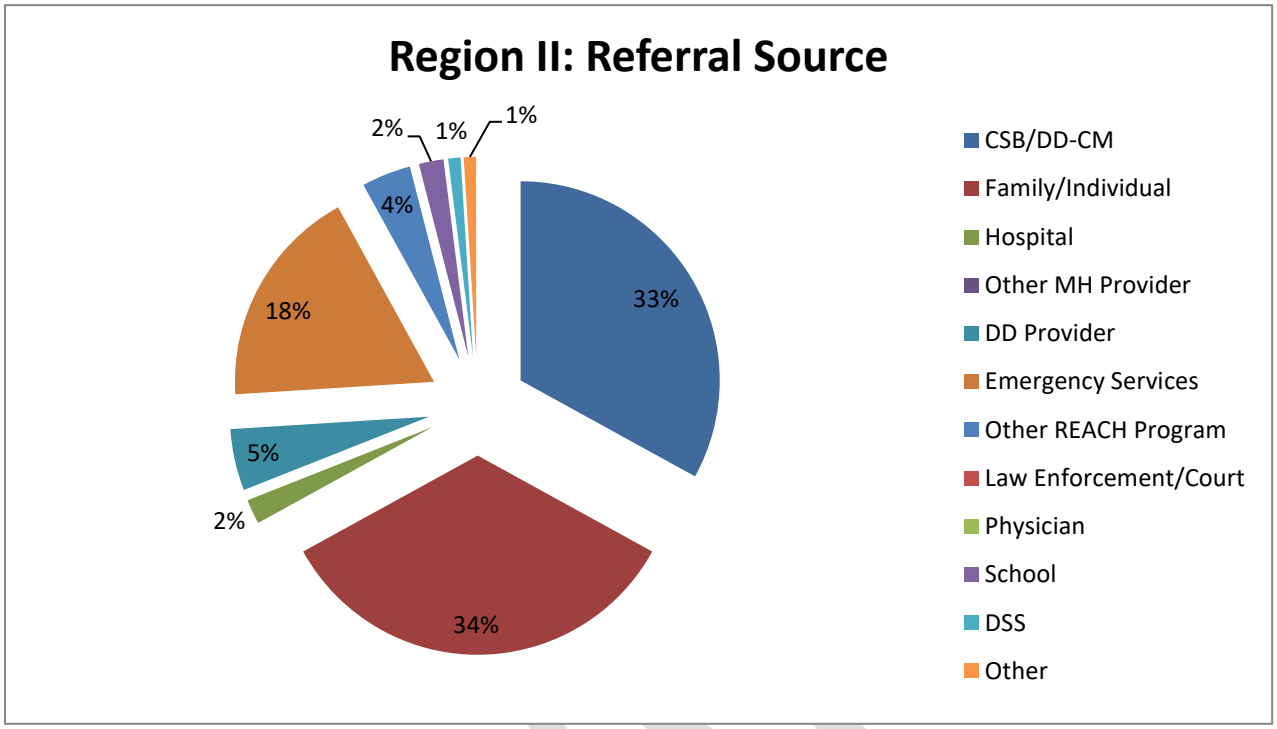


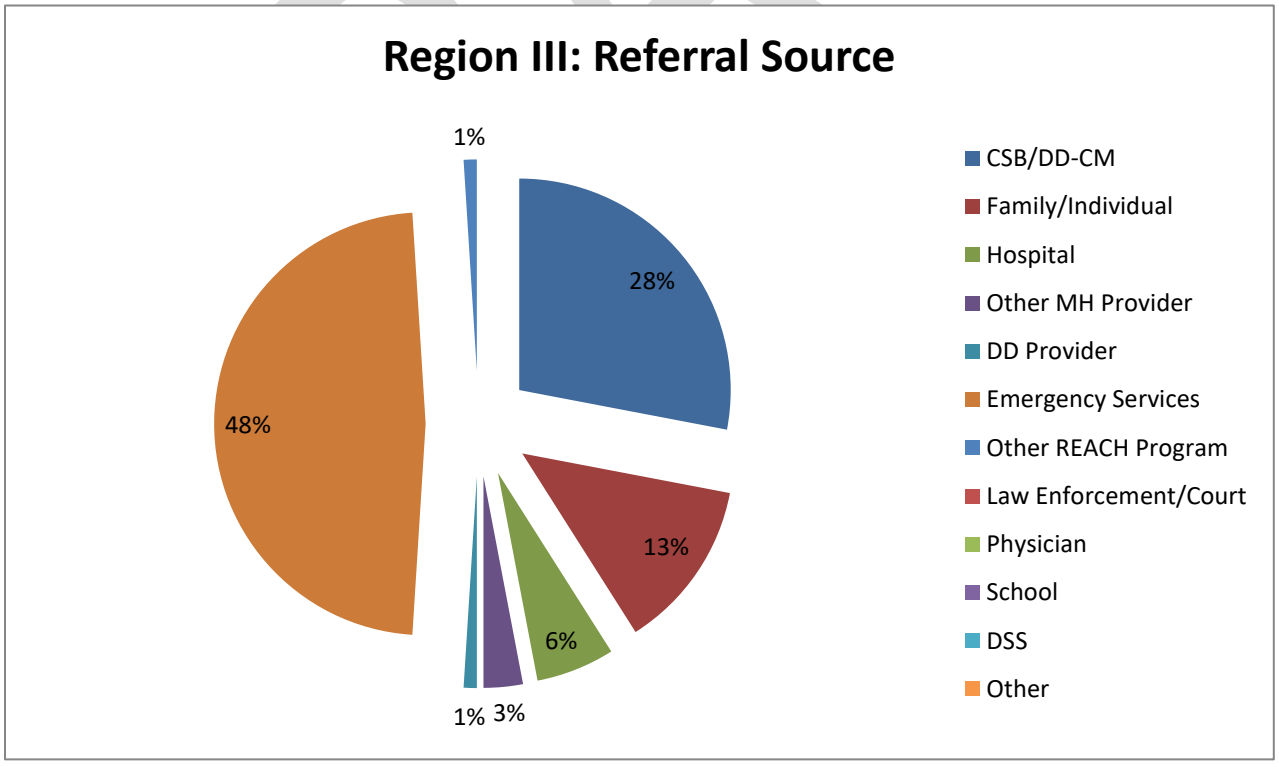


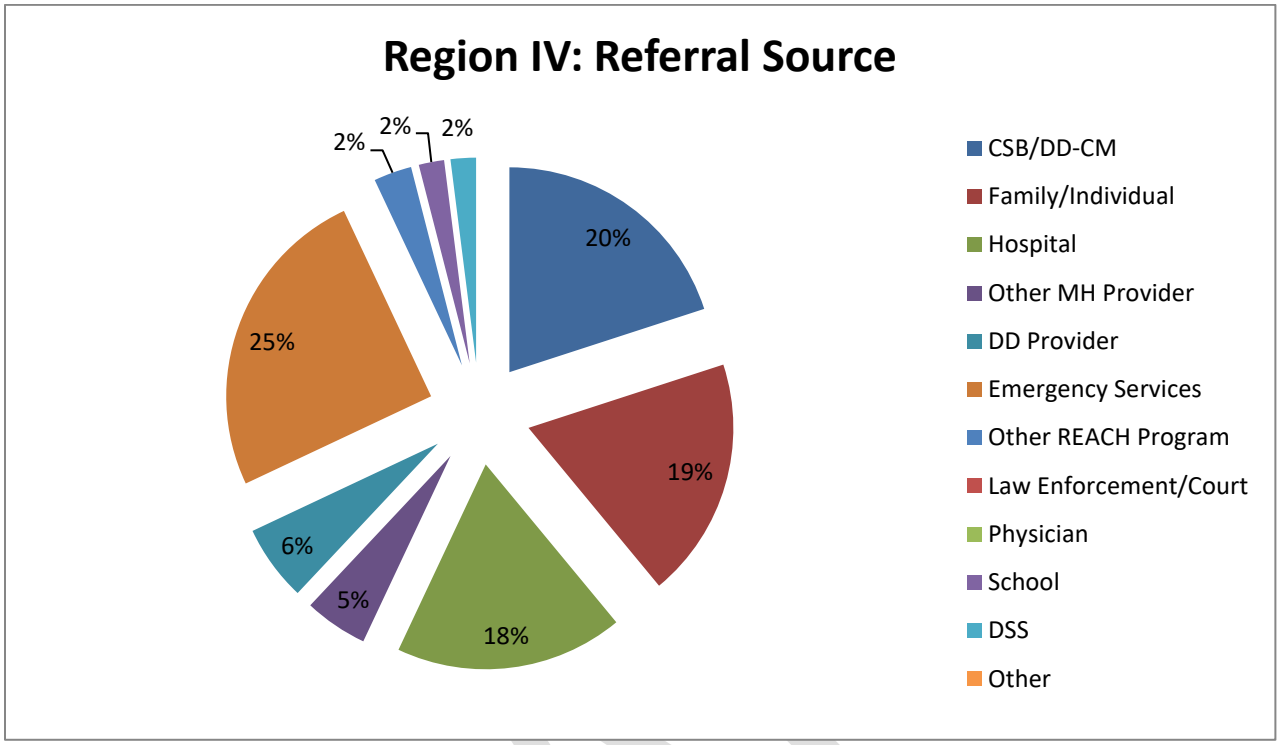
For FY22 Q3, there was an increase in total referrals as compared to FY22 Q2, 446 to 499. The data regarding the breakdown of types of referrals for Regions I, II, III and IV denote more non-crisis referrals than crisis referrals, whereas Regions V received more crisis referrals in the third quarter. This trend is the similar as compared to the previous quarters with the exception of Region IV receiving more non-crisis referrals than crisis in the third quarter.

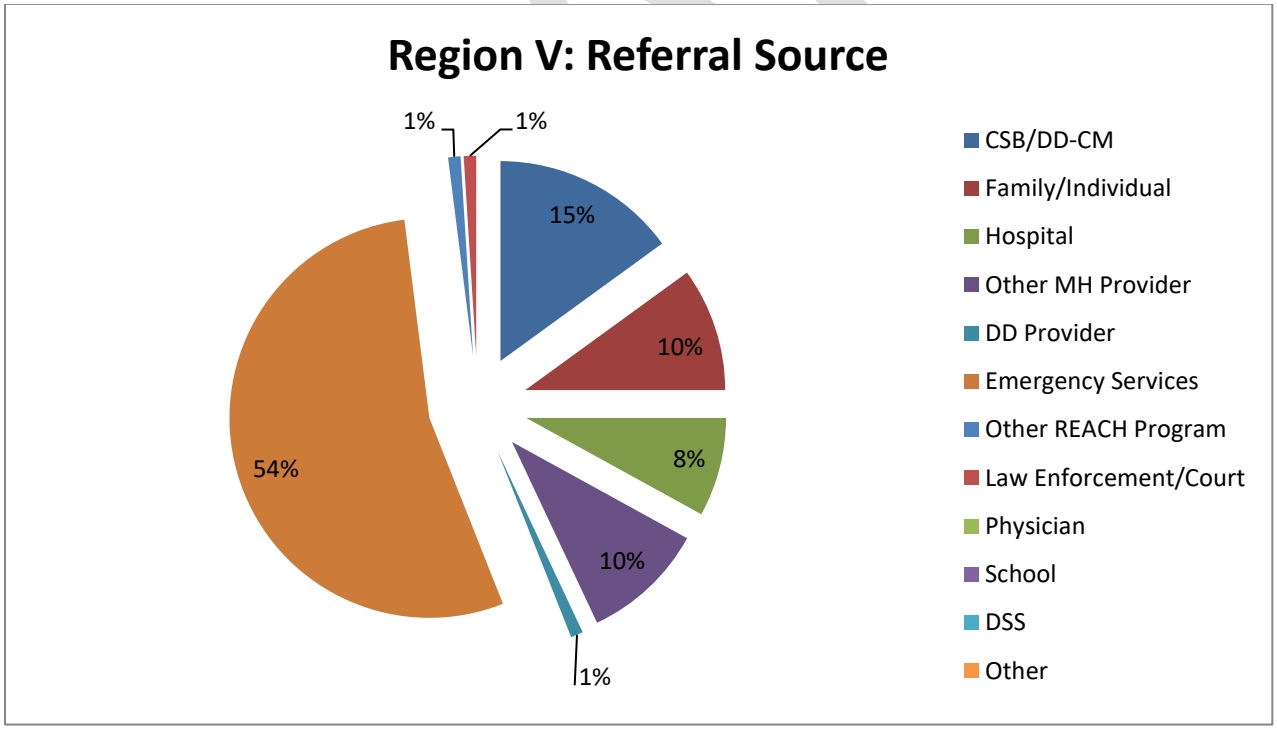
Referral activity is also considered by differentiating the source of the request for service. The following five charts show a breakdown by Region of referral source data. Referral sources cover a broad range of stakeholders when the state is considered as a whole and primary referral sources vary by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




Region II: Referral Source
33%
34%
2%
5%
18%
4%
2%
1%
1%
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: Referral Source
1%
28%
13%
6%
3%
1%
48%
CSB/DD-CM
Family/Individual
Hospital
Other MH Provider
DD Provider
Emergency Services
Other REACH Program
Law Enforcement/Court
Physician
School
DSS
Other


Region IV: Referral Source
20%
19%
18%
5%
6%
25%
2%
2%
2%
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
15%
10%
8%
10%
1%
54%
1%
1%
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	51	114	86	118	57	426
Weekends/Holidays	5	10	14	26	18	73
7am - 2:59pm	34	79	55	73	24	265
3pm - 10:59pm	18	41	34	59	31	183
11 pm - 6:59 am	4	4	11	12	20	51

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, RI, III and V 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	18	30	47	72	11	178
DD only	22	63	34	51	35	205
ID/DD	16	30	18	16	28	108
Unknown/None	0	1	1	5	1	8
Total	56	124	100	144	75	**499**

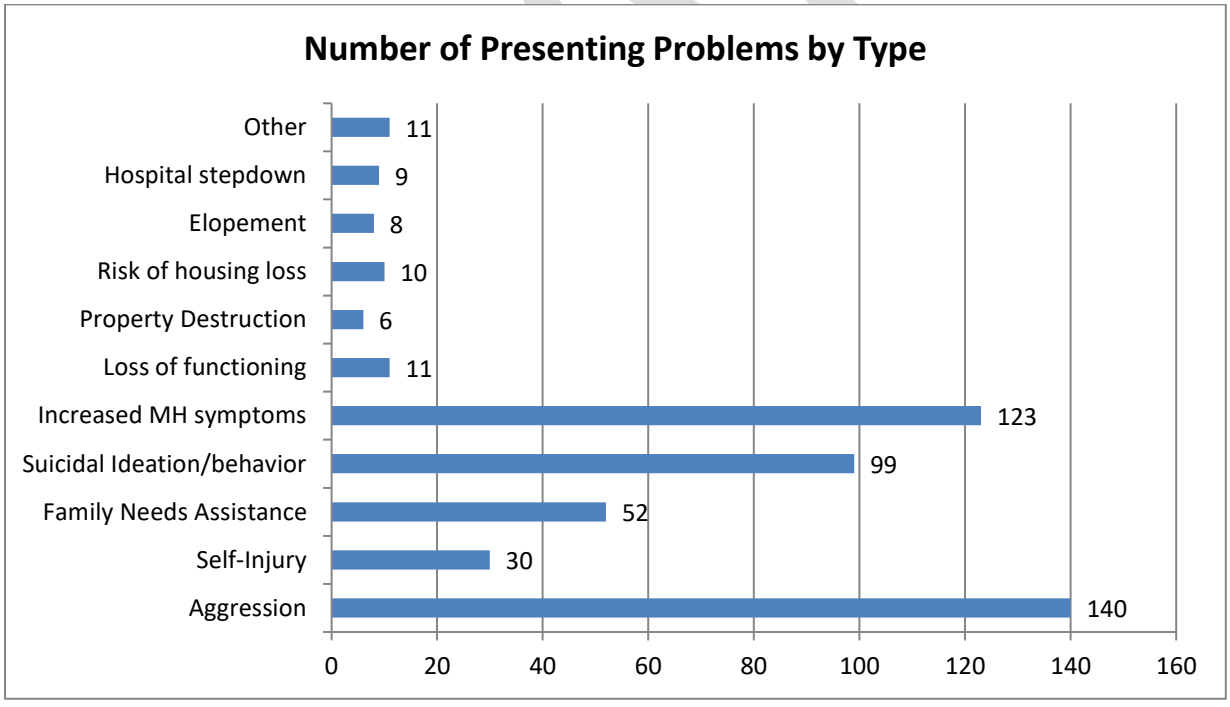
In terms of what type of clinical issues bring individuals to the REACH programs for support; aggression and increased MH symptoms were the main reasons for referral during FY22 Q3, with suicidal ideation as the third most common reason for referral. This pattern is consistent across reviewed quarters. 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	25	33	25	34	23	140
Self-Injury	1	8	6	9	6	30
Family Needs Assistance	2	13	6	29	2	52
Suicidal Ideation/behavior	9	13	26	29	22	99
Increased MH symptoms	7	43	25	31	17	123
Loss of functioning	2	4	1	2	2	11
Property Destruction	1	2	1	2	0	6
Risk of housing loss	5	1	4	0	0	10
Elopement	0	2	0	5	1	8
Hospital stepdown	3	0	1	3	2	9
Other	1	5	5	0	0	11
Total	56	124	100	144	75	499

Other: law enforcement interaction/jail, ATH admit, New group home

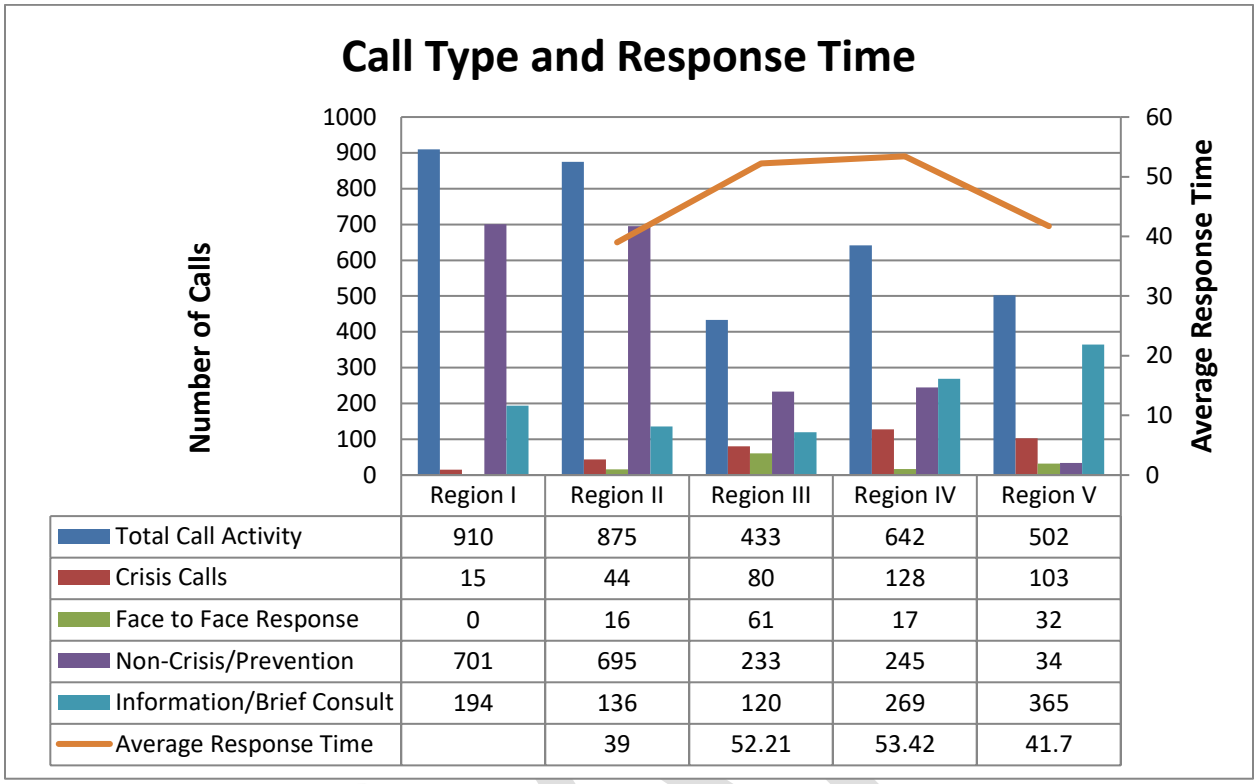


REACH Crisis Response

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 on the following page. 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.



	Region I	Region II	Region III	Region IV	Region V
Total Call Activity	910	875	433	642	502
Crisis Calls	15	44	80	128	103
Face to Face Response	0	16	61	17	32
Non-Crisis/Prevention	701	695	233	245	34
Information/Brief Consult	194	136	120	269	365
Average Response Time		39	52.21	53.42	41.7

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. This with the exception of Region I who provided all (100%) response via telehealth. All four regions that delivered face-to-face responses 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 have an average response of within two hours as designated rural setting. Region I provided 100% of their response as telehealth, while Region II met 88%. Region III met 95%, Region IV met 88%, 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, weather and multiple calls were the reasons given for delays in response. This is consistent with the previous quarter.

Response Time

	Region I	Region II	Region III	Region IV	Region V	Total Calls
Response Interval: 0 - 30	0	5	25	1	12	43
Response Interval: 31 - 60	0	9	18	14	14	55
Response Interval: 61 - 90	0	2	8	0	4	14
Response Interval: 91 -120	0	0	7	0	2	9
Response Interval: 120+	0	0	3	2	0	5
Total	0	16	61	17	32	126

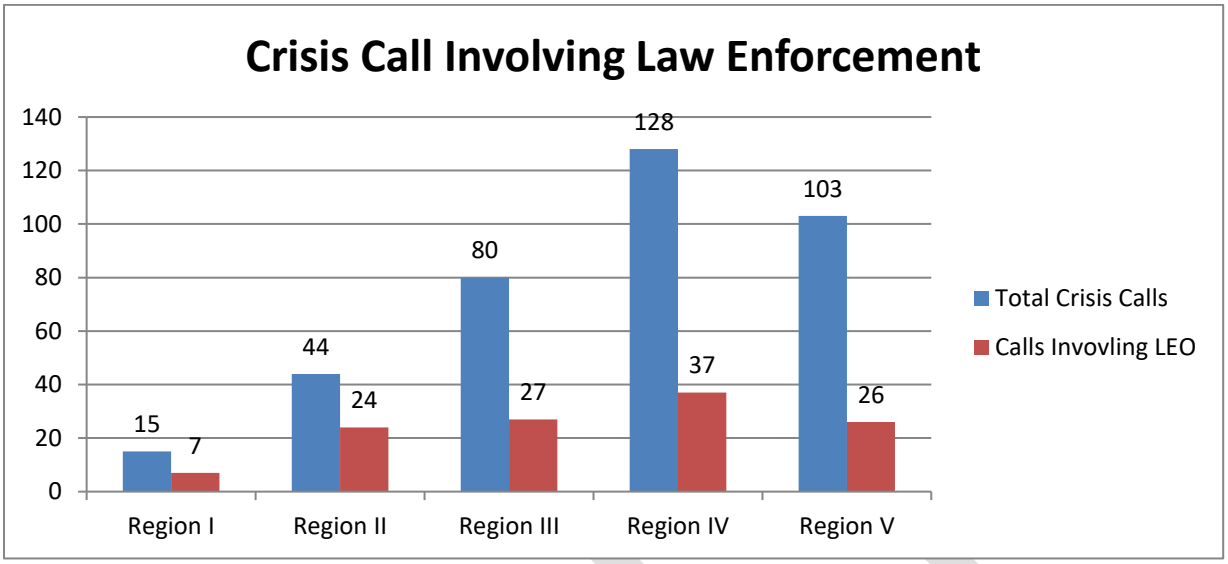
Region 1 provided 100% telehealth and response times are not tracked, as travel is not required. For those at +120 multiple calls, weather and distance were a factor in not meeting timeframe.

Location of Crisis Assessments

Assessment Location	Region I	Region II	Region III	Region IV	Region V	Total
Individual Home/Family Home	0	7	9	13	20	49
Hospital/Emergency Room	15	18	46	84	71	234
Emergency Services/CSB	0	10	10	7	7	34
Residential Provider	0	8	11	15	4	38
Police Station	0	0	2	5	1	8
Day Program	0	0	2	0	0	2
School	0	1	0	1	0	2
Other	0	0	0	3	0	3
Total	15	44	80	128	103	370

Other response settings include Crisis Triage center and Community location.

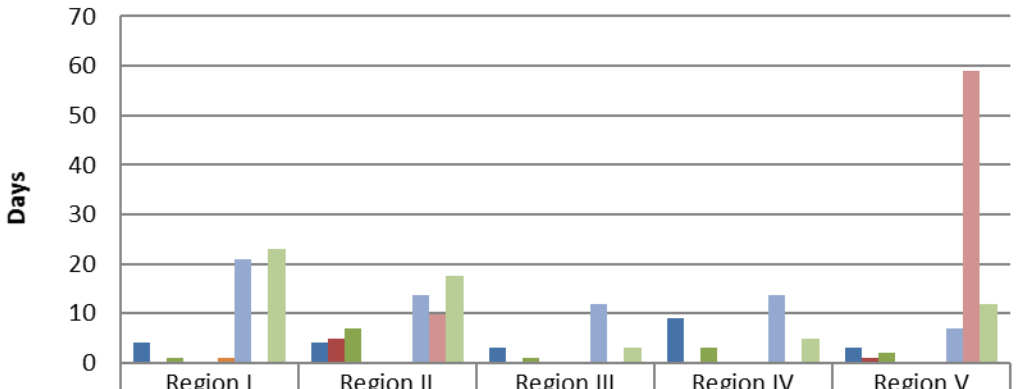
When indicated, the REACH programs are expected to arrive at the physical site of the crisis event, regardless of the nature of the setting. The table above provides a summary of the various locations where mobile crisis assessments took place over the course of FY22Q3. The location of assessments listed 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. It is likely that COVID 19 impacted certain locations traditionally utilized by individuals seeking services. The data denotes that in the third quarter of FY22, 37% of all assessments occurred outside of a hospital emergency department. The data on the following page denotes a decrease in law enforcement presence for the third quarter as compared to the previous quarter, 37% to 33%.



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 page 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 third quarter admissions/readmissions across all Regional programs. During FY22Q3, there were 23 crisis stabilization admissions, 6 prevention admissions, and 16 step-down admissions (inclusive of 2 readmits).

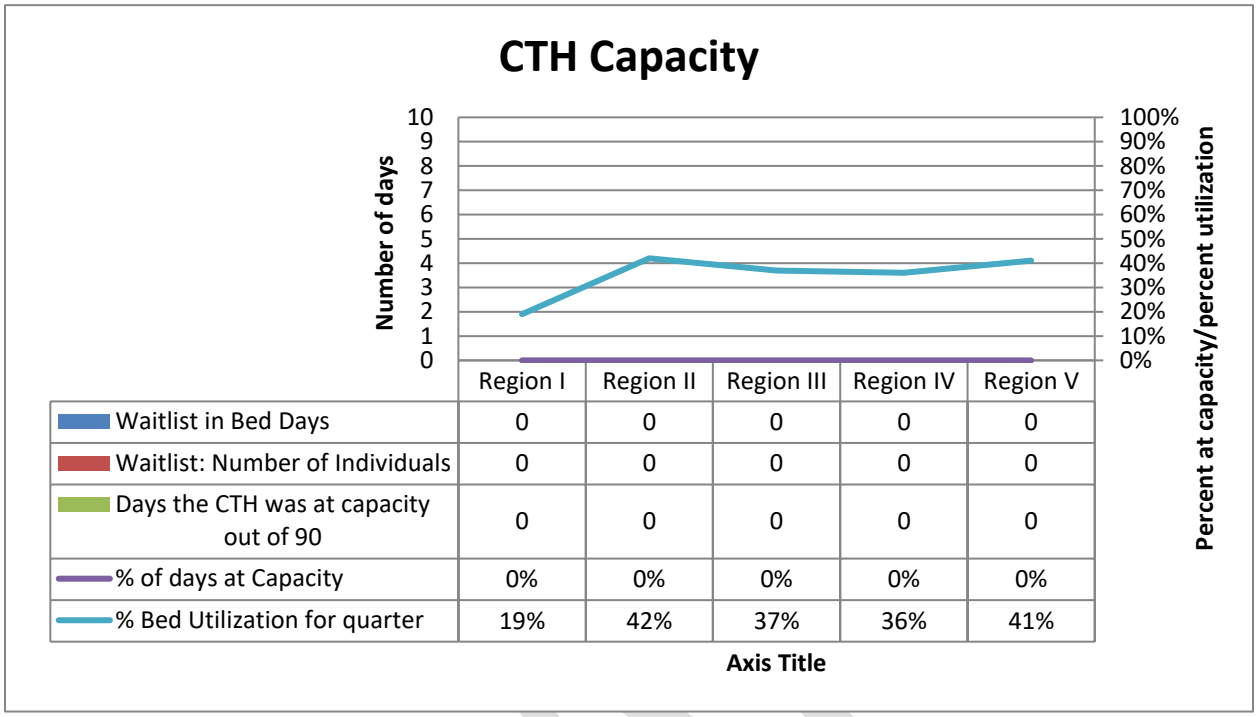


	Region I	Region II	Region III	Region IV	Region V
Admits/stab	4	4	3	9	3
Admits/prevention	0	5	0	0	1
Admits/stepdown	1	7	1	3	2
Readmits/stab	0	0	0	0	0
Readmits/prevention	0	0	0	0	0
Readmits/stepdown	1	0	0	0	0
Avg. LOS for crisis stab admits/readmits	21	13.75	12	13.67	7
Avg. LOS for prevention admits/readmits	0	9.8	0	0	59
Avg. LOS for step-down admits/readmits	23	17.57	3	5	12

The average length of stay reflected for each type of admission on the previous chart reflects that with the exception of one person in Region V (prevention admission), the average length of stay is at 30 days or less. 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: 3 crisis stabilization admissions with LOS ranging from 64 to 85 days, 4 step-down admissions with LOS ranging from 11 to 60 days, and 2 prevention stays with 122 and 104 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 1	Step Down	60
	Person 2	Crisis Stab	74
Region II	Person1	Step Down	11
Region III	Person 2	Prevention	122
	Person 3	Step Down	34
Region IV	Person 1	Crisis Stab	64
	Person 2	Crisis Stab	85
Region V	Person 1	Prevention	104
	Person 2	Step Down	20

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 19% to 42% during the third quarter. All five regional REACH programs experienced the impact of continued staffing shortages, which impacted the ability to maintain full occupancy of 6 beds due to health and safety guidelines impacting available staff to client ratio. Positive rates of COVID 19 across the regions affected the occupancy rates and availability of beds/staffing during the third quarter similarly to the second quarter of FY22.

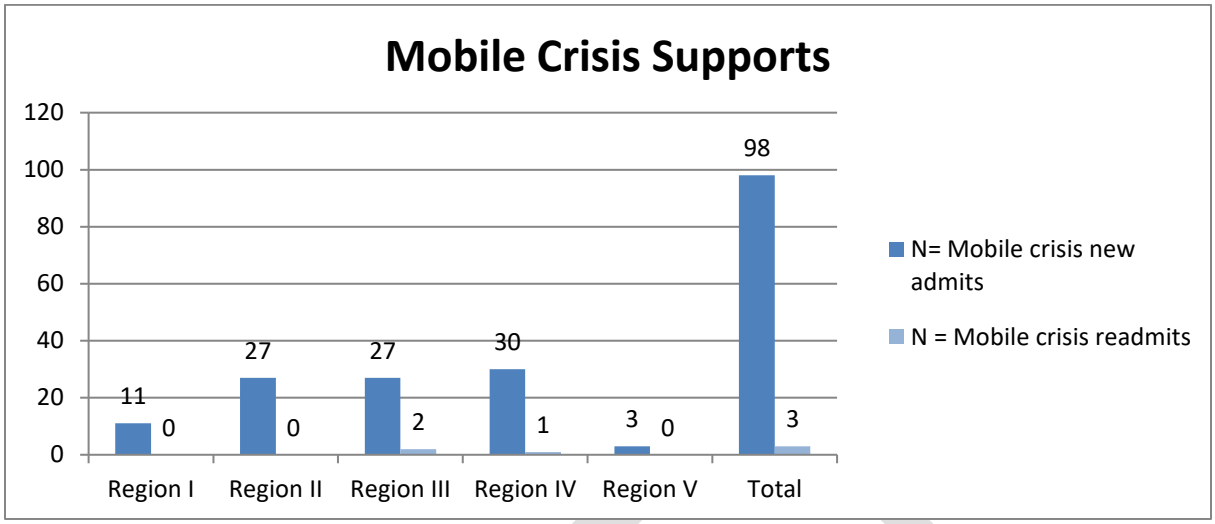


	Region I	Region II	Region III	Region IV	Region V
Waitlist in Bed Days	0	0	0	0	0
Waitlist: Number of Individuals	0	0	0	0	0
Days the CTH was at capacity out of 90	0	0	0	0	0
% of days at Capacity	0%	0%	0%	0%	0%
% Bed Utilization for quarter	19%	42%	37%	36%	41%

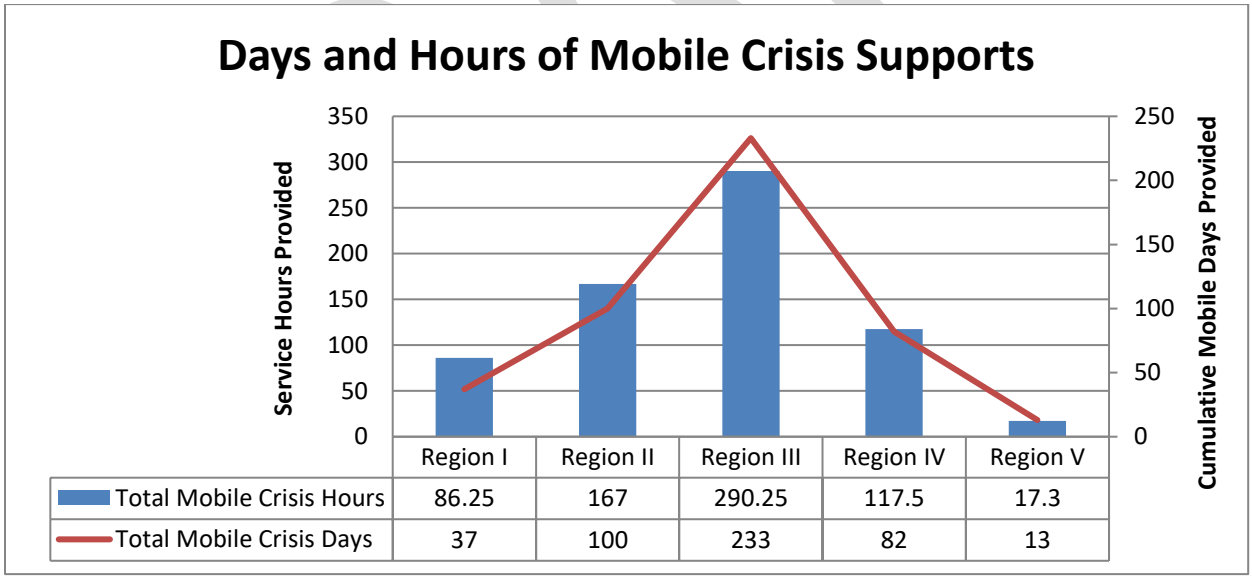
Beds Used Out of 540 Beds Available:	195	228	198	196	221

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 remained steady with 98 in FY22Q2 and 98 in FY22Q3. The total number of readmissions also remained stable with three in Q2 to and three in Q3.



In addition to collecting information related to the number of admissions into the mobile crisis supports, data related to service provision is also collected for review. 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.

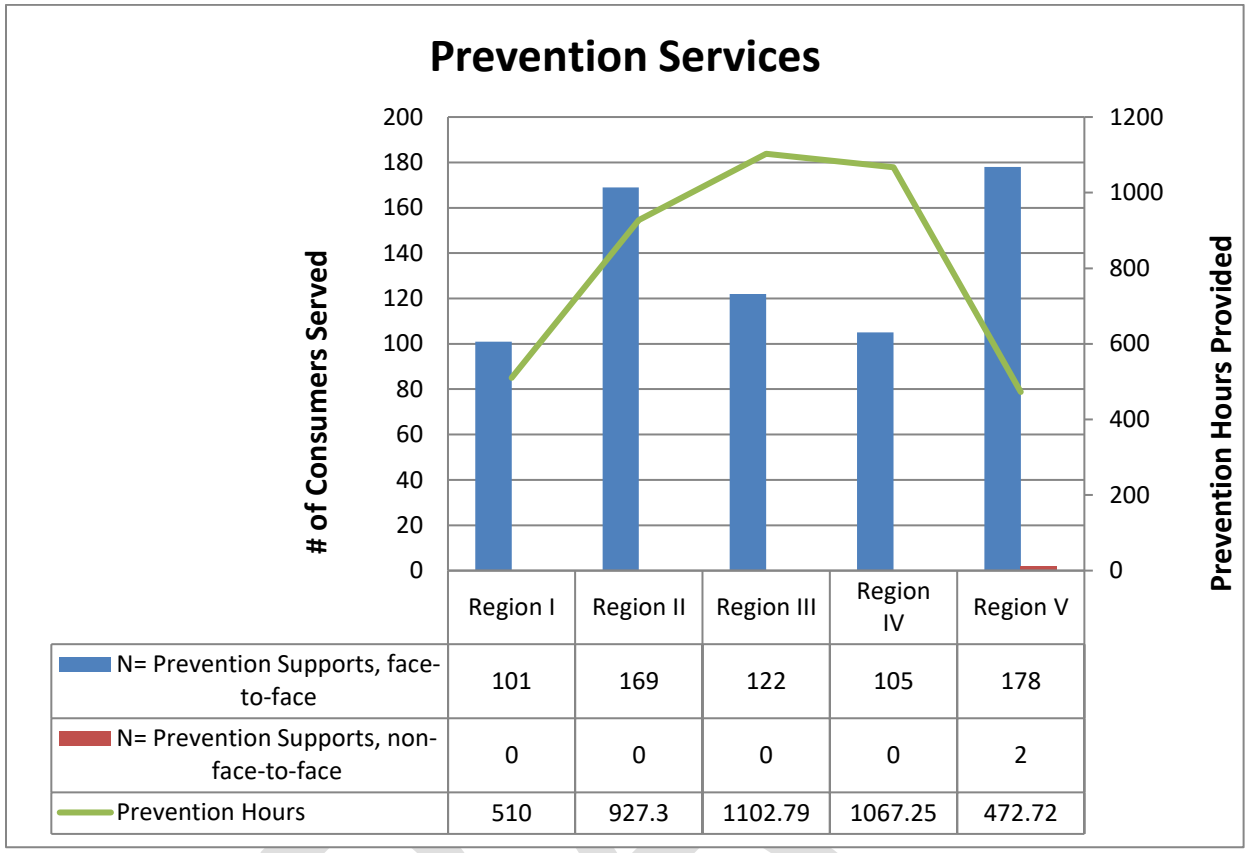


Mobile crisis stabilization services typically involve REACH clinicians going to the homes, day program, work site, or recreational site frequented by the individual to work with them on developing and practicing coping skills, and problem solving situations that arise in the settings where they spend 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 a decrease from 778.36 hours in FY22Q2 to 678.3 in FY22Q3 of mobile crisis supports across 465 days. Generally, individuals are provided with crisis service for about 3 to 5 days with a targeted average per day of 2 hours. The third quarter data shows a range of between 1-15 days of services provided with a range of 3.8 to 10 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	2-5	1-4	1-15	1-5	2-9
Average Days/ Case	3.4	3.7	8.0	2.6	4.3
Average Hours/Day	2.3	1.7	1.2	1.4	1.3
Average Hours/Case	7.8	6.2	10.0	3.8	5.8

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. FY22 quarter three as in the previous quarter were impacted by COVID-19 precautions, face prevention services (e.g. telephonic communication); are included in the total number of prevention hours provided, across each program. On the graph that follows, 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.



	Region I	Region II	Region III	Region IV	Region V
N= Prevention Supports, face-to-face	101	169	122	105	178
N= Prevention Supports, non-face-to-face	0	0	0	0	2
Prevention Hours	510	927.3	1102.79	1067.25	472.72

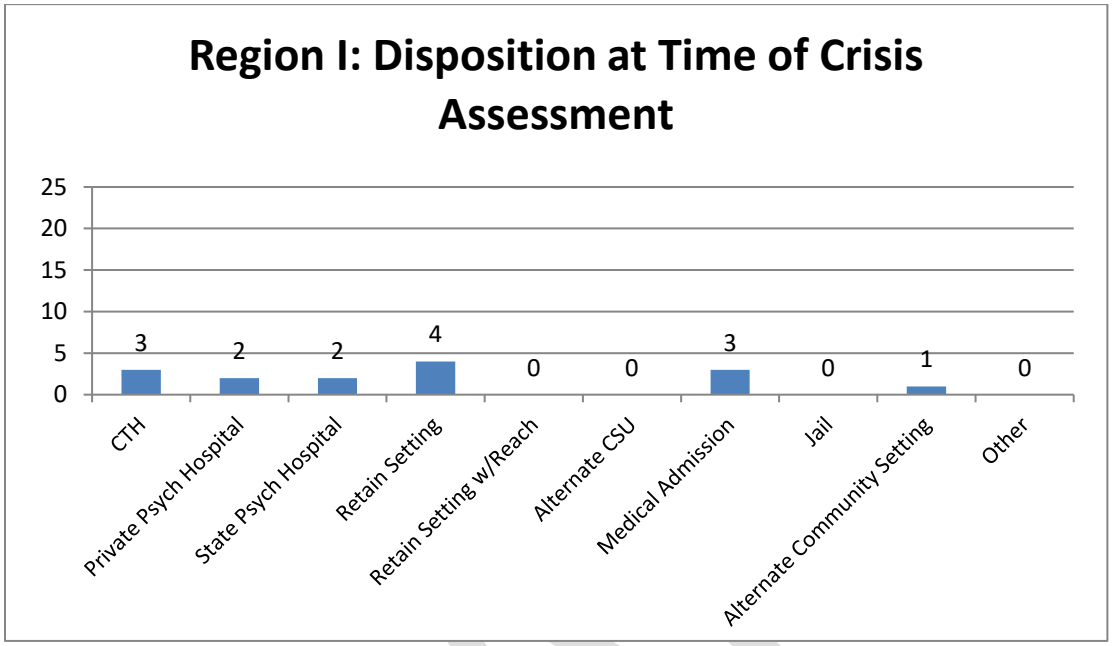
The total number of individuals receiving face-to-face prevention for FY22Q3 was 675. The total number of prevention hours provided by all programs in quarter three was 4080.06, which is a slight decrease from FY22Q2.

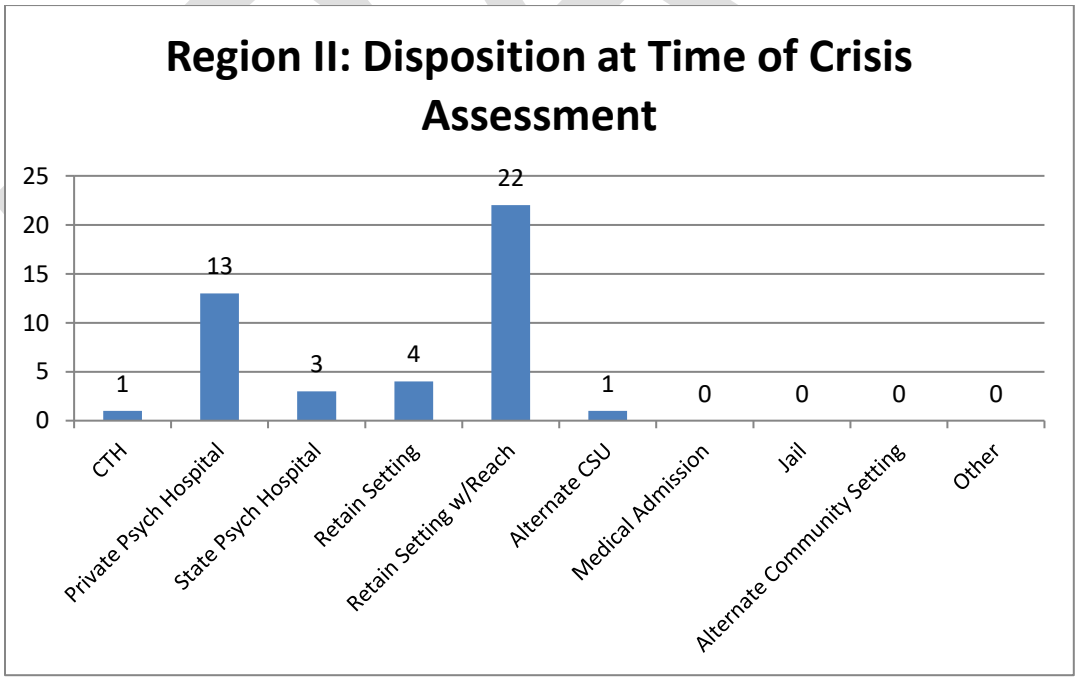
Crisis Service Outcomes/Dispositions

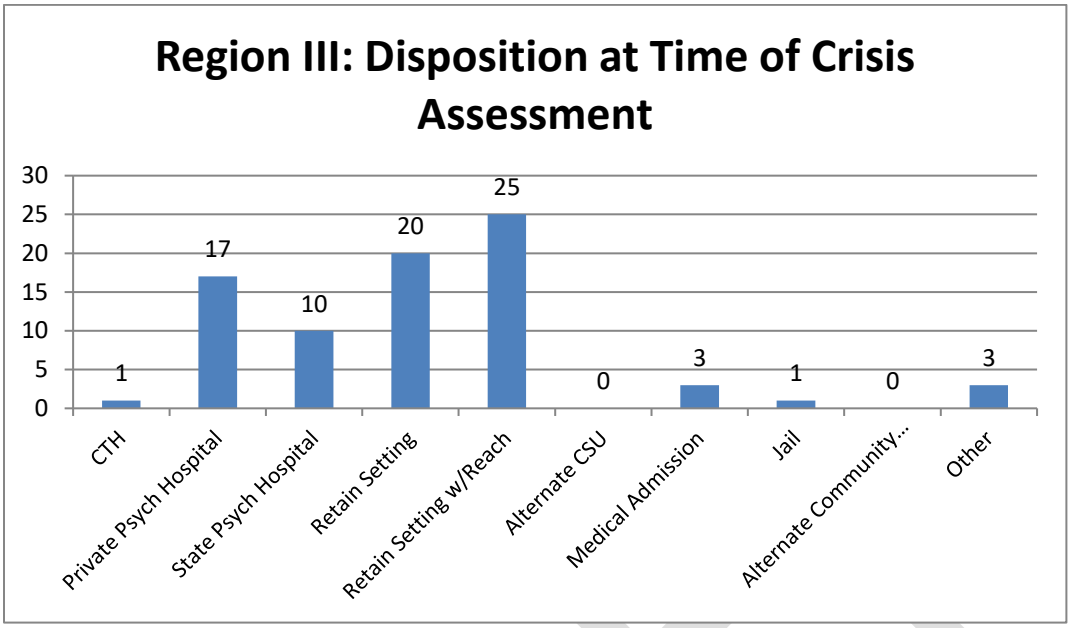
Maintaining residential stability and community integration is one of the primary goals of the REACH programs. Disposition data from three different perspectives are considered in this report. First, what is the outcome when a crisis assessment is needed? Second, what is the outcome when one is admitted 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, 45.4% of the individuals receiving a crisis assessment were able to retain their original residential setting, 18.6% of individuals were able to retain their setting with REACH support, 3.5% were diverted to a CTH, 1% of individuals diverted to an alternate CSU or residential setting, and 18.6% were psychiatrically hospitalized in a private hospital, while 8.3%

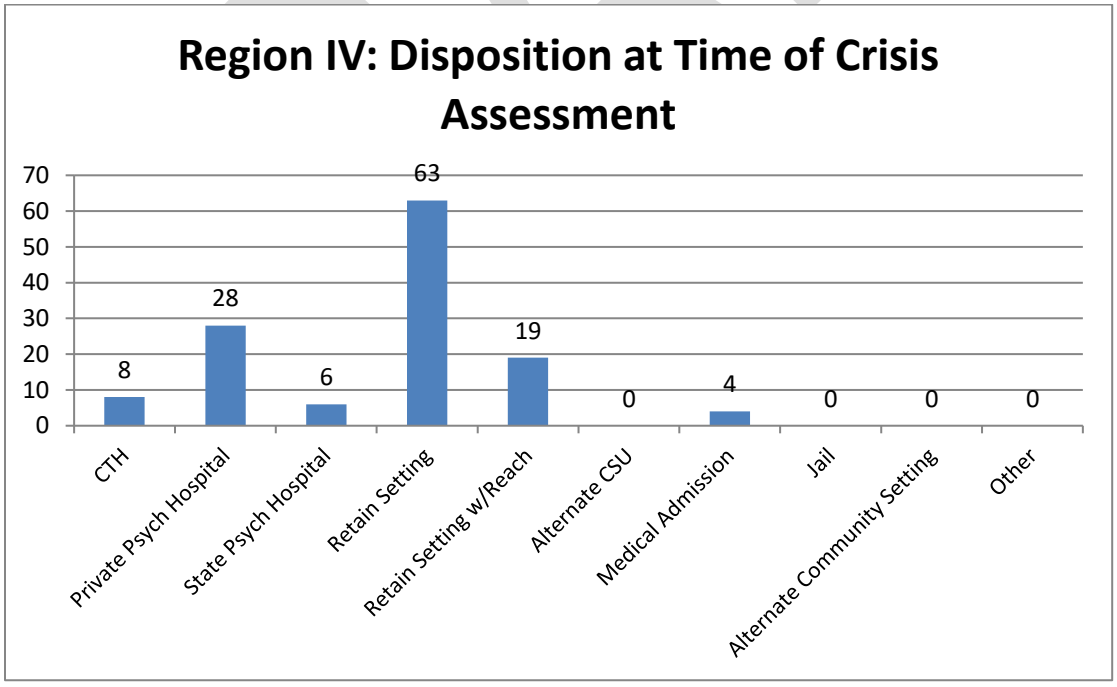
were hospitalized in a state psychiatric hospital, and 2.9% were medically hospitalized. The following graphs display the outcomes of the crisis assessments across each regional program.

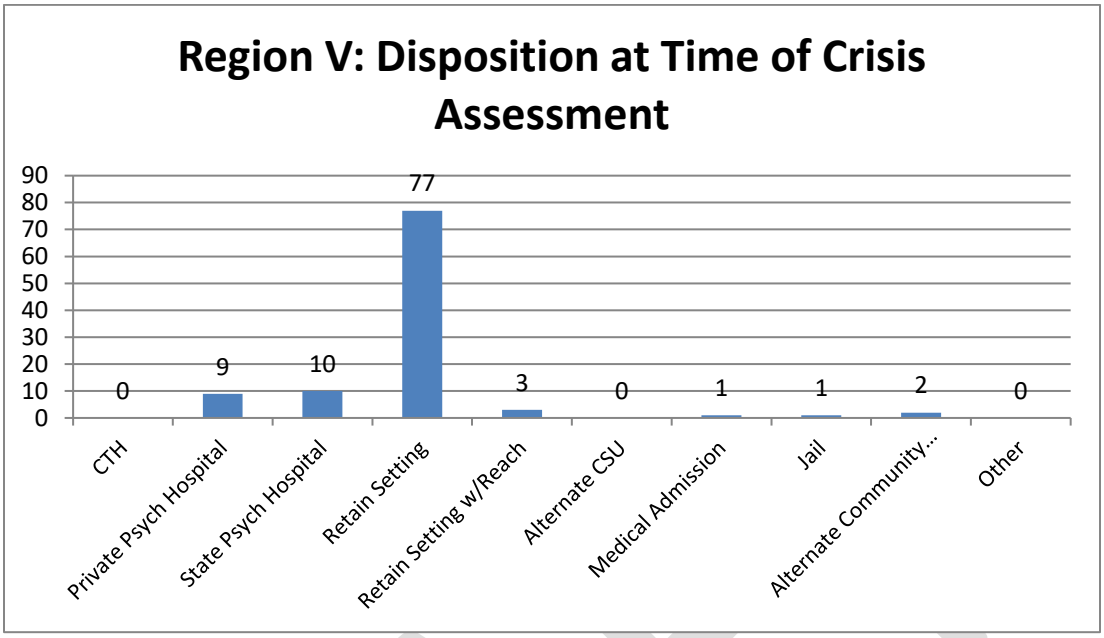






Other: Two individuals received ALT crisis supports, 1 remained at ER.

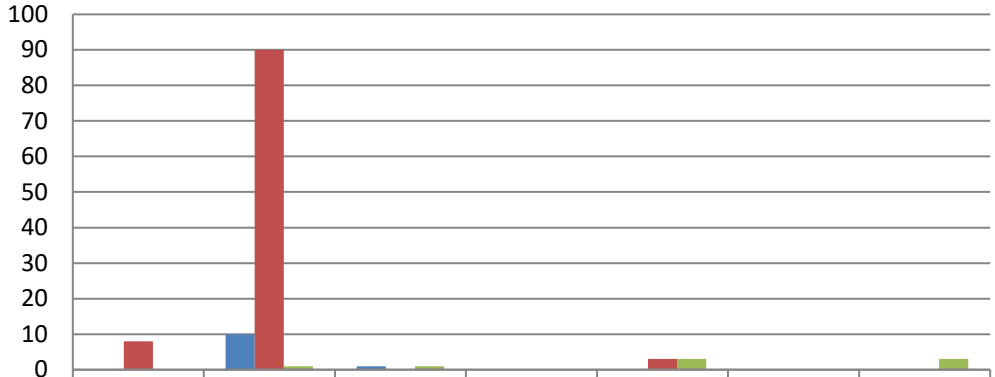




Outcomes that are also of interest are those for individuals that have accessed REACH mobile crisis and mobile prevention services during the quarter in addition to the CTH. Similar to the preceding set of graphs, the following graphs provide a summary of outcome status for adults that accessed ongoing REACH services during the quarter. Based upon mobile crisis support outcomes for adults, approximately 98% of were able to avoid psychiatric hospitalization with the provision of mobile crisis supports. Based upon reported data of mobile prevention supports, approximately 91% were also able to avoid psychiatric hospitalization. For CTH services, approximately 92% were able to avoid hospitalization. These data suggest that community based REACH supports are overall effective in helping families and their children through times of crisis and in maintaining stabilization post-crisis such that placement in the community can be maintained.

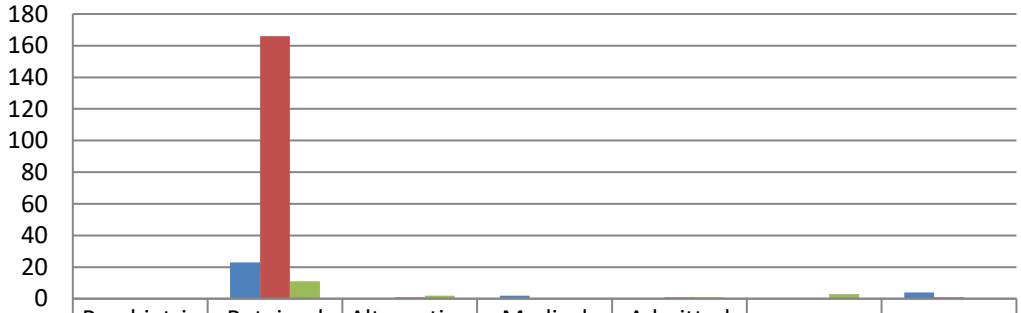
The following graphs display the outcomes of the support services across each regional program. These charts also include outcomes for re-admissions and people carried over and discharged in the quarter.

Region I: Discharge Disposition by Service Type



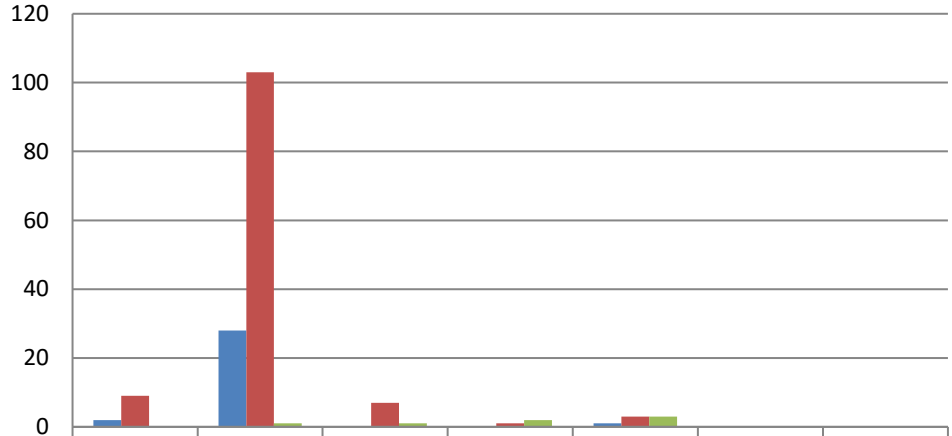
	Psychiatric Hospital	Retained Placement	Alternative Residential	Medical Treatment	Admitted to CTH	Jail	Other
Mobile Crisis	0	10	1	0	0	0	0
Mobile Prevention Services	8	90	0	0	3	0	0
CTH	0	1	1	0	3	0	3

Region II: Discharge Disposition by Service Type



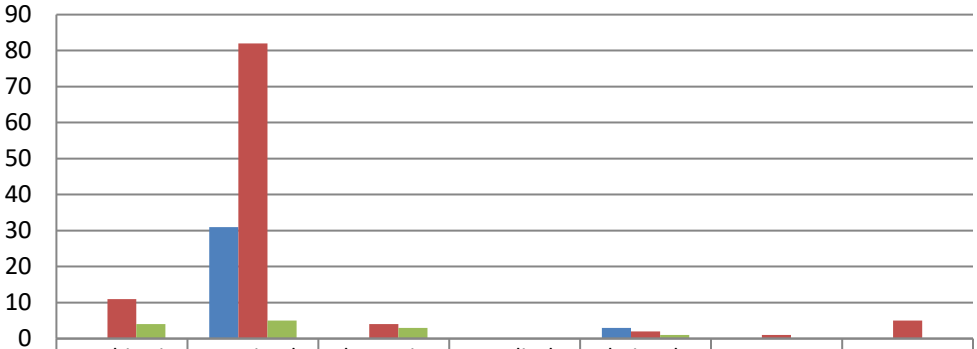
	Psychiatric Hospital	Retained Placement	Alternative Residential	Medical Treatment	Admitted to CTH	Jail	Other
Mobile Crisis	0	23	0	2	0	0	4
Mobile Prevention Services	0	166	1	0	1	0	1
CTH	0	11	2	0	1	3	0

Region III: Discharge Disposition by Service Type

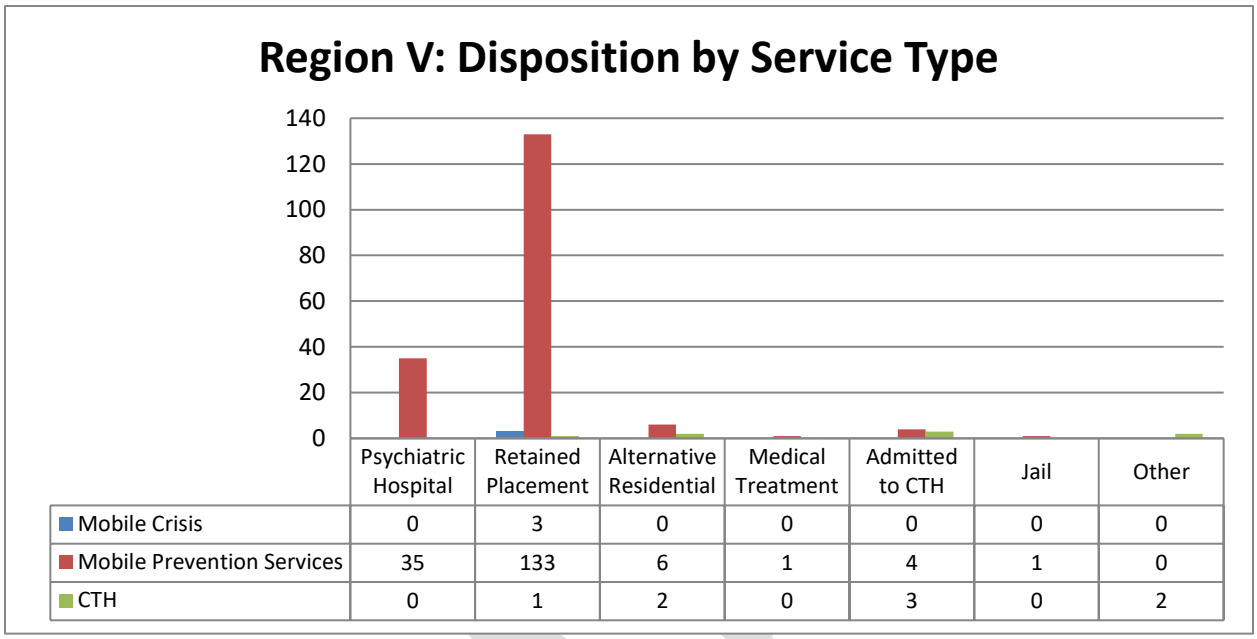


	Psychiatric Hospital	Retained Placement	Alternative Residential	Medical Treatment	Admitted to CTH	Jail	Other
Mobile Crisis	2	28	0	0	1	0	0
Mobile Prevention Services	9	103	7	1	3	0	0
CTH	0	1	1	2	3	0	0

Region IV: Discharge Disposition by Service Type



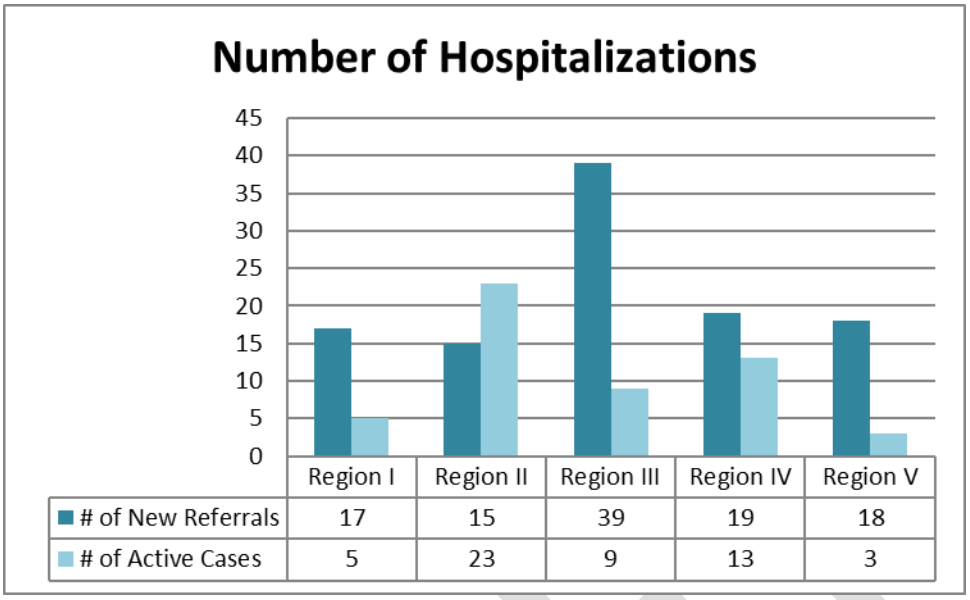
	Psychiatric Hospital	Retained Placement	Alternative Residential	Medical Treatment	Admitted to CTH	Jail	Other
Mobile Crisis	0	31	0	0	3	0	0
Mobile Prevention Services	11	82	4	0	2	1	5
CTH	4	5	3	0	1	0	0



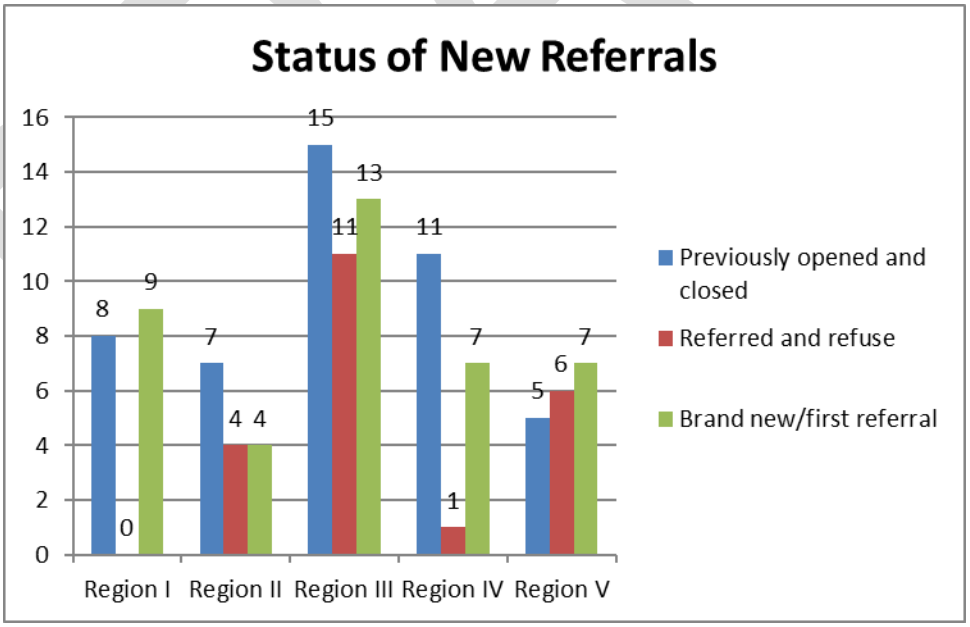
	Psychiatric Hospital	Retained Placement	Alternative Residential	Medical Treatment	Admitted to CTH	Jail	Other
Mobile Crisis	0	3	0	0	0	0	0
Mobile Prevention Services	35	133	6	1	4	1	0
CTH	0	1	2	0	3	0	2

Hospitalizations

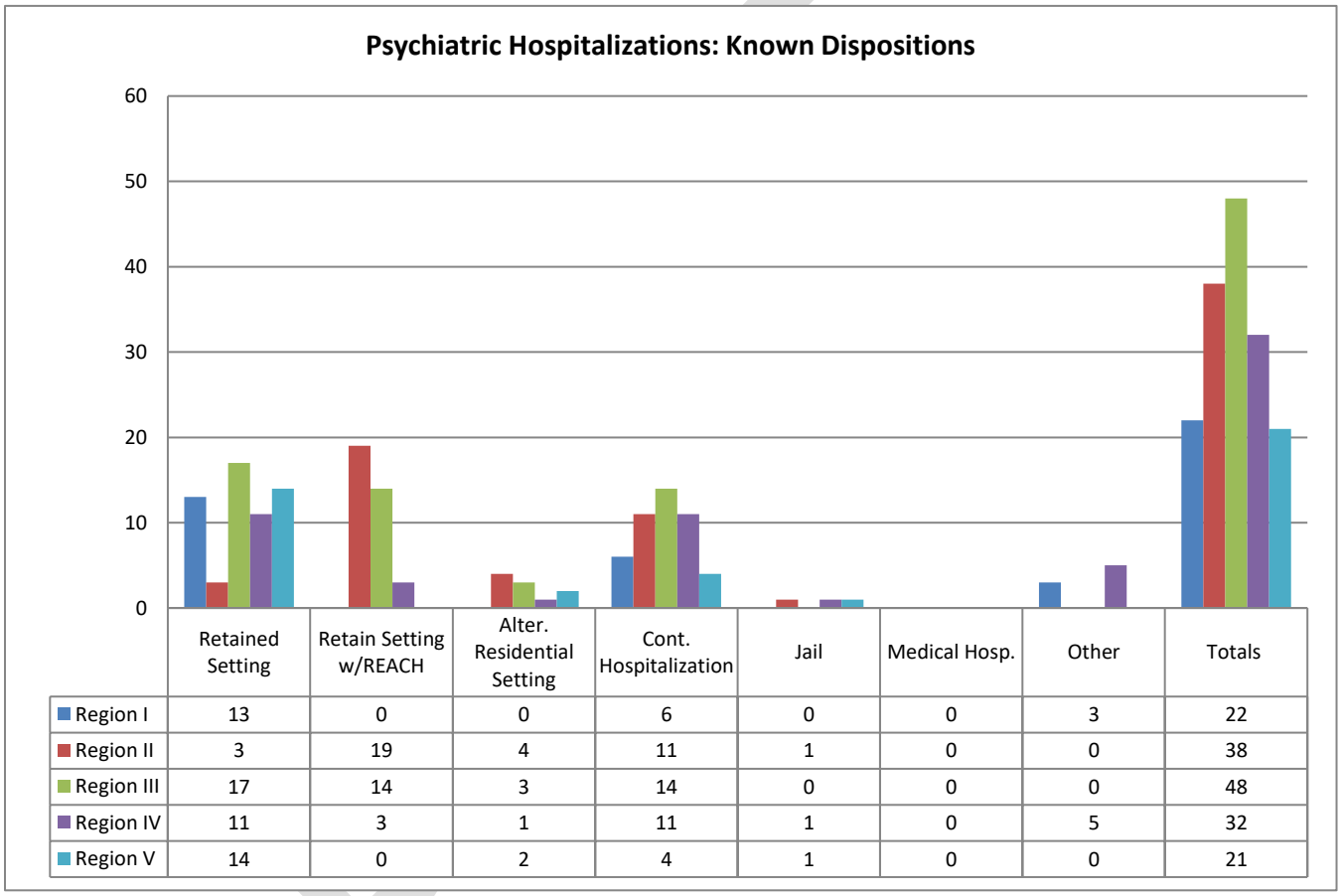
The next graphs provided are intended to supplement the information contained in the larger quarterly report. While the REACH programs remain actively involved with all hospitalized cases *when they are aware of this disposition*, they may not always be apprised that a REACH consumer has been hospitalized 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.



Sixty-seven percent (67%) of all hospitalizations were "new referrals" to the REACH program. Of the **new** referrals to REACH that were hospitalized, 37% of the individuals were new to the program, 20% were referred to REACH but refused services, and 43% had been previously discharged (inactive) from REACH services. Of the known dispositions of the people hospitalized and discharged, 83% 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.



	Retained Setting	Retain Setting w/REACH	Alter. Residential Setting	Cont. Hospitalization	Jail	Medical Hosp.	Other	Totals
Region I	13	0	0	6	0	0	3	22
Region II	3	19	4	11	1	0	0	38
Region III	17	14	3	14	0	0	0	48
Region IV	11	3	1	11	1	0	5	32
Region V	14	0	2	4	1	0	0	21

Includes readmit outcomes. Other: CTH admissions, re-hospitalization, shelter, hotel, and death of an individual.

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 instances 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, as well as individuals that will receive a CEPP or training in the coming quarter, the combined REACH programs trained providers/families on 91% 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. The reasons identified for those not completing training this quarter is as follows: Multiple included serviced ended at end of quarter and not due, teams or individuals declined training, medical admission, still admitted to service.

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	4	4	3	10	10
Consultation	4	4	3	10	10
Crisis Education Prevention Plan	3	4	3	10	9
Provider Training	2	3	2	10	9

R1 1 individual no team to train, I admitted end of quarter. R2 CEPP training planned due to short LOS. R3 training delayed due to no provider to train, R4 individual out of region, no CEPP developed. R5 1 left AMA, 2 scheduled at dc.

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	0	0	0
Consultation	0	5	0	0	0
Crisis Education Prevention Plan	0	5	0	0	0
Provider Training	0	4	0	0	0

R 2: 1 training scheduled.

Service Type: Crisis Stepdown (CTH)					
Service Type Delivered per Case	Region I	Region II	Region III	Region IV	Region V
Comprehensive Evaluation	0	7	2	2	3
Consultation	0	7	2	2	3
Crisis Education Prevention Plan	0	6	2	1	3
Provider Training	0	5	0	1	3

R2 1 individual remained admitted to CTH 1 med hospitalized. R 3 no provider identified to train,

Service Type Provided: Mobile Crisis Support					
Service Type	Region I	Region II	Region III	Region IV	Region V
Comprehensive Evaluation	11	27	29	31	3
Consultation	11	27	29	31	3
Crisis Education Prevention Plan	11	22	13	31	3
Provider Training	6	17	12	31	3

R1 Training: 2 finished end of quarter not due, 1 declined due to health issues, 1 moved; R2 CEPPS: 4 carried over into 4th qtr, and 1 other due in Q4, R2 -Training: 2 teams declined, 1 refusal, 1 postponed due to illness and 1 medically admitted; R3- 16 individuals will receive CEPP and training in FY22Q4 ,1 previous quarter trained.

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 1210 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	20	72	14	49	23	178
Case Managers/Support Coordinators	0	27	10	4	17	58
Emergency Service Workers: #Trained	0	5	1	2	8	16
Family Members: #Trained	0	176	0	12	12	200
Hospital Staff: #Trained	0	2	1	0	0	3
DD Provider: #Trained	0	151	2	281	4	438
Other Community Partner: #Trained	20	8	306	3	0	317
Totals	20	441	334	351	64	**1210**

*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 third 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 implement and sustain consistent processes, training requirements, and documentation across all of the REACH Programs. During FY22Q3, the regional programs continue to experience impact due to COVID-19 and the national staffing shortage. REACH programs continue to follow CDC and local VDH guidelines for health and safety measures. Staffing shortages have affected CTH capacity rates and the programs are working diligently on recruiting and also retaining those qualified and veteran staff within the programs. The combination of staffing shortage and COVID-19 positive rates have resulted in temporary census reductions due to the health and safety of individuals and staff in staffing to ensure REACH programs meeting licensing requirements for staff ratios and continued support of those requiring an increased level of care during their admission to services. The programs continue to provide a combination of telehealth in-person responses as much as possible while maintaining COVID-19 precautions and meeting system/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 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.