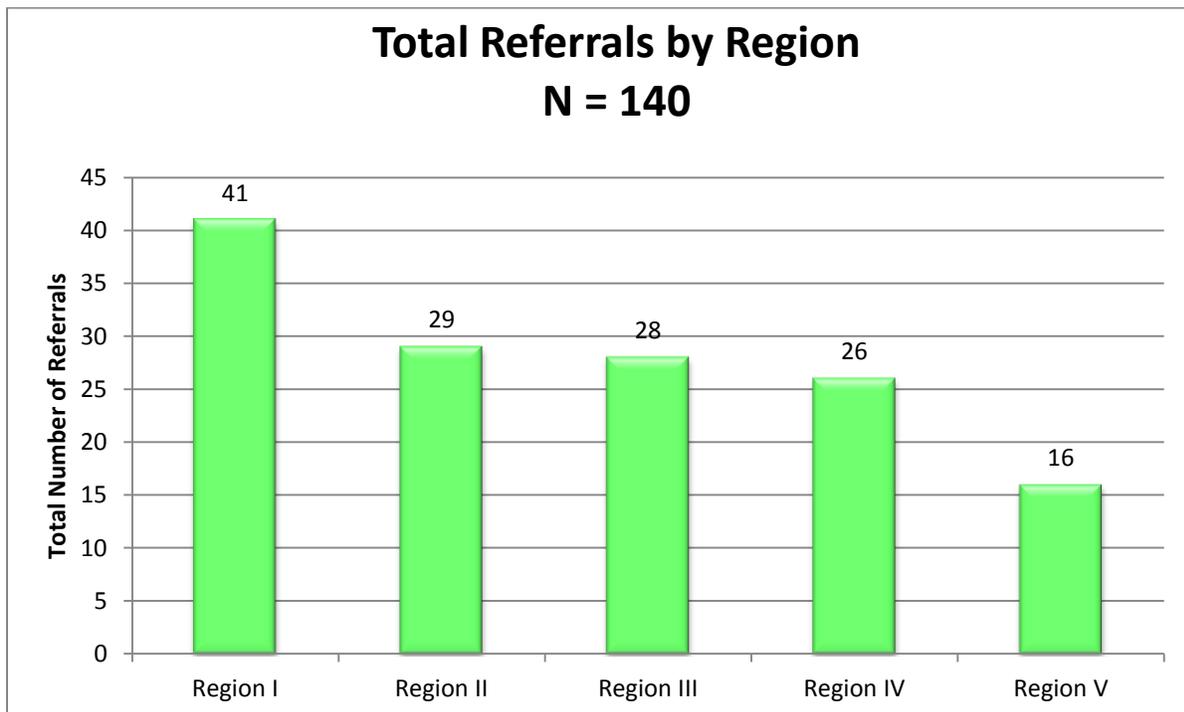


REACH Data Summary Report: Quarter III/FY15

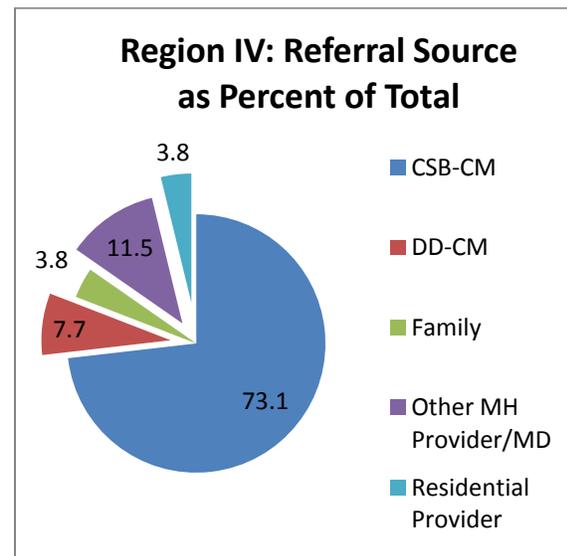
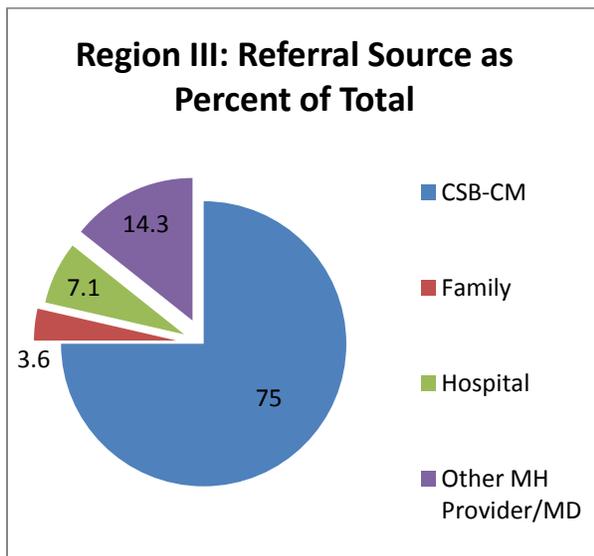
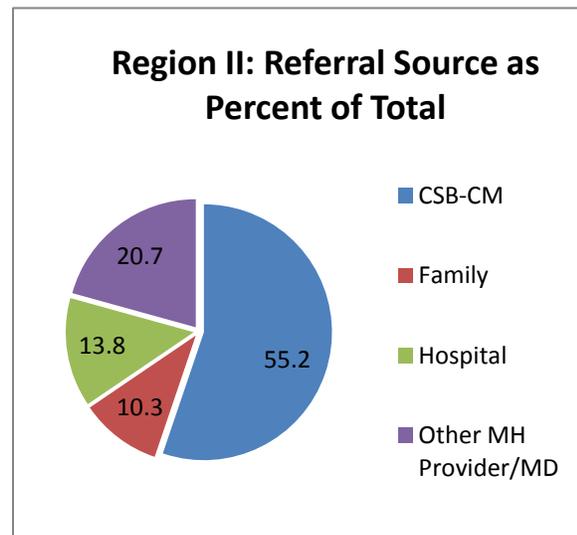
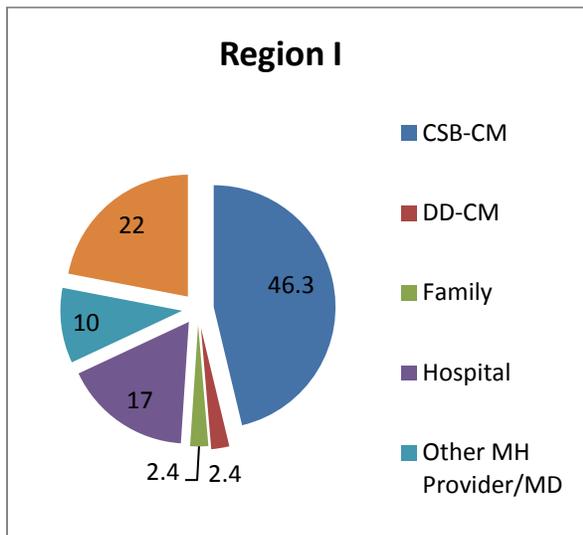
The following report provides a summary of data related to the operation and utilization of the regional REACH programs for adults. It updates the report written in March of 2015, providing the same type of information with updated data and analysis. As with the previous quarter, this document is organized to address the referral process to the REACH programs, the operation of the 24/7 crisis lines, the Crisis Therapeutic Home (CTH), the Mobile Crisis Response, and training and outreach efforts.

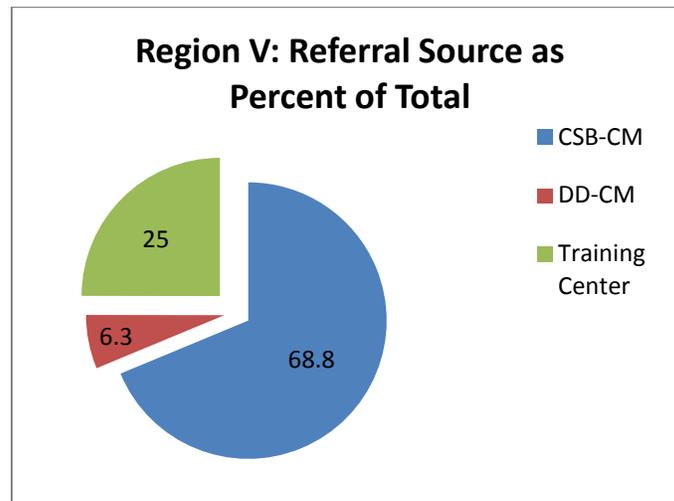
REACH Referral Process

The REACH programs have continued to receive new requests for services at a fairly steady rate. The total number of referrals received for the quarter was 140, an increase of only 7 referrals from the second quarter of Fiscal Year 2015. Despite this small overall increase, there were changes in the distribution of referrals across the five regions. While Region I continues to receive the highest number of referrals, Region II has increased their referral activity significantly, assuming the second position in terms of degree of referral activity. This is a positive sign for the Region, as they had the fewest number of referrals in quarter II. Region V's service requests dropped by seven for the current review cycle. They received the fewest referrals of the five programs. Likely, it is too early in the data review process to understand the patterns of fluctuation in service requests between and within regions. It will be important to continue to track this data and identify any patterns that may exist. It will potentially be helpful in preparing staffing patterns and planning for the growth of services. The graph below visually summarizes this information, highlighting regional differences in referral activity.



Using referral source data continues to be one way of assessing the REACH programs' visibility in the community and integration into the larger behavioral health service system throughout the Commonwealth. Trends in this data were identified early in the initiation of the REACH service, with referral activity dominated by case managers from local Community Services Boards (CSB). This finding remains robust across the state, and there appears to be no identified reason that this trend should shift. Most mental health and behavioral health services in Virginia are initiated and coordinated through case management services. The fact that the REACH programs fall within this practice suggests that they have become fully incorporated into the case management process for building a plan for wrap around services or Individualized Service Plans (ISPs). Referrals do come from a variety of additional sources, but generally, each source contributes only a small amount to the overall pool. The pies are cut into one very large piece and several smaller portions. Further detail may be seen in the graphs below.



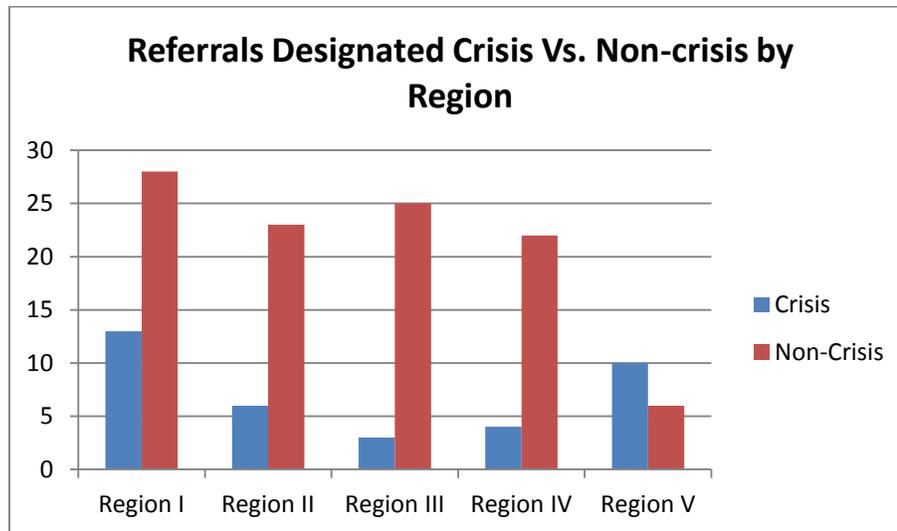


It is interesting to note that Regions IV and V did not receive referrals from psychiatric hospitals, despite multiple state hospital admissions within their respective regions. This may suggest a greater need for active networking and collaboration between the REACH programs and the inpatient providers in their Region. Region V has begun to formalize this process through the joint efforts of REACH, Eastern State Hospital, and Southeast Virginia Training Center (SEVTC). These agencies are working together to create a more appropriate continuum of care for individuals with an intellectual disability and serious mental illness. It will be interesting to see how these efforts to partner with other agencies create a more seamless experience for individuals who need more intensive services.

Consistent with last quarter, referrals to the REACH programs are overwhelmingly received Monday through Friday during normal business hours (8:00 am to 5:00 pm). On rare instances, referrals do come in after hours. For the quarter under review, only one service request came in on a weekend. Fifteen came in after hours, with most of these coming in between the hours of five and 9 p.m., and only 2 coming in the early morning hours. This positive trend continues from last quarter, and adds additional support to the notion that the REACH programs are being accessed prior to a crisis developing. The fact that referrals, with extremely few exceptions, are addressed as an element in the routine work day also indicates that the prevention model that the programs work to promote is finding its way into the daily practice of case managers and other mental health providers. An interesting next step may be to look at the source of referrals that are received after hours. While it would be a lengthy process to get a sufficient number of cases to analyze in a meaningful way, the data could highlight where additional program education and outreach may be needed. Given that REACH is seen and acknowledged as the statewide "crisis" system for individuals with intellectual and developmental disabilities, it is quite possible additional efforts to re-frame the program's mission and identity would be helpful.

Another way to consider the degree to which referrals are made due to a prophylactic need versus a reactive one is to examine how the referrals are designated by the service system when

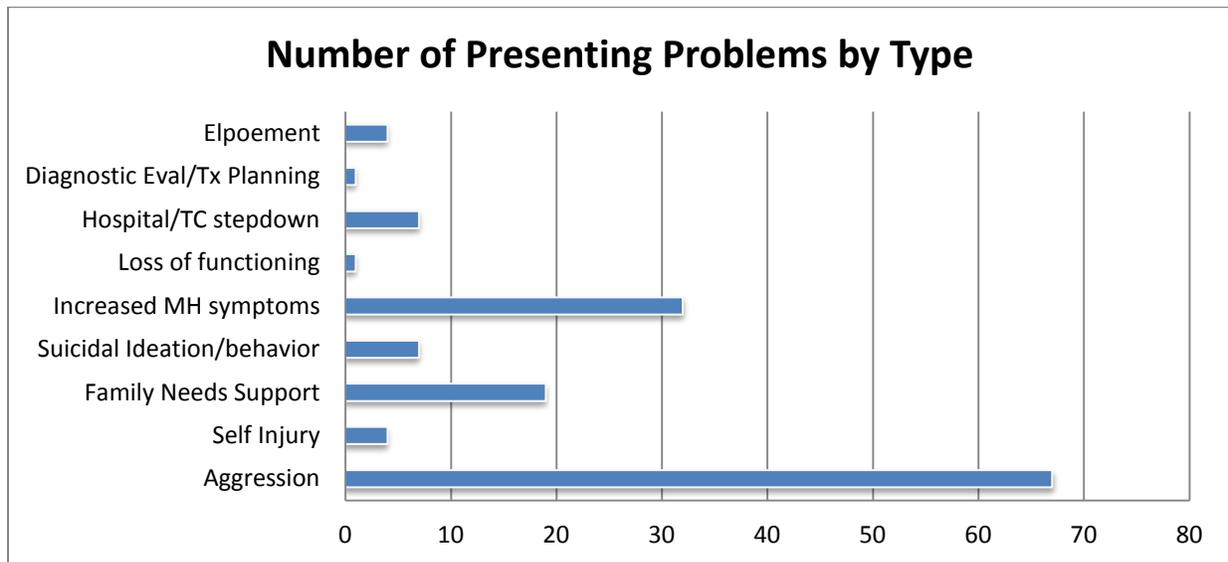
they are received. Across regions, requests for service are deemed to be non-crisis in nature 74.3% of the time, while 25.7% reflect acuity consistent with a crisis.



Referral Time	Region I	Region II	Region III	Region IV	Region V
Monday-Friday	40	29	28	26	16
Weekends/Holidays	1	0	0	0	0
After 5:00	6	3	4	1 (5:01)	0
8:00 am to 2:00 pm	24	17	16	16	8
3:00 pm to 8:00 pm	14	7	10	10	6
9:00 pm to 2:00 am	0	2	0	0	1
3:00 am to 7:00 am	0	0	2	0	0

In terms of what type of clinical issues bring individuals to the REACH programs for support, aggressive behavior, to include physical aggression, verbal threats, and property destruction, is what most often necessitates a referral, although this is not the case in Regions II and III. The table below provides program specific information on presenting problems. Aggregated data is presented in the graph just below this table.

Presenting Problem	Region I	Region II	Region III	Region IV	Region V
Aggression	18	12	12	15	10
Self Injury	1	0	1	0	2
Family Needs Support	8	0	6	4	1
Suicidal Ideation/Gesture	3	1	2	1	0
Increased Mental Health Symptoms	5	15	7	3	2
Loss of Functioning	0	0	0	1	0
Hospital/TC Step-down	4	0	1	2	0
Diagnostic Eval/Tx Planning	0	0	1	0	0
Elopement	2	1	0	0	1



Aggregated information about primary presenting problem is unchanged from last quarter's information. The three most frequent presenting problems remain aggression, increased mental health symptoms and families in need of support. Likewise, their relative order is the same, with aggression being the most commonly reported referral issue and family requesting support being the third. The reader is reminded of the significant relationship between aggression and increased mental health symptoms such that, in some cases, identifying *the* primary presenting problem might be somewhat arbitrary. The data continue to support the conclusion that the REACH programs are primarily addressing behavioral challenges and increased psychiatric acuity. This is consistent with their admission criteria and their overall mission for the Commonwealth. Other presenting problems appear idiosyncratic in nature and may be as much a function of regional differences as of pure chance. Efforts will continue to look for emerging trends in this data in the hopes of better understanding the population the programs serve.

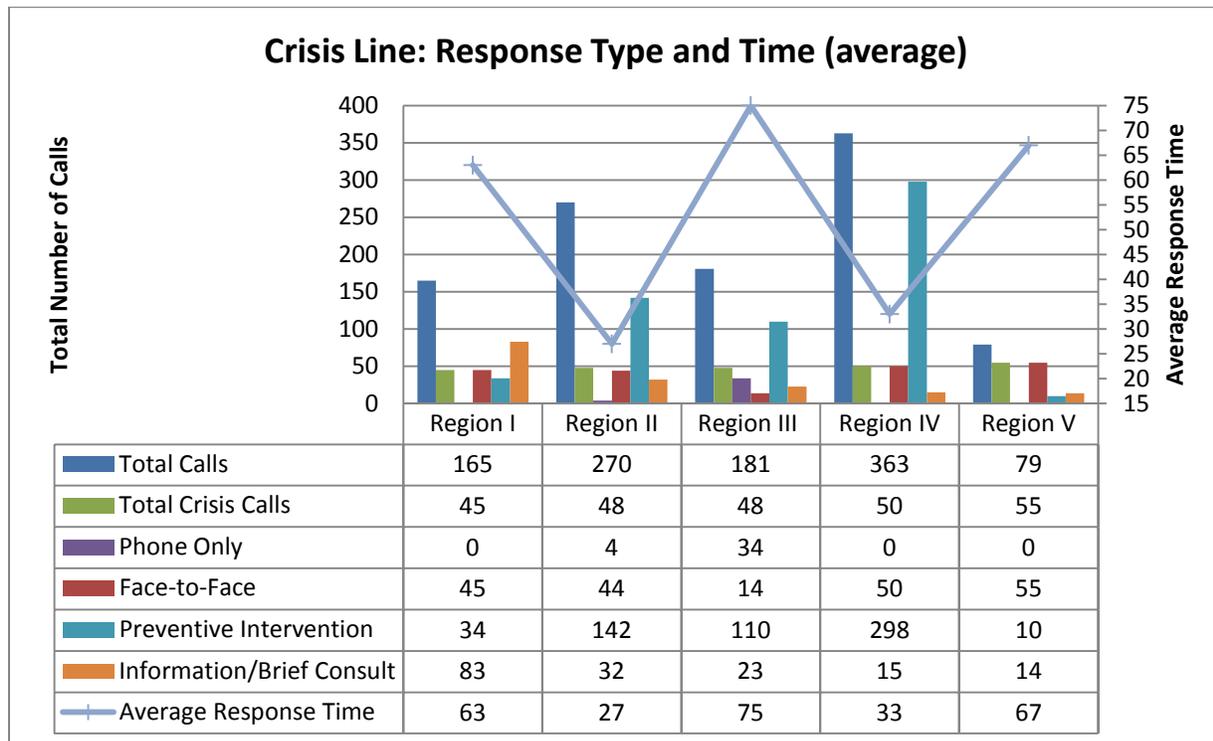
REACH Crisis Response

Each of the five regional REACH programs operates a crisis line 24-hours per day, seven days per week. Calls coming into the crisis lines may be from existing REACH clients 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. Domains of interest related to crisis response include the type of response, the response time to the site of the incident, the location where an on-site assessment and intervention took place, and the outcome of the mobile crisis response. Last quarter, it was reported that only a minority of crisis calls required an on-site response. The report suggested that, "the crisis lines may be serving a preventive function by allowing providers and individuals to reach a clinician to

resolve an issue before it develops into an emergency. This prophylactic function is wholly in keeping with the REACH model that emphasizes skill building and crisis prevention.” In further exploring this hypothesis and talking with the programs over the course of the quarter, it was determined that the term “crisis” lacked precision in its definition. All calls coming in on the 24-hour crisis line had been categorized as crises in previous quarters. However, what became apparent during the quarter under review was that many of these calls were more preventive in nature. Such calls were effectively resolved through telephone consultation or intervention. For example, a REACH client may call the crisis line due to an interpersonal conflict with family or a residential provider. REACH staff may then assist the individual with problem solving, or coach them through the use of an identified coping skill. Frequently, this works well and a potential crisis has been prevented. Therefore, to increase accuracy, data regarding crisis line activity is now being parceled out in the following way:

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

This breakdown provides a better method for understanding the REACH programs and how they have operationalized crisis services. A summary of information about crisis calls and responses is depicted in the graph below. Please note that this graph encompasses all calls received on the crisis line during the review cycle. Therefore, it includes on-site responses to existing REACH clients, repeat calls from individuals, and new referrals. Therefore, call totals when combined across categories will exceed the total number of referrals for the quarter.



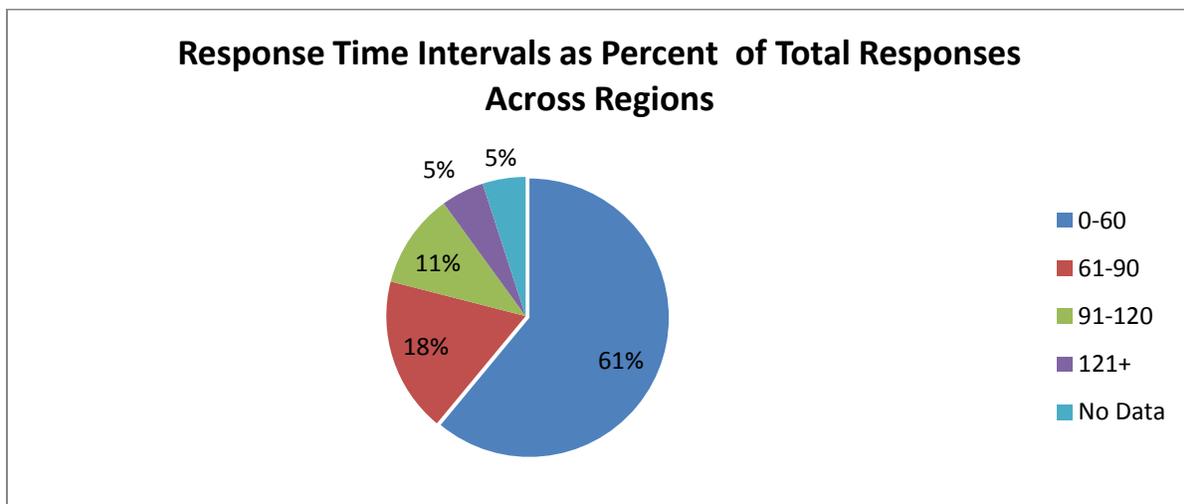
In terms of response times to the site of a critical event, all five regions are currently meeting the expected standard for their regions when response times are averaged within region. Regions II and IV are expected to respond to the site of a crisis call within 60 minutes. Average response times for these regions are 27, and 40 minutes, respectively. Regions I, III and V, designated as rural regions, are allowed a two hour response time, which all were well below (Region I: 63; III: 75; Region V: 67). Indeed, Region I's response time average only exceeds the more stringent standard of urban areas by three minutes.

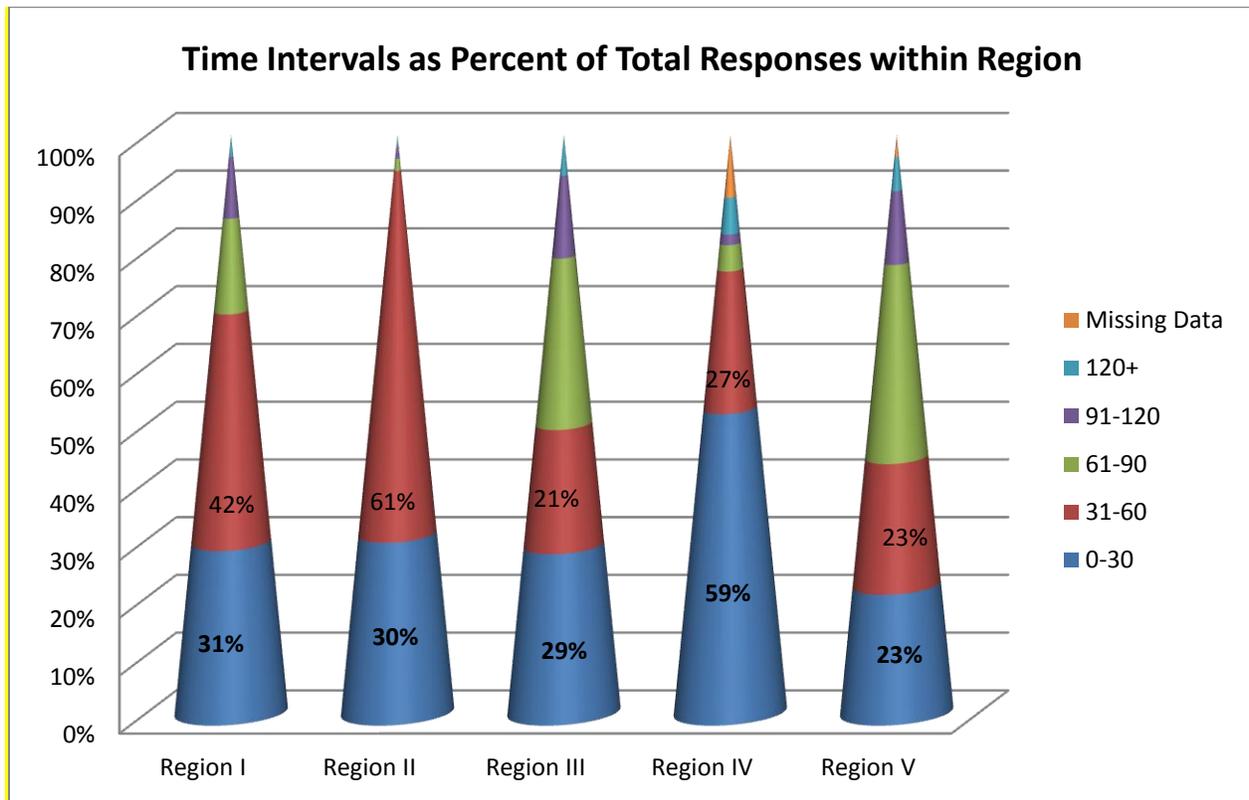
Examining individual response times also provides very useful information. When reviewing the raw data as documented in regional call logs, it can be seen that responding outside of the standard designated in the Settlement Agreement is at a very low rate. Across the quarter, only 8 on site responses exceeded expectations set for the regions. Reasons given for the extended response times included traffic, long travel distance, change in the person's location and driver getting lost. The table below provides a summary of response times broken out by 30 minute time intervals. The table presents both regional and aggregate data in a single table. On-site crisis responses reflect responses to new referrals, existing Reach clients, and multiple responses to the same client over the quarter.

Region	Total On-site Responses	0-30	31-60 Minutes	61-90 Minutes	91-120 Minutes	121+
Combined	208	66	69	34	22	6
I	45	14	10	7	13	1
II	44	13	27	2	1	1
III	14	4	3	4	2	1
IV*	50	24	18	4	0	0
V*	51	11	11	17	6	3

* Note: Regions IV and V have missing data. The above table is based upon information available.

As noted in last quarter’s report, meaningful information can also be gleaned by considering the percentage of responses that fall into the “hit rate”, meaning those that meet established standards. This can be looked at in aggregate or differences between regions can be explored by calculating hit rates regions by region. The aggregate data offer the broadest view, but do not allow for an understanding of regional differences. By looking at each region and considering the contribution each time interval makes to that region’s overall response rate, the region is compared only to itself. The two charts below offer these different perspectives in graphic form, affording the reader additional clarity on the relationships within and among regions. The overall hit rate across all regions is 83.6%, indicating that only about 16.4 % of responses did not meet their target. Note that these figures do not include missing data which may either increase or decrease the overall hit rate. Region IV had 4 missing response times and Region V had 3 missing responses.





The chart on the previous page (*Response Time Intervals as Percent of Total Responses Across Regions*) offers a slightly different interpretation on response time by making finer distinctions in the time intervals considered. Regardless of regional designations, well over 50 percent of crisis calls resulted in the on-site presence of REACH staff within 60 minutes. In 79% of cases, on-site assistance was achieved within 90 minutes.

The chart above illustrates each region’s contribution to the response intervals noted on the x-axis of the chart. Within each time interval, the cones represent the percent each region added to cumulative total (i.e. 100%) of the responses within that time interval. By looking at this pattern, we can see that Region V had the longest response times of any region, while Region II had the shortest. Region I has very little inconsistency among the response times, which suggests that the two hour response time generally “matches” the demographics and geography of the region.

Arriving at the crisis on time is one way to examine the mobility of a service. Where services are rendered provides a complimentary perspective. When responding to a crisis in person, REACH clinicians conduct assessments and initial interventions in a variety of settings. The table below provides information about where mobile responses occur throughout the five regions. These data suggest that mobile crisis teams are active and fluid in responding to the scene of a crisis in the natural setting. Clear statewide patterns do not emerge, although it is the

case that most crisis assessments occur in either the family home or the hospital emergency room setting. Indeed, these two settings account for 67.6% of all assessments completed.

Region IV is unique in that most assessments were conducted within residential provider homes, with very few taking place in other settings. Of the five regions, Region IV is the only one that has successfully seen the closure of a state training center. Only one individual from Southside Virginia Training Center (SVTC) left the institution to live with family, creating an immediate need for a larger pool of residential placements in the community. Therefore, throughout that process of closure, *many* residential providers were developed and existing providers contacted to support the replacement of the training centers with community options. While SVTC residents likely populate many residential providers in Region IV, the wealth of placements within the Region are also a resource for other intellectually disabled individuals, some of whom receive REACH services. Therefore, the closure of SVTC may be one element, albeit an indirect element, that contributes to this pattern. However, the reader is cautioned that there are many other factors that likely contribute to Region IV's data. Given the data that is currently being collected, even identifying other variables would be a speculative process, open to all of the concerns that arise from "data mining" practices, in the traditional sense of the phrase.

In three out of five regions, hospital emergency rooms are the most common location for mobile assessments while family homes hold the secondary position. While Region II conforms to this pattern, this is only true by the smallest of margins, as 9 mobile crisis assessments occurred in the CTH itself as opposed to 10 taking place in the family home. Given that Region II has the highest rate of hospitalization following a mobile crisis response, it may be that they serve a more acute population. If one combines the number of evaluations completed in the CTH, the hospital, and the Emergency Services office, all higher intensity settings, this accounts for 61% of all assessments completed. This may be a function of the urban setting and its proximity to Washington, D.C.

Location of Mobile Assessments

Assessment Location	Region I	Region II	Region III	Region IV	Region V
Family Home	14	10	4	2	34
Hospital/Emergency Room	22	14	8	1	10
Residential Provider	0	6	0	12	5
Day Program	2	0	0	0	4
CTH	1	9	1	0	1
Emergency Services/CSB	3	4	0	2	0
Other Community Setting*	4	1	1	0	1

*Community crisis stabilization unit, hair salon, medical clinic

Crisis Therapeutic House

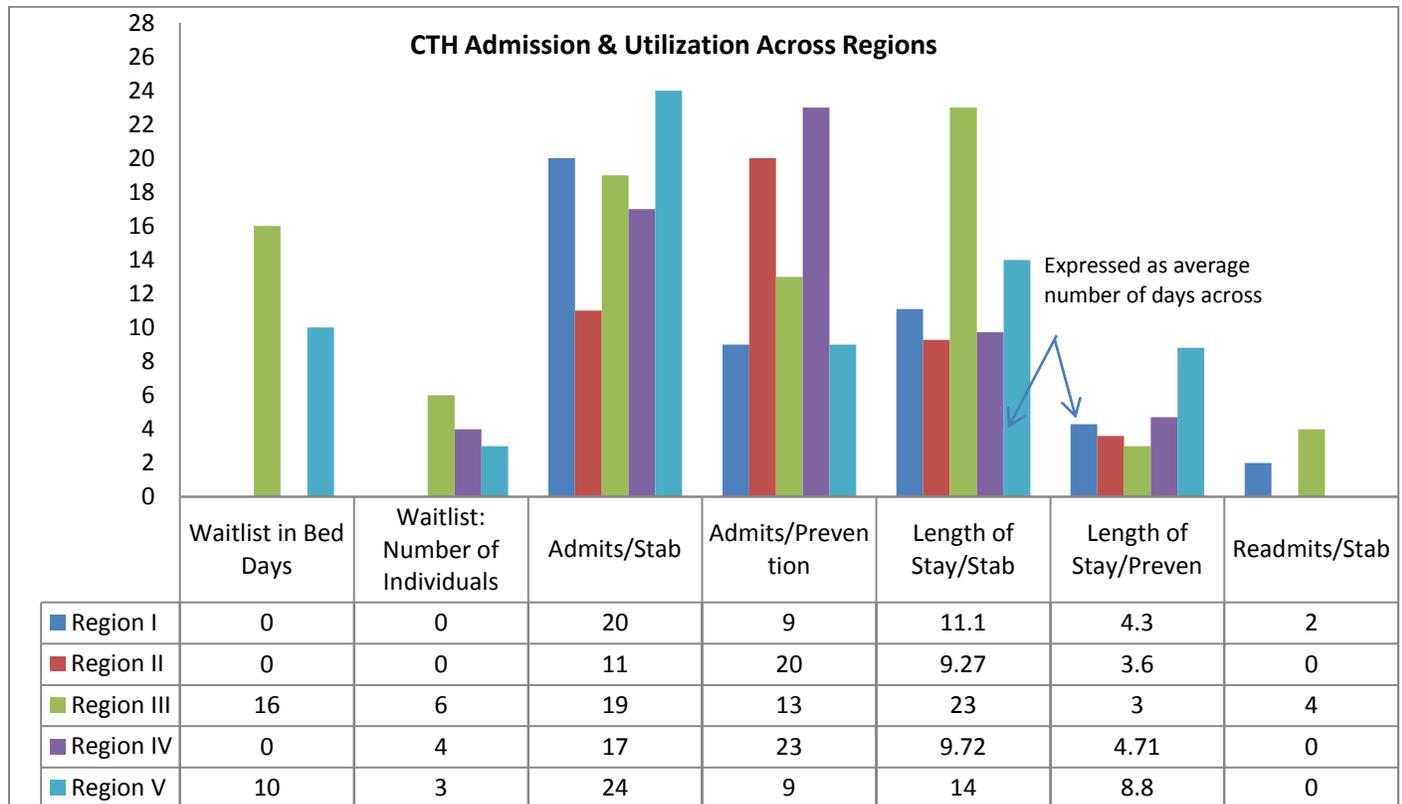
Each of the five REACH programs operates a CTH that accepts both crisis stabilization admissions as well as planned, preventive stays. Region IV, whose CTH is currently located on the campus of a facility serving children, has purchased land within the region and is working with an architect to draft plans for what will be a custom designed and built CTH. All other regions continue to operate their existing homes, and Region III has added one bed to their home. This allows them additional flexibility to serve individuals with less definite discharge plans who may need to extend their stay well beyond 30 days while appropriate services are located and/or developed. While it is not the intent that the CTH will routinely maintain a census of 7, the additional bed allows for brief periods of time when this may be necessary. It is anticipated that the 7th bed will be used only for intervals of one to three days, and that would be needed only sporadically. Region III's CTH does consistently run at capacity, and the addition of the 7th bed is intended to ease this.

In reviewing utilization patterns for the CTH programs, Regional differences still exist in types of admissions to each of the five CTH's, with Region II being utilized more frequently for planned/preventative admissions while the other regions utilize more bed space for stabilization services. This distinction may lessen over the next few months. Region II has successfully hired a Director after a protracted recruitment period. She is making a number of procedural and programmatic changes, with one identified outcome being an increase in crisis stabilization admissions to the CTH.

Information related to waitlists, length of stay, readmissions, etc. are presented in the graph below. 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. This quarter, three regions reported that individuals were informed of the need to wait for admission into the CTH due to lack of capacity or safety concerns related to the acuity of the census. In two regions, this resulted in bed space being unavailable for 16 days in one case and 10 days in the other. In the third case, 4 individuals could not be served when requested, and alternative services separate from REACH were accessed if the system agreed to the plan. This explains Region IV reporting an overall waitlist of zero.

In cases where admission to the CTH had to be delayed two outcomes were noted. Either mobile supports were put in place to sustain the individual in his/her setting until more comprehensive stabilization services could be provided through the CTH or alternative crisis stabilization services were established. In Region III, the available option was psychiatric hospitalization in three cases for initial stabilization with step down services at the CTH provided as bed space became available. Providing a CTH admission to a sister REACH program continues not to be a preferred alternative. While out of region admissions have been considered over the quarter,

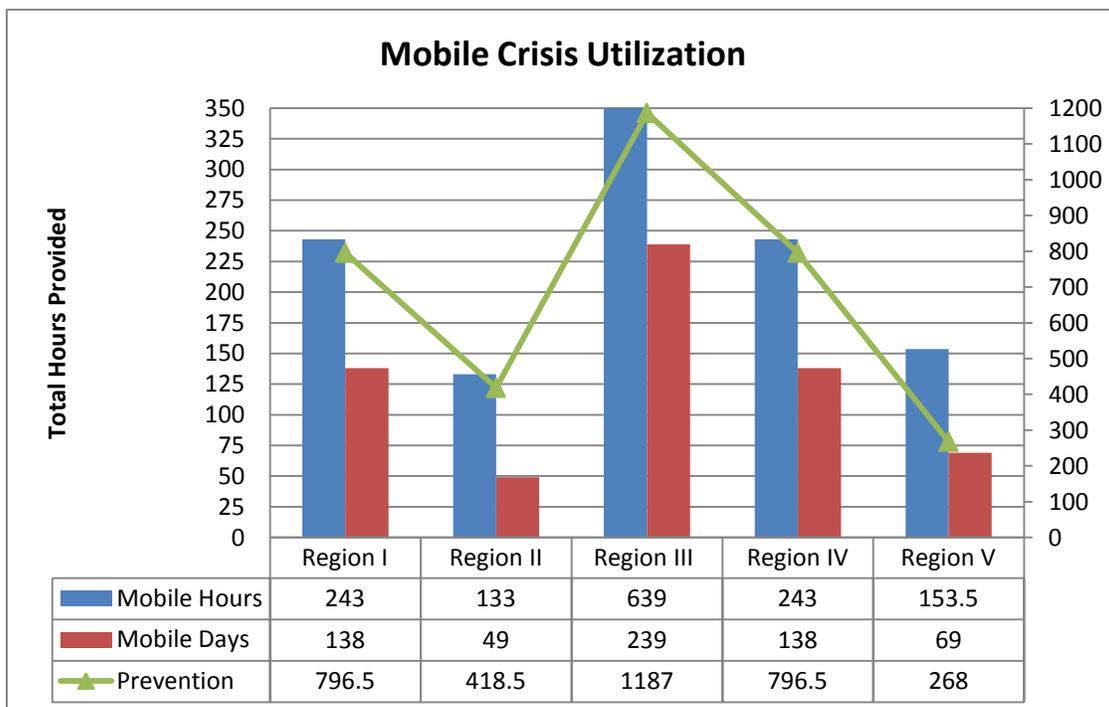
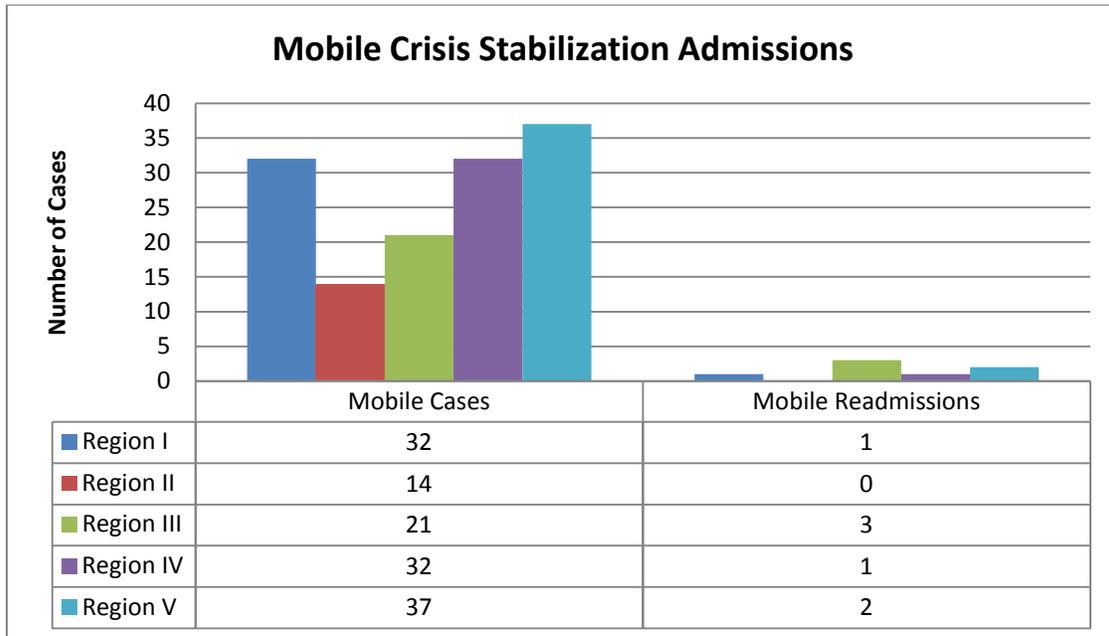
they have never resulted in an admission to a sister REACH program. Families often protest their loved one receiving services far away, and it is generally preferable for the individual to receive day-to-day support from their local REACH staff. While the regional REACH programs do offer support to one another, the shape that this support takes continues to evolve. Indeed, it may need to remain somewhat amorphous in order to remain flexible and creative enough to be truly helpful.



Mobile Crisis Stabilization

In addition to the Crisis Therapeutic Home, the REACH programs offer mobile, community based crisis intervention and stabilization plans. This service is preferable to the use of the CTH because it allows the situation to resolve within the individual’s natural social environment. A review of the utilization of mobile crisis supports indicates that the use of this service is more frequent across all regions than the use of the CTH. In Regions II and III, this difference is negligible, but in the remaining regions it is significant. In fact, in Region IV, it is nearly twice as likely that the individual will be provided with mobile supports as to be admitted to the CTH. Mobile support interventions, while appearing less intensive on first glance, actually offer an extended service period of highly individualized supports based on the needs of the situation rather than on the setting. In home intervention is considered to be a less restrictive alternative,

which may support the conclusion that the REACH programs are continuing to permeate the service system such that they are viewed as a first line source of support. The graphs on the following page summarize basic information about the use of the Mobile Crisis Stabilization service.

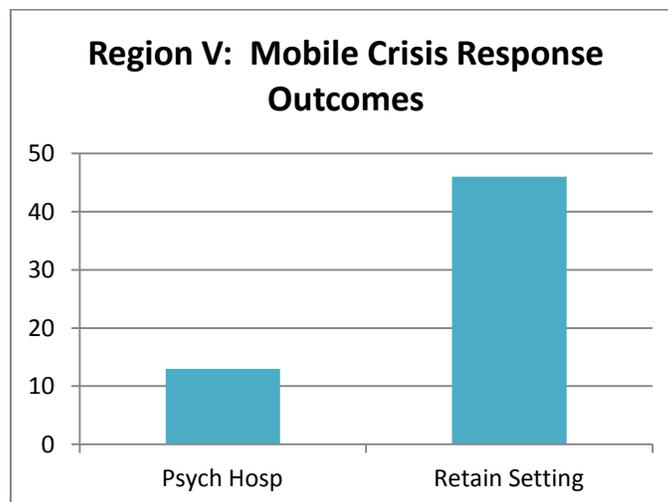
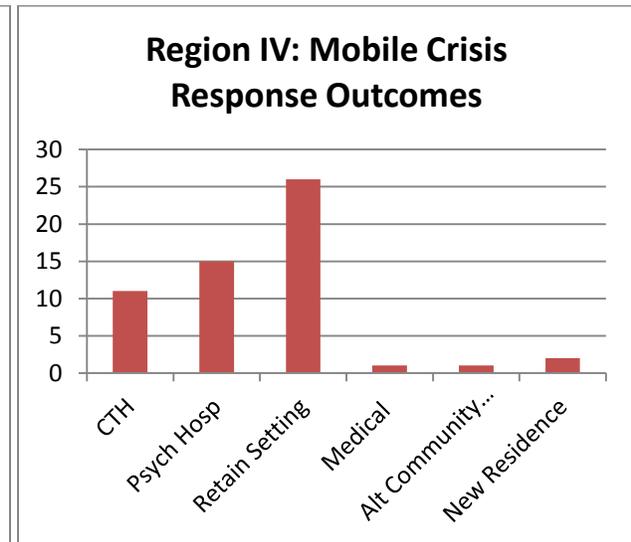
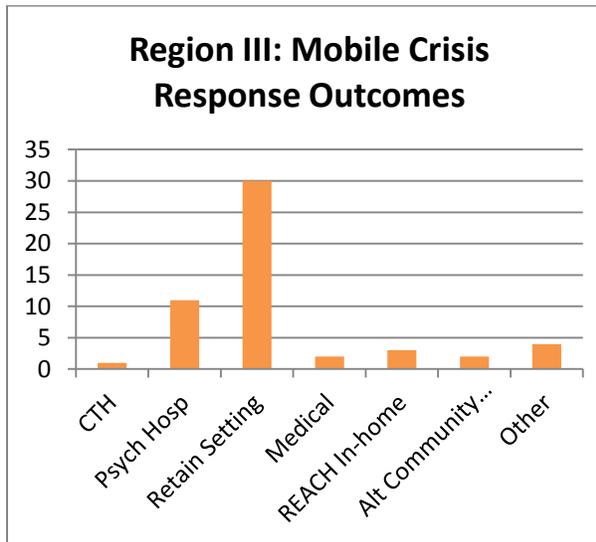
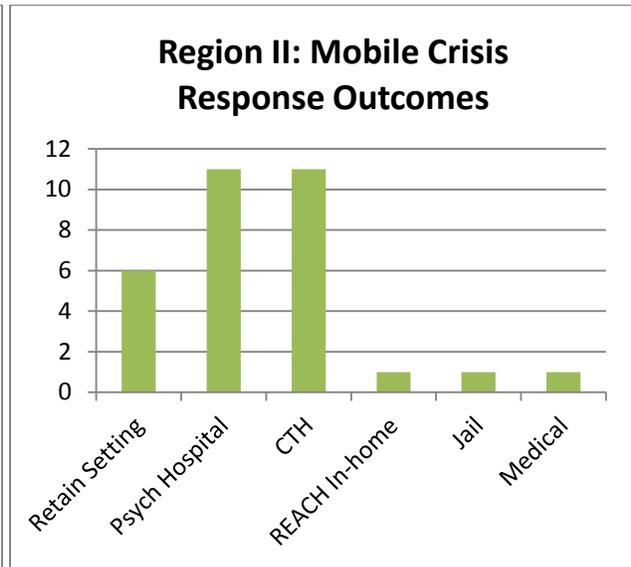
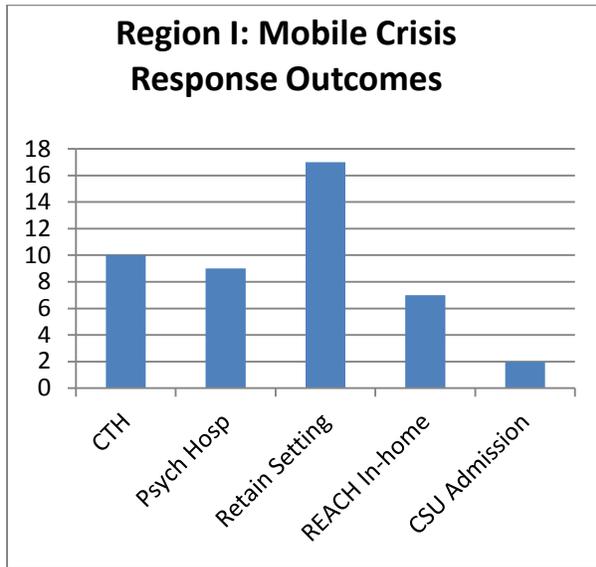


Almost across the board, the average number of days that mobile supports are in place following a crisis exceeds the three days noted in the settlement agreement (“Mobile crisis teams shall provide local and timely in-home crisis supports for up to three days...”). In contrast with last quarter’s data, the range of service days provided has decreased considerably. Three out of five regions are providing up to 14- 15 days of mobile support, while Regions II and V provide roughly half of that. This data pattern is considerably different from that observed last quarter. It will be interesting to see if the current picture of shorter intervention periods with fewer regional differences will continue. For the present quarter the range in the number of mobile crisis supports across regions is as follows:

- Region I: 1 to 15 days
- Region II: 1 to 6
- Region III: 5 to 15
- Region IV 1 to 14
- Region V 1 to 8

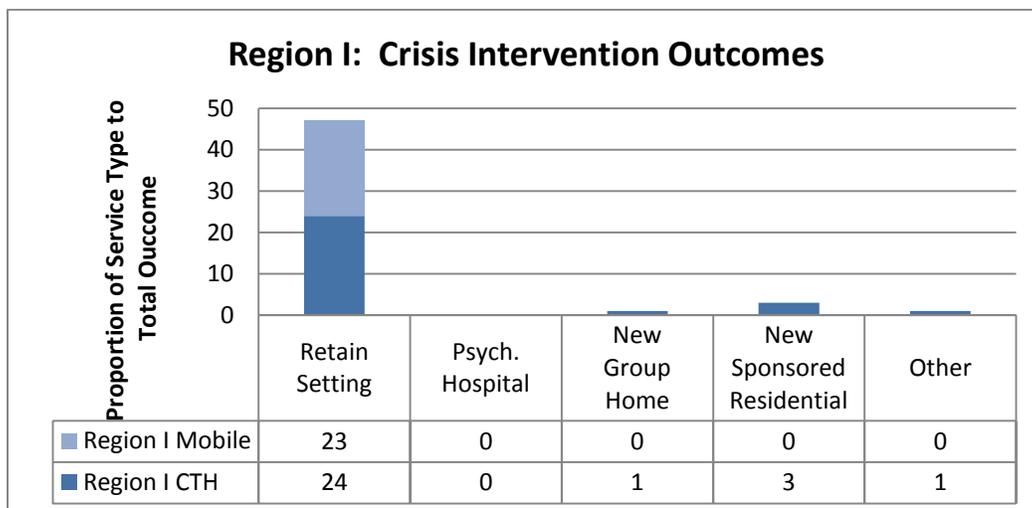
Crisis Service Outcomes/Dispositions

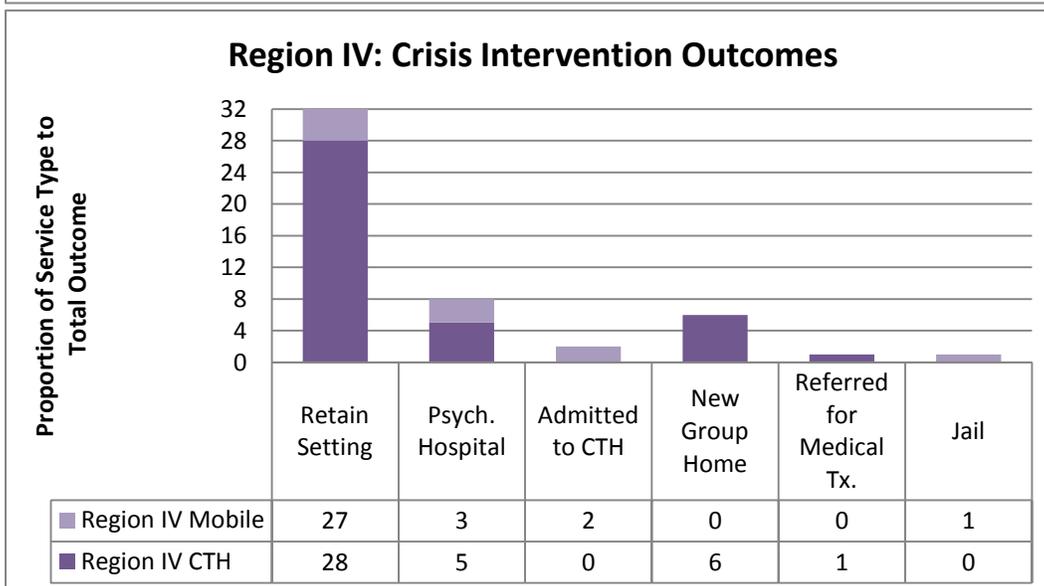
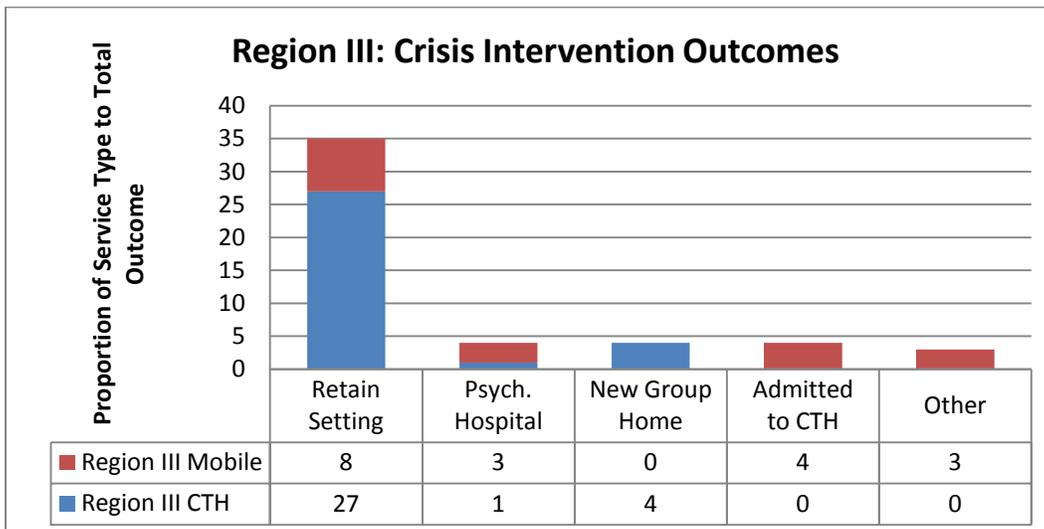
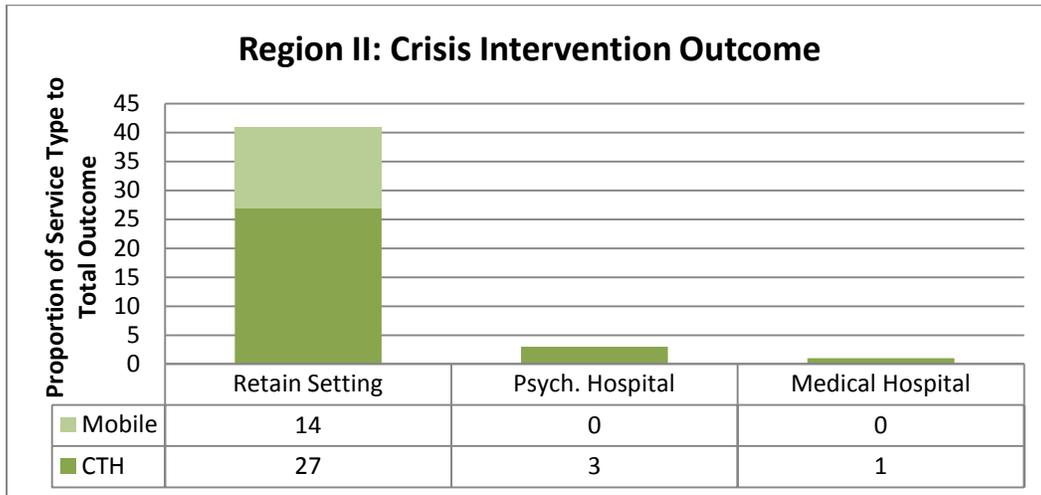
An aerial view of the REACH data suggests that the programs are becoming increasingly imbedded into the communities they serve. Community based supports are generally being used more often than center based interventions, and a substantial number of referrals continue to come from CSB case managers, which clearly indicates that these key players are setting up services prior to an emergent crisis and that they see the programs as a viable additional service for the individuals with whom they work. When crises do emerge and REACH staff is called into the situation to assess and intervene, examining the outcomes to these events is helpful both in understanding mental health trends in the regions and evaluating outcomes of crisis intervention services. The graphs below provide a summary of this information in graphic form, and highlight regional differences across the Commonwealth.

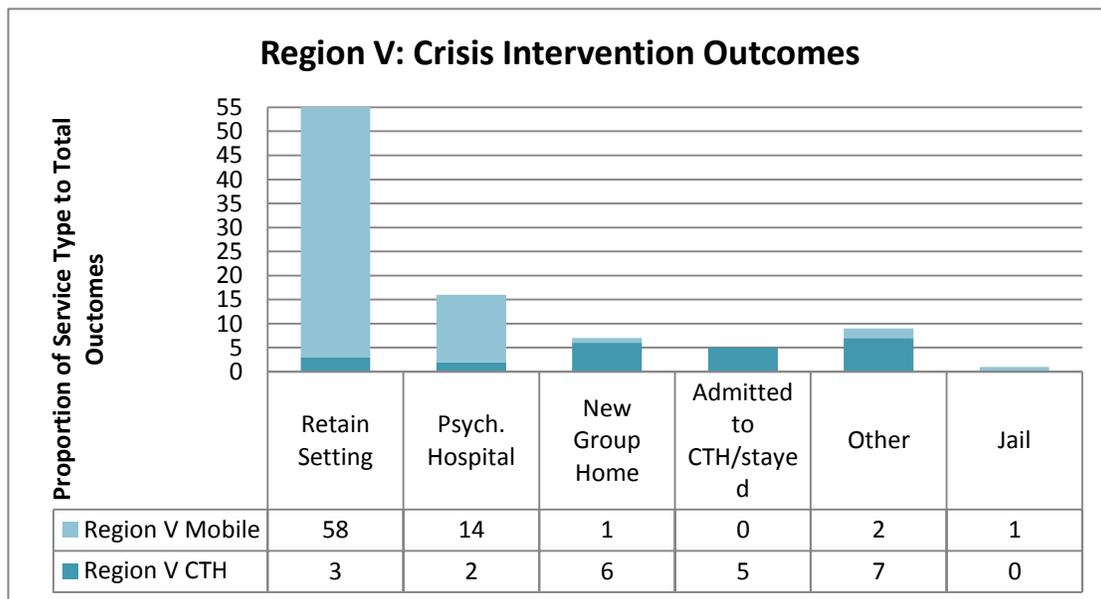


In reviewing these data, it is interesting to note that for all but one region (Region II), the most common outcome of a mobile crisis response is that the individual remains in their current setting. Given that residential stability is correlated with positive outcomes for individuals receiving mental health or behavioral supports, this trend reflects a beneficial outcome of the REACH programs as a whole. It is somewhat disappointing that psychiatric hospitalizations are another fairly routine disposition. The reasons for this are not entirely clear. Part of the explanation likely lies in changes to the TDO regulations which require State Hospitals to accept all TDO's. It also appears that there may be a cohort of young intellectually/developmentally disabled individuals reaching early adulthood and experiencing their first major psychiatric episode, which is consistent with the on-set of major mental illness in the general population. We do know that many of the individuals who are being hospitalized are in their late teens or early twenties. There also appears to be a cohort of young individuals with severe personality disorders requiring hospitalization to treat the mood component of their condition. These are only working hypotheses and are not based on a systematic review of the data, although they do conform to a number of cases that the Department has been following.

The graphs below provide a different view of outcome data. These graphs depict outcomes based upon the type of intervention received, either Mobile In-home or CTH stay. In other words, once REACH has assessed the crisis situation and made an initial determination about the appropriate type of support, and implemented this support, what is the outcome of these efforts? For each outcome noted, the graphs depict the relationship of service type to the total number of individuals falling into the various placement categories. This provides a better point of comparison across regions given that the number of relevant outcome categories differs from one region to another.







Service Elements

Each of the five regional REACH programs provides an array of services to their ID/DD communities. These services include prevention and education services, assessment services, and consultation services. At the time of last quarter’s report, information about service elements provided by the programs was presented in table format, with some regions reporting that every service was provided in all cases. Discussions about this data element that have taken place with REACH Directors over the past quarter have allowed for clarification and better understanding of the various service elements and their relationship to each other. Under Medicaid Billing requirements, certain service elements are required for crisis intervention and stabilization services in order for the service to be reimbursable. The service elements contained in the table were, in fact, those required elements, although the wording was different. Given that the State’s expectation has continued to emphasize active billing for those services that are “billable” and that this is now being monitored (to ensure the sustainability of the programs over time), all regions are working to provide all required services for crisis intervention and stabilization. Therefore, this data element will cease to be relevant as variability between the regions disappears. The data contained in the table below should be interpreted with some caution, as different regions may have interpreted this data element from different perspectives. Please note that Region V does not currently have a psychiatrist assigned to their program, although they are trying to fill this position. They work in concert with community physicians to obtain medication evaluations if needed and have had some success with this practice as an interim approach. Because the program does not actually provide the service, they have entered zeros under this category. Region IV completes comprehensive evaluations and formal crisis

education and intervention plans only as needed and in limited cases. As noted above, this is a practice that will be changing in the coming months.

Service Type Provided: Crisis Stabilization (CTH)					
Service Type	Region I	Region II	Region III	Region IV	Region V
Comprehensive Evaluation	20	11	19	0	25
Crisis Intervention/Prevention Planning	20	11	19	19	25
Crisis Education Intervention Plan	20	11	19	0	0
Crisis Prevention/Follow Up	20	11	19	17	5
Medication Evaluation, if needed	0	7	19	17	0

Service Type Provided: Mobile Crisis Support					
Service Type	Region I	Region II	Region III	Region IV	Region V
Comprehensive Evaluation	6	0	21	0	0
Crisis Intervention/Prevention Planning	23	14	21	39	37
Crisis Education Intervention Plan	23	14	21	0	1
Crisis Prevention/Follow Up	23	14	21	33	9
Medication Evaluation, if needed	0	0	21	19	0

REACH Training Activities

One of the most important functions of the REACH team is to build resource capacity for ID/DD individuals within the communities they call home. Across the Commonwealth, the REACH programs are actively involved in training law enforcement officers to communicate more effectively with individuals who are intellectually or developmentally disabled. One element of this training is providing information about the REACH program and how it can help increase the likelihood that the exchange will be as successful as possible. The REACH teams have also been providing training on mental health topics pertinent to work with ID/DD individuals and their families. These trainings have been attended by CSB staff, community providers, state hospital staff, and other mental health professionals. All of the programs advertise their willingness to create trainings on topics needed by the community, and all offer trainings in the settings that requested the information or in a central community location.

Region II holds a monthly Clinical Education Team meeting, where people can come to discuss challenging cases or hear an hour long presentation about a specialty area. Region I has elected to use some training dollars to support providers in pursuing the Registered Behavior Technician (RBT[®]) credential, which will enable their staff to work more effectively with challenging behaviors. The table below provides a general summary of training programs offered by the regions for the quarter. It is not intended to be all inclusive, but to provide an overview of

essential training efforts. In addition to these more formal training activities, Regions II and IV also had successful outreach events. Region IV had an exhibitor table at the 2015 Spring Meeting of the Psychiatric Society of Virginia. They had a total of 127 people stop by their table. Region II has participated in a number of local resource fairs, including one at Northern Virginia Mental Health Institute. They report that 126 people made contact with REACH staff at these events.

Differences between the regions are clear and difficult to pinpoint with any degree of precision. It is the expectation that all regions make themselves available to meet the training needs of the communities that they serve. However, whether or not agencies and localities request or participate in trainings is outside of the control of the REACH programs. Demand for trainings likely depend upon staffing patterns, degree of saturation in the area for various training topics, the number of individuals served who will require specialized provider training as part of their plan of care, among other specific regional differences.

Overall, the Commonwealth continues to focus on training as a preventative service. The Commonwealth has also developed a plan to increase general awareness and training opportunities for law enforcement agencies throughout the state, and REACH will be included in these efforts. Other training initiatives are also underway through DBHDS, and these include financial assistance to those who want to pursue the PBS facilitator credential or the RBT© training for provider staff. At this point, it is anticipated that regional differences in training statistics will continue. It is the intent of the Commonwealth to ensure that opportunities for training continue to be offered through the REACH programs and that specific requests for trainings are being met in a timely manner.

Community Training Provided					
Training Activity	Region I	Region II	Region III	Region IV	Region V
CIT/Police: #Trained	18	0	3	0	74
CSB Employees: # Trained	91	8	28	16	33
Emergency Service Workers: #Trained	0	0	3	0	0
Hospital Staff	0	0	9	0	0
Other Community Partners: #Trained	4	6	31	53	42

Summary

This report provides an interpretive summary of the Regional REACH programs based upon data for referrals received from January 1, 2015 until March 31, 2015. By and large, the programs are

continuing to build upon the efforts of previous quarters to build a true continuum of care for individuals with intellectual and developmental disabilities. The Commonwealth continues to monitor relevant information about the population utilizing REACH services to ensure the program serves *all* of those under its mission's umbrella. To that end, DBHDS has continued with outreach efforts to the DD community. For the current quarter, a total of 34 individuals with a diagnosis of a developmental disorder were referred to REACH and received services. This is a significant increase above the 19 referrals that were reported last quarter. During the course of the past quarter, in discussion with the REACH directors, it was determined that data regarding services to the DD population was being underrepresented. The data definition that had been in use specified the tallying of those with a *primary* diagnosis of DD. This was leaving out all of those individuals who had *both* ID and a DD diagnosis. This definition has now been revised to include this broader range of service customers. Consistent with last quarter's data, Region II served the highest number of DD individuals (12 of 34). The most likely explanation for this difference is the population density within Region II.

The CTH's have played a role in preventing psychiatric hospitalizations in some situations. However, admissions of individuals with intellectual and developmental disabilities to state hospitals continue to be a significant concern, and rates of admission in Regions IV and V are currently on the rise, although this trend was not yet evident in the data for this quarter. The Commonwealth is actively working on a number of solutions to address these trends, including developing specialty providers in the community, developing a community readiness program through the joint efforts of Southeast Virginia Training Center and Eastern State Hospital, and potentially adding resources in Region III to expand their capacity and enable them to accept individuals into the CTH who might require a more secure setting than is currently being provided. It is hoped that these efforts will initially stabilize admissions into the CTH and then begin to drop these numbers as much as possible. It continues to be true that individuals with intellectual disabilities are at increased risk for mental illness, and the Commonwealth is invested in providing the correct services to meet the needs of those served. In some cases, longer term inpatient psychiatric treatment is completely necessary and entirely appropriate.

At the time of the last quarterly report, concern was expressed by the Independent Reviewer that the lack of affiliation with the START model in Regions III, IV, and V presented a potential deficit for these programs. During the course of the quarter under review, these three regions have adopted a unified training curriculum as well as a standardized method for mentoring and supervising staff who are beginning their careers with the REACH programs. This will ensure that all regions maintain a qualified workforce and one that can meet the demands of a challenging program.

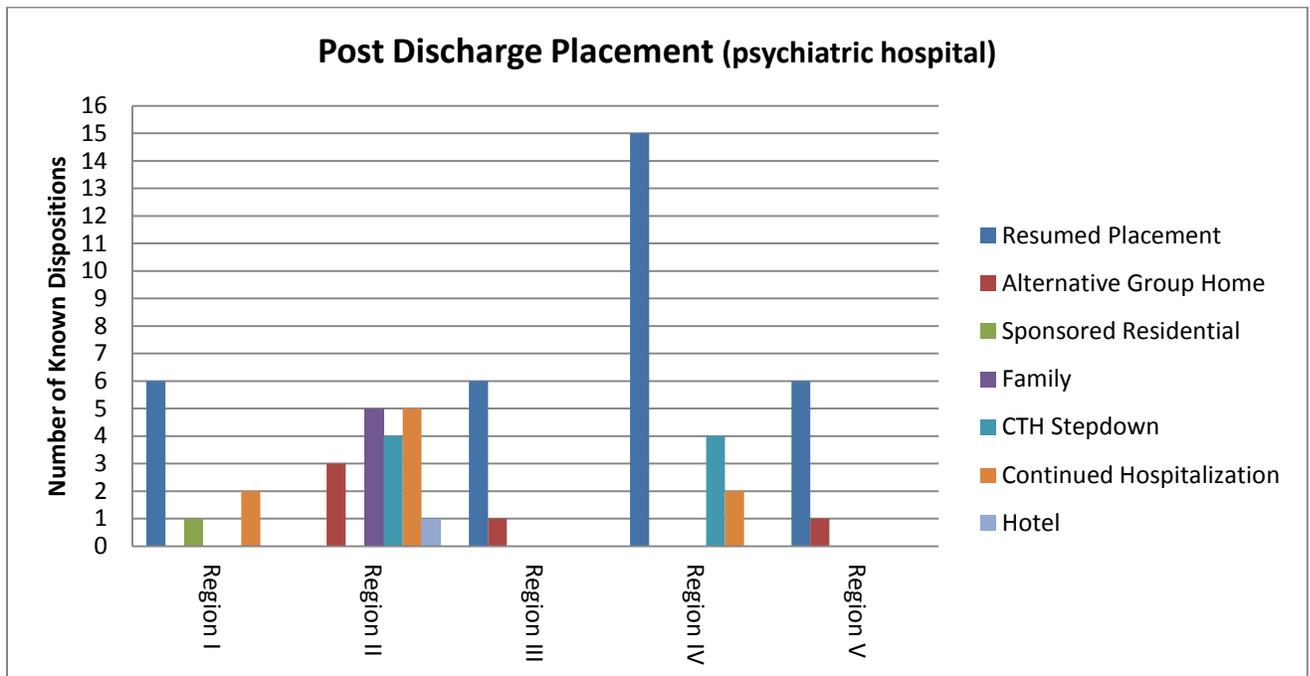
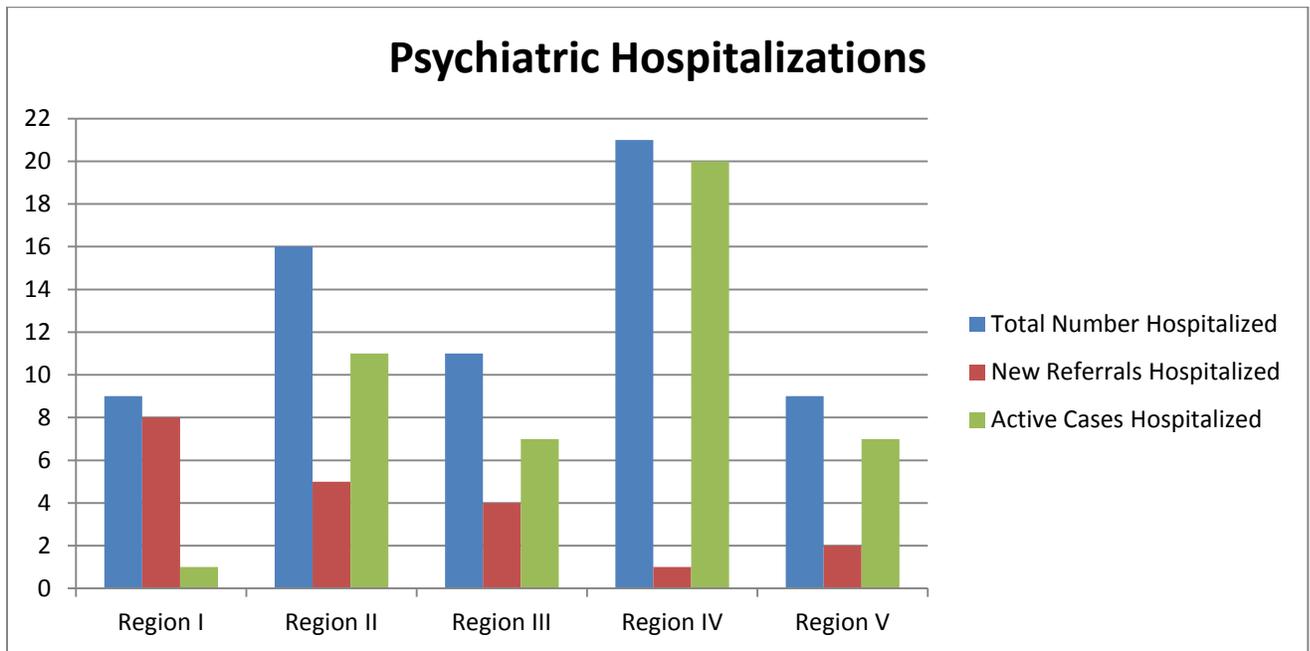
Finally, ensuring that all crisis calls are responded to within the time frames established by the settlement agreement is an area that DBHDS continues to monitor closely. While we

acknowledge that the State likely will never be 100% compliant with the designated response times due to idiosyncratic obstacles that are out of the control of the programs, we likewise understand that there is room for improvement. The goal of the Commonwealth is to achieve a 90% hit rate, meaning that 90% of all calls received will be within established time frames. This is a more stringent criterion than averaging response times, given that some calls are responded to very quickly which allows for the impact of delayed responses to be washed out. Currently, we are below the 90% goal by about 7 percent. As we continue to look at the reasons for this, responses, operational changes to the programs may be necessary.

The REACH programs have been in operation for approximately three and a half years. While they continue to evolve into distinct resources for their regions, all programs are meeting the expectations of the Commonwealth to provide 24-hour a day/365 days per year of crisis services for adults with intellectual or developmental disabilities. Each Region faces their own challenges and each has their unique strengths. Moving forward, it is the goal of the State that the programs become more cohesive, and mentor one another through the growth process.

ADDENDUM

The graphs in this addendum are provided to supplement the information contained in the larger quarterly report. The reader is cautioned that information about hospitalizations is likely not entirely reliable, and conclusions drawn from it may be speculative. Many private hospitals across the Commonwealth provide psychiatric care to individuals with ID/DD. 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 client has been hospitalized. This is particularly true when private hospitals are involved. The Commonwealth is currently exploring ways to acquire reliable data regarding private hospital admissions, and the REACH programs continue to network with Emergency Services personnel to ensure REACH involvement in every hospitalization. REACH is active throughout all known psychiatric admissions, including attending commitment hearings, attending treatment team meeting, providing supportive visits, and consultation to the treatment team.



Discharge Placement as Percent of Known Dispositions

