Program Standards

ADULT REACH

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I. OVERVIEW

The REACH (Regional Education Assessment Crisis Services Habilitation) program has been built upon the current components of the community crisis system to create a more comprehensive Developmental Disability Crisis Response System (DDCRS). This statewide system is designed to meet the crisis support needs of adults who have an intellectual and/or developmental disability and are experiencing crisis events which put them at risk for homelessness, incarceration, hospitalization, and/or danger to self or others. For individuals age 18 and above, the REACH programs offer an additional layer of support to Emergency Services, the state hospital system, and caregivers who work the most closely with individuals with developmental disabilities.

The mission statement of the REACH program reads as follows:

Individuals with developmental disabilities shall be supported with services that allow the individual to live the most inclusive life possible in his/her community which includes access to appropriate and effective crisis stabilization, intervention, and prevention services including mental health treatment services when indicated.

REACH serves a target population of people with co-occurring diagnoses of developmental disability (DD) and behavioral health needs. REACH services enhance local capacity and provide collaborative, cost-effective support to individuals and their families through exemplary clinical services, education and training. All REACH programs operate from a "'not no', but 'how'" point of view. This means the REACH programs are committed to finding a way to serve *all* individuals with DD who are at risk for a behavioral or mental health crisis. When standard services are not appropriate, REACH staff are committed to developing interventions to support the system in some way. At times, this will mean supporting the individual through locating other services, working with DBHDS to secure additional resources, or assisting with the psychiatric hospitalization process and providing transition and step-down services. All services are provided within a context of on-going attention to service outcomes.

The REACH Crisis Service System shall be trauma informed while meeting the following objectives:

- Provide timely crisis interventions to adults who are experiencing a crisis event of a behavioral and/or psychiatric nature, as well as supports to families and other care providers. REACH is unable to accept individuals into the CTH who have met criteria for a TDO by an Emergency Service certified pre-screener.
- Provide mobile in-home, and community-based crisis assessment and direct crisis services, designed to address and resolve the immediate stressors so that the risk of the individual losing their current living arrangement is eliminated or mitigated.
- Have trained clinicians who recognize the symptoms of trauma and engage people with such histories effectively.
- Provide crisis supports in a Crisis Therapeutic Home (CTH). The CTH offers a community home for stabilization that shall be used when community based crisis services or supports are not effective or clinically appropriate. DBHDS has determined that it is best practice to provide supports where the crisis occurs whenever possible as outlined in the commitment made between the parties of the Settlement Agreement.

- Collaborate with the treatment team including the individual, case manager, providers, family, guardian, etc. to develop a crisis education and prevention plan (CEPP) that provides guidance to the system of care regarding subsequent crisis situations.
- Provide or identify resources to meet the training needs of the system of care, including families, Emergency Services, residential providers, day support providers, outpatient providers, psychiatric facilities, state training centers, schools, law enforcement, and others to increase the system's capacity to serve the individual.
- Promote the development of least-restrictive, life-enhancing services and supports for the individuals referred for services.
- Measure outcomes, review data, and modify strategies to meet the above goals.
- Provide effective behavioral consultation, assessment, and plan development that offers specific interventions to address challenging behavior and teach positive replacement behaviors and coping skills. This service is offered only when no other community provider is available, REACH has capacity to address, and the situation warrants an immediate need.

II. PROGRAM DESCRIPTION:

Each of Virginia's 5 Health Planning Regions' REACH programs is operated through a designated lead CSB or BHA. REACH services include collaboration with service providers and families who support individuals ages 18 and up with a co-occurring diagnosis of Developmental Disability (DD) and behavioral health needs and/or significant behavioral challenges.

A. Definitions/Criteria:

The Commonwealth of Virginia has adopted the following definition as part of Code of Virginia:

Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

1. Admission Criteria:

   All individuals receiving REACH services must be aged 18 or older and have a diagnosis of a Developmental Disability, with co-occurring mental illness and/or significant behavioral challenges. Additional information regarding requirements for specific services is outlined below.

Individuals must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric or behavioral nature that puts the individual at risk of psychiatric hospitalization or disruption to their residential stability. This can include difficulty in maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization, homelessness or isolation from social supports; difficulty in activities of daily living (ADLs) such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, managing finances or recognizing basic safety risks to such a degree that health or safety is jeopardized. In addition, any behavior that is not appropriate to such a degree that immediate intervention by mental health, social services, or the judicial system is necessary suggests the need for REACH intervention.

2. Exclusion Criteria for the Crisis Therapeutic Home:
   - The REACH Program will not provide long-term residential services.
   - REACH will not serve individuals in the Crisis Therapeutic Home (CTH) who are currently abusing substances or requiring medically managed detox treatment.
   - When notified by emergency services or other providers, REACH will be physically present for all psychiatric pre-screenings to (a) determine if REACH services can sufficiently mitigate the immediate crisis or prevent hospitalization and (b) to ensure that REACH services are fully activated and (c) provide initial crisis stabilization efforts are through the prescreening process. REACH will not serve individuals in the CTH who currently are under a TDO.
   - Admission to the CTH may be denied if there is clear evidence that the admission poses a serious threat to the individual or other guests. In the event that an individual is denied admission, REACH will facilitate a meeting with the individual's support network to develop alternatives. DBHDS will be notified in these events and a rationale for the denial will be provided. Final decisions regarding the appropriateness of admission to the CTH are made by the REACH Director or designee.
   - Individuals who do not reside within the HPR catchment area may be admitted to the CTH under arrangements between the Director of the REACH program in the individuals' home district and the receiving REACH Director.

3. Discharge or Transition Criteria:

All Services:
Transitioning between REACH Service regions or discharging from the REACH Program is negotiated between the individual, their system (guardian, authorized representative, service providers, and caregiver/residential provider) and REACH staff.

In order to facilitate discharge from the REACH program, at a minimum a discharge meeting and written discharge summary will be completed. While it is understood that the full team will likely not be available for a discharge meeting, every effort should be made to meet with the individual, REACH clinical staff, and one member of the individual's system of support.

REACH services are available to individuals at all times who meet eligibility requirements for the program. The goal of REACH is to provide services to individuals for a period of at least 6-12

months, with the potential for a longer period of support when indicated. Additionally, cases may be easily reactivated as needed.

Additionally, all REACH programs will have a discharge process in place for individuals who wish to leave the Crisis Therapeutic Home in advance of their planned discharge date that will include a discharge meeting and a discharge summary.

Examples of discharge readiness include:

- minimal contact with their REACH Coordinator by the individuals themselves or members of their system
- demonstrated stability with their crisis plan
- their system of providers report confidence that the individual has tools to maintain stability in the community
- documented treatment plan goals and objectives have been substantially met

Additionally, individuals will be discharged from REACH support services upon their request (refuse/decline services), their guardian's or authorized representative's request, if they move to another state or out the catchment area, pass away, or if they have not had contact with their REACH Coordinator within the past 90 days despite Coordinator's attempts. Their case can be transferred to another REACH Program if they relocate within Virginia. (See Procedures to Transfer from one VA REACH Region to Another) or can be re-opened if the need for services arises in the future.

4. Advisory Council

   The Advisory Council is made up of a group of regional community stakeholders who review the REACH outcomes and challenges while representing the needs and values of the community and service recipients. The Advisory Council should meet at least every six months. Meetings may be scheduled more frequently based on the needs or interest of the program and community stakeholders.

B. Licensed Services

REACH programs are licensed by the Department of Behavioral Health and Developmental Services to provide an array of services including: ID Crisis Stabilization, ID Crisis Supervision, MH Crisis Stabilization, MH Crisis Intervention, and ID Supportive In-Home. Data (see section 3.F.) will be collected by all REACH programs on services delivered and will be reported regularly to DBHDS.

1. ID Crisis Stabilization/Supervision:

   Service Description:

   Crisis stabilization is direct intervention (and may include one-to-one supervision) to persons with MR/ID who are experiencing serious psychiatric or behavioral problems which jeopardize their current community living situation. The intent is to stabilize the individual and to strengthen the current living situation so the individual can be maintained during and beyond the crisis period.

   Service Objectives:

The goal is to provide temporary intensive services and supports to avert emergency psychiatric hospitalization or institutional admission or to prevent other out-of-home placement.

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

Service Credentials:
A crisis stabilization clinical or behavioral intervention services provider must be licensed by DBHDS as a provider of outpatient services, residential services, supportive residential services, or day support services. In addition to meeting the above licensing requirements, the clinical services provider must employ or utilize qualified mental retardation professionals (QMRPs) (QIDP), licensed mental health professionals, or other personnel competent to provide clinical or behavioral interventions. These might include crisis counseling, behavioral consultation, or related activities to individuals with MR/ID who are experiencing serious psychiatric or behavioral problems.

The face-to-face assessment or reassessment required to initiate or continue this service must be conducted by a QMRP (QIDP).

The QMRP (QIDP) providing crisis stabilization services must have:
1. At least one year of documented experience working directly with individuals who have MR/ID or developmental disabilities.
2. A bachelor's degree in a human services field including, but not limited to, sociology, social work, special education, rehabilitation counseling, or psychology; or a bachelor's degree in another field in addition to an advanced degree in a human services field; and
3. The required Virginia or national license, registration, or certification, as is applicable, in accordance with his or her profession.

Crisis supervision is an optional component of crisis stabilization in which one-to-one supervision of the individual in crisis. Crisis supervision may be provided as a component of this service only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. To provide the crisis supervision component, providers must be licensed by DBHDS as providers.

https://www.ecm.virginiamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vsId={0E2B1682-F345-43CD-87EA-27ECF5CA3884}&impersonate=true&objectType=document&id={439DA59B-0E7B-46D8-9671-9338F477F071}&objectStoreName=VAPRODOS1

2. MH Crisis Stabilization:
Service Definition:
Crisis Stabilization services are direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation.

Service Objectives:

The goals are to avert hospitalization or hospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

Service Credentials:
Crisis Stabilization providers must be licensed by DBHDS as a provider of Nonresidential Crisis Stabilization or Residential Crisis Stabilization; Crisis Stabilization services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a certified Pre-screener.

https://www.ecm.virginiamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vsId={55A77B4E-28A7-4A9C-B6E5-7DA9C2D71E5C}&impersonate=true&objectType=document&id={CF8A90C3-1055-42B0-9996-58108B375E18}&objectStoreName=VAPRODOS1

3. MH Crisis Intervention:
   Service Definition
   Crisis intervention shall provide immediate mental health care, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. Crisis intervention services must be available 24 hours a day, seven days per week.

   Service Objectives
   • Prevent the exacerbation of a condition
   • Prevent injury to the individual or others; and
   • Provide treatment in the least restrictive setting.

   https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

   Service Credentials
   Crisis Intervention providers must be licensed as a provider of Emergency Services by DBHDS; Crisis intervention shall be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, or a certified pre-screener.

   https://www.ecm.virginiamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vsId={55A77B4E-28A7-4A9C-B6E5-7DA9C2D71E5C}&impersonate=true&objectType=document&id={CF8A90C3-1055-42B0-9996-58108B375E18}&objectStoreName=VAPRODOS1

C. Service Descriptions

REACH is part of a statewide network of supports and services that can be accessed as needed and is available regionally throughout the state.

Elements of the REACH programs are, but not limited to:

- 24 hour services, 365 days of the year.

- Crisis stabilization through in-home services, planned and emergency admissions to the Crisis Therapeutic Home.
- Triaging of crisis services each business day (admission, discharges, crisis in-home services, crisis calls and responses).
- Ongoing training to team members, community providers, law enforcement agencies, and family members.
- Development of Crisis Education and Prevention Plans and continual assessment of individuals and their systems to build the system's ability to prevent crisis situations through the use of timely and effective interventions providing technical support and guidance to those implementing the plan.
- Provision of multiple and regular contacts with individuals and their service providers who are experiencing severe and chronic problems in daily living. Contacts will occur not less than weekly for the first month of service and may be adjusted down after that point based on clinical need.
- Clinical staffing and regular contacts between Reach Mobile Crisis Team members and Crisis Therapeutic Home members in an effort to provide seamless cross-system interventions.
- Development and maintenance of MOUs between CSBs and community mental health partners.

1. Referral, Intake and Assessment

   Written and/or telephone referrals will come to the REACH Director or designee. If a telephonic referral is received, it must be documented on a referral form. Calls for general information that are NOT in relation to a specific individual need not be documented in writing.

   REACH receives both emergent and non-emergent referrals from a variety of sources, including community providers and case managers. Referral sources are contacted by REACH Crisis Team Members when the referral is received and follow-up is initiated. This takes place within 24 hours or on the next business day. Intakes into the REACH program are scheduled within 10 business days of the initial contact with the referring party. When they occur, exceptions to the 10-day rule are made to accommodate the referring party. In the event that a referral source does not respond to multiple attempts to schedule an in-person intake assessment, a letter will be sent to the referral source reminding them of the need to schedule the intake appointment. If there is no response to this correspondence within 15 days, then an additional letter will be sent indicating that the continued lack of response will result in the case being closed. Such letters will include a specific date by which the referral source must reply to retain the case on open status.

   If the referral is crisis in nature, the response will occur more immediately. The on-call clinician will respond to the site of the event within 1 to 2 hours and will complete a crisis assessment at that time. This will ensure that the individual is admitted to REACH services without delay, and a more formal intake process will be scheduled after the immediate crisis has passed. In the event that the crisis resolves with an admission to a psychiatric inpatient unit, REACH will continue to be involved and actively working through the intake process to the extent possible so that the individual may receive step-down or transitional services as they return to the community.

Elements of an intake/admissions process must include the collection of demographic data, completion of release and consent forms, basic medical information, the creation of an initial crisis plan, and orientation to REACH services. Intakes are conducted through a face-to-face meeting that includes REACH staff, the individual, case manager, and as many other members of the individual's support team as possible. To supplement the elements noted above, additional clinical assessment procedures, gathering of medical records and previous psychological evaluations, and information regarding psychiatric history are obtained during the intake process. The intake/admissions process allows for active collaboration between the individual and his/her team of providers, and should include as many members of the individual's care network as possible. From this collaboration, an updated ISP/PCP, specific to the recent crisis event, will be completed by the case manager with input from REACH. This update will include an outcome defined in measurable terms related to reducing the risk of future crisis.

It is expected that an initial crisis education and prevention plan (CEPP) be completed within 15 days of admission to the REACH program or at the conclusion of the crisis intervention plan, for those individuals who come into services initially as a result of a crisis event. While it is understood that initial plans will not be as comprehensive as is optimally desired, they will be sufficient to provide timely support to the system while additional information gathering and discussion are occurring. Although all CEPP's are considered to be working documents that will evolve over time, it is expected that a "final" plan will be available to the support team within 45 days of its initiation. Provisional crisis plans must include the following elements:

- a detailed summary of the current crisis event, including both immediate and remote antecedents, if known;
- information regarding mental status;
- psychiatric and medication history;
- active medical problems, both chronic and acute;
- recent stressors;
- strengths;
- specific objectives related to increasing adaptive behavior;
- individualized interventions to support meeting defined goals;

2. <u>Community Crisis Response</u>
   a) Crisis Stabilization Services
   "Crisis" is defined as a deteriorating or unstable situation often developing suddenly or rapidly that produces acute, heightened, emotional, mental, physical, medical, or behavioral distress; or any situation or circumstance in which the individual perceives or experiences a sudden loss of his/her ability to use effective problem-solving and coping-skill (12Vac35-105.20.Definitions).

   REACH offers immediate 24/7 telephone crisis response to provide support, initial consultation, and assessment. An on-site response will follow within 1 hour in urban areas

and within 2 hours in rural regions. REACH team members are trained and capable of providing clinical supports to ameliorate the crisis on-site. The REACH coordinator will assess the situation to evaluate the need for in-home or other intensive community supports, as well as admission to the CTH as deemed clinically necessary by the REACH coordinator. In the event that Emergency Services or law enforcement need to be contacted, REACH staff will still respond when notified in person to whatever location the situation requires.

When notified by emergency services or other providers, REACH will be physically present for all psychiatric pre-screenings to (a) determine if REACH services can sufficiently mitigate the immediate crisis or prevent hospitalization and (b) to ensure that REACH services are fully activated and (c) provide initial crisis stabilization efforts are through the prescreening process. REACH will not serve individuals in the CTH who currently meet TDO criteria.

REACH teams will provide crisis supports based on the location of the crisis so it may be important for REACH teams to work in collaboration with one another for example if a person resides in one catchment area but receives day services in another.

3. Triage Meetings

All REACH teams meet every business day morning for a triage call meeting. This will occur with members present either in-person or on conference call. The meeting will review on call updates, crisis plans staffed, discharges staffed, any jail, or psychiatric discharges or step downs staffed, client updates, new referrals, CTH updates. Agendas and minutes are maintained. A call log will be maintained to provide information about each call that is received as well as any notes taken by REACH staff as a result of the call. Additional information will be entered into the EHR so that it becomes part of the clinical record.

4. Crisis Therapeutic Homes (CTH)

REACH programs admit persons to the Regional Crisis Therapeutic Homes (CTH) on both a preventative (planned) and a stabilization (crisis) basis. The CTH can provide in depth assessments, a change in setting to allow for stabilization, and a highly structured and supportive environment to improve coping skills and work on other goals. REACH therapeutic homes are located in each of the 5 health planning regions of the state.

In addition to being an element of a crisis stabilization plan, REACH may provide support to the individual through an admission to the CTH following psychiatric hospitalizations before returning home. Admissions of this nature will be coordinated through close collaboration with the individual's treatment team.

As a part of this service, REACH staff will participate in team meetings at the treating facilities and will maintain weekly contact with the individual while they are preparing for discharge. Visits to the treating facility are intended to provide support and connection to the individual as well as on the spot education and training to facility staff. REACH staff will complete a consultation note at the conclusion of each visit to an outside treatment setting. A copy of this

note will be provided to nursing staff for inclusion in the individual's medical record, according to the protocol for the treating facility. This note will document the visit and provide written recommendations as needed.

Admissions to the CTH adhere to all state licensing standards including, but not limited to, the following medical documentation: Physician's review/medical clearance (in part to ensure crisis is not medically related), standing orders, TB Screen signed, and copies of current medication orders. While admission may not occur until medical clearance is obtained, REACH staff actively and systematically work to obtain needed documentation as quickly as possible.

a) *Crisis Prevention Admission*: Crisis prevention admissions will be provided to individuals who are receiving ongoing REACH services and need temporary, therapeutic interventions outside of their home setting in order to maintain stability. At a minimum, individuals must be enrolled in REACH services to be eligible for a prevention admission. Prevention admissions can also be utilized as crisis prevention or as a step-down from training centers, psychiatric hospitals, or Crisis Stabilization Units. Prevention admissions may also be part of a structured transition between placements.

REACH staff provide direct therapeutic care to individuals admitted to the Crisis Therapeutic Home. All admissions to the CTH must be guided by a treatment plan that has been developed specifically for the CTH stay. The treatment plan will detail specific outcomes that are measurable and observable through the objectives that support the overarching outcome. Staff assist with skill building in areas such as self-care, communication strategies, and effective coping skills. They monitor medication compliance and conduct daily therapeutic groups and activities (i.e.: self-esteem building, wellness groups, appropriate self-expression, problem solving, coping skills/relaxation strategies, and recreational, social, and leisure activities).

Discharge from a REACH Crisis Prevention Admission is pre-determined and scheduled at the time of admission. Recommended length of stay is 3-5 days per admission. Discharge meetings are required at the conclusion of the stay and are intended to consolidate skills learned, inform care providers of progress made, and discuss ways to generalize skills to the home environment. No more than one crisis prevention stay per month is recommended. Crisis Prevention Admissions should not exceed 5 consecutive days per stay unless warranted by clinical presentation and the individual's need.

b) *Crisis Stabilization Admissions*: Crisis Stabilization supports are provided to individuals admitted to the CTH to assist them through an acute crisis event. Crisis stabilization admissions will be provided to individuals who are experiencing an identified behavioral health need and/or a behavioral challenge that is preventing them from reaching stability within their home setting. An example of when an individual may be appropriate for a crisis stabilization admission are:
    - When experiencing behavioral challenges or increased mental health issues that puts their current placement and/or systems of support at risk.
    - When caregivers are unable to support the person at the time due to behavior that is aggressive, excessively risky, or beyond what the home can tolerate.

- When interpersonal conflict within the setting suggests the need to provide a period of separation and an opportunity to revise treatment strategies to address the root of the disagreement.

Admission to the CTH must stem from a current crisis assessment conducted by REACH staff. Admission is based on bed availability. An initial ISP must be implemented within 72 hours of admission to the home. Additionally, an updated ISP and discharge summary for each crisis stay are required. Additionally, a discharge summary within (5 days) of discharge is necessary.

A crisis stabilization admission to the Crisis Therapeutic Home is meant to be short-term, and therefore may be approved for up to 15 consecutive days per event with the possibility for one 15 day reassessment. To ensure that the individual's progress through the program is carefully monitored and managed, an admission meeting will be held within the first 72 hours of admission with discharge planning meetings occurring weekly until the individual is successfully transitioned to a permanent home. (See Request for extension of CTH services below).

c) *Extensions to the 30 Day Rule:* There will be circumstances when the need for a crisis stabilization stay will exceed 30 days. When clinically indicated, extensions may be granted. The procedure for requesting an extension of the therapeutic stay beyond the 30-day time frame is summarized below:

1. On or before the 25th day of stay at a regional Crisis Therapeutic Home, the Regional REACH Director will submit a request to the Office of Developmental Services for a 15-day extension. This is a written request which may be submitted through encrypted email or secure fax (804-692-0077).
2. Requests for further extensions will be made by updating the original request and resubmitting it 5 days prior to the extension end date.

<u>REQUESTS WILL INCLUDE:</u>

a. Client name
b. Region
c. Date of admission
d. Reason for extended stay
e. Length of extension requested

3. Within 24 hours of receiving a request for an extension of a Crisis Therapeutic admission, DBHDS, shall inform the Regional REACH Director whether the individual is eligible for continued stay.
4. No Case Manager/No Disposition: When a person is admitted to the CTH without a Case Manager or without a place to return to upon discharge from the program, the REACH director for the program will contact the Director of Community Support Services or designee.
    a. Regional Community Resource Consultant will be contacted.
    b. An RST referral will be initiated if there is no placement available upon discharge.

c. Local CSB or Waitlist CM will be contacted for Case Management services.

5. Community Based Crisis Supports

REACH provides community based crisis support to individuals who may have a history of multiple psychiatric hospitalizations; frequent medication changes; enhanced staffing requirements due to mental health or behavioral concerns; and/or frequent placement changes. Individuals who are at risk of losing a job placement or residential services may also be appropriate for community based crisis supports.

Supports are provided in the individual's home and community setting. REACH staff work directly with the individual and their current support provider or family. Techniques and strategies are provided via coaching, teaching, modeling, role-playing, problem solving, or direct assistance. Examples of supports provided are assisting with skills building such as self-care/ADLs, independent living skills, self-esteem building activities, appropriate self-expression, coping skills, emotion recognition/regulation and monitoring of medication compliance through daily check-ins.

Specific interventions may include:

- Comprehensive assessment and crisis planning
- Skills training and coaching
- Supportive mental health counseling
- Psychological and/or psychiatric assessment
- Medication monitoring
- Intensive care coordination with other agencies and providers to assist with the planning and delivery of support services geared toward maintaining community living
- Training of family members and other caregivers and service providers in positive behavioral supports, mental illness, and healthy coping strategies to maintain the individual in the community.

D. Crisis Calls/Response Process

In order for community partners to be able to contact REACH, there is always at least one designated REACH Mobile Crisis Team Member on call for each region 24 hours a day, 7 days a week.

Region I	855-917-8278	Central Virginia
Region II	855-897-8278	Northern Virginia
Region III	855-887-8278	Southwest Virginia
Region IV	855-282-1006	Richmond Area
Region V	855-807-8278	Tidewater Hampton Roads

Crisis calls come from a variety of sources. Although not an exhaustive list, REACH may receive emergency calls for assistance from: CSB Emergency Services, Hospital Emergency Departments, Mobile Crisis Teams, Clinical Homes, Community Providers, Families, Law Enforcement, and the individuals needing assistance or experiencing the emergent situation.

1. Should the REACH program receive a call directly from a provider other than CSB Emergency Services or from the individual upon completion of that call, the REACH Crisis Team Member or the provider may collaborate with Emergency Services for their assistance/involvement.

2. If the REACH Crisis Team Member feels there is imminent danger they should immediately call 911 or instruct the caller to contact 911. REACH staff will present to the site of the call as soon as possible to assist in supporting the individual, assisting other responders with information or consultation, and ensuring that there is communication with the point of final disposition.

3. REACH personnel do NOT pre-screen individuals for inpatient admission.
However, REACH personnel will support the pre-screener by responding to the call with the Emergency Services worker. Should an in-person response be clinically contraindicated, this rationale will be clearly documented on the call log and in the individual's EHR if they have been admitted to the REACH program. However, follow up to ensure that the clinical issue is appropriately addressed is required as is follow-up with DBHDS to ensure follow up has been effective. Dependent upon reason for clinical contraindication, a plan will be developed to mitigate any future contraindication of future REACH involvement. Whenever possible, if an ECO or TDO is issued, REACH staff will remain with the individual until an appropriate bed is located or the individual is stabilized within the emergency room setting. REACH will attend the initial hearing, either in person or via telephone, and will maintain weekly contact with the individual and hospital staff for the initial duration of the admission. For those admissions extending beyond three months, monthly contact will be maintained but will be increased to weekly as the individual approaches discharge. REACH coordinators will also participate in monthly team meetings and discharge meetings unless there is a specific contraindication for this involvement. Attendance at team meetings may be combined with individual visits as needed. Whenever a REACH staff visits with an individual during an inpatient stay, a consultation note documenting the visit, pertinent mental status information, and any recommendations made to hospital staff will be completed and a copy given to nursing or social work staff.

4. When REACH accompanies an Emergency Services worker to assess an individual, the REACH Crisis Team Member will complete a triage form to document:
    - Demographic information about the individual in distress
    - The presenting issue or reason for the call
    - The REACH staff receiving the call
    - The time of the call
    - Consultation with all parties involved, if necessary, to determine nature of the crisis
    - The outcome of the call
    - The name and signature of the responding clinician

5. After a crisis call is received, REACH Mobile Crisis Team Member(s) will arrive within two hours for calls within rural areas and one hour within urban areas. Written elements of the assessment will be minimal due to the critical nature of the call and will include a triage form (see elements above), release of information, and a written crisis assessment only.

6. All calls and initial interventions will be documented on the triage form with additional documentation entered into the individual's EHR to ensure the completeness of the clinical record.

7. All calls coming into the crisis line will not require an on-site response. There are times when such responses are neither efficient nor clinically indicated. The following are potential reasons why an in person response may not be indicated:

    a. when the person experiencing an emergent situation is placed in a different setting such a respite facility, crisis stabilization unit or alternate residential setting (i.e. family member; friend; etc)
    b. when the caller (individual, family member, provider) makes it clear to the REACH Mobile Crisis Team Member that immediate response is not requested
    c. when the person is identified as not being eligible for REACH services
    d. when over the phone consultation is sufficient to mobilize the individual's coping skills and mitigate the crisis.

Following a crisis response, if the individual is not already enrolled into REACH Services, contact is made with the support system in order to initiate a referral.

E. Crisis Prevention

The first and perhaps most important way to handle a crisis is to avoid its occurrence whenever possible. The use of crisis services most often follows severe challenging behaviors on the part of the individual (e.g., assault or property destruction or serious self-injury). Crisis prevention intervention and planning can provide a long-term strategy to assist an individual and the people who provide support to better cope in times of difficulty. The REACH programs offer crisis prevention services in concert with crisis response.

(a) *Prevention Calls*

Often times, calls will come into the crisis line, although they are not crisis in nature. Rather, they reflect the daily challenges and stressors that individuals will experience as they navigate their social environment. At these times, REACH staff can intervene to assist the person with problem solving, providing reassurance, or coaching them through the application of a coping skill that they are working to develop. These types of responses are vital to building independence and personal self-efficacy. They also provide natural opportunities to practice implementing coping skills in response to real stressors. These calls are preventive in nature, both because they focus on skill building and because they help the person address the immediate situation before it escalates.

(b) *The Crisis Education and Prevention Plan (CEPP)*

The CEPP is an individualized, client-specific written document that provides a concise, clear, and realistic set of supportive interventions to prevent or de-escalate a crisis and assist an individual who may be experiencing a behavioral loss of control. The goal of the CEPP is to identify problems that have arisen in the past or are emergent in order to map out strategies that offer tools for the circle of support to assist the individual in addressing problems in a healthy way and provide teaching healthy coping skills that the individual can apply independently.

The CEPP serves as the foundational document that explains the rationale for various interventions and describes those interventions operationally so that they can be implemented effectively by the system of care. Every individual who receives crisis services from REACH will receive a CEPP. Ideally, meetings are scheduled within 7 days of receiving the initial referral and are conducted as soon as possible thereafter. These meetings are scheduled so as to include as many of the individual's support network as possible. Team members should include the REACH coordinator, the individual, the guardian (if applicable) members of the mental health service team, members of the developmental disabilities service team, the case manager, and as many of the individual's family and friends as possible. The purpose of the meeting is to gather information, discuss goals, and begin to develop a plan to assist the individual and his or her caregivers during times of difficulty. Following the initial meeting, REACH staff will complete additional assessments, interview informants, and do behavioral observations within the individual's primary settings.

Crisis Education and Prevention Planning meetings are scheduled within 7 days of referral and are held as soon as practical. A full and comprehensive CEPP should be written within **45** days of initiating the process. The CEPP is considered to be a working document, and it is to be modified as needed and reviewed frequently to ensure all elements of the plan are understood by the support system and are effective. It is expected that this document will be referenced frequently during the early stages of intervention such that the language of the plan becomes incorporated into the individual's daily life.

(c) *Training and Outreach*

REACH programs operate from the perspective that building capacity within the community for effective services is the best long-term strategy for crisis prevention. Therefore, training and outreach services are vital components to the REACH programs. REACH teams provide individualized, case specific training to caregivers and providers who have accessed crisis services for someone they live or work with. Training is required and should include the following elements:

- a review of all new information learned about the individual during the assessment and intervention process
- a review and discussion of the CEPP to ensure that it is understood well enough to be implemented across environments and situations where it may be needed
- role modeling of any interventions detailed in the CEPP, including communication strategies, early intervention strategies, and coaching/teaching techniques designed to increase positive coping skills
- A discussion of any medical conditions that affect the person's behavior, where applicable

In addition to training related to specific individuals, the REACH programs offer outreach and training to all community partners, including law enforcement, CSB staff, day support providers, or other agencies that provide services to the DD community. The REACH programs will offer trainings to community partners at least quarterly and

more often than this if necessary to meet training requests from the community. These trainings may be conducted by REACH staff or sponsored by the REACH program in cases where other professionals are providing expert training. For each training, a training log that includes the date, duration, and title of the training, along with attendees name and agency affiliation must be completed.

Finally, REACH staff are able to develop trainings on specific topics of interest to the field. Topic specific trainings may be requested by community stakeholders or may be offered by REACH to address regional trends observed in the clinical population being served. As with required trainings, documentation of attendance, training title, and date, time and duration of the program is required.

(d) *Follow up*

Follow up is an integral part of REACH services, and is provided to all individuals who have received crisis intervention services. Follow up benefits both the individual and their systems of care, allowing residual problems to be addressed at their lowest level of intensity. REACH staff is in frequent contact with service providers and individuals to ensure that they remain stable and continue to receive effective services. Follow up activities include home visits, phone contacts, in person consultation with day support and residential providers, and attendance at team meetings to remain in-touch and aware of emergent issues as they arise. All active cases receive at least monthly phone contact to check in and ensure that the individual continues to do well.

Individuals are followed by REACH staff for six months to a year once stabilized.

(e) *Clinical Outreach*

REACH staff and other members of the REACH team provide outreach support through:

- Home visits
- Assistance in attending appointments with mental health providers
- Attendance at admission and discharge planning meetings for psychiatric inpatient stays
- Visits to residential and day providers to provide consultation and training
- Other community-based contact as needed
- Rapport building activities with individuals who are reluctant to use REACH services or feel they have experienced a negative outcome due to REACH intervention

III. REACH PROCESSES

A. Procedure to refer individuals from one REACH Program to another:

1. The REACH programs are operated by 5 separate providers, regionally distributed according to Health Planning Regions (HPR). Nonetheless, REACH programs work together to ensure that appropriate services are available at all times and to all individuals regardless of geographic location. Therefore, an individual may receive services from a REACH program outside of their residential area if they move to a new HPR or if their

regional REACH CTH program is at capacity. In these cases, transfers from one REACH service to another will be facilitated from one REACH Director to the other REACH Director.
2. The individual and/or guardian must sign an Authorization to Release PHI in order to permit information from one REACH program be provided to another REACH Program.

B. Emergencies and Use of Restraints

Each regional REACH Mobile Crisis Team maintains a plan of action for appropriate staff response to psychiatric, behavioral, medical and/or other emergencies that place individuals in imminent danger of harm. Regional REACH teams have and follow policy and procedures related to use of restraints, and behavioral interventions and supports.

All REACH Mobile Crisis Team members are trained in recognizing, preventing, intervening and de-escalating aggressive behaviors. REACH Mobile Crisis Team members receiving instruction in the behavior management technique employed by their respective REACH program and take annual refresher courses.

In general, all REACH programs prohibit the use of physical restraint except in emergent situations when there is imminent risk of harm to an individual or others. In these situations, only techniques supported by the programs' regional crisis intervention training may be used.

C. Complaint Process

All REACH programs are committed to providing the best possible quality of service. To maintain this commitment, each program has a process for investigating and resolving complaints. Following are expectations for the complaint process:

1. Each Region will develop a complaint form that is offered to any stakeholder of family member who is expressing a significant concern.
2. Complaint forms must include space for the nature of the complaint, what was done to resolve it (if applicable) and the name and contact information of the person making the complaint.
3. Completed complaint forms will go to the Fiscal Agent of the program or designee. A copy should be submitted electronically to DBHDS. DBHDS will not respond to complaints at this level but will use the information for tacking purposes.
4. Anonymous complaints may be used for information purposes by the Fiscal Agent if desired but do not need to be submitted to DBHDS unless special circumstances are evident.
5. Upon receipt of the written complaint, the Fiscal Agent or designee will make contact with the agency, provider, or family making the complaint. This initial contact should be made within 48 hours of the complaint being received. Next steps should be determined and documented on the complaint form.
6. Within 10 days from the point of initial contact a resolution should be presented to the complaining party. If this is accepted, the case is closed. If no resolution is garnered, the complaint should be forwarded to the Director of Community Support Services or designee.

D. Data Collection

All data will be entered into and maintained in the statewide Data Store. Each Region will receive two licenses to facilitate efficient data entry. Data elements relevant to assessing the quality and effectiveness of the REACH programs will be documented in the Data Store, with reports built from this source available at the Department's request. Additionally, each Regional Program will track trends in the use of crisis services and gather information about the population served (i.e. age, nature of disability, geographic area, etc) in their respective Health Planning Region. In addition to establishing needed clinical information, these data will be useful in service and financial planning. Data elements related to crisis response will be entered into the Data Store within 5 business days of the crisis event. Requests by DBHDS for additional data will be honored and responded to promptly.

E. MOU Agreements

REACH develops relationships with community partners in order to bridge service gaps and improve service outcomes. Formal Memorandums of Understandings (MOU) are important to defining those partnerships. These agreements link the REACH program with mental health and medical providers, inpatient mental health units, developmental disabilities providers, residential providers, vocational and day services providers, state agencies, dentists, neurologists, experts in the field, etc. Affiliates are partners with signed MOUs that the REACH programs maintain frequent and ongoing collaboration with as part of the infrastructure.

Further, REACH has numerous partners providing services in the community; partners are defined as those agencies with which REACH does not have a formal MOU, but with whom they work in collaboration. This approach is adaptable to the changing needs of the people and systems supported.

One of the most critical MOU functions is to develop a crisis support continuum. This includes development of agreements and collaboration with mobile crisis teams and first responders for increased diversion and collaboration with hospitals regarding admittance and discharge planning and transition.

IV. MONITORING AND EVALUATION OF SERVICE QUALITY:

The REACH monitoring and evaluating service quality policy shall comply with all Federal and State laws including *Commonwealth of Virginia, Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Development Services,* 12 VAC 35-105. These regulations can be found online at the Department of Behavioral Health and Development Services website. All revisions to this policy shall be submitted for review and comment to the Local Human Rights Committee prior to implementation. The goals and objectives of the REACH program are consistent with requirements of DBHDS, guidelines for federal block grants, and all applicable laws and administrative rules.

A. Quality Monitoring and Evaluation

REACH programs fully participate in evaluation and quality assurance activities mandated by DBHDS and/or other funding sources. REACH Program's planning and evaluation system is oriented to the mission and purpose of the program and gives primary emphasis to services and outcomes, priorities, needs, and constituencies (consumers and communities). Planning and evaluation is characterized by a long-term perspective and ongoing analysis. The planning and evaluation system is also designed

to encourage participation, awareness, and review by Advisory Council members, staff and volunteers, consumers, and the general public. Results of evaluation are used for planning, and for modification of REACH activities when necessary. It is essential that all REACH programs continue to evaluate service needs and outcomes through the continuous process of data collection and evaluation, both for reporting purposes and to improve service effectiveness over time.

C. Advisory Council

Regional Advisory Councils meet at least twice annually to provide support and review the progress of the program. They also have role in outlining future directions. Regional Advisory Councils enhance our capacity to remain accountable to everyone involved. Based on regional needs, Regional Advisory Councils may meet more frequently.

D. Staff Qualifications

The REACH Mobile Crisis Teams consist of qualified staff who are educated and trained to provide services to individuals with ID/DD. REACH Mobile Crisis Team Members Staff are qualified to provide:

- Crisis assessment, stabilization & intervention;
- Symptom assessment & management;
- Consultation and training to consumers, families, and other service providers;
- System linkages;
- Social, interpersonal, and leisure time activity services; and
- Support services or direct assistance to ensure consumers obtain the basic necessities of daily life.

The REACH Director is responsible for ensuring that the REACH Mobile Crisis Team members comply with minimum licensure guidelines and demonstrate core competencies as related to crisis services, mental health disorders, and intellectual and developmental disabilities. To facilitate this, DBHDS in conjunction with the REACH directors have developed a set of core competency trainings to ensure that a well-informed and knowledgeable workforce responds to crisis situations and is available to provide effective treatment and follow up care. All newly hired REACH staff must complete a structured training and mentoring program to ensure that they are sufficiently trained to meet the service standards listed above. While additional training related to general operating procedures, agency-specific practices and documentation is included in the orientation of REACH staff, structured training is provided in the following areas, according to the timelines specified:

1. To be completed within 30 days of hire
    - Introduction to the REACH program, including history, mission of the program, roles within the team, documentation requirements, and orientation to the CTH, including engaging at the home for blocks of time as scheduled by the REACH director or designee
    - Introduction to crisis assessment and intervention planning
    - Introduction to Intellectual and Developmental Disability, including Autism and dual diagnosis
    - Introduction to Trauma Informed Care

2. To be completed within 60 days of hire
    - Introduction to waiver services and the different waivers available

- Introduction to the Mental Status Exam
- Assessing and evaluating symptoms and behaviors
- Medication and medical causes of behavior
- Developing long-term goals and treatment planning

3. To be completed within 120 days of hire
    - Orientation to DD/ID
    - Orientation to family systems and ECO maps
    - Orientation to Systems Theory, including working with the interdisciplinary team and communication strategies between systems
    - Behavioral interventions, including overviews of Positive Behavior Support, Applied Behavior Analysis, and behavioral management
    - Discussion of special populations (i.e. forensic issues, geriatrics, trauma, and sexual offenders.

For each content area noted above, staff must complete and pass an objective comprehension test. While formalized training as outlined above serves as the minimum necessary to prepare staff to provide expert crisis and prevention service, completing these is not sufficient to ensure competency across areas. Therefore, in addition to the tasks outlined above, in-coming REACH staff must complete a process of supervision and mentoring. This process must include at a minimum:

- Weekly individual supervision for the first 120 days of service
- Group supervision twice per month for the first 120 days of hire
- Regularly scheduled shadowing of staff within the CTH for the first 30 days of service
- Shadowing of at least 6 in person crisis responses, with three of these being purely observational and three being handled as a team
- Observation by clinical staff of at least 6 in person crisis responses in which the new staff independently (to the degree appropriate) provides the assessment and intervention
- Observation of at least two trainings conducted by REACH staff and delivered to family, group home staff, or other community partner.
- Completion of one training provided to family, group home staff or other community partner that is observed by licensed clinician or supervisory staff
- Development of a formal case presentation, prepared under the direct supervision of a licensed clinician, and delivered to the larger REACH team for peer feedback (to be completed within the first 90 days of service)
- Review and feedback on all Crisis Education and Prevention Plans by licensed or licensed eligible staff for the first 120 days of service

The above activities must be completed and documented in the employee's personnel record. The trainings and supervision practices as described in these standards ensure that competencies are grown over time. However, just as important as developing competencies is establishing that staff retain high levels of competencies throughout their service to the program. Therefore, after completing their first year of satisfactory service, all REACH staff will receive the following supports:

- At least 12 hours of continuing education in topics related to mental health, trauma informed care, intellectual disability, developmental disability, behavioral supports or related topics. Note that this requirement relates to all staff employed at the program,

including staff of the CTH. All training should be commensurate with the level of expertise of the receiving staff.

- Direct observation of clinical service delivery with feedback provided at least every 6 months for residential staff and at least every four months for REACH coordinators and other clinical staff. At the discretion of the REACH director, this requirement may be made less stringent for those staff with a proven track record of success within the program.
- Review of written work (CEPP's, progress notes, crisis assessments, etc.) at least yearly with written feedback provided of all reviews.

V. Contact Information

Regional Addresses and phone numbers for referral and intake:

Region I
672 Berkmar Circle
Charlottesville, VA 22901
434-962-9220
855-917-8278

Region II
3460 Commission Court Suite 202
Lakeridge, VA 22192
855-897-8278

Region III
824 West Main Street
Radford, VA 24141
855-887-8278

Region IV
7700 Brook Road
Richmond, VA 23227
804-303-0741 ext. 302
855-282-1006

Region V
300 Medical Drive
Hampton, Virginia 23666
855-807-8278