**Category 1 Project Narrative**

**Bluebonnet Trails Community Services ‐ 126844305.1.2**

**Project Area, Option and Title:** 1.13.1 – Develop and implement crisis stabilization services to address the identified gaps in the current crisis system

**RHP Project Identification Number:** 126844305.1.2

**Performing Provider Name:** Bluebonnet Trails Community Mental Health and Mental

Retardation Center dba/ Bluebonnet Trails Community Services

**Performing Provider TPI #:** 126844305

**Project Summary:**

* **Provider Description:** Bluebonnet Trails Community Services (BTCS) is the Local Mental Health Authority for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. They comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. BTCS is the public provider of behavioral health services for the poor, under and uninsured in Williamson County.
* **Intervention:** BTCS proposes to create, certify and provide for an involuntary emergency detention unit for the purpose of providing crisis stabilization. A 48‐Hour Observation Unit will be established in Georgetown, Texas to provide for emergency and crisis stabilization services in a secure and protected, clinically staffed, psychiatrically supervised treatment environment. This 48‐Hour Observation Unit will provide assessment and active intensive treatment for adults.
* **Project Status:** This is a new project, no facility or service now exists in any of the Counties served by BTCS that accepts and evaluates adults on emergency detention orders. We expect to serve about 300 people a year when the project matures.
* **Project Need:** No 48 Hour Observation Units exist in BTCS’s area. This addresses RHP 8 Community Needs Assessment needs: CN.2.1 ‐ Limited access to behavioral health services to rural, poor and under & uninsured populations (meds, case management, counseling, diagnoses) in Williamson County; CN.2.2 – Limited access for serious mentally ill adults to crisis services in Williamson County; and CN.2.13—Limited access to adult behavioral health services in Williamson County.
* **Target Population:** The target population is adults presenting a significant threat to the safety of self or others and exhibiting behaviors consistent with acute psychiatric disorder. Of adults served by BTCS in FY 2012, an average of 43% were Medicaid‐eligible; 73% of BTCS clients are below the federal poverty level. We estimate approximately 70% of those benefitting from this project will be poor, under or uninsured. We expect to serve 250 people in DY4 and 300 in DY5.
* **Category 1 or 2 Expected Project Benefit for Patients:** The project helps patients by providing access to care locally and proactively so that they are not taken out of County and hospitalized. Quick local assessment supports local stabilization and reduces the number of short inpatient stays which result from using the hospital as an assessment location. The project seeks to provide assessment and stabilization services to 250 people in DY4 and 300 people in DY5.
* **Category 3 Outcomes:** IT‐3.14: Our goal is to reduce the behavioral health/substance abuse 30-day readmission rate to hospital by a percentage TBD based on baseline established DY3. What the achievement of this goal means is to provide services to the target population of people who have been hospitalized or experienced a crisis event and/or have been in the Crisis Respite facility and to assist them to regain functioning and self‐manage their wellness. Improvement in functioning and self‐management of symptoms and wellness are critical patient outcomes. When the goals are achieved, program participants should experience a reduction in symptoms and a reduction in crisis events. We expect to serve 250 people in this community based crisis alternative in DY4 and 300 people in DY5. Our goal is to serve people in the community. This not only represents a substantial savings over using hospital and ED, but more importantly improves the lives of those who otherwise would have go to hospital out of County or spend wasted time in inappropriate ED settings. Currently hospital and EDs are the only options.
* **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative and regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider‐ related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self‐fund the required IGT, could participate in the waiver. This project is transformative in that it creates an alternative for those in behavioral health crisis that is local, reduces hospital admissions and use of EMS and EDs. There are no community- based crisis stabilization alternatives except hospitals and EDs.

**Project** **Description:**

*Crisis Stabilization for Persons in Behavioral Health Crisis*

BTCS is the LMHA for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. BTCS proposes to create, certify and provide for an involuntary emergency detention unit for the purpose of providing crisis stabilization. To do so, a 48‐Hour Observation Unit will be created to provide for emergency and crisis stabilization services provided to individuals in a secure and protected, clinically staffed, psychiatrically supervised treatment environment with immediate access to urgent or emergent medical evaluation and treatment. This 48‐Hour Observation Unit will provide active intensive treatment for adults in need of acute inpatient psychiatric service; with suicidal indication; persons presenting a significant threat to the safety of self or others; and persons exhibiting behaviors consistent with acute psychiatric disorder which may include significant mental status changes.

The 48‐Hour Observation Unit will be fully compliant with all regulations and health and safety standards. This option will be accomplished by modifying our current voluntary Crisis Respite facility in Georgetown. A physical separation will be created between an area comprising two rooms and the remainder of the sixteen bed facility in order to establish a locked unit that is suitable for patients in crisis to be securely and safely detained for up to 48 hours. During the 48 hours, the individual in crisis will be assessed; will receive medication and intensive psychiatric treatment meeting their needs; and will be provided short term care, step down respite care and assisted transition into outpatient services and community resources. The facility will provide access to emergency care at all times and will safely and appropriately manage individuals with the most severe psychiatric symptoms. It is designed to provide a safe and secure environment for short‐term stabilization of behavioral health symptoms that may or may not require a continued stay in an acute care facility. Extended observation and treatment can take place for up to 48 hours. Individuals who cannot be stabilized within that timeframe would be linked to the appropriate level of care (inpatient hospital unit).

This involuntary behavioral health facility has the potential to serve an additional 300 people a year. The proposal builds on the current crisis system established by the LMHA and the relationships with local law enforcement agencies. To accomplish this we propose to make necessary building modifications, increase professional staff for the facility to meet standards requiring 24 hour nursing coverage, MD assessment within one hour and transfer capability to another inpatient facility if appropriate. Establishing the capacity to accept persons who are under Emergency Detention and hold them for assessment and short term stabilization will reduce the unnecessary utilization of Emergency Departments (EDs), psychiatric inpatient facilities and jail. This project reduces preventable readmissions to hospital by providing a community alternative for rapid stabilization and referral to appropriate residential options. Since the service is located in the same building as voluntary Crisis Respite, those who can achieve sufficient stability can transfer to the voluntary program to complete treatment. For persons requiring higher levels of medical expertise, and to ensure easy access to medical services, the clinic will be linked by telemedicine to our locations with additional physicians.

BTCS reviewed data related to admissions to the State Hospital and to the voluntary Crisis Respite facility. We found a large percentage of the 218 year to date admissions to the State Hospital‐‐17% accounting for 37 of the 218 admissions‐‐were made without prior screening and authorization by BTCS, the LMHA. In meetings with stakeholders in Williamson County, we learned that those admissions are being taken directly to the hospital by law enforcement officers because they have no local crisis alternative and have been requested to take individuals from ED’s or have taken them upon their own screening and assessment. They transport for direct admission to the State Hospital when in their judgment the individual needs an involuntary facility even for a short period of time. No such facility exists in Williamson County or any other County served by BTCS. Analysis of those State Hospital admissions reveals a substantial number with very short lengths of stay, indicating that they were inappropriately admitted and might be prevented with a community alternative for crisis stabilization. The number of individuals with lengths of stay less than 3 days reflects that 61 persons may have been inappropriately admitted year‐to‐date. When we reviewed the admission data for the voluntary Crisis Respite facility, it revealed that there were 252 admissions in FY 2012 and 95% of those were from Williamson County. Of those admissions, 13% were from EDs and local Hospitals; 8% were from the State Hospital; and 13% were from jail. Clearly, all of these individuals were candidates for crisis stabilization as a first option rather than hospitalization— expending valuable time and resources in the wrong setting. This project directly addresses the problem of inappropriate admission by creating the 2 beds for the 48‐Hour Observation Unit as an option for law enforcement in lieu of jail, ED or State Hospital. We will ensure that qualified assessment staff will be available at all times so that when an individual is brought to the facility he/she can be assessed and disposition made as quickly as possible, thereby allowing the law enforcement officer to return to regular duties. Social Service staff will provide for follow up to refer the individual to other levels of care upon stabilization or to prepare and process legal mental health commitment as needed.

**Goals and Relationship to Regional Goals:**

**Project Goals:**

* Establish an involuntary crisis stabilization service in Williamson County through a 48‐HourObservation Unit
* Develop a professional team on site and supported by telemedicine
* Provide this crisis service in a safe and secure environment that allows for those in custody and under detention order to be detained and assessed
* Reduce or eliminate the inappropriate utilization by the mentally ill of ED’s, jails, private hospitals and the State Hospital for short stays

**This Project meets the following Regional Goals:**

* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs
* Reducing inappropriate utilization of services

We are proposing this project in Williamson County because it is the largest county in the BTCS catchment area, with 55% of the population. Additionally, data above indicates that 95% of the admissions for crisis residential services came from Williamson County. Williamson County also has a well‐developed mental health deputy program and provides the opportunity for expansion and refinement of that program. This location is a good strategic choice because the County shares a border with 3 of the other 8 Counties we serve. As the program matures, the number of beds can be expanded easily to serve half of the catchment area if needed.

**Challenges:**

The primary challenge for this project is to achieve widespread use of the 48‐Hour Observation Unit as a first option by law enforcement. There are established law enforcement patterns of detention and disposition for mental health cases in Williamson County—as well as Burnet County. Just providing a new option will not automatically lead to acceptance and utilization. We plan to communicate to law enforcement leadership in the county and to the front line officers. We currently provide training and have routine communication with the major law enforcement agencies, Williamson County Sheriff’s Office, Burnet County Sheriff’s Office and the police departments of Round Rock, Georgetown, Burnet and Marble Falls. We plan to continue these activities and add additional communication and education meetings for the first year of the project to foster acceptance and use of the services.

**5‐Year Expected Outcome for Provider and Patients:**

Over the next 5 years, we expect the outcomes to include reduction of hospitalizations for persons who are currently admitted for very short stays, reduction of ED utilization by law enforcement that have behavioral health clients in custody, and reduction in incarceration of the mentally ill.

**Starting Point/Baseline:**

Currently, no involuntary crisis stabilization service exists in Williamson County; therefore, the baseline is 0 in DY2. We do not have the data to estimate the number of people who were admitted to jail inappropriately, who were admitted to private psychiatric facilities in adjacent Counties or who were detained in EDs. A major effort is needed during DY2 to identify the extent of the resources needed and ensure that the intervention is appropriate and adequate. We will use the number of admissions into the State Hospital System and Psychiatric Inpatient Units during FY 2012 as our baseline for the performance indicators.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 – Limited access to primary care
* Specific Community Need:

o CN.2.1 – Limited access to behavioral health services to rural, poor and under & un‐ uninsured populations (meds, case management, counseling, diagnoses) in Williamson County

o CN.2.2 – Limited access for serious mentally ill adults to crisis services in Williamson

County

o CN.2.13 – Limited access to adult behavioral health services in Williamson County

A secure and safe community based crisis stabilization alternative will give law enforcement officers and crisis responder’s new opportunities to help people. Someone experiencing a mental health crisis is assessed to determine if he/she is ‘a danger to self or others’. It is that standard in the law that must be met in order to detain someone, transport them to a safe place, conduct a thorough evaluation and determine the most appropriate course of action to assist the individual. A law enforcement officer, who has someone in custody under this circumstance, has little recourse other than to transport the person to the nearest safe and secure facility for evaluation. Jail, EDs and psychiatric hospitals are secure options and generally safe options. But as referenced in the RHP Planning Protocol – Category 1, page 141, *Behavioral Health News* Vol. 7 Issue 3 reported that “Community‐based crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays. For example, state psychiatric hospital recidivism trended downward coincident with implementation of crisis outpatient services in some Texas communities. The percent of persons readmitted to a Texas state psychiatric hospital within 30 days decreased from 8.0% in SFY2008 (before implementation of alternatives) to 6.9% in SFY2011.” A project to improve stabilization services and add a missing part of the continuum of care, the capacity to assess and treat people who are on emergency detention orders, is needed in Williamson County. BTCS participates in the Mental Health Task force for Williamson County and this group of leaders and health care professionals report that mentally ill people are taken inappropriately to EDs, jail and the State Hospital. Other than the data reported above related to admissions to the voluntary Crisis Respite facility, the community need being expressed is, to a certain extent, anecdotal. However it is clear that we need to begin offering a community based crisis stabilization option even as we address the core components of this Project Option.

**Project Components:**

This project to provide involuntary Crisis Respite services for adults will address all of the required core project components:

a*) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps.* We will work with health care and law enforcement stakeholders to identify gaps that lead to inappropriate admission to jail, EDs and short term stays in psychiatric hospitals. We will convene community stakeholders during the remainder of FY 2013 to identify information needed to assess the gap in crisis services and assess root cause.

*b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.* We know that law enforcement is transporting to and from EDs in their own community and in Austin and one cause is limited crisis response services and/or concern for the safety and security of the patient and the community. We will identify tools and agreements needed to access and analyze to determine capacity for service, current utilization patterns and to identify the key characteristics of the people to be served.

*c) Assess the behavioral health needs of patients currently receiving crisis services. Determine the types and volume of services needed to resolve crises in community‐based settings. Then conduct a gap analysis that will result in a data‐driven plan to develop specific community‐based crisis stabilization alternatives that will meet the behavioral health* *needs of the patients.* We will use BTCS staff to assess admissions and dispositions to voluntary Crisis Respite and to all psychiatric facilities in the area. We will focus on those detained and transported during the last year.

*d) Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.* Using the information from stakeholders, from capacity and utilization tools and from assessment of those detained, we will assess the intervention we are providing to determine if it is sufficient in bed capacity and scope of evaluation and treatment options available. We will use that information to recommend next steps for RHP 8.

*e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated* *with expansion of the intervention(s), including special considerations for safety‐net populations.* We will review the impact of involuntary Crisis Respite and identify lessons learned and adjust the model with respect to area, intensity and population.

**Continuous Quality Improvement:**

BTCS is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as “lessons learned” and identifying project impacts. In addition, we are participating in a regional learning collaborative which shares information such as challenges, lessons learned and considerations for safety net populations.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** This project provides crisis services to enhance the initiatives currently funded by the U.S. Department of Health and Human Services (DHHS). BTCS receives funds to operate substance abuse Outreach Screening and Referral services in Williamson and several other counties, and Mental Health block grant funds for outpatient mental health services. Those DHHS funds will not be used for direct services in this project; however, this project enhances and extends the care currently provided with Federal funds by a providing a local option to address crisis needs. We believe this crisis service will improve the healthcare outcomes for entire community, relieve pressure on law enforcement and ED’s and promote stable community tenure for our patients.

**Related Category 3 Outcome Measure:**

* OD‐3 Potentially Preventable Re‐Admissions‐ 30 day Readmission Rates (PPRs)

o IT‐3.14 Behavioral Health /Substance Abuse 30-day Readmission Rate

Reasons/rationale for selecting the outcome measure: Readmissions to psychiatric facilities are driven by a number of circumstances surrounding the initial hospital stay. Those include inaccurate assessment of acuity and early release, poor or hurried discharge planning, inadequate knowledge of community resources, inadequate resources to accommodate a sound community placement. Creating the option to provide involuntary detention and evaluation in the community provides the opportunity to address several of these drivers. We can provide timely evaluations and quick stabilization linked to community follow up. We know the community resources including housing and treatment options. It also gives us the chance to intervene with those who otherwise would be readmitted rather than getting community help. Admissions to inpatient settings should be more appropriate and readmissions reduced.

Baseline Information: The baseline rate established in DY3 was 6.04%. Our baseline measurement period established in DY3 was 09/01/2013-08/31/2014.

**Relationship to Other Projects:**

This enhances additional projects that BTCS is pursuing related to Child Crisis Respite (#126844305.1.2) and Emergency Services Diversion (#126844305.2.2) in that it provides access to care following those emergency interventions. We expect the other projects will demonstrate improved outcomes due to availability of outpatient and aftercare services in the communities in which people live. It both supports and relies on the Transitional Housing (#126844305.2.1) projects which provide a place for people to continue recovery in the community after stabilization is achieved. This option supports substance abuse treatment as a back‐up for relapse and crisis events. Routine outpatient care is enhanced by the safety net of short term crisis resolution.

This project also supports the intensive outpatient crisis services (#126844305.1.4) project to be implemented by the LMHA in Burnet County, in RHP 8. By providing the involuntary crisis stabilization service in Williamson County, the providers in Burnet County (25‐45 minutes from the proposed 48‐Hour Observation Unit) will be supported by a resource previously unavailable for persons in crisis.

**Relationship to Other Performing Provider Projects and Plan for Learning Collaborative:**

BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improving and adjusting the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. The exchange of ideas through both developing and existing relationships will keep the line of communication open and will help us adjust and refine our programs and approaches to behavioral health care.

**Project Valuation:**

We expect to serve 250 people in this community based crisis alternative in DY4 and 300 people in DY5. Serving people in the community is a substantial savings over using hospital and ED, which are now the only options. The valuation calculated for this project used cost‐utility analysis which measures program cost in dollars and the health consequences in utility‐ weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality‐adjusted life‐years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided).

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to [www.bbtrails.org](http://www.bbtrails.org/) under the Medicaid

1115 Transformation Waiver tab. A complete write‐up of the project will be available online.