**Category 1 Project Narrative – Pass 2**

**Central Counties Services – 081771001.1.4**

**Project Area, Option and Title:** 1.13.1 Develop and implement crisis stabilization (respite and transitional) services to address the identified gaps in the current community crisis system.

**RHP Project Identification Number:** 081771001.1.4

**Performing Provider Name:** Central Counties Services

**Performing Provider TPI #:** 081771001

**Project Summary:**

* **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012, we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations.
* **Intervention:** This project provides 24/7 residential-based crisis respite (15 beds), transitional living (15 beds) and supportive day services at a properly equipped facility within our service area to persons with severe and persistent mental illness who have experienced a recent mental health crisis, in lieu of these persons being sent to the state psychiatric hospital system or incarcerated in local jails.
* **Project Status:** This is a new project.
* **Project Need:** CN.2.10 Limited access for seriously mentally ill adults to crisis services in Bell, Lampasas and Milam Counties. Our service area currently does not have crisis residential services.
* **Target Population:** 97% of all of the Center’s patients are Medicaid (41.89%), uninsured or indigent. We anticipate this project will benefit this same population.
* **Category 1 or 2 Expected Project Benefit for Patients:**This project seeks to provide crisis services to patients in more appropriate and less costly setting than psychiatric hospitalization or incarceration (Improvement Milestone I-11.1 and I-11.2). This project intends to provide 700 crisis respite bed days in DY-3, 2,550 crisis respite bed days of service in DY4 and 3,180 bed days of crisis respite services in DY5. The maximum expected Quantity Patient Impact (QPI) is (DY-3: 700: + DY-4: 2,550: + DY-5: 3,180 = 6,430) 6,430 crisis respite bed days. It is important for this project that the QPI be measured in encounters (1 encounter = one bed day) instead of people served as it is unknown how many of the people served will be re-admissions to these services. Measuring bed days gives the Center full credit for actual resources consumed getting the same credit for a patient who stays ten days instead of one day.
* **Category 3 Outcomes:** IT-9.1: An expected outcome for this project is to reduce the mental health admissions/readmissions to criminal justice and psychiatric hospital settings with the percent of improvement to be determined once the baseline is set in DY3.From this point in the following DY’s such as DY4 the amount should increase from 5% over the baseline that is established and then in DY5 should be 10% over the baseline.
* **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

**Project Description:**

*Crisis Respite Services*

The Center’s service region has an immediate need for crisis respite services/transitional living services for those persons in mental health crisis who have no place to live (see Rationale Section below). The description of Crisis Respite Services to be implemented in this project is: Crisis Respite Services (CRS) provides short-term (3-7 days) structured residential treatment organized in a non-medical, psycho-social recovery-focused service model that focuses on the person’s strengths to manage/reduce their crisis. CRS provides a calm, protected, and supervised non-hospital setting where the patient can stabilize, resolve problems and link with possible sources of ongoing support. CRS includes supervised, structured room/board available 24 hours/day, 7 days/week and is an immediate alternative to acute hospitalization or incarceration in emergency situations. The CRS facility would be an unlocked unit that relies on voluntary patient participation. It serves as an early intervention for persons showing signs of deteriorating ability to self-manage their behavioral health problems/symptoms, and can be a “cooling off” place for persons whose home situation has become intolerable. It can serve as a “step-down” (less intensive service) for someone being discharged from inpatient psychiatric services. Treatment services offered at this CRS are intended to keep the person safe, stabilize the person’s acute psychiatric symptoms, and return the person to their familiar living situation and treatment quickly. Actual treatment services may include milieu therapy, psychotropic medications, solution-focused brief therapy, assertive case management, housing assistance, etc. The CRS target population is described as: adults with a diagnosed or suspected mental illness; in behavioral health crisis, but whose behavior is under sufficient control to not be considered an immediate risk of self-harm, or harm to others; agree to voluntarily participate in CRS; for whom CRS is deemed a safe, appropriate, beneficial level of care; and do not have medical problems requiring regular medical treatment beyond a self-care level. Persons excluded from CRS would be persons who are: under 18 years old, have a blood alcohol/drug level putting them at risk of withdrawal symptoms, or impaired judgment about their behavior; unwilling to voluntarily take part in services or comply with services rules; have a medical condition requiring intervention above a self-care level; have not yet fully recovered from the physical symptoms associated with a suicide attempt; or has any other condition/circumstance judged to be beyond the service capability of the crisis respite staff.

The description of Crisis Transitional Services (CTS) to be implemented in this project is: Crisis Transitional Services are a step-down service for the Crisis Respite Services that provides short –term (3-7 days) structured residential treatment organized in a social recovery model that focuses on the person’s strengths to get themselves re-established in their own living setting in the community of their choice. These services would include support to apply for any social support benefits for which the person might be eligible due to their disability, income or social status. Patients would have access to local telephone service and the internet in a computer lab set up to use to assist them in making living arrangements in the community of their choice. These services will include an assessment of each person’s independent living skills and knowledge needed to live successfully by themselves in their own apartment/home. Identification of skill/knowledge deficit areas will form the basis for a brief skills training program that is individualized to help meet each person’s need to increase his/her readiness to live successfully in their own setting. This service will also assist the patient in contacting their previous living arrangement(s) and extended family to determine if any of those living arrangements are still available to the patient. The patient would also be assisted with their application for public/subsidized housing in the community of their choice. This service would provide transportation for consumers to assist their getting settled in the community, and would also work with the consumer’s use of the public transportation system to meet their mobility need. This service would also link the patients to supportive day services if the patient desires such and can work out personal or public transportation to the day services upon discharge from crisis transitional services. The Crisis Transition Services target population would be adults who have become stabilized after a recent mental health crisis but do not have an immediate, stable living arrangement to go to upon discharge from Crisis Respite Services.

The Center is planning a multiphase project approach to address this unmet service need as soon as possible with interim arrangements while more desirable ways of addressing these unmet behavioral health needs gets worked out. The first step contracts for CRS with Heart of Texas Regional MHMR Services (HOTRMHMRS) in Waco Texas (40 miles north of Temple). While this CRS is not in our service region, it is closer than Austin State Hospital (68 miles from Temple). HOTRMHMRS has extra CRS capacity and can make 5-10 beds available to our Center, depending on their daily census. This will provide some immediate relief to our Center’s recent overuse of our state psychiatric hospitals. Within 3 months of project approval Coryell County will begin to remodel, furnish, and equip the former Coryell County Hospital for interim use as transitional living services, with a target start date of Oct. 1, 2013. This interim arrangement is limited to 8 bed capacity due to not having a fire/safety sprinkling system. This project may also include partnering with the Coryell Memorial Healthcare System (CMHS) for medical screening, patient minor health issues treatment, and food services contracting. It will have 16 beds and can serve both male and female patients. During DY2, the Center will convene the main stakeholders for behavioral health CRS, namely, every local law enforcement agency, hospital emergency department, and the Bell, Coryell, Hamilton, Lampasas and Milam County Judges to ask them to support an intense needs gap analysis process on the amount of CRS needed by our service area and the best location of these services. This gap analysis process would track the number of persons who present or are brought to local emergency departments in mental health crisis, and if a CRS care level would have met their needs. We will also collect data on the number of persons in mental health crisis arrested for minor crimes who could benefit more from CRS than jail. This gap analysis process will also document if post-crisis respite service is needed by the person in crisis (e.g. housing, day support services, transportation, transitional living support, medical care, substance abuse services, medicine, etc.). The maximum capacity of the new CRS will be set by Health and Safety code and licensing requirements – likely 16 beds. Two admissions per day would lead to someone having to be discharged by the 7th day to allow further admissions. If the patient is homeless, it is difficult to stabilize the patient and set up a new living situation in 7 days. The only way to have an effective, accessible CRS would be to also have step-down, transitional living services so patients who are stable, but homeless, could be in a crisis transitional living setting a few more days while living arrangements are worked out.

**Goals and Relationship to Regional Goals:**

**Project Goals:**

This project’s goal is to establish crisis-responsive residential services within our service area that provide a less restrictive/costly level of care for persons in behavior health crisis than admission to the state psychiatric hospitals or jailed for a minor offense. The goal is to provide successful interventions for persons in early stages of crisis before the crisis situation reaches the complexity that institutional level of care becomes the only care option resulting in the person’s support system and living arrangements being disrupted and jeopardized.

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

Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.

**Challenges**:

Perhaps the biggest challenge will be managing the gap analysis, local planning, program design/documentation, securing an appropriate facility that meets licensing and health/safety codes requirements of CRS, and staffing up/fully operationalizing the services by the end of DY3 so project outcomes can be properly measured in DY4 and DY5. Our Center will do as much local organizational work with stakeholders, gap analysis partnering, and CRS planning as it can in early 2013 in order to have as much information in place as possible to expedite the actual establishment and operations of these CRS for our area.

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

In 5 years, our Center intends to have fully functioning CRS with step-down transitional living services available to our service area. It is also our goal to have strong working relationships with our local hospital EDs and our local law enforcement agencies such that persons are identified in early stages of behavioral health crisis and assisted through these proposed services, rather than admitted to the state psychiatric hospital system or local jails. We would expect that psychiatric hospitalizations and the incarceration of persons with mental illness would decrease/100,000 population in our service area.

**Starting Point/Baseline:**

Our Center and its staff have previously provided both crisis stabilization services (16 bed medical model) and transitional living services (15 bed capacity), and both were usually close to capacity by serving persons from our area until they closed due to funding reductions. Our service demand for residentially-based behavioral health crisis services exceeds our regional capacity at this time as shown by our Center’s overuse of state psychiatric hospitals, the keeping of patients in EDs while waiting for a state psychiatric hospital bed to be open, and the anecdotal reports from local law enforcement agencies/County Judges that persons who have committed minor crimes while in a behavioral health crisis who would be better served in a mental health residential facility than incarcerated as is currently occurring. The Bell County 2010 Community Needs Assessment that 27% of the 715 homeless persons interviewed had mental health problems and were at risk of mental health crisis due to homelessness: <http://www.co.bell.tx.us/2010%20Needs%20Assessment.pdf>.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 - Limited access to mental health/behavioral health services
* Specific Community Need: CN.2.10 - Limited access for serious mentally ill adults to crisis services in Bell, Lampasas and Milam Counties

The Center provided Crisis Stabilization Services from the late 1980’s until June 2000 when the services closed due to higher service demand and less resources to provide them. The Center also provided transitional living services from the late 1980’s until 1995 when these services had to close due to state funding reductions. Now Bell, Lampasas, Milam, Coryell, and Hamilton Counties do not have any residential services to assist residents experiencing a mental health crisis. Persons in a mental health crisis in this service region must be guided to one of four options, namely, 1) admission to the state psychiatric hospital, 2) kept in a local ED for stabilization while waiting for a state psychiatric hospital bed (most recent severe case was for 13 days), 3) being jailed for a minor crime, or 4) released to community supports; at times, a less-than-desirable choice. Our county jails now track the number of inmates having a mental illness/take psychotropic medications and report that 28% of the inmates have mental health problems. The Center is allotted a portion of state psychiatric hospital days in proportion to its percent of the state’s population being in our service area.

Last fiscal year (ending 8/31/12), our service area used 110.87% of the bed days allotted for our service area, thus demonstrating a much greater demand for resources than are available to respond to persons in our region who experience severe mental health crises. Comparing our use of bed days to Local Mental Health Authorities (LMHA) who have CRS near us proves this point. The LMHA to the North used 99.27% of their bed days and the LMHA to the South used 71.9% in FY2012. HB2292 in the 78th Texas Legislature required each LMHA to have a Jail Diversion Task Force to expedite the diversion of mentally ill persons arrested for minor crimes while in a mental health crisis. The Center’s Community Jail Diversion Task Force consists of local law enforcement agencies, community social service agencies and local Judges. This Task Force’s jail diversion efforts are hampered by the lack of residential options needed to divert a mentally ill offender from incarceration.

**Core Project Components:**

1. *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.* There was much stakeholder support for CRS prior to our having to close them.
2. *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.* There are no residential crisis stabilization or CRS, and consequently, no crisis residential service capacity in our area at this time.
3. *Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. 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 (e.g. minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings).* Having operated crisis stabilization and transitional living services for 10+ years in the past, we know that these two levels of CRS are needed in our area and were well received and supported by the EDs and law enforcement agencies in our service area. These partnering agencies were greatly disappointed and adversely affected when these services ended. Our partners had to transport crisis patients to Austin State Hospital instead of accessing local services.
4. *Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.* Our past experience of providing CRS and transitional living services, which were in separate communities, has brought us to the conclusion that these two levels of care can operate best if they are proximate to each other, perhaps in the same building, if possible. Having them in the same building would give more flexible use of staff and gain various operating efficiencies, such as meal preparation, laundry facilities, etc.
5. *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.* See Milestones 9 and 11. Our Center’s project #081771001.1.5 – Enhance Improvement Capacity through Technology, will also assist our Center with its commitment to continuous quality improvement of these services.
6. Continuous Quality Improvement: The Center 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 share 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 does not supplant any services or funds currently provided to Central Counties Service from the U.S. Department of Health and Human. The services proposed to be provided under this project serve to enhance, but not duplicate, the services provided by our Center to persons with severe and persistent behavioral health problems.

**Related Category 3 Outcome Measures:**

* OD-9 – Right Care, Right Setting
  + IT-9.1 Decrease in mental health admissions and readmissions to institutional psychiatric hospitals or criminal justice settings such as jails or prisons.The goal of this project is to increase the number of persons in mental health crisis who have or are about to be involved in a mental breakdown situation and to be diverted from the legal justice system into an appropriate level of behavioral health care. This basis is based on central counties establishing a baseline in a period of 6 months or more and then improving over the following DY’s. This can be shown by improvement in DY4 of increasing the amount that is needed by improving 5% over the baseline number that was previously established. Then in DY5 there would be an improvement of 10% over the baseline that was established.

This outcome measure is chosen because it directly addresses and measures the impact of this project’s goal or purpose, namely to provide effective local crisis residential services that can be utilized by persons in behavioral health crisis in lieu of admissions and readmissions to more restrictive/expensive institutional levels of care in EDs, psychiatric hospitals or local jails.

**Relationship to Other Projects:**

This project is related to our Temple Day Services (#081771001.2.3) which also has the purpose of lowering the frequency of admissions/readmissions to psychiatric hospitalization and /or incarceration. Our telemedicine project (#081771001.1.2) is also intended to improve patients’ access to psychiatric care and compliance with anti-psychotic medication, both of which are key elements in persons with severe and persistent mental illness maintaining stability in their community setting. The Center’s “enhance improvement capacity through technology” project (#081771001.1.5) has as its service objective to increase the number of timely follow-up visits with patients after they have been discharge from psychiatric hospitalization – also a very important service that is aim at reducing hospital readmissions. The use of data dashboards created under this project will greatly assist the Center’s work with Milestones 6, 9, and 11 to continuously improve our crisis respite services.

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

Bluebonnet Trails is also proposing 3 crisis respite services projects (#126844305.1.2, #126844305.1.3, and #126844305.1.4) for Williamson and Burnet Counties. The Center is committed to improving services and broad-level delivery system transformation. We are willing to participate in learning collaboratives with providers in RHP 8 to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis allows providers to strengthen their partnerships and continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8.

**Project Valuation:**

This project is transformational in that these services are currently not available in our service region, and this project will make crisis respite services available to all regional communities. The project valuations takes into account that this project is of great value to our service region and is transformational in that these services are currently not available in our service region, and this project will make crisis respite services available to all regional communities and the combined RHP-8 & RHP-16 cost of up to 4000 hospital ($461/day/FY12 at Austin State Hospital – average length of stay = 21 days\*)/incarceration ($50+/day with average time in pre-trial services is 145 days\*\*) days will be avoided by these services in DY5. Assuming that all days of crisis respite services would take the place of days in the state hospital, this project would save the State of Texas approximately $1,383,000 in DY4 and $1,844,000 in DY5. **\***Austin State Hospital Regional Planning Meeting Oct.31, 2012, pp.30, 35. **\*\***”A Simulation Modeling Approach for Planning and Costing Jail Diversion Programs for Persons with Mental Illness. David Hughes, et al, Criminal Justice and Behavior, Vol. 39 No 4 April, 2012, p. 438.

DY2 project valuation includes contracting costs for CRS from HOTRMHMRS, a minivan, costs to trans-port persons to/from CRS in Waco, costs for screening and follow-up for persons referred to HOTRMHMRS, renovation, furnishing and equipping costs to make the former Coryell County Hospital building useable for our service region and hiring/training costs for staff to provide these post-crisis, respite transitional living services. DY2 also has costs for convening stakeholders multiple times, hiring consultants to complete the in-depth gap analysis/service planning implications and final project proposal required by this project. DY3 valuation continues the HOTRMYMRS contract for CRS, and includes transitional living service costs, while ramping up operation of CRS within our service area, which involves acquiring office and patient area equipment/furnishings, vehicles, operating supplies, food storage/handling equipment, telemedicine equipment, phone, electronic health record access, and data services, etc. needed to start CRS in our service area (see Milestone 8). DY3 also includes hiring/training crisis respite staff, including a psychiatric advance nurse practitioner, obtaining proper Dept. of State Health Services' site approval/licensing, the design and writing of service protocols and manuals. DY4 and DY5 valuation reflects the operations of the residential crisis services called for in the gap analysis, planning and design process. The DYs 2-5 valuation includes Center indirect program and administrative overhead costs. This project’s valuation also considers the psychiatric hospitalization and incarceration costs that can be saved by local access to CRS. If this project keeps half of its patients (10-15) out of psychiatric hospitals (15 days/admission) or jails (30 days/event), it will save our state/communities considerable financial and personnel costs. Admission/ readmission to criminal justice settings is disruptive/deleterious to behavioral health crisis recovery. Studies of recidivistic criminal justice patients in Texas and other states show poorer physical health status, increased homelessness, and increased use of ED and inpatient services. Services that keep persons from cycling through the criminal justice system help avert poor health/ mental health outcomes, reduce long term medical costs and improve personal functioning. This valuation reflects 79.5% of the total valuation (Region 8 has 79.5% of our service region’s population) while 20.5% of this project’s valuation is reflected in our project submitted to RHP 16.