**Category 2 Project Narrative**

**Bluebonnet Trails Community Services – 126844305.2.1**

**Project Area, Option, and Title:** 2.13.1 Design, implement, and evaluate research‐supported and evidence‐based interventions tailored towards individuals in the target population.

**RHP Project Identification Number:** 126844305.2.1

**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 state designated Local Mental Health Authority (LMHA) for Williamson and Burnet Counties in RHP 8. Burnet and Williamson Counties comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. We are responsible for behavioral health planning and coordination throughout our local service area and are the sole provider of public behavioral health services in these counties.
* **Intervention:** BTCS proposes to implement a Peer led transitional support services program. We will secure, prepare and staff community living settings suitable for no more than 6 individuals at a time who will be provided behavioral health services in this transitional service program to improve community living skills and residential stability with the goal of achieving permanent supportive housing.
* **Project Status:** This is a new project for BTCS. No such service exists from any provider in these Counties and there are limited affordable housing options and Permanent Supportive Housing options in the area.
* **Project Need:** This project addresses RHP 8 Community Needs Assessment: CN.2.1 - Limited access to behavioral health services to rural, poor and under & uninsured populations (meds, case management, counseling, diagnoses) in Williamson County; and CN.2.12 - Limited access in Williamson County to behavioral health services for adults with serious mental illnesses who are transitioning from inpatient care and crises into community living.
* **Target Population:** The target population is people with mental illness referred from crisis services, criminal justice and inpatient settings. We will prioritize admissions to those with long or repeated stays in those settings or with frequent contacts with the criminal justice system. BTCS served 7,769 persons with behavioral health disorders in FY 2012. An average of 43% of adults were Medicaid-eligible; and 73% of BTCS clients were below the federal poverty level. We expect 70% of those benefitting from this project will be poor, under or uninsured. This project will serve 48 people in DY5.
* **Category 1 or 2 Expected Project Benefit for Patients:** This project seeks to provide transitional housing services for 36 people in DY4 and 48 people in DY5. Stable living provides an opportunity to improve life skills and functioning.
* **Category 3 Outcomes:** IT‐11.26.c: Our goal is to improve functioning demonstrated by progress made on the Adults Needs and Strengths Assessment (ANSA) by a percentage TBD based on a baseline established in DY3.
* **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 broader, transformative, 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 to the community because there are no affordable housing options for those who are treated and released from inpatient psychiatric settings or who have experienced a crisis event that dislocates them from community and family. Psychiatric/medical stability is impossible without housing.

**Project Description:**

*Peer Supported Transitional Services Program*

BTCS is the state designated LMHA for Williamson and Burnet Counties in RHP 8. We are responsible for an array of public services as well as for behavioral health planning and coordination throughout our local service area. That responsibility includes identifying gaps in service or barriers to access for persons with behavioral health issues residing in the area. We serve a variety of persons through various contracts and payors. Among those, BTCS has a contract with the state to serve adults who are primarily diagnosed with Serious Mental Illnesses (SMI); the Federal definition can be found at (Federal Definition for SMI <http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc>).

This group of patients generally suffers from the most profound deficits in functioning and are often unemployed, homeless or living in sub-standard housing and without natural family or community supports. Recovery is possible for these individuals but it is a difficult journey requiring help and supports. BTCS and community partners are responsible for aftercare upon release from hospital and for stability in the community following Emergency Department (ED) visits, jail stays and the number disruptive of events that happen for those with SMI. Community stability cannot occur for anyone without access to housing.

BTCS proposes to implement a transitional support services program that is provided consistent with SAMHSA recognized recovery principles (National Consensus Statement on MH Recovery, <http://www.samhsa.gov/SAMHSA_News/VolumeXIV_2/article4.htm>) and staffed in large part by peer support specialists. Based on our treatment efforts and with the consensus of community leaders, we realize that with few permanent supportive housing options client transition from crisis services to recovery can entail additional barriers. BTCS is developing a program that includes not only transitional services but staff and resources to improve housing stock and locate and help individuals achieve Permanent Supportive Housing that comports with SAMHSA guidelines (<http://homeless.samhsa.gov/channel/Permanent-Supportive-Housing-KIT-557.aspx>).

We will identify suitable sites in Williamson and Burnet Counties that provide a safe place to live on a temporary basis and in which peer led transitional services can be provided. The program will accept referrals from our Crisis Respite Unit, State psychiatric inpatient facilities, criminal justice diversion programs and the local Community Center. The referrals will be screened and considered based on need. The program will be for individuals who have a need for housing. We will offer an array of services for voluntary client directed Recovery-Based Program participation options led by the Peer support staff and integrated into additional support services. We will encourage but not require individuals to accomplish their goals and objectives to increase financial, psychological and financial stability. While in the program, Peer Specialists will teach skills to improve the likelihood of a successful transition to residential stability with the goal of achieving permanent supportive housing. Peer Specialists in Recovery will assist those in the program to better understand their particular recovery needs while providing hope and encouragement. All admissions to the program will participate in a Wellness, Recovery, Action Plan (WRAP) to help target the individual needs. This evidenced based program focuses on promoting recovery and self –responsibility (*Developing a Recovery and Wellness Based Lifestyle Guide*, <http://store.samhsa.gov/product/Developing-a-Recovery-and-Wellness-Lifestyle-A-Self-Help-Guide/SMA-3718> ; and *Consumer Operated Services – EBP*, <http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD> ).

WRAP is listed on the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) registry of evidenced based practices. WRAP is an effective, manual-based group intervention for adults with mental illness. WRAP guides participants through the process of identifying and understanding their personal wellness resources (wellness tools) and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness symptoms. These peer led services will lead into and be supported with client directed choice into community-based interventions which are comprehensive. The comprehensive and multispecialty services offered include permanent supportive housing services, supportive employment services, psychosocial rehabilitation and transitional assistance. Each program participant will have access to a Qualified Mental Health Professional (QMHP) Psychosocial Rehab Specialist, (QMHP) Supportive Housing Specialist and a (QMHP) Supportive Housing Specialist. These support services center on the person centered recovery plan developed through interaction with the peer support specialists.

Recognizing limited area housing resources and client income limitations, the program will provide client assistance to establish a basic household, including security deposits, essential furnishings, moving expenses and bed and bath linens. These interventions will have significant flexibility to add more components if they are appropriate to meet the needs of the target population.

Community‐based tools and practices such as these will stem from client direction and client choice identified and supported during ongoing activities. The program will be evaluated quarterly and outcomes will be closely monitored. We plan for active peer participation in the PDSA cycle to assess the efficacy of WRAP and explore other wellness and recovery EBP’s if options are needed. All services will be documented in our electronic information system. Data will determine the amount and frequency of the services being provided and will be utilized to help guide the program quarterly. Satisfaction surveys will be provided for individuals leaving the program to ensure we gather personal attitudes regarding the effectiveness of the program. The program and the additional staff as described above are charged with providing direct service and developing community resources that will facilitate rapid access to Permanent Supportive Housing including transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses and bed and bath linens so that individuals can smoothly move into community living.

**Goals and Relationship to Regional Goals:**

Over the next five years we expect to fully develop this program of peer led transitional support services based on recovery principles with an average census of around 10 persons who will stay from between one to six months depending on assessed need. We expect to serve 36 to 48 people each year after the program is underway. The goal of the program is to facilitate the change process for individuals with SMI through skills building, self-awareness, self-advocacy and providing the supports necessary for stable lives in a community setting.

**Project Goal:**

* Establish a Peer Led Transitional Services program based on Recovery Principles;
* Recruit, train and certify Peers to provide transitional services;
* Provide services to the target population of people who have been hospitalized or experienced a crisis event and have been in the Crisis Respite facility;
* Assist people to regain functioning and self-manage their wellness;
* Identify project impacts, “lessons learned,” opportunities to scale all or part of the project to a broader patient population. As stated above, we plan for active peer participation in the PDSA cycle to assess the efficacy of WRAP and explore other wellness and recovery EBP’s if options are needed both for the target population and any expanded populations.

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

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

As this program is established and grows, we expect individuals will have fewer ED visits, fewer state hospitalizations, a lower rate of arrests and fewer days incarcerated. An additional benefit of this program is that it can serve as a recovery resource to the broader community of persons in Williamson County with SMI who are in the process of recovery.

**Challenges:**

Challenges include the limited stock of affordable housing for persons who are ready to exit the criminal justice system, crisis and emergency services and illness related skill deficits needed to live independently or in a supportive living situation in the community. We have a long standing presence in the community and the support of community leaders who can assist in identifying suitable locations for Permanent Supportive Housing. Staff will work with clients to continually assess opportunities for Affordable, Accessible and Integrated Permanent Supportive housing choices for clients. Another key challenge is training and certifying peer support specialists and ensuring they have the knowledge necessary to make linkages with other programs such as crisis respite and federally qualified health clinics. During DY2 we will be actively recruiting individuals with SMI for training and certification as Peer Support Specialists. We will also begin a review and inventory of community resources.

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

Over the next 5 years, we expect the outcomes to include a reduction of readmissions to psychiatric hospitals within 30 days. The goals of this project are to establish a service that helps people live successfully and gives them the opportunity to be assisted by their peers as they make that transition. Community tenure will improve with these supports and readmissions will be reduced.

**Starting Point/Baseline:**

Currently no Transitional Services Program exists in the Counties; therefore, the baseline is 0 in DY2. Baseline data is expected to be based on patients entering the peer led transitional services program DY3. The precise metrics are to be determined based on the planning and research cycle of the project. As stated, we expect to impact ED visits, arrests, utilization of crisis respite services and state hospitalizations but we must determine the baseline number during the initial phase.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 - Limited access to mental health/behavioral health services
	+ Specific Community Need: CN.2.12 - Limited access in Williamson County to behavioral health services for adults with serious mental illnesses who are transitioning from inpatient care and crises into community living.

In Category 2 - Innovation and Redesign; Project Area and Option: 13 –“Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ED, urgent care etc.); 2.13.1 Design, implement, and evaluate research‐supported and evidence‐based interventions tailored towards individuals in the target population. The project incorporates at least six of the community‐based interventions including:

* Residential Assistance (Foster/Companion Care, Supervised Living, Residential Support Services);
* Psychosocial Rehabilitation;
* Supported Employment;
* Transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens;
* Transportation to appointments and community‐based activities;
* Prescription medications; and
* Peer support – A service that models successful health and mental health behaviors. It is provided by certified peer specialists who are in recovery from mental illness and/or substance use disorders and are supervised by mental health professionals.

**Project Components:**

Required Core Components:

1. *Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement.* We will convene community stakeholders during the remainder of FY 2013 to identify information needed to assess the gaps that must be filled to secure housing and to gain the skills for a smooth transition. With these stakeholders, we will identify tools to provide data to obtain an inventory of community resources currently utilized and those needed by the people we expect to serve.
2. *Review literature / experience with populations similar to target population to determine community‐based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* We will use the current staff to assess current needs of those who are now hospitalized and soon to be discharged and those experiencing crisis events needing transition to community housing. Using the information from stakeholders, from capacity and utilization tools, from further literature reviews and from assessment of those potential referrals, we will assess the intervention we are planning to provide.
3. *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes*. As we implement the project, we will plan a rapid cycle quality improvement component through our Quality Management Department at BTCS. As discussed above, we plan for active peer participation in the PDSA cycle to assess the efficacy of WRAP and explore other wellness and recovery EBP’s if options are needed both for the target population and any expanded populations.
4. *d) Design models which include an appropriate range of community‐based services and residential supports.* We plan to continuously improve the program over the next 5 years as we adjust the interventions, peer supports and make changes based on lessons learned and client need. Those changes may include adjustments to the model with respect to interventions, intensity and population.
5. *e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.* BTCS is a Community Mental Health Center and during FY 2014 we will be using the ANSA as a standard tool for assessment. Every program participant will be assessed and those documented in the electronic health record and available for report and analysis.

We expect the milestones and metrics in the first 2 years to reflect the innovative and developmental nature of this project. We will measure progress toward community assessment and development of infrastructure such as policies, training materials, contracts and support. This innovative community alternative to institutional care not only saves money through reduced hospitalizations but also provides people the opportunity for recovery with the help of their peers.

The Milestones selected for DY’s 2 and 3 are:

* P‐1 Milestone: Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources;
* P-2 Milestone: Design community‐based specialized interventions for target populations. Interventions may include (but are not limited to)
	+ Residential Assistance (Foster/Companion Care, Supervised Living, Residential Support Services);
	+ Psychosocial Rehabilitation;
	+ Supported Employment;
	+ Transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens;
	+ Transportation to appointments and community‐based activities;
	+ Prescription medications; and
	+ Peer support – A service that models successful health and mental health behaviors. It is provided by certified peer specialists who are in recovery from mental illness and/or substance use disorders and are supervised by mental health professionals.
	+ Residential Assistance;
* P‐4 Milestone: Evaluate and continuously improve interventions.

We selected these because we are starting a new program that has not been implemented in this Region and must ensure that the right population is targeted with the right interventions and then continuously adjusted as we learn how to help people succeed through the use of peers, supports and transitional services. The metrics are a combination of program reports and logs and census numbers.

The Milestone for DY’s 4 and 5 are:

* I-5 Functional Status: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on ANSA; we selected the target 30% in DY4 and 40% in DY5.

We selected Functional Status because we expect the period of Transition will improve functioning and our goal is to return to community life.

These Milestones and Metrics are specifically related to the targeted population of individuals who have recent crisis events that sometimes result in hospitalizations with the aim of providing them the best opportunity to make a recovery oriented transition to the community and thereby prevent further crises and hospitalizations.

**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 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 housing 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. BTCS currently employs Peer Support Specialists to enhance services in all outpatient programs. Peer Support and services based on Recovery Principles are system reform initiatives that we are proud to support. This system reform initiative will be enhanced by utilizing additional Peers in the vital role of promoting wellness and self-management. Also as stated above, this will create a community hub for Recovery activities.

**Related Category 3 Outcome Measure(s):**

* OD‐11 Behavioral Health/Substance Abuse Care
	+ IT‐11.26.c: Adult Needs and Strength Assessment (ANSA)

Reasons/ rationale for selecting the outcome measure: This is a stand-alone measure. The goal of the program is to secure, prepare and staff community living settings suitable for individuals in need who will be provided behavioral health services in this transitional service program to improve community living skills and residential stability with the goal of achieving permanent supportive housing. Our goal is to improve functioning demonstrated by progress made on the Adults Needs and Strengths Assessment (ANSA) by a percentage TBD based on a baseline established in DY3. This assessment will be coupled with Stretch Activity CMHC.1.

Baseline Information: The baseline rate established in DY3 was 3.76. Our baseline measurement period established in DY3 was 10/01/2013-09/30/2014.

**Relationship to Other Projects:**

The project will be intertwined with new projects proposed by BTCS and existing programs. It is anticipated that some referrals will come from individuals who have been diverted from county jails or emergency services in our Emergency Service Diversion Project (#126844305.2.2). Also we expect persons to be admitted from the Crisis Respite Project (#126844305.1.2) and to use that program in lieu of hospitalization if short term stabilization is required. We also anticipate that some high functioning individuals with Intellectual and Developmental Disabilities (IDD) who are provided WRAP around services through our IDD Assertive Community Treatment project (#126844305.2.3), in Pass 2 may be eligible for and need these transitional support services. Currently, BTCS has an active effort underway to recruit and certify peer specialists and this program will provide a great fit for the skills and commitment of those individuals.

**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. This exchange of ideas is important and helps us adjust and refine our programs and approaches to behavioral health care.

**Project Valuation:**

This project seeks to provide peer led transitional support services for 18 people in DY4 and 48 people in DY5. Although this is a small number of people, the acuity is such that we expect 1,080 bed days in DY4 and 1,620 bed days in DY5 since this is a group of people who have multiple hospitalizations and great difficulty maintaining community tenure. Transitional services leading to Permanent Supportive Housing with community supports provides an opportunity to improve life skills and functioning. This represents a substantial savings when compared to bed day costs for inpatient psychiatric facilities and substantial patient benefit in that it supports a healthy life in the community. 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 under the Medicaid 1115 Transformation Waiver tab. A complete write-up of the project will be available at performing provider site.