**Category 2 Project Narrative – Pass 2**

**Bluebonnet Trails Community Services – 126844305.2.3**

**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:** 126844305.2.3

**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 Authority (LA) for persons with Intellectual and Developmental Disabilities (IDD) for Burnet and Williamson Counties in RHP 8. The two Counties comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. The LA designation includes the requirement to serve as the Safety Net for individuals with IDD in the region.
* **Intervention:** BTCS proposes to provide intensive wrap around services called Assertive Community Treatment (ACT) for individuals with IDD at the point of crisis and during life transitions to prevent them from being placed in institutions or inappropriately using EDs and crisis services. These services include crisis response, assessment, behavior plans and management. We will also train and educate health care providers on serving those with IDD.
* **Project Status:** This is a new service and an innovative application of ACT teams.
* **Project Need:** This project addresses RHP 8 Community Needs Assessment needs: CN.2 – Limited Access to Mental Health/Behavioral Health Services; and CN.2.14 ‐ Limited access to behavioral health services and disparities in access to care and health outcomes for adults and youth who are intellectually and developmentally disabled in Williamson County.
* **Target Population:** The target population is individuals with IDD who are taken to EDs in our region or in jeopardy of losing community living placements due to behaviors that are challenging or dangerous. We anticipate serving about 50 persons annually once the program is matured. BTCS served 882 persons with IDD in these counties in FY 2012 and 50% were Medicaid eligible. We expect at least 50% of those benefitting from these services to be Medicaid beneficiaries.
* **Category 1 or 2 Expected Project Benefit for Patients:** We expect to serve 30 people in DY4 and 50 people in DY5. The behavior plan and team services will help individuals to improve and regain their functioning level and return to community living. Services will continue until the individual is stable and comfortable in their setting.
* **Category 3 Outcomes:** IT‐11.26.b: Our goal is to improve upon problem behaviors identified by the Aberrant Behavior Checklist (ABC) and exhibited by those individuals served in this program.
* **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

**Project** **Description:**

*Assertive Community Treatment (ACT) Team Services for Persons with Intellectual and* *Developmental Disabilities (IDD*)

BTCS is the state designated LA for Burnet and Williamson Counties in RHP 8. That designation includes the requirement to serve as the Safety Net for individuals with Intellectual and Developmental Disabilities (IDD) in the region (TAC Title 40, Part I, Chapter 2, Subchapter G, Rule 2.303). In that capacity we are responsible for assessing the service and support needs of individuals with IDD, coordinating service planning for them and assembling a network of providers to meet those needs. In our role as LA, BTCS has identified that individuals who experience behavioral issues in foster care, group homes and Intermediate Care Facilities/Intellectual Disabilities‐Related Condition (ICF/ID‐RC) settings are frequently brought to Emergency Departments (EDs) in Williamson and Burnet Counties for treatment and stabilization of what is identified by the provider as a mental illness. Persons with IDD are frequently misdiagnosed and responded to improperly when they are exhibiting behavioral issues. These behavioral issues are often preceded by times of stress such as changes in care giver, changes in living situations, other life changes that might be customary but still result in a need for crisis response. Sometimes the behavior issues are a result of co‐occurring mental illness. Research indicates that as many as 33% of individuals with IDD have a co‐existing mental illness (*Social Work Today*, Vol. 10 No. 5; Quintero & Flick, 2010: [http://www.socialworktoday.com/archive/092310p6.shtml).](http://www.socialworktoday.com/archive/092310p6.shtml))

BTCS has developed specialized interventions for persons diagnosed with Autism Spectrum Disorders and currently provides ACT Team services for persons who need intensive mental health services. We plan to build on these areas of expertise. BTCS proposes to provide ACT Team services for individuals with IDD at the point of crisis and during life transitions such as when individuals move from natural supports, discharge from State Supported Living Centers (SSLC) or ICF/ID‐RC facilities. Through this project we will divert people with IDD from higher cost, institutional placement and into local resources. The project will also provide specialized consultation to attending physicians providing primary care and emergency medicine services, allowing them to provide proper care rather than expending resources trying to diagnose and treat outside of their area of expertise. Stakeholders in the region have provided the impetus for the project with their requests for assistance to avoid disruption of long‐term residential placements. Families of individuals with IDD report an inability to address needs of their family members or to find a skilled provider to assist them to keep family members at home or be accepted into residential placement because of repeated visits to EDs and admissions to mental health facilities or jails.

ACT Teams are well documented best practice as intervention for persons with Serious Mental Illnesses (SMI) who have a difficult time maintaining community tenure. The intervention is included in the Substance Abuse and Mental Health Services Administration (SAMHSA), Evidence Based Practices registry and a Toolkit for implementation of ACT is available through SAMHSA (<http://store.samhsa.gov/product/Assertive>‐Community‐Treatment‐ACT‐Evidence‐ Based‐Practices‐EBP‐KIT/SMA08‐4345). We plan for the ACT Team for persons with IDD to be led by a Licensed Masters Level professional and will include a psychologist who is a behavioral expert and a psychiatric consultant, nursing, service coordinator and community skills trainers. We will locate the team in Round Rock to respond to requests for intervention from either County we serve. At the time of referral we expect to go where the individual is and provide assessment and intervention to stabilize the situation. Following that we will continue assessment that leads to the development and implementation of a behavioral plan to help the individual return to his/her current living situation and to successfully maintain in that setting. Wrap around services will continue until transition to other community resources can be achieved and the person is comfortable and stable with the new resource provider. Team intervention is envisioned to be short‐term and intensive with the goal of helping persons retain community placement, with referral to long term provider resources where appropriate. In addition to direct client intervention, we propose to use the resources of the team to begin educating law enforcement and emergency rooms as well as IDD group home providers to create referral paths that are well known and easy to use. For DYs 2 and 3 we selected Process Milestones, P‐2, designing the intervention; P‐3, enroll and serve persons in the targeted population with complex needs; and P‐7, participation with other providers and the RHP to promote collaborative learning. We will document the activities associated with design in implementation plans and the adjustment of that design in the CQI notes, minutes and real time data from electronic health record (EHR) as relates to assessment of functioning, treatment participation and patient goal achievement. We will document enrollment and service in the EHR. We selected these Milestones because we are starting a new program, reflecting an innovative use of the well‐known ACT team concept. This approach, as we have proposed it, has not been implemented in this RHP or anywhere else. We must ensure that the right population is targeted with the right interventions and that the program is continuously adjusted as we learn how to help people succeed. We selected the I‐5 Milestone: Functional Status, for both DYs 4 and 5. We have identified preliminary research indicating that the BPI‐01 and/or ICAP could be useful as a functional assessment for this project (*Research in Developmental Disabilities* 2010 Jan‐Feb 31(1) 97‐107 [http://www.ncbi.nlm.nih.gov/pubmed/19800760#).](http://www.ncbi.nlm.nih.gov/pubmed/19800760#)) We selected this Milestone because it is important to us that persons with IDD remain in their long‐term placements. Achieving the goal of improved functioning will preserve placements and reduce ED utilization.

**Goals and Relationship to Regional Goals:**

This project proposes to use multi‐disciplinary ACT Teams to intervene during the utilization of emergency services and reduce further ED use by persons with IDD.

**Project Goals:**

* Develop an ACT Team model specializing in the assessment and stabilization of persons with IDD and utilizing existing resources in the community where appropriate;
* Provide training to law enforcement, emergency room personnel, health care providers, psychiatric hospital providers, and community residential and non‐residential providers regarding the project and how to access the services;
* Implement the project to target group as requests for services are received; and
* Gather data for outcome measures reflecting services utilized and effectiveness of these services to ameliorate crisis and preserve undisrupted community living for persons with IDD.

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

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

**Challenges:**

The biggest challenge is that there is a pervasive misunderstanding in the health care community and in broader community concerning the differences in diagnosis and treatment between behavioral issues for persons with IDD and mental health crises for persons with SMI. Another challenge will be acceptance by caregivers that the intervention will work and that services will be wrapped around the individual until the crisis is resolved. This project will address the first challenge through education by engaging emergency medical professionals, IDD consumers and advocates throughout the RHP 8 to assist us in developing a protocol to implement ACT Teams for persons with IDD. We will then widely disseminate that protocol through a communication plan that utilizes resources of community partners. This same education and communication approach will be used with caregivers in order to address the second challenge.

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

Over the next five years we expect the outcome of this project to include providing training to law enforcement, ED personnel, health care providers, psychiatric hospital providers, and community residential and non‐residential providers regarding how to recognize behavioral issues in persons with IDD and how to access appropriate services. The outcome for program participants will be avoidance of unnecessary inappropriate ED utilization and the resulting loss of community living arrangements and overuse of institutional care. When persons with IDD receive the proper care and interventions, then admissions to institutional care and multiple visits to EDs are avoided.

**Starting Point/Baseline:**

Currently no ACT Team Services for persons with IDD exists in the four Counties; therefore, the baseline is 0 in DY2. We will enroll and serve individuals in DY3; therefore, the baseline will be established during DY3.

**Rationale:**

**Community need addressed:**

* Community Need Area: CN.2 – Limited Access to Mental Health/Behavioral Health Services
* Specific Community Need: CN.2.14 – Limited access to behavioral health services and disparities in access to care and health outcomes for adults and youth who are intellectually and developmentally disabled in Williamson County. There is no ACT team for persons with IDD currently in place in RHP 8 but there is evidence that a specialized intervention is needed for these individuals when they are taken to EDs. An ACT Team that includes specialists in IDD who can assess needs and apply behavioral plans or other IDD specific interventions will reduce time in the ED, misdiagnosis and placement in more restrictive settings. Currently available data does not accurately identify the number of persons with IDD who have been taken to EDs due to behavior problems. We can identify the number of persons in service through the LA who have been removed from placement and admitted or referred to a higher level of care. However, visits to EDs are coded as interventions for mental illness diagnoses regardless of the presence of IDD, frequently resulting in the misidentification of behavior problems as other mental illnesses. Our estimate of the number whose admission is a result of behavior problems is around 30% based on experience working with this group of persons.

BTCS participates in a pilot program through the Department of Aging and Disability Services (DADS) the aim of which is to reduce institutional placement using the team approach. There are an increased numbers of individuals that have been referred at intake that are in crisis due to the lack of appropriate resources to respond to the behavioral crisis. The persons that are at high risk display one or more of the following needs: danger or risk of losing their support system, especially those supports a person requires to continue living in their own or family home; at risk of being abused or neglected; basic health and safety needs are not being met through current supports including mental health needs; at risk for loss of the functional skills that keep them in their community; or repeated criminal behavior or dangerous behaviors or threats, but incarceration is not an option because of their low level of cognitive ability. An increase of referrals from SSLCs is expected for individuals transitioning to community living. They will need a crisis intervention plan developed to insure supports are in place prior to the move for successful community living. At this time 5 referrals from the SSLC have been made. The ACT Team will enhance this current pilot project and serve as a safety net for those individuals.

**Project Components:**

The ACT team services for persons with IDD will address all of the required core components:

a*) Assess size, characteristics and needs of target population.* Although the initial data cited above, gives a picture of the number of persons with IDD referred to EDs, all EDs are not included and the cause of referral does not differentiate for behavioral issues. We will define the data needs and then gather information from electronic health records and case management reports to further refine the characteristics and needs.

*b) Review literature / experience with populations similar to target population to determine community‐based interventions that are.* The staff for the LA has done some literature review to identify basic design of this project and the application of ACT to persons with IDD. As described above, we need to engage stakeholders to develop specific protocols for the intervention. We will use that coalition to promote community understanding and response.

*c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* We will use BTCS quality management staff to facilitate the formation of learning collaboratives with the other community centers in RHP 8, all of which provide services and supports to persons with IDD. We will meet and disseminate information among the group to ensure qualitative and quantitative metrics will be used to measure outcomes.

*d) Design models which include an appropriate range of community‐based services and residential supports.* Using the information from stakeholders, community centers, evaluation metrics, functional assessments and reports; we will evaluate interventions to determine if they are sufficient in capacity and scope. We will adjust our model accordingly.

*e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.* As indicated below, preliminary research leads us to consider using Behavior Problems Inventory ‐01 (BPI‐01) or the Inventory of Client and Agency Planning (ICAP) as a functional assessment. Our staff is familiar with both and we expect one of these will give us the best measure of individual improvement. However we will perform additional research prior to implementation of the tools. Aggregated data from the assessment selected along with number of ED visits will be used to assess community impact and identify and respond to lessons learned.

**Continuous Quality Improvement:**

The 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:**

As stated above, BTCS currently participates in a team based pilot to reduce institutional care through the DADS. This project supports and enhances that system reform initiative that supports the Promoting Independence goals of DADS. BTCS is also a recipient of a grant through the Health Resources and Services Administration Division of the US Department of Health and Human Services (DHHS) to develop a primary care/behavioral health care another RHP in partnership with the Federally Qualified Health Center for Guadalupe County. BTCS also receives funds from DHHS 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 those services that will be needed as the ACT Team assists in transitioning individuals back to their long‐term living environment and community living.

**Related Category 3 Outcome Measure:**

* OD‐ 11 Behavioral Health/Substance Abuse Care
  + IT‐11.26.b Aberrant Behavior Checklist (ABC)

Reasons/rationale for selecting the outcome measure:

Rationale: The goal of the program is to develop community assessment and intervention options that result in a reduction of inappropriate hospital admissions for this special population. The results of those interventions will be measured by improvements in the ABC scale and the stretch activity will connect any person that is admitted to timely effective community services.

Baseline Information: The baseline rate established in DY3 was 96.94. Our baseline measurement period established in DY3 was 04/01/2014-09/30/2014.

**Relationship to Other Projects:**

This project to intervene and stabilize persons with IDD in Crisis enhances additional projects that BTCS is pursuing in that they relate to additional crisis services and supportive aftercare such as Transitional Housing. Related Projects include:

* The Transitional Housing initiative (#126844305.2.1) will solidify success in remaining in the community and offer expertise, support and experience through a Peer Support Specialist;
* The Crisis Stabilization project (#126844305.1.2) for persons in behavioral health crisis will provide a safety net for those individuals who may be in need for more intensive care without requiring the restrictive level of care provided by a psychiatric hospital; and
* Crisis Assessment for Persons in Behavioral Health Crisis (Burnet County) (#126844305.1.5) to support and enhance the ACT for persons with IDD responses in this County.

We expect these interrelated projects will demonstrate improved outcomes due to availability of outpatient and aftercare services in the communities in which people live. The plans and supports employed by ACT Teams depend on community resources. The projects noted above improve the community network of resources for people.

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

While this project shares a number of things in common with other LMHA’s, the project Central Counties is planning regarding a Coffeehouse for High Functioning IDD (#081771001.1.3) addresses the same audience.

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:**

We expect to serve 30 people in DY4 and 50 people in DY5. The behavior plan and team services will help individuals to improve and regain their functioning level and return to community living. This reduces inappropriate use of inpatient hospital and is of substantial benefit to the patient who can remain in a community living setting. 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.bbtrrails.org](http://www.bbtrrails.org/) under the Medicaid 1115 Transformation Waiver tab. A complete write-up of the project will be available at performing provider site.