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**MONEY FOLLOWS THE PERSON –
BEHAVIORAL HEALTH PILOT**

YEAR 4 EVALUATION: FINAL REPORT

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Executive Summary

The Money Follows the Person Behavioral Health Pilot (BH pilot) offers Cognitive Adaptation Training (CAT) and enhanced substance abuse services to help individuals with mental illness and/or substance abuse leave nursing facilities for independent living. The BH pilot is funded by a grant from the Centers for Medicare and Medicaid Services to the Texas Health and Human Services Commission/ DADS, and is administered by the Department of State Health Services. The University of Texas at Austin Addiction Research Institute (UTARI) conducted a long-term quality improvement evaluation of the BH pilot. The evaluation was intended to answer the broad questions: How does the pilot help participants in nursing facilities successfully transition to the community? How can the pilot be improved and sustained? What lessons learned in the pilot can inform home-and-community-based services for individuals moving to the community as part of the Medicaid managed care system of long-term services and supports?

Based on direction from BH pilot program administrators, UTARI extended its focus during this evaluation year to include the San Antonio State Hospital pilot (SASH pilot), which helps state hospital patients move back to the community with similar supports as those provided in the BH pilot. We conducted interviews with SASH pilot staff and a participant, and analyzed data on state hospital participant characteristics (Chapter 5). We also carried out updated data analyses of BH pilot participant characteristics, functioning, quality of life, length of community residence and factors associated with successful community tenure (Chapters 2 – 4). Finally, we produced a draft policy brief focused on assessing and treating substance abuse problems among people moving from nursing homes to the community (Appendix A).

Findings from the data analyses, as well as from previous interviews with participants and staff, demonstrate that the BH pilot has had a positive impact and enables most to remain successfully in the community. Overall, almost 70% of those who completed the BH pilot are still resident in the community. Participants have shown increased functional status and quality of life across time, and gains achieved during the intervention persist for at least a year after the end of services. The most important factor associated with community tenure appears to be stability of physical health and timely receipt of health services, including home health care and outpatient visits. Participants interviewed over the course of the multi-year evaluation strongly credited the assistance and support they received from CAT therapy – including specific skills learned, reduced social isolation, and the feeling that someone cared about and believed in them - with their ability to be successful. The SASH pilot has also demonstrated a positive impact in helping state hospital patients return to the community.

Specific recommendations from the findings include:

- Continue participant check-ins with CAT therapists on an occasional or per need basis for at least a year after participants have completed the BH pilot intervention (or similar intensive services, such as CAT therapy, provided through MCOs).
- Incorporate tele-health interventions for care management, information and support into the pilot, as an adjunct to in-person services (see Kim et al., 2011; Choi et al., 2014).
- Continue assessing participants' functioning and quality of life after completing CAT therapy to see how long gains achieved during the BH pilot intervention persist, and when further intervention may be needed (see Chapter 3).
- Continue conducting analyses of Medicaid and other data (e.g., MDS, vital statistics, and cost information) to better understand factors associated with successful community tenure as well as cost savings associated with moving from institutions to the community (see Chapter 4).

- Ensure close liaison with contracted relocation specialists and potentially employ an additional dedicated housing specialist to identify appropriate and affordable housing options for clients, help obtain housing vouchers, and work with landlords to increase acceptance of and knowledge about tenants with mental health challenges.
- As services transition to MCOs, try to ensure a single point of contact (e.g. a primary care coordinator) for clients, so that a personalized relationship can be developed and clients can feel more comfortable discussing their needs and be more motivated to participate in services. In this regard, retention of qualified and committed staff, and reasonable caseloads, should be a priority for service delivery agencies.
- Recognize the importance of identifying and addressing concomitant substance use disorders, which are a particular challenge for clients with psychiatric disorders (see Appendix A).
- Share evaluation findings with the clinicians, administrators and policy makers who develop and provide services for clients with mental health issues who move to the community.

Chapter 1. Background

1.1. The Money Follows the Person Behavioral Health Pilot

Money Follows the Person (MFP) is a federally-funded national demonstration program that helps Medicaid enrollees transition from institutional to community-based care. In addition to offering more independence and a potentially better quality of life for individuals who participate, the program may save money by shifting spending from more costly institutional care to potentially less costly home and community-based services (HCBS).

Since 2001, when Texas first pioneered MFP as a state initiative, more than 46,000 Texans have returned to the community. However, people with serious mental illness and substance use disorders have remained more difficult to relocate, and Texas Medicaid assistance lacked home and community-based services geared toward these individuals (Stoner & Gold, 2012). In 2008, the Texas Department of State Health Services partnered with the Department of Aging and Disability Services to create a Behavioral Health Pilot (BH pilot) that integrates mental health and substance abuse services into standard HCBS. The BH pilot targets adults who have lived in nursing facilities for at least three months, meet nursing facility medical criteria and have serious mental illness or a behavioral health condition with serious functional impairment (Stoner & Gold, 2012).

The BH pilot began in Bexar County (San Antonio) and spread to adjacent counties and to Travis, Hays, and Williamson Counties (Austin). The cornerstone of the behavioral health services offered is Cognitive Adaptation Training (CAT) (Maples & Velligan, 2008; Velligan et al., 2008; Velligan, Ritch & Maples, 2010) and enhanced substance abuse services, which helps empower people to take charge of their lives and reach their full potential (Stoner & Gold, 2012). CAT services provide assistance and environmental modifications to help people establish daily routines, organize their environment, and build social skills, with the ultimate goal of increasing independence. The substance abuse services include individual counseling, group therapy, and connection to other community programs such as Alcoholics Anonymous or

Narcotics Anonymous. Both CAT and substance abuse services are available to participants for six months before nursing facility discharge and one year after relocation to the community.

Although not originally envisioned to be part of the Behavioral Health Pilot, additional services have been included as needed throughout the course of the program. These include enhanced relocation services (e.g. taking the participants to visit potential apartments or other community residences) and some limited case-management type services, such as accompanying participants to obtain IDs or other needed documents, making calls to locate resources for participants, helping procure or coordinate services and medical equipment, or providing emergency transportation. (The ultimate goal of the CAT intervention is to enable participants to perform these activities independently). Participants also receive ongoing home- and-community-based services (HCBS) through their Medicaid Managed Care Organization (MCO).

The BH pilot will continue until December 2017. In part based on the success of the BH pilot, behavioral health services (mental health rehabilitation and targeted case management) have been carved into Texas Medicaid managed care as of September 2014.

As of fall 2015, the BH pilot had received a total of 492 referrals. According to data from the pilot sites, 64 individuals were currently receiving community or pre-transition services and 211 had successfully completed their year in the program.¹ Participant demographics are described in Chapter 2. Based on Medicaid records, 68% of all BH pilot participants and 72% of those who had completed the full year of pilot services remained in the community.²

1.2 Quality Improvement Evaluation of the Behavioral Health Pilot

Since 2011, the University of Texas Addiction Research Institute (UTARI) has conducted a quality improvement evaluation of the BH pilot to guide process improvement and inform policy recommendations.

The long-term evaluation seeks to answer the broad questions: How does the pilot help participants in nursing facilities successfully transition to the community? How can the pilot be improved and sustained? Do participants improve their functioning, quality of life and satisfaction under the pilot, and are improvements sustained? What factors are associated with successful community residence? What lessons learned can be integrated into the Medicaid managed care system of long-term services and supports? What is the cost/benefit ratio of providing these services?

¹ The others had died, dis-enrolled prematurely, moved out of area, stayed in the nursing facility or returned to the nursing facility before completing the program.

² Although not a direct comparison, a report by Mathematica Policy Research (Schurrer and Wenzlow, 2011) noted that 87% of Texas MFP participants without mental illness remained in the community for a full year after transition.

The Year 1 evaluation, conducted during SFY 2012, used qualitative interviews with current and discharged pilot participants to learn about their experiences and satisfaction with pilot services and long-term outcomes after completing the program; interviews with project partner key informants to gain perspective on the project from the staff point of view; and analysis of quantitative data to document measurable outcomes after discharge from the pilot. A full report of the Year 1 evaluation findings was presented to DSHS in August 2012 (Wallisch, Bell, Bohman, Spence & Robles, 2012) and its findings remain relevant. The Executive Summary of the Year 1 evaluation is included in the Appendix.

The Year 2 evaluation, conducted during SFY 2013, presented findings from additional interviews with current and completed participants and their family members, and members of MFP Community Transition Teams to determine their current practices and need for information about working with behavioral health clients. It also reported findings on participant functioning and quality of life based on quantitative data collected quarterly. A full report of the Year 2 evaluation was submitted to DSHS in August 2013 (Wallisch, Bell & Bohman, 2013) and the Executive Summary is also included in the Appendix.

The Year 3 evaluation (SFY 2014) focused on understanding long-term outcomes of participants and factors associated with successful independent living, based on interviews with completed participants and analysis of project and Medicaid data. A full report of the Year 3 evaluation was submitted to DSHS in August 2014 (Wallisch, Bell & Bohman, 2014), and the Executive Summary is included in the Appendix.

This year's evaluation (calendar year 2015) updates analyses of BH participant data, based on comprehensive data since the start of the program, and extends the evaluation to include the SASH pilot, which offers CAT therapy and other services to individuals transitioning from the San Antonio State Hospital (SASH) to the community. It also includes a discussion of treating substance use among individuals moving from nursing facilities to the community.

Chapter 2. Demographic Characteristics of BH Pilot Participants

Executive Summary

From 2008 through fall 2015, a total of 492 individuals (276 in San Antonio and 216 in Austin) had been enrolled at some point in the Behavioral Health Pilot. This report describes the demographic characteristics of current and completed participants (56% of all participants ever enrolled) and those who received pre-transition services but never exited the nursing home (12% of participants). (The other participants had died, moved out of the service area, or not received the full pilot intervention for a variety of other reasons).

Participants were about equally likely to be women and men, with an age range of 27 to 89 (average = 60). Overall, 57% were non-Hispanic white, 25% Hispanic and 16% African American, with more Hispanics in San Antonio than Austin.

About 74% of participants had one of the three serious mental illness diagnoses of depression, bipolar disorder or schizophrenia. The most prevalent diagnosis (47%) was depression. About one-third of all participants had received services for a substance use disorder through the BH pilot, although it was a primary diagnosis for only 2%.

Participants who received pre-transition services but never exited the nursing home looked substantially like participants who had moved to the community in terms of gender, race/ethnicity, age and diagnosis.

2.1 Introduction

This report describes Behavioral Health Pilot participants in San Antonio and Austin as of fall 2015 when participant data were provided to UTARI by the project sites (Center for Health Care Services and UT Health Science Center San Antonio). These data sets included all participants enrolled at some point in the pilot (N=276 in San Antonio and 216 in Austin) and cover gender, age, race/ethnicity, primary behavioral health diagnosis, services received, and status in the project/community.

In the tables below, yellow highlights indicate a reliable difference between sites, based on chi-square and difference-of-proportions statistical tests. Reliable differences mean that a difference would likely be found in the larger population of nursing home residents entering a program such as the BH pilot. However, differences are not necessarily meaningful for clinical or policy purposes.

2.2 Participant Status in Program/Community

Table 2.1 shows that, overall, 43% of participants successfully completed one year of BH pilot intervention. Since the program began earlier in San Antonio than in Austin, it is not surprising that somewhat more participants in San Antonio (47%) than Austin (38%) completed twelve months of the intervention. Conversely, Austin had a higher proportion (19%) of current participants than San Antonio (9%).

Somewhat more participants in San Antonio (11%) than Austin (4%) had returned to nursing facilities before completing the pilot. It is important to note that the designation of having returned to a nursing facility in this Chapter is based on project staff knowledge at the time these datasets were compiled and may not correspond exactly to Medicaid data indicating nursing home residence, as reported in Chapter 4. On average for both sites, about 6% had died, 4% had moved out of the service area, and 15% had exited the BH pilot program early, for a variety of reasons including not benefitting from services, non-compliance, or declining to receive services. In Austin, 16% had received pre-transition services only as compared to 9% in San Antonio.

Table 2.1: Program/Community Status of All BH Pilot Participants, by Site

	San Antonio	N=276	Austin	N=216
Completed	130	47%	81	38%
Current	24	9%	40	19%
Died	11	4%	16	7%
Disenrolled prematurely*	51	18%	22	10%
Out of area	6	2%	13	6%
PreTransition Only	25	9%	35	16%
Returned to NF**	29	11%	9	4%

*Inappropriate for services, refused services, non-compliant, lack appropriate insurance, unable to locate.

**Per project staff knowledge.

In this report, demographic characteristics are presented separately for current or completed participants and participants who received pre-transition services only but no further pilot services.

2.3 Current and Completed Participants

For this report, current and completed participants are those who had received or were receiving pilot services in the community or who were currently receiving pre-transition services with the expectation of moving out.³ Table 2.2 presents demographic characteristics by project site, and these data are summarized in the text below. Reliable (statistically significant) differences between the project sites are highlighted in yellow.

³ It is possible that a small percentage of participants currently in pre-transition may end up never moving to the community.

Table 2.2: Demographic Characteristics of Current and Completed Participants Who Moved Out to the Community, by Site

	San Antonio	N=154	Austin	N=121	Total	N=275
Gender						
Female	85	55%	56	46%	141	51%
Male	69	45%	65	54%	134	49%
Age						
Range	27 - 89		32 - 86		27 - 89	
Mean	60		60		60	
18-30	3	2%	0	0%	3	1%
31-40	8	5%	7	6%	15	5%
41-50	22	14%	14	12%	36	13%
51-60	48	31%	45	37%	93	34%
61-64	20	13%	20	16%	40	15%
65-70	23	15%	19	16%	42	15%
71+	30	19%	16	13%	46	17%
Race/Ethnic						
African American	20	13%	24	20%	44	16%
White non-Hispanic	73	47%	84	69%	157	57%
Hispanic	56	36%	13	11%	69	25%
Other/Unknown	5	3%	0	1%	5	2%
Primary Diagnosis						
Dementia	6	4%	4	3%	10	4%
Depression	58	38%	72	60%	130	47%
Schizophrenia	21	14%	8	7%	29	10%
Bipolar	30	19%	16	13%	46	17%
Anxiety	23	15%	15	12%	38	14%
Substance Abuse	2	1%	3	2%	5	2%
Other psychiatric	7	5%	3	2%	10	4%
Physical/unknown	7	5%	0	0%	7	3%

Services Received

CAT+AOD	36	23%	50	41%	86	31%
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Gender. Participants were approximately half female and half male in both sites.

Age. Ranged from 27 to 89, with an average age of 60. About one third of all participants were in the 51 – 60 age range. Although the BH pilot program was initially intended for individuals under age 65, about 32% of participants were aged 65 and older.

Race/Ethnicity. The race/ethnic composition of participants varied between the sites, as might be expected given the different underlying population demographics. In San Antonio, 36% of participants were Hispanic vs 11% in Austin. In Austin, 20% of participants were African American (vs 13% in San Antonio) and 69% (vs 47%) were non-Hispanic white.

Primary Behavioral Health Diagnosis. The BH pilot intervention was initially intended to focus on individuals with Serious Mental Illness (SMI), which includes schizophrenia, bipolar disorder and major depression; however, in the course of the project, these criteria were broadened to include nursing home residents with other primary behavioral health diagnoses.

About 74% of participants had one of the three SMI diagnoses. The most frequent diagnosis for all participants was depression (47%), although it was more frequent in Austin (60%) than in San Antonio (38%). About 17% of all participants had a primary diagnosis of bipolar disorder, 14% anxiety disorders, 10% schizophrenia, and 2% substance use disorder. Four percent of participants had dementia, which may be a reasonable criterion for exclusion from future BH pilot-type interventions, based on the experience of program staff.

Services Received. All participants had received CAT services. Additionally, almost one-third of participants had received services for a substance use disorder (SUD).

A higher percentage in Austin (42%) than San Antonio (23%) had received substance disorder treatment; whether this difference reflects higher need, better identification, or higher availability of services in Austin as compared to San Antonio is a question for further investigation. We do know that during one period, CAT therapists in Austin were referring any client with a history of substance use problems to an SUD counselor for assessment, even if the client did not seem to present with a current problem. With her specialized training, the SUD counselor was able to identify a potential need for services that might have been missed by CAT therapists.

Further issues relating to identifying and treating substance use disorders in the BH pilot population are discussed in Appendix A.

2.4 Participants Who Received Pre-Transition Services Only

Table 2.3 shows the characteristics of the participants who received only pre-transition services but then terminated pilot services (they may have never left the nursing home or left without pilot services).⁴ There were 60 such participants (25 in San Antonio and 35 in Austin). Due to these small numbers, most differences between sites were not statistically reliable.

Table 2.3: Demographic Characteristics of Participants Who Received Pre-Transition Services Only

	San Antonio	N=25	Austin	N=35	Total	N=60
Gender						
Female	16	64%	18	51%	34	57%
Male	9	36%	17	49%	26	43%
Age						
Range	43 - 84		30 - 83		30 - 84	
Mean	62		64		63	
Race/Ethnic						
African American	4	16%	11	31%	15	25%
White non-Hispanic	8	32%	20	57%	28	47%
Hispanic	10	40%	3	9%	13	22%
Other/Unknown	3	12%	1	3%	4	7%
Primary Diagnosis						
Dementia	1	4%	6	17%	7	12%
Depression	13	52%	17	48%	30	50%
Schizophrenia	4	16%	5	14%	9	15%
Bipolar	1	4%	2	6%	3	5%
Anxiety	0	0%	1	3%	1	2%
Substance Abuse	0	0%	2	6%	2	3%
Other	6	24%	2	6%	8	13%

⁴ This group does not include participants currently receiving pre-transition services and who are expected to move out (they are considered current participants, and included in the previous section).

Services Received

CAT+AOD	8	32%	13	37%	21	35%
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Gender. 57% of individuals who only received pre-transition services were women. This is not reliably different from the percentage of women among current and completed participants.

Age. Ages ranged from 30 to 84, with an average age of 63, similar to that of current and completed participants.

Race/Ethnicity. The race/ethnic composition of pre-transition only participants differed between the sites, with San Antonio having a higher proportion of Hispanics and Austin having a higher proportion of non-Hispanic whites (reflecting the pattern also seen among current and completed participants).

Primary Behavioral Health Diagnosis. About 50% of pre-transition only participants had a diagnosis of depression, 15% schizophrenia, 7% bipolar or anxiety disorder, and 12% had dementia. These percentages were not reliably different from those of current and completed participants.

Services Received. Similarly to what was found among current and completed participants, about one third of pre-transition only participants received services for a substance use disorder. Among pre-transition participants, however, similar proportions of San Antonio and Austin participants had received these services, whereas there was a difference by site for current and completed participants.

This analysis suggests that participants who received pre-transition services only and did not move to the community under pilot services were similar in demographic and diagnostic factors to those who had completed the pilot or were currently receiving pilot services. There may be other unmeasured factors, such as medical fragility, the inability to find appropriate housing, absence of informal support, the need for more intensive case management than can be provided by available community resources, or even something more intangible (resilience, motivation, self-efficacy) which prevent some who enter the pilot from being able to move out, at least in the short term.

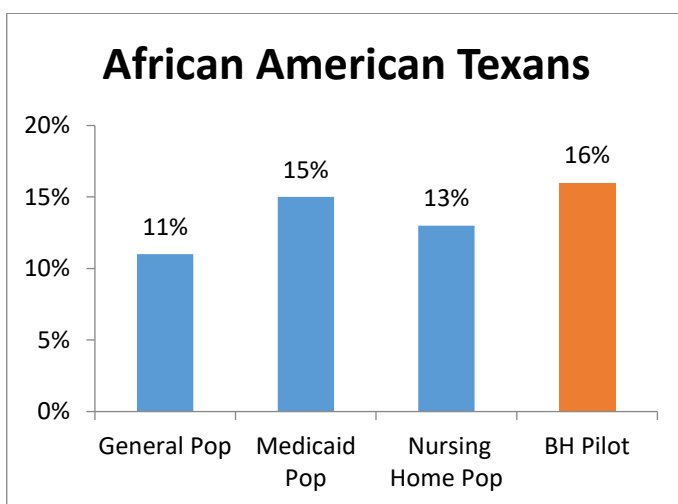
UTARI recommends continuing to investigate – through periodic interviews with participants and their caregivers, and standardized assessments (see Chapter 3) – which characteristics, circumstances or situations appear most associated with individual’s success in moving to and staying in the community.

2.5 How Does Participants' Race/Ethnicity Reflect the Underlying Population?

The charts below provide an indication of how the race/ethnic composition of BH pilot participants reflects that of the Texas general population, the Medicaid population, and the nursing home population.⁵

It is important to emphasize that these comparisons are suggestive only and should be interpreted with caution. Statistics for each of the populations compared come from a different data source, and do not control for differences in age or diagnosis among the race/ethnic groups. Additionally, except for the BH pilot numbers, they represent Texas as a whole, and it is possible that the race/ethnic proportions in the pilot sites may differ from those of the state as a whole.

For this analysis, the proportions of BH pilot participants are based on all participants, including current, completed, pre-transition only, and others.

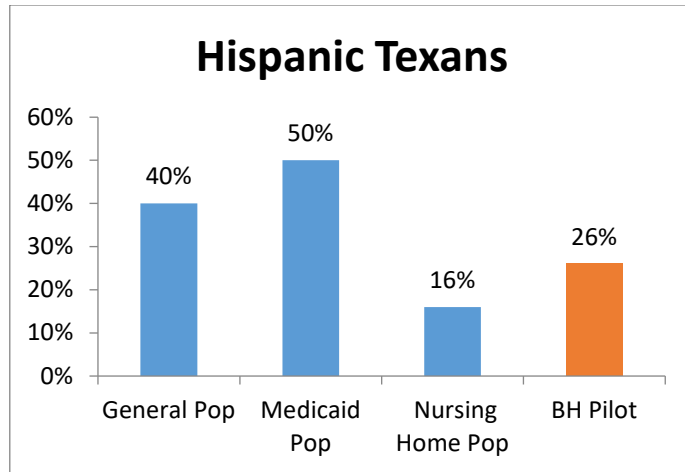


Among African Americans, the proportions in the general population, in the Medicaid population, in nursing homes, and in the BH pilot were similar, suggesting that African Americans are represented among Medicaid recipients, in nursing homes and in the pilot roughly proportionally to their share in the overall population.

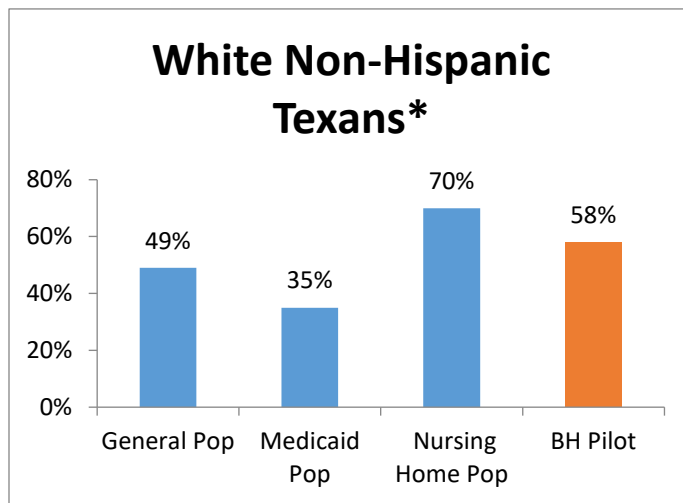
⁵ General population: Texas Department of State Health Services, Texas Population, 2015 (Projections), <https://www.dshs.state.tx.us/chs/popdat/ST2015.shtm>

Medicaid population: Texas Department of Health and Human Services Texas Medicaid and CHIP in Perspective, Tenth Edition, Feb. 2015. <http://www.hhsc.state.tx.us/medicaid/about/PB/PinkBook.pdf>

Nursing home population: Center for Medicare and Medicaid Services, Nursing Home Data Compendium, 2013 edition (data for Texas 2012) https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/downloads/nursinghomedatacompendium_508.pdf



Hispanics in Texas were more likely than their proportion in the general population to be Medicaid recipients but less likely to be in nursing homes. Their lower proportion among nursing home residents has also been found nationally, and may be due to cultural differences in family structure and expectations about providing care. (Additionally, as noted above, race/ethnic differences in age or disability status may affect these findings). However, once in a nursing home, they were more likely than average to participate in the BH pilot. It is possible that the factors that are associated with their lower likelihood to enter nursing facilities also motivate them to participate in programs that help them move back to the community.



*Includes 'other' and 'unknown' race/ethnicity.

Conversely, non-Hispanic white Texans were less likely than their proportion in the general population to be Medicaid recipients, but more likely to be nursing home residents. Among nursing home residents, they were less likely to participate in the BH pilot.

Chapter 3. Participant Functioning and Quality of Life During and After the BH Pilot

Executive Summary

Client functioning and quality of life are assessed by project staff at entry to the pilot, quarterly, and then at six and 12 months after completion of the intervention. UTARI analyzed scores on the Quality of Life Scale, the Multnomah Community Ability Scale, and the Social and Occupational Functioning Assessment Scale to determine whether and how functioning and quality of life changed over the course of the intervention and beyond.

The data show that participants improve functioning and quality of life in the pilot. The improvement is most dramatic in the first 90 to 180 days, and gains are maintained throughout the intervention and for at least a year after its completion. URARI recommends continuing to follow up with completed participants to see whether functioning and quality of life remain high beyond the first year.

In addition, analyses of individual differences in functional outcomes showed that men, older participants, those with dementia or schizophrenia, and those who did not complete the intervention tended to have worse scores on some of these measures. These participants may need additional resources to help them remain successfully in the community. Neither race/ethnicity nor receipt of pre-transition services were associated with functioning or quality of life.

3.1 Introduction

Behavioral Health Pilot participants were assessed using several quantitative measures of quality of life and functioning. During the intervention, participants were assessed at baseline (entry to the pilot after they have moved to the community) and every three months during the pilot year, for a total of five times (0, 90, 180, 270 and 365 days). Beginning in spring 2012, these assessments were extended to completed participants at six and 12 months (545 and 730 days) after the end of pilot services and this report incorporates those extended ratings. The measures (described in section 3.2 below) were completed by research staff from UTHSCSA (initially, they were done by the CAT therapists).

These measures were used primarily for evaluating participant outcomes over the course of the program. The post-discharge ratings measured whether outcomes were sustained after the end of services. The key questions asked in this analysis are:

- Did BH pilot participants show improved functioning and quality of life?
- Were improvements sustained over time?
- Were individual participant characteristics related to participant functioning?

For these analyses, UTARI obtained the most recent data (comprehensive through November 2015) available from the Austin and San Antonio project sites. Functional data were obtained for 368 participants (Austin=132 and San Antonio=236), although not every participant was assessed at each time point. Participant demographic characteristics were obtained for 492 participants. The functional data and

demographic data were merged, which resulted in a match of 320 participants with both kinds of data. There were 48 participants with functional data who did not have demographic data,⁶ and 172 participants with demographic data who did not have functional data.⁷ Only matched participants were used in analyses to address the above questions.

3.2 Measures

Quality of Life Scale (QLS) - The QLS was developed to evaluate deficit symptoms and impaired functioning in people with schizophrenia (Heinrichs, Hanlon & Carpenter, 1984). It comprises 21 items that assess interpersonal relationships, instrumental role functioning and psychological traits, such as sense of purpose and motivation. Data were available for 318 participants (Austin=129 and San Antonio=189). Scores range from zero to 6.

Multnomah Community Ability Scale (MCAS) - The MCAS is a 17-item scale designed to measure the functioning of chronically mentally ill persons living in the community (Barker et al., 1994a). The domains assessed include interference with functioning, adjustment to living, social competence, and behavioral problems. Data were available for 320 participants (Austin=131 and San Antonio=189). Scores range from 1 to 5.

Social and Occupational Functioning Assessment Scale (SOFAS) - The SOFAS, a scale that is part of the DSM-IV, measures an individual's level of social and occupational functioning but, unlike the GAF, is not directly influenced by the overall severity of an individual's psychological symptoms. It includes impairments in functioning that are a direct consequence of mental and physical health problems. The effects of lack of opportunity and other environmental limitations are not considered. Data were available for 315 participants (Austin=129 and San Antonio=189). Scores range from 1 to 100.

⁶ The matched (had both functional and demographic data) and unmatched participants (only functional data) were compared on the three functional outcomes to see if they differed. The comparison of means showed there was a reliable difference on the SOFAS score (Matched mean=39.9, Unmatched mean=37.6) and QLS score (Matched mean=3.0, Unmatched mean=2.7), suggesting that limiting the analysis to only matched participants may have slightly inflated the functioning and quality of life scores for the sample as a whole.

⁷ The matched (had both functional and demographic data) and unmatched (only demographic data) participants were compared on participant demographic characteristics to see if they differed. No difference was found for gender, race/ethnicity or age. Unmatched participants were more likely to have an 'other' diagnosis (14.5% versus 5.6%) and less likely to have an anxiety diagnosis (4.1% versus 12.5%). However, overall, the non-matched were similar to the matched.

3.3 Results

3.3.1 Did BH Pilot participants show improved functioning and quality of life? Were improvements sustained over time?

Table 3.1 shows the mean score, the standard deviation, and the number of observations for each of the three scales at each assessment point.

Individual QLS scale scores ranged from 0.6 to 5.5. The mean at baseline was 2.7, the mean at pilot discharge was 3.0, and the mean at 730 days was 3.1, suggesting there was improvement over time during the intervention, which was maintained after the end of the intervention.

Individual MCAS scores ranged from 1.8 to 4.8. Mean MCAS scores showed an early increase (from a mean of 3.4 at baseline to 3.6 at 90 days), which was maintained subsequently.

Individual SOFAS scores ranged from 10 to 71. The mean SOFAS score was 36.1 at baseline, 41.1 at the end of intervention and 41.3 one year after intervention, which also indicates that gains were maintained over time.

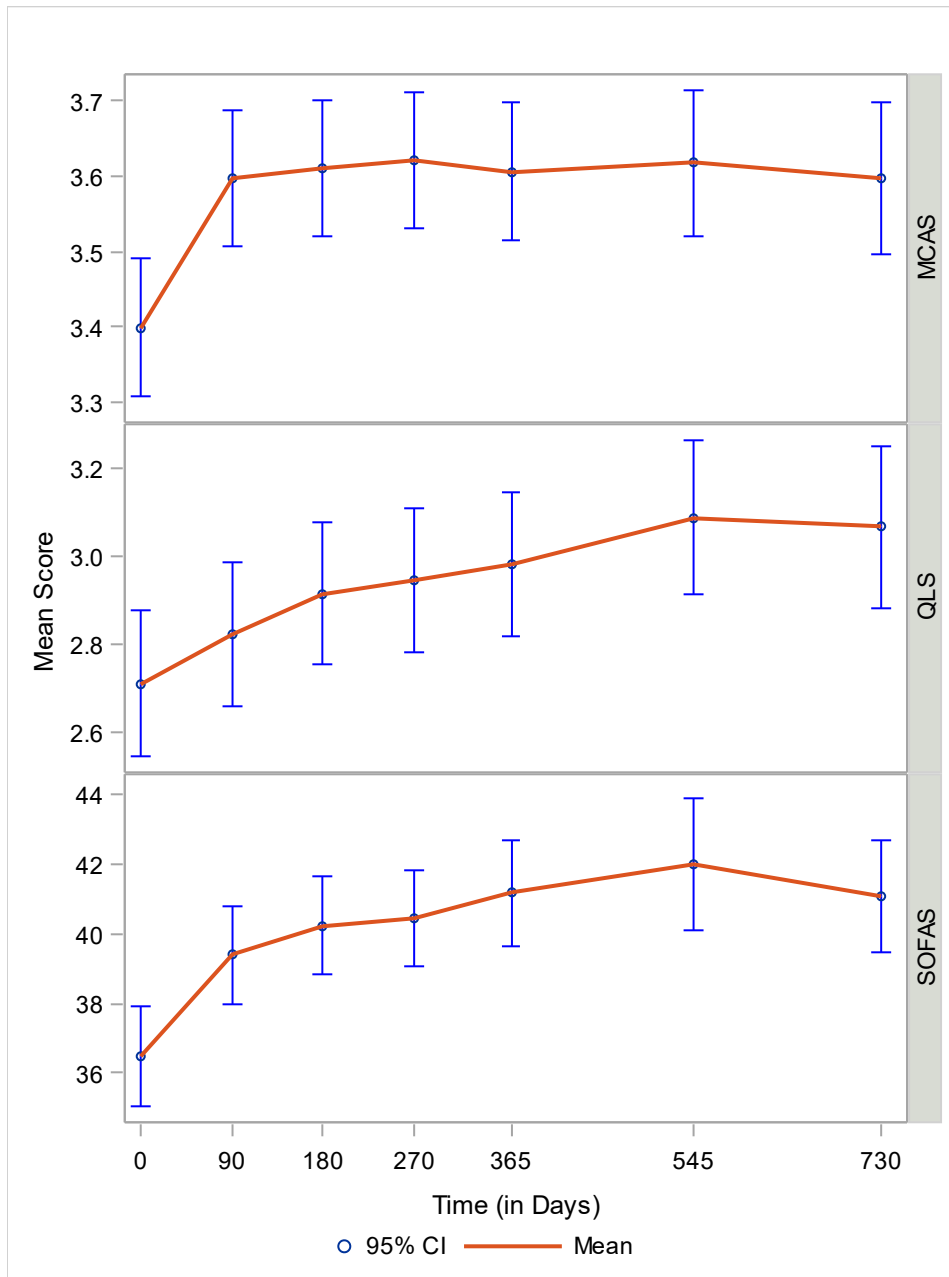
Table 3.1: Means, Standard Deviations and Sample Size for QLS, MCAS and SOFAS at Each Measurement Time Point

Time Point in Days	QLS			MCAS			SOFAS		
	N	Mean	Std	N	Mean	Std	N	Mean	Std
0	282	2.7	0.7	283	3.4	0.4	279	36.2	6.4
90	241	2.9	0.7	243	3.6	0.4	240	39.2	5.7
180	216	3.0	0.7	215	3.7	0.4	215	40.1	6.1
270	193	3.0	0.7	192	3.7	0.4	191	40.4	5.7
365	176	3.0	0.7	178	3.7	0.4	177	41.1	7.1
545	65	3.2	0.8	65	3.7	0.4	65	43.0	7.7
730	65	3.1	0.8	65	3.6	0.4	61	41.3	6.9

Figure 3.1 shows the means at each time point and the associated 95% confidence intervals. The 95% confidence intervals help show whether the means differ across time points. Usually, when the confidence intervals overlap, those means are not reliably different. For all three scales, there was a reliable increase in

mean scores from baseline (0 days) to 90 days and then maintenance at that higher level.⁸

Figure 3.1: Means and Confidence Intervals Across Time for Functional Measures



⁸ While the confidence intervals do appear to overlap for the QLS scale, the baseline to 90 day increase was reliable, based on further statistical testing. For the QLS scale, the increase from 90 to 180 days was also reliable.

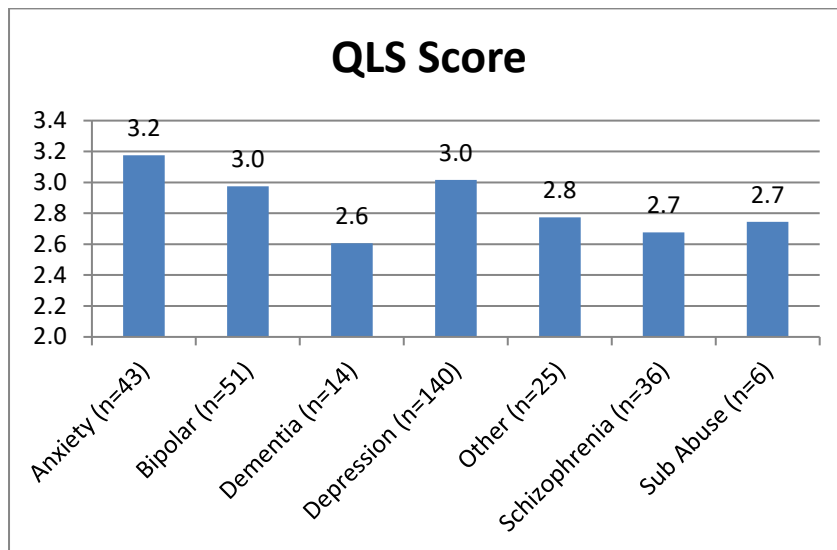
3.3.2 Were individual participant characteristics related to participant functioning?

The following participant characteristics were included as potential predictors of the QLS, MCAS and SOFAS scores: age, gender, race/ethnicity (Anglo, African-American, and Hispanic), primary diagnosis group (anxiety, depression, bipolar, dementia, schizophrenia, and 'other' [including other psychiatric or primary physical diagnoses]); the provision of pre-transition services; and early termination of services.

QLS Outcome

For the QLS outcome, participants differed on diagnosis, age, and whether services were terminated. Younger and current/completed participants were rated higher on quality of life than older participants and those who had terminated services. Figure 3.2 shows the adjusted means for each diagnosis group. Participants with a primary diagnosis of anxiety had a higher QLS score compared to participants with dementia, schizophrenia or 'other' diagnoses. Participants with a primary diagnosis of bipolar disorder had a higher QLS score compared to participants with schizophrenia diagnoses; participants with depression were rated higher than participants with dementia or schizophrenia.

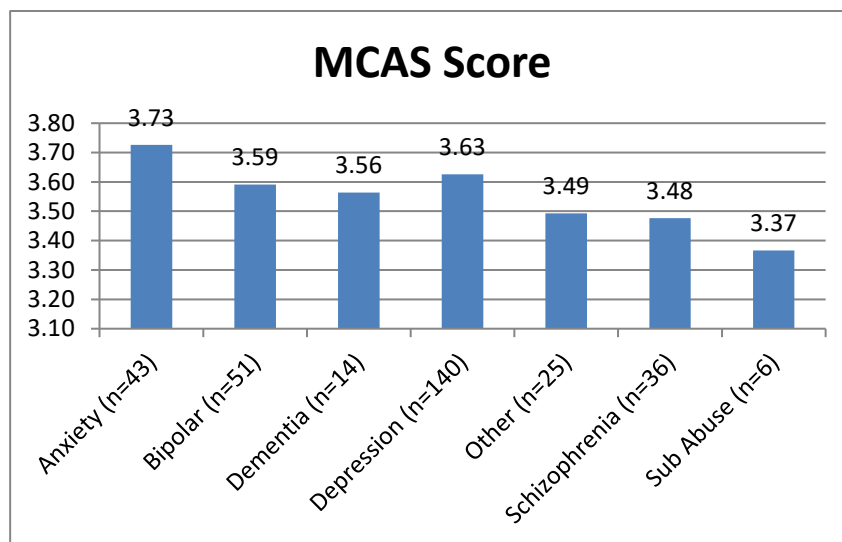
Figure 3.2: QLS Means by Diagnosis Group



MCAS Outcome

This chart shows that participant outcomes again differed by diagnosis, age, and whether services were terminated. Age was negatively related to MCAS score, meaning that older participants had lower functioning. Participants who terminated services were rated lower than current or completed participants. Figure 3.3 shows the adjusted means for each diagnosis group. Participants with a primary diagnosis of anxiety had a higher MCAS score compared to participants with substance abuse, schizophrenia or 'other' diagnoses. Participants with depression had higher MCAS scores than individuals with schizophrenia.

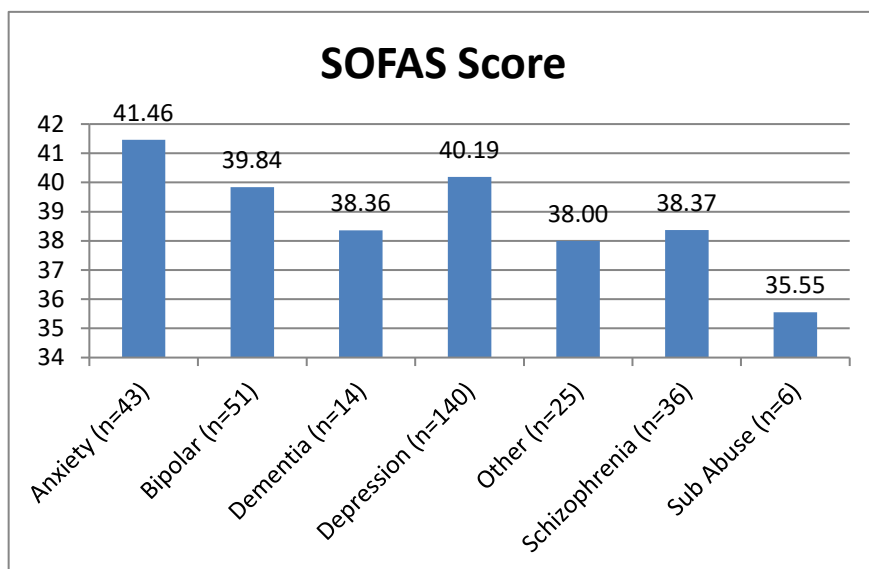
Figure 3.3: MCAS Means by Diagnosis Group



SOFAS Outcome

For the SOFAS outcome, participants differed by diagnosis and gender. Females were rated higher than males overall. Figure 3.4 shows the adjusted means for each diagnosis group. Participants with a primary diagnosis of anxiety had a higher SOFAS score compared to those with schizophrenia, substance abuse, or 'other' diagnoses.

Figure 3.4: SOFAS Means by Diagnosis Group



3.4 Summary and Discussion

These analyses show that BH pilot participants increased their quality of life and functional status after entering the pilot program. The gains were most dramatic in the first 90 days of the intervention and then were maintained at least a year after the intervention ended.

In addition, analyses of individual differences in functional outcomes showed that on quality of life and the MCAS (but not on the SOFAS), older participants were rated lower, which suggests they may be less successful at remaining in the community and have a lower quality of life. Overall, participants with schizophrenia, dementia and 'other' (primarily physical) diagnoses also were rated lower. These participants may need additional assistance to remain successfully in the community. Not completing services and being male were also negatively associated with some but not all of the measures. However, neither race/ethnicity nor receipt of pre-transition services were associated with any of these measures.

A separate analysis showed that the three scales were highly correlated for each individual. Therefore, if reducing the amount of time spent on assessment was desired, a single measure, such as the SOFAS, would probably be sufficient for tracking overall patient functioning and quality of life.

Chapter 4. Prevalence and Correlates of Continued Tenure in the Community or Need to Return to Nursing Facilities

Executive Summary

UTARI merged BH pilot participant data and state Medicaid data to examine participants' periods of institutionalization (return to nursing home or hospitalization, if any) after moving to the community and factors predicting the ability to remain in the community. About 65% of BH pilot participants overall, and 70% of those who completed the year of pilot services, remained in the community (defined as having no recorded periods of institutionalization), some for as long as seven years.

None of the participant characteristics examined (age, gender, race/ethnicity, receipt of substance abuse services, or diagnosis) was related to whether or not they remained in the community or returned to a nursing home. However, having more outpatient visits in the year prior to returning to the community correlated with staying in the community, while having more emergency room visits after returning to the community was associated with a higher likelihood of returning to a nursing facility.

These findings suggest that medical stability, rather than particular client characteristics, is the primary factor in successful community tenure. UTARI recommends that health care providers, such as nursing facilities and MCOs, ensure that individuals obtain the medical care they need, particularly preventive care and stabilization, before returning to the community, and that once in the community, clients should be monitored to ensure that conditions that are ambulatory care sensitive be proactively treated so as to avoid a potentially preventable return to a nursing home.

The analyses also showed that the number of months BH pilot participants remained in the community resulted in large potential savings to Medicaid, even accounting for the initial costs associated with transitioning to the community.

4.1 Introduction and Data Sources

To better understand long term outcomes in terms of how long individuals remain in the community or whether and when participants return to a nursing facility after entering the BH Pilot, UTARI conducted analyses of Texas Medicaid data on institutional status and associated factors. The following key questions are addressed in these analyses:

- What percentage of participants eventually return to a nursing facility?
- What participant characteristics predict the probability of return to nursing facility?
- What are the characteristics of BH pilot tenure in the community?
- What are the potential cost savings due to BH pilot tenure in the community?

Two data sources were used for this analysis. First, data were obtained from the UTHSCSA and CHCS intervention sites (Austin and San Antonio) regarding age, gender, race/ethnicity, diagnoses, services received, date of first community service and status in the BH pilot. In addition, Medicaid data were obtained from the Texas Health and Human Services Commission regarding nursing facility experience

(dates of NF residence that occurred after first moving to the community) and emergency room visits, outpatient visits, and inpatient hospitalizations experienced from 12 months before entering the community to present.

4.2 Sample for Analysis

The sample for these analyses comprised those BH pilot participants who had received services in the community and who were able to be matched with the Medicaid data. The following sections describe how these numbers were derived.

How Many Participants Received BH Pilot Services in the Community? In fall 2015, each BH pilot project site provided a list of participants with their study numbers and Medicaid ID. The San Antonio site provided 274 participants and the Austin site provided 214 participants, for a total of 488 participants.⁹

Table 4.1 shows how many participants at each intervention site moved into the community. Compared with San Antonio, a higher percentage of Austin participants received pre-transition services and did not leave the nursing facility (at least not under the auspices of the BH pilot). The 102 patients who did not leave their nursing facility after being enrolled in MFP were excluded from further analysis, leaving 386 participants to be matched with the Medicaid data.

Table 4.1: Receipt of BH Pilot Community Services by Site

<i>BHP Community Service Status</i>	<i>BHP Intervention Site</i>		
	<i>Austin</i>	<i>San Antonio</i>	<i>Total</i>
Did Receive BHP Community services	136 (64%)	249 (91%)	386
No Community Services Received (pre-transition only) ¹⁰	78 (36%)	25 (9%)	102
Total	214	274	488

⁹ Four participants with duplicate Medicaid IDs were excluded from this analysis.

¹⁰ For this analysis, status (pre-transition only vs in-community) was determined by whether a date of first community service was recorded in the project databases.

How many BH Pilot participants were matched with Medicaid nursing facility data?

UTARI matched participants who had received community services with Medicaid data on nursing facility stays using Medicaid IDs. Of the 386 participants who had received community services, 369 had Medicaid IDs in the project dataset that matched IDs in the Medicaid data, and these participants were used for analyses¹¹.

For some of these analyses, the 369 BH pilot participants were further broken down into two groups based on their latest program status as reported by the project sites. Table 4.2 shows this breakdown. The first group (N=299) included those who had completed the intervention year or were currently receiving services. UTARI also included those who had died, since for many elderly, dying in the community rather than in an institution is considered a positive outcome.

The second group (n=70) included participants who either dis-enrolled prematurely, were identified as not appropriate for services due to health or cognitive status, or moved out of the service area. The overall group results provide a view of the outcomes that may be obtained if the BH pilot is expanded and implemented in other settings.

Table 4.2: BH Pilot Program Status for the Analysis Sample

<u><i>Project Site- Reported Participant Status</i></u>	<u><i>Frequency</i></u>	<u><i>Percent</i></u>
Completed	201	54.47
Current	43	11.59
Died	19	5.12
Returned to NF	36	9.70
Dis-enrolled prematurely	57	15.36
Pre-trans only	3	0.81
Out of service area	10	2.70

4.3 Outcome Measures

Nursing Facility Status

Nursing facility status was determined by identifying from the Medicaid data whether each of the 369 participants in the analysis experienced a Medicaid-funded nursing facility stay after having received BH pilot community services (i.e. any nursing facility entry after the date of the first community service; some participants who returned to a NF may have subsequently moved back to the community again).

¹¹ The 17 who could not be matched likely had incorrect Medicaid IDs in the project datasets; however, their exclusion does not affect the robustness of the findings.

Time in Community

Regardless of whether a person eventually returns to a nursing facility or not, longer community tenure is an important goal, both for quality of life and to reduce the typically higher costs of institutional care. The length of time in the community was calculated as the number of months between first community Pilot service (i.e. entry to the community) and subsequent return (if any) to a nursing facility. For participants who have stayed in the community, the calculation of time in the community used December 1, 2015 as the final date, since that is when the dataset was generated.

4.4 Predictive Measures

Behavioral Health Diagnosis

Behavioral health diagnoses were categorized into seven categories: Anxiety, Bipolar, Dementia, Depression, Substance Abuse, Schizophrenia, and Other (i.e. other psychiatric diagnoses or a primary physical diagnosis). These categories were based on diagnoses recorded in the project data sets provided by UTHSCSA and CHCS.

Demographics

Participants' age, gender, and race/ethnicity were obtained from the project databases. Race/ethnicity was recoded into four groups: Anglo, Hispanic, African-American and Other. Because of the small number of participants in the 'Other' category, they were dropped from these analyses.

Pilot Services Received

Since all participants received CAT therapy, an additional variable identified whether participants had also received substance use disorder treatment.

Status in BH Pilot

As described in section 4.2, status in the BH pilot was coded into two categories: 1) Received services (current, completed, died, or returned to NF), or 2) Dis-enrolled prematurely, was not appropriate for services, or moved out of the service area.

Health Status/Hospitalizations

Several measures of participant health status were constructed from the HHSC data. These included hospital inpatient stays, emergency room visits, and outpatient visits, both during the 12 months prior to date of entry to the community and during the period of time participants were in the community.

For the 12-month pre-BH pilot visits, the simple number of visits in each category was used, since the time period was constant. For the visits since entering the community, rates were used (number of visits/time in community), since each participant had been in the community for a different length of time. Since the length of time varied after return to the community, a rate of visit was calculated by dividing the number of visits by the number of six-month periods post-return. A six-month period was used to represent a meaningful time period.

For outpatient visits, any visit to an office where they received professional services was counted. No distinction was made depending on the diagnoses listed for that visit.

4.5 Results

4.5.1 Descriptive Characteristics by Site

Table 4.3 shows participant characteristics and outcomes by site and for the overall sample. Statistical significance (whether differences between sites were reliable) was assessed by Chi-square tests of association for categorical measures and t-tests for continuous measures.

There were reliable differences between Austin and San Antonio participants in race/ethnicity, diagnosis category, whether substance abuse services were received, and months in the community (double asterisks in the table represents reliable [statistically significant] differences between sites). There was also a significant difference between the two sites in the likelihood of return to a nursing facility: 38% in San Antonio versus 28% in Austin (not shown in table).

These site differences may reflect true underlying differences in the populations of the two project sites, differences in recruitment strategies, the length of time each program was operating, or how the intervention was implemented. Further investigation will be done in 2016 to try to better understand these differences.

Table 4.3: Participant Characteristics and Outcomes by Site

	Bexar		Travis	
	Frequency	Percent	Frequency	Percent
Received Substance Abuse Services**				
No	190	80.2	75	56.8
Yes	47	19.8	57	43.2
Program Status				
Completed, current	185	78.1	114	86.4
Fail to complete	52	21.9	18	13.6
Gender				
Female	129	54.4	61	46.2
Male	108	45.6	71	53.8
Diagnostic Category**				
Missing	2	.8	0	.0
Anxiety	32	13.5	12	9.1
Bipolar	44	18.6	19	14.4
Dementia	11	4.6	6	4.5
Depression	81	34.2	74	56.1
Other	30	12.7	5	3.8
Schizophrenia	33	13.9	11	8.3
Sub Abuse	4	1.7	5	3.8
Race/Ethnicity**				
Other/Missing	5	2.1	0	.0
African American	26	11.0	26	19.7
Hispanic	92	38.8	14	10.6
White	114	48.1	92	69.7

	<i>Mean</i>	<i>Std. Dev.</i>	<i>Mean</i>	<i>Std. Dev.</i>
<i>Age</i>	61.6	13.3	61.0	11.1
<i>Months in Community**</i>	31.6	23.2	28.1	17.4
<i>Outpatient visit count 12 months before return to community</i>	3.45	6.97	4.61	8.54

<i>Rate of Outpatient visits per six-month periods while in community</i>	2.95	5.67	3.91	6.57
<i>Inpatient visit count 12 months before return to community</i>	0.55	1.13	0.93	1.71
<i>Rate of inpatient visits per six-month periods while in community</i>	0.66	1.42	0.55	1.42
<i>ER visit count 12 months before return to community</i>	0.64	1.12	0.75	1.32
<i>Rate of ER visits per six-month periods while in community</i>	0.41	0.81	0.44	0.83

** = Double asterisk indicates a statistically reliable difference between groups.

4.5.2 Percentage Who Returned to a Nursing Facility or Remained in the Community (based on Medicaid data), by BH Pilot-Reported Program Status

Table 4.4 shows the percentage of participants who returned to nursing facilities by their status in the BH pilot as described in Section 4.2.

Overall, 241 (65.3%) of 369 participants were still in the community defined as having no stays in a nursing facility after first date of community service according to the Medicaid data. For those participants who completed the intervention, were currently receiving pilot services, died, or were reported by the project as having returned to a nursing facility, 200 of 299 (66.9%) remained in the community according to Medicaid data. For those participants who dis-enrolled from the pilot, moved out of the service area, or were not appropriate for pilot services, 41 of 70 (58.6%) remained in the community. Of the 201 participants who had received the full year of services, 140 (69.7%) remained in the community [not shown in table].

Table 4.4: Nursing Facility (NF) vs In-Community (IC) Status, by BH Pilot Program Status

<i>BHP Program Status</i>	<i>Nursing Facility Status (per Medicaid)</i>		
	<i>NF</i>	<i>IC</i>	<i>Total</i>

<i>BHP Program Status</i>	<i>Nursing Facility Status (per Medicaid)</i>		
	<i>NF</i>	<i>IC</i>	<i>Total</i>
Completed, Currently receiving services, Died, Returned to nursing facility (per project knowledge)	99 33.1%	200 66.9%	299 100%
Dis-enrolled, Not appropriate for services, Moved out of service area	29 41.4%	41 58.6%	70 100%
Total	128 34.7%	241 65.3%	369 100%

Percentages read across.

4.5.3 Predicting Nursing Facility Return

To better understand the factors associated with return to a nursing facility, UTARI conducted additional analyses that looked at how strongly each of the participant characteristics described in Table 4.3 above “predicted” (was associated with) return to the institution vs residence in the community. UTARI used a statistical method called logistic regression to estimate the increased or decreased predicted probability of returning to a nursing home that could be attributed to a one unit increase in each predictor included in the model.

Table 4.5 shows the results of this analysis. For each factor, its contribution to predicting return to a nursing facility, net of all the other factors, is shown. The most important columns in this table are the P-value and the Odds Ratio columns. Predictors that are statistically “reliable” (i.e. are likely to be true predictors of nursing home return) have values less than .05 in the column entitled “P-value.” There were three predictors that met this criterion and one predictor that was close to meeting this criterion. The Odds Ratio¹² column indicates the magnitude and direction of the effect of each predictor.¹³

¹² An **odds ratio** (OR) is a measure of association between an exposure and an outcome. The OR represents the **odds** that an outcome will occur given a particular exposure, compared to the **odds** of the outcome occurring in the absence of that exposure. The odds ratio can also be used to determine whether a particular exposure is a risk factor for a particular outcome, and to compare the magnitude of various risk factors for that outcome.

- OR=1 Exposure does not affect odds of outcome
- OR>1 Exposure associated with higher odds of outcome
- OR<1 Exposure associated with lower odds of outcome

¹³ The associated Lower and Upper 95% confidence interval (CI) help show the variability in these estimates. If the CI includes the value “1,” this indicates the estimated Odds Ratio is not reliably different from “no effect.”

Table 4.5: Predictors of Return to Nursing Facility

Predictor	Estimate	Standard Error	P-value	Odds Ratio	Lower 95% CI	Upper 95% CI
Age	0.01	0.01	0.404	1.01	0.99	1.04
Black (compared to White)	-0.35	0.31	0.261	0.60	0.24	1.51
Hispanic (compared to White)	0.18	0.24	0.449	1.01	0.53	1.91
Bexar (compared to Travis)**	0.39	0.17	0.028	2.16	1.09	4.29
Female (compared to Male)	-0.15	0.16	0.353	0.74	0.40	1.39
Bipolar (compared to Anxiety)	0.22	0.35	0.521	1.48	0.49	4.53
Dementia (compared to Anxiety)	-0.46	0.58	0.430	0.75	0.16	3.53
Depression (compared to Anxiety)	0.12	0.29	0.675	1.34	0.48	3.78
Other (compared to Anxiety)	0.34	0.45	0.446	1.67	0.46	6.14
Schizophrenia (compared to Anxiety)	0.33	0.41	0.431	1.64	0.48	5.67
Substance Abuse (compared to Anxiety)	-0.39	0.89	0.667	0.81	0.09	7.46
Received Substance Abuse services (compared to none)	-0.26	0.17	0.140	0.60	0.30	1.18
Completed/Current (compared (to Disenrolled etc.)	0.01	0.19	0.970	1.02	0.47	2.18
Outpatient Visit Rate After Return to Community (RTC)*	-0.12	0.03	0.001	0.89	0.83	0.95
ER Visit Rate After RTC*	1.68	0.31	<.001	5.36	2.90	9.91
Inpatient Visit Rate After RTC	0.17	0.12	0.154	1.18	0.94	1.49
Outpatient Visits Before RTC	0.00	0.02	0.954	1.00	0.95	1.05

ER Visits Before RTC	0.04	0.12	0.770	1.04	0.81	1.32
Inpatient Visits Before RTC	-0.09	0.11	0.436	0.92	0.73	1.14

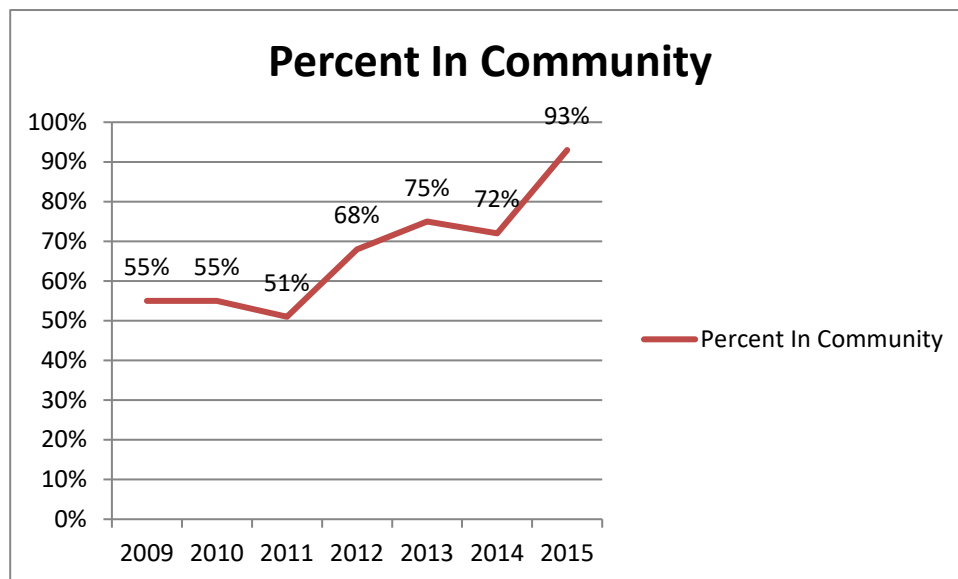
Factors that have a reliable association with return to NF are indicated in bold and starred.

Table 4.5 shows that none of the demographic characteristics are associated with the probability of returning to a nursing facility. After adjusting for all of the other factors, the only variables that reliably predicted whether or not a participant returned were the project site (San Antonio participants were twice as likely as Austin participants to have returned to a NF) and the rates of outpatient and emergency visits participants experienced after returning to the community. Notably, a higher rate of outpatient visits after return to the community under the BH pilot was related to a lower probability of return to a nursing facility. Each outpatient visit during a six-month period after return to the community contributes an 11% reduction to the probability of NF return. On the other hand, emergency visits were associated with a five-fold higher probability of return to a nursing facility. Inpatient visits after return to community were slightly, but not reliably, associated with NF return.

Overall, these results suggest that patients who are connected to appropriate outpatient care while in the community do better remaining in the community, while participants who experience higher medical care needs once in the community, particularly if they result in emergency room visits, are more likely to return to a nursing facility. (Interviews conducted in previous years with some pilot participants who had returned to a nursing facility also suggest that return was generally necessitated by a situational or physical health crisis, and that these individuals were motivated to return to the community as soon as they were able to do so.)

The fact that participants in San Antonio were more likely to return to a nursing facility may have to do with the site’s longer program duration, and consequently, more “exposure” time for participants to experience the possibility of NF return. For example, Figure 4.1 shows that the percentage who eventually returned to a NF is higher for earlier cohorts. Yet, even for those who entered the pilot four to six years ago, the percentage who have remained in the community remains above 50%.

Figure 4.1: Percentage Still in Community (as of Fall 2015) by Year of Enrollment in Pilot



4.5.4 Length of Community Tenure by BH Pilot Status

Table 4.6 shows the amount of time participants remained in the community, based on Medicaid data. Participants are further stratified by reported status in the BH pilot. The 'Primary' status group includes those who completed the BH pilot intervention, were currently receiving the intervention, had died, or were reported by the project as having returned to a nursing facility, while the 'Other' status group comprises those who dis-enrolled prematurely, left the service area or were considered not appropriate for services.

On average, participants remaining the community have been there about twice as long (about 38 months) as those who had returned to a nursing facility (about 16 months). Within these groups, contrary to our expectations, there was no difference in community tenure between the Primary and Other status groups, suggesting that those with less exposure to the pilot fared about as well, in terms of time in the community, as those with greater exposure.

The table also reports Total Person Months for each status, which is the mean number of months in the community times the number of participants who experienced them. This number is used in the analysis of potential cost savings in Section 4.5.5.

Table 4.6: Length of community stay in months by Community Status and BH Pilot Status

Community Status	BHP Status	Community Stay in Months					Total Person Months
		N	Mean	Median	Min.	Max.	
Returned to NF	Other	29	9.7	8	0	35	282
	Primary	99	17.7	17	0	59	1756
Remained in com'ty	Other	41	36.1	35	8	91	1480
	Primary	200	38.4	39	4	91	7688
All Participants		369	30.4	27	0	91	11206

BHP Status: Other = Dis-enrolled/not appropriate/moved

Primary = Completed, current, died, returned to NF (according to project site)

4.5.5 Potential Cost Savings

The monthly cost of living in the community under MFP is 71% of the cost of living in a nursing facility (\$3,391 in nursing facility versus \$2,407 in MFP, accounting for initial expenses).¹⁴ To estimate the total cost savings that may have been realized through the MFP Pilot project, we multiplied the months in the community by the incremental savings per months while subtracting the initial additional cost of \$2,407. The overall estimated savings were \$9,633.416, with a median savings per participant of \$22,937.

¹⁴ This analysis compares the monthly Medicaid reimbursable cost for a Texas nursing home resident with the cost of Medicaid recipients who participated in the Money Follows the Person program. The Texas Medicaid rates (http://www.dads.state.tx.us/news_info/budget/docs/fy15referenceguide.pdf) assume that each nursing facility provides institutional care to Medicaid-eligible recipients covering the total medical, social and psychological needs of each client, including room and board, social services, over-the-counter drugs, medical supplies and equipment, and personal needs items. The DADS 2015 Reference Guide reports the net nursing facility cost per Medicaid resident per month was \$3,390.84 assuming 30 days in each month. For MFP costs, Table 1 in Irvin et al. (2012) shows the costs for MFP participants in multiple categories. Excluding those with Intellectual Disabilities (n=1,466) and Unknown disabilities (n=269), the average weighted cost per month, accounting for initial costs, was \$2,407. This cost includes all Medicaid reimbursable costs. This figure represents 71% of the comparable Nursing home per person per month cost.

Another way to look at the effect of the \$2,470 additional first month costs on total costs is to estimate how many months it would take to recover this amount from the overall savings accrued by living in the community. Given that the estimated incremental savings per month is \$941, it would take only 2.6 additional months of community residence to recover these costs. Of the 369 participants used in this analysis, 350 (95%) met this criteria.

4.6 Summary and Discussion

Overall, these results highlight the continuing impact of the BH Pilot on helping nursing facility residents with significant behavioral (and physical) health issues return to and remain in the community. Among the entire 369 participant sample, 65% of participants have remained in the community, and for those who completed the full one-year intervention, this percentage was higher (70%). Some participants had been in the community for as long as seven years.

UTARI's findings also demonstrate that receiving more outpatient care in the community under the BH pilot was linked to higher probabilities of staying in the community. This suggests that health care providers, such as nursing facilities and MCOs, can improve the likelihood of successful community tenure by ensuring that individuals get the outpatient care that is needed to help facilitate medical stability in the community. We also found that higher rates of ER visits after moving to the community were linked to a higher probability of return to nursing facilities. Health care providers may want to identify MFP participants with an emergency room visit for an additional health assessment and more intensive efforts to make sure they get services focused on allowing them to stay in the community.

The analysis shows that BH pilot participants have remained in the community for an average of 2.5 years. If we link these additional months in the community to the cost differential between nursing facility care versus MFP community care, the pilot has led to significant cost savings for the state Medicaid program. These cost savings may encourage both state policy makers and health care provider institutions to invest in the types of services the BH pilot provides.

Chapter 5. SASH Pilot: Helping State Hospital Patients Move to the Community

Executive Summary

The SASH pilot, aimed at helping San Antonio State Hospital patients return to the community, has served 70 participants since it began in 2012. At least half were able to return to the community under SASH pilot auspices, while the others received pre-transition services only, generally because they refused community services or were lost to contact. This may be in part due to the short timeframe that SASH pilot staff have to engage participants before they move out. About a quarter of participants received less than two weeks of pre-transition services before being discharged.

SASH pilot participants were about equally likely to be men and women and ranged in age from 25 to 79 (mean age = 50). About 80% were diagnosed with schizophrenia, 13% had bipolar disorder or major depression, and 6% had dementia or psychosis. Some 30% had a secondary diagnosis of alcohol or drug use disorder.

Interviews with SASH pilot staff highlighted several particular challenges of the SASH pilot, especially as compared to the BH pilot. These include a more psychiatrically disabled clientele, who experience more social isolation, have more history of homelessness, and need more intensive pilot services; reduced pre-transition time; high staff turnover; sometimes unbalanced caseloads due to client severity; and the challenges of finding and keeping appropriate housing. Yet the SASH pilot has demonstrated clear success in helping a significant number of SASH patients move to and remain in the community.

5.1 Introduction and Characteristics of SASH Pilot Participants

The SASH pilot began in 2011. Funded with Mental Health and Substance Abuse block grant dollars, the SASH pilot assists individuals with serious mental health issues to effectively transition from state facilities into the community. The following sections describe participant characteristics and staff feedback about the purpose, client functioning, and challenges of the project.

Data for SASH pilot participants were obtained from the Center for Health Care Services in June 2015.

5.1.1. Number Enrolled by Year

70 SASH pilot participants have been enrolled between 2012 and 2015.

<u>Year Enrolled in SASH Pilot</u>		
<i>Year</i>	<i>Percent</i>	<i>N</i>
2012	37%	26
2013	27%	19
2014	23%	16
2015	13%	9

5.1.2. Community Status

At least half (34) of the 70 enrollees had returned to the community (as indicated by receiving at least one SASH pilot service in the community). The others (36) had received pre-transition services only and either did not move to the community or transitioned outside of the pilot. (Reasons for not receiving community services are discussed later). The percentage of participants who received community services increased steadily from 2012 (35%) to 2015 (67%).

5.1.3. Demographic Characteristics

Sex: Participants were about evenly divided between women and men. Those who returned to the community were somewhat more likely to be men (62%) [a marginally reliable difference].

Race/ethnicity: Almost half of all participants (49%) were Hispanic, almost a third were white (31%), and 19% were African American. There was no reliable difference by race/ethnicity on whether participants returned to community.

Age: Participants ranged in age from 25 to 79, with both a mean and median age of about 50; there was no reliable difference in age by return to community status.

5.1.4. Medicaid Status

Overall, about 59% of the 70 pilot participants had a Medicaid ID indicated. Those who had received pilot services in the community were almost twice as likely (76%) as those who had received only pre-transition services (42%) to be on Medicaid [a statistically reliable difference].

5.1.5. Primary Diagnosis

Most SASH pilot participants (80%) had a primary diagnosis of schizophrenia, while 13% had bipolar disorder or major depression and 6% had dementia or psychosis. There was no difference in diagnosis by community status.

5.1.6. Secondary Diagnosis

While participants had a variety of secondary diagnoses, it is worth noting that 30% were diagnosed with alcohol dependence or drug-related disorders. However, only two of the participants who received CAT services under the SASH pilot had also received pilot substance abuse services. One possible explanation may be that dealing with their severe and complex psychiatric conditions, as well as the issue of getting clients to engage with any pilot services, presented more immediate challenges.

5.1.7. Current Residential Placement

For the 34 SASH pilot participants who had transitioned to the community with pilot services, their current residential situation as reported by SASH staff is shown below:

Current Residential Placement

Placement	Percent	N
Assisted Living Facility	25%	8
Family	16%	5
Rec'd housing voucher/apt	16%	5
Independent living	13%	4
Returned to SASH	9%	3

Other housing situations for this group included boarding home (1), hospitalized (1), and jail (1); no information was available for 6 participants.

5.1.8. Participants Who Received Pre-Transition Services Only

Of the 70 SASH residents referred to the pilot, 36 had received pre-transition services only. Of these, the CHCS data suggest that only 7 actually remained in SASH, while the others did not receive pilot community services for a variety of reasons.

The most prevalent reason was refusal of services (9 individuals), followed by inability to locate participants once they moved out. One explanation for these findings may be the short timeframe that SASH pilot staff sometimes have to engage these participants. Other reasons included relocating to a nursing facility, IOPC, or jail, moving out of the service area, or lack of discharge planning or follow-up, sometimes pending receipt of documents.

Some information on current housing situation was available for about half (15) of the participants who received pre-transition services only: 3 were living with family, 1 was in a nursing facility, 1 in assisted living, 1 in a boarding home, 1 in Cloud Haven, and 1 discharged to University Hospital. Seven were indicated as having remained in SASH.

5.1.9. Duration of Pilot Services

Duration of Pilot Services in the Community: Among the 34 participants indicated as having received a community service, only 18 had an indication of an ending date for pilot services. About half of those without an end date were still within their first year after receiving first community service, so may still be receiving them; the others without an end date of services had had their first community service

more than a year ago, so it is not known what the absence of an end date means – perhaps a hiatus in services or else just a lack of data.

For the 18 participants with a beginning and ending date of pilot community service, the duration of services ranged from 36 days to 382 days; the mean was 265 days (about 8-9 months) and the median was about a year.

Duration of Pre-Transition Services: For the 34 participants who eventually received a pilot community service, this was calculated as the number of days between the date of their first pre-transition service and their first community service. It is possible, however, that individuals were not actually receiving services during the entire interval bracketed by these dates.

For these participants, the duration of pre-transition services ranged from 0 days to 720 days (only one individual had 720 days between first pre-trans service and first community service; the next longest interval was 332 days). Excluding the 720-day interval, which may have been an anomaly, the average length of time in pre-transition, for participants who went on to receive pilot community services, was 84 days (almost 3 months), with a median of 53 days. About one-quarter of participants had received less than two weeks of service before moving to the community. Having such a short pre-transition period in which to try to engage clients in CAT services was one of the challenges discussed by CAT therapists in interviews reported later in this Chapter.

For the 36 participants who had received pre-transition services only, length of pre-transition services was calculated as the time between first pre-transition service and end of pilot services (if indicated). Information was available for 29 of the 36 participants. The time in pre-transition ranged from 0 to 982 days. Excluding the 982-day outlier, the next longest time was 386 days. The mean time in pre-transition was 117 days (about 4 months), and half the sample received pre-transition services for 3 months or more.

Does Longer Pre-Transition Lead to Longer Community Stay? For the 17 participants who had a date for both duration of pre-transition and duration of community services, there did not appear to be any association between them, i.e. longer pre-transition did not lead to longer duration of community services. However, as suggested earlier, short duration of pre-transition services, which is sometimes a consequence of pilot staff not being notified of transition until late in the process, may be associated with a subsequent lack of engagement in pilot community services.

5.2 Institutional Status of SASH Pilot Participants

In July 2015, some minimal data on SASH pilot institutional status (readmitted to hospital, remained in community) were obtained from DSHS. Due to data confidentiality, only aggregate results were received.

Additionally, not all pilot participants were able to be matched in the DSHS data, probably due to incorrect SSNs in our dataset.

Of the 29 pilot participants who moved to the community under the pilot and who were able to be matched (5 additional ones were not found in the DSHS data), 12 of them were readmitted to SASH or another state hospital after an average of 220 days (range 9 to 813 days). The other 17 appear to have remained in the community, and had been there for an average of 403 days (range 77 – 1,014). This would suggest a rough “success rate” (i.e. sustained community tenure) of 59%. It is possible that some of those in the community will end up being re-hospitalized at a later date; however, the fact that half of them had remained in the community for a least one year after enrolling in the pilot is a positive outcome.

Of the 31 participants who only received pre-transition services and who could be matched to DSHS data, 24 were eventually discharged from SASH, after an average of 246 days (range 0 - 986) from initial pilot contact. Seven remained in the hospital and never moved back to the community, with an average hospital stay of 596 days (range 120 – 1,257 days).

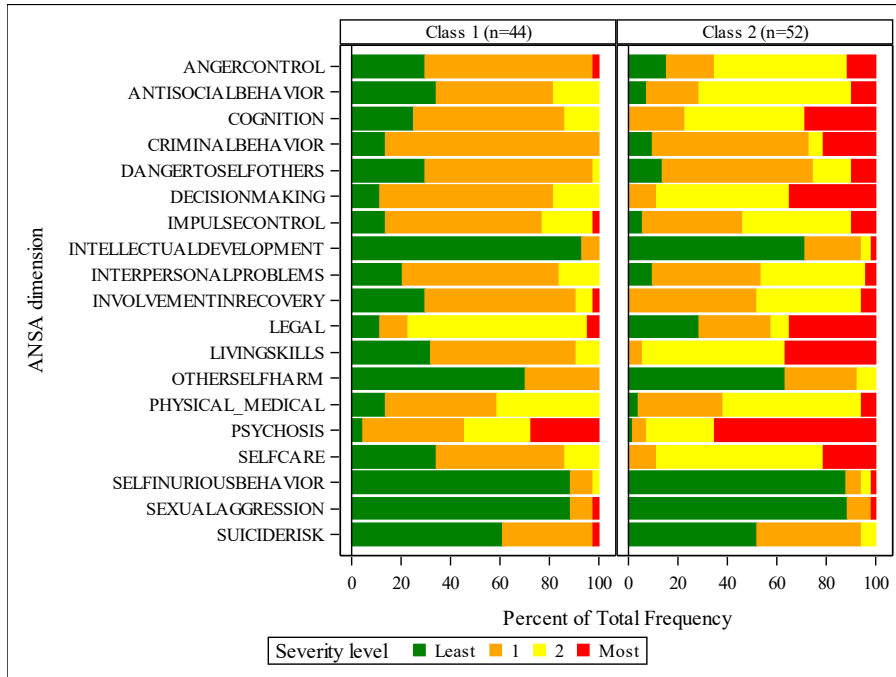
5.3 Can Appropriate SASH Pilot Participants Be Identified Based on ANSA Scores?

In summer 2015, UTARI staff analyzed data collected by UTHSCSA on Adult Needs and Strengths Assessment (ANSA) scores from 96 patients in state hospitals across Texas, in order to see whether the ANSA might be useful in helping identify individuals best suited for pilot services.

Latent class analysis conducted on 19 ANSA items suggested that, broadly, patients could be classified into two groups, representing those with acute and those with less acute symptoms of dysfunction.

Figure 5.1 shows how the average severity levels on different symptoms or behavioral domains tend to cluster in individuals who might be considered more severe and less severe. For example, the greater quantity of scores in the red range for Class 2 suggests that this group’s impairment is more severe, while the greater quantity of scores at the lower end of severity (green) and fewer red scores, suggest that Class 1 shows better functioning. The relative consistency of ANSA scores across all the domains of functioning measured therefore makes it a promising instrument for distinguishing overall severity in state hospital patients and potentially identifying those who would benefit the most from a program such as the pilot.

Figure 5.1: Latent Class Analysis of Severity Levels on 19 ANSA Domains



Although there are no data to show whether those with less acute symptoms actually have more success in moving to the community, it is reasonable to expect that this would be the case. If pilot services cannot be extended to all individuals interested in moving to the community, targeting those with lower severity based on their ANSA scores would be a possible way to target services.

5.4 Interviews with SASH Pilot Staff

In summer 2015, the UTARI evaluation team interviewed six staff and one participant involved with the SASH pilot. The staff included two SASH caseworkers, two CAT therapists from Center for Health Care Services, a research specialist who conducts functional assessments, and a clinical supervisor from UTHSCSA. The following section distills the information received about the history, purpose and functioning of the pilot, and recommendations for the future.

5.4.1. Program Purpose and Activities

The purpose of the SASH pilot program is the same as that of the BH pilot, but addressed to a different client population. Once potential SASH clients are clinically stabilized, the SASH pilot assists them with developing and maintaining the basic living and coping skills needed to return to independent living in the community. The program activities are similar to those of the BH pilot, and consist of housing assistance, CAT therapy, home health care, benefits coordination, and referrals to appropriate mental health, medical, and human service agencies. The main difference between the pilots is that the SASH pilot focuses on

individuals who have spent at least 90 consecutive days in SASH or have had three hospitalizations that add up to 90 days in the past year.

5.4.2. Staff Roles

SASH caseworkers initially provide clients with crisis stabilization and medication management services to alleviate their current acute mental health situation. Once stabilized, the caseworker's role is to determine whether the potential pilot client has insight into taking their medication successfully; their medication is working effectively; they can have a lucid, two way conversation; they demonstrate logical reasoning and rational thinking; and they have the motivation and willingness to engage in the pilot program. SASH staff then contact the CAT therapist to begin pre-transition services. If possible before they leave the hospital, SASH caseworkers begin the process of helping clients get IDs, check on government benefits (Medicare, Medicaid, etc.), and identify what resources they will need after discharge to make a successful transition.

CAT therapists work with SASH social workers and psychiatrists to identify potential clients whom they believe are ready for discharge and could benefit from the pilot program. They then assist the client with finding appropriate housing, preparing housing applications, negotiating fees, deposits, utility set up, paying the first month's rent and groceries, buying clothes and household supplies, getting birth certificates, social security numbers, personal IDs, and completing any other necessary paperwork.

Once the client has transitioned to the community, the therapist meets with them 2-3 times per week, providing CAT services and helping them work on their goals, budgeting, safety plans and medication management. They routinely work on life skills, coping, reasoning, and decision making skills, on learning to evaluate the trustworthiness of people they encounter so as not to be exploited, and on how to differentiate between the voices they hear in their heads and the voices of their caregivers. CAT therapists also provide referrals and transportation to other needed resources for medical, employment, educational and community services. Once clients are stable, the therapists may reduce the number of visits to 1-2 per week.

5.4.3. Initial Client Contact

SASH caseworkers: Since all the clients are still current SASH residents who are seen daily, they are routinely assessed to make sure they have stabilized mentally and emotionally. The caseworkers then encourage them to begin formulating a plan for a successful transition out of the hospital. SASH caseworkers make the clients aware of the pilot program and what it can offer, and do their best to motivate and encourage them to participate.

CAT therapists and Supervisor – When the SASH social workers identify a potential client, they meet with the CAT team to review the client's DSM diagnosis, medications, and particular situation. At the first client meeting, the CAT therapists explain the program, determine the participant's level of interest, and discuss

personal goals, resources and/or challenges (family, finances, legal issues) relating to moving back into the community. The CAT therapists also develop a brief clinical history in order to determine the level and types of CAT and housing services that will be needed.

5.4.4. Challenges of the SASH Pilot

Although the program design of the SASH pilot is similar in many respects to that of the BH pilot, SASH pilot faces several additional challenges due to the severity of mental illness in the client population served as well as some structural issues of the program.

Reduced Pre-transition Time. Pre-transition time with clients in the SASH pilot is significantly shorter (sometimes only 2-4 weeks or even none at all) than in the BH pilot, since SASH's policy is to discharge patients as soon as they are stabilized. That makes it extremely difficult for CAT therapists to establish rapport and adequately prepare clients for the transition. In addition, the amount of work during pre-transition is more intense and time consuming due to the fact that the clients suffer from more recent and intense serious mental illness issues such as hallucinations, delusions, hearing voices and paranoia.

Mental Health Issues. The SASH clients routinely require a great deal more assistance than the BH pilot participants. They have more mental health disability, so their level of care is a 3-4 (more intense) rather than a 5-6. They need to be seen more often, sometimes 2-3 times per week, and CAT therapists work with them on more basic things. They have very little social, coping and reasoning skills, or family support. Also, many don't have current IDs, so work with their CAT therapists has to start from the "ground up."

Increasing Motivation. Most clients are motivated to participate, but some are suspicious. Clients with court-ordered requirements fear getting in any more trouble and having to go back to jail. Some are reluctant because they fear that the pilot is going to be "just another [burdensome] program" whose benefits they don't understand. Currently, the CAT therapists don't have enough pre-transition time to get clients to fully understand, trust, and be motivated to participate.

Widening Eligibility. SASH pilot participants are required to have been in a state facility for 90 days or have multiple admissions that equal 90 days within one year to be eligible for the program. The reality is that many of the clients haven't been resident in SASH long enough during their most recent stay to be able to meaningfully engage with the pilot before discharge. Once they are clinically stabilized (30-45 days), participants are anxious to get out and the medical staff is focused on discharging them as soon as medically feasible. As a result, the pool of clients to recommend for the program is limited. It would be helpful to expand the pool of clients that could benefit from the program by eliminating the 90-day rule. There are numerous clients outside those eligibility criteria who could be successful in the pilot.

Finding Appropriate Housing. Housing poses a significant set of challenges for the program. There is no one type of housing that is most appropriate, as each client has different wishes, needs and capabilities. In

determining the most appropriate kind of housing to look for, CAT therapists work with the SASH social workers and psychiatrists to assess how well the clients can manage their own medications, how they function socially, and whether they can function alone or need assistance. That said, the available choices are very limited. At best, they include living with family; independent apartments; assisted living; group homes (shared rooms); a Christian boarding home; or, in the worst case, jail if they have charges pending. Some clients refuse certain housing options, ruling out boarding homes, roommates, parts of town, or the rules that come with Section 8 housing.

For clients with a criminal justice history, housing options can be more limited. Few apartments or assisted living facilities are willing to rent to someone with a felony, and the few that will accept them require an additional “risk” fee, which is not always feasible.

Staff emphasized that there are not enough different types of housing available to pilot clients. They have too few choices and most sites don’t know how to deal with people with mental illness. There is a great need for supportive housing for this population, which should include staff with appropriate education on mental illness that can interact with them effectively in case of crisis or a behavioral issue.

Social Isolation. Social isolation is always a concern for the clients. Many lack socialization skills so prefer to spend time alone rather than interact with others. CAT therapists monitor clients regularly for signs of isolation and encourage them to attend mental health groups or day programs that offer structured activities, and to contact family and friends when possible.

Homelessness. Many of the clients have experienced long-term housing instability, enduring repeated cycles of intake and residence at SASH and discharges into homelessness (a cycle of 20 years, in one case).

Uneven Caseloads. Currently, each CAT therapist is mandated to carry a caseload of ten. However, this state mandate was designed for other client populations that are much higher functioning than SASH clients, who have recent and severe psychiatric disabilities. The supervisor initially assigns caseloads based on their best assessment at discharge. However, it is never completely clear how much intervention and assistance each client will really need once they return to the community. Inadvertently, one therapist could receive an extremely demanding caseload that makes it difficult to serve the clients adequately. Yet, since these clients don’t respond well to change, and require a long time to come to trust and work with a therapist, it is not advisable to transfer clients between therapists to even out the caseloads. Such disruption could hinder progress or, in the worst case, precipitate a relapse and need to return to SASH.

Reduced Agency Partner Support. Due to the Medicaid IMD exclusion, which does not allow using federal MFP funds for patients in mental health institutions, as well as the fact that not all pilot participants are eligible for Medicaid (only about 59% had a Medicaid ID), or do not meet nursing facility level of care requirements that would qualify them for most HCBS services, the SASH pilot does not benefit from the

same set of agency partner supports in service delivery as the BH pilot. Specifically, the SASH pilot does not have the same access to (1) the relocation specialist (Center for Independent Living) to assist with securing Section 8 Housing vouchers, searching for housing locations and completing applications, facilitating rent payments and deposits, and purchasing household furniture, kitchen supplies, food and clothing; 2) MCO follow-up regarding medical services and home health care; and, 3) caseworker help for clients to complete applications for social security, Medicare, and Medicaid benefits, and to secure valid IDs. This lack of additional agency support has added significantly to the CAT therapists' workloads.

Staff Turnover. One of the biggest problems over the last few years has been the constant high turnover of caseworkers, which creates a lack of consistency and predictability for clients and lessens their ability to function well in the community. This is particularly troublesome because of the trust issues mentioned above and the fact that this limits the amount of time the therapists actually get to do productive work with them within their year in the pilot.

5.4.5. Factors Associated with Client Success

According to staff experience, characteristics of SASH pilot participants who are most successful moving to the community include a more recent and less severe psychiatric diagnosis; more motivation to succeed; family and other informal support; a history of successful independent living; and the ability to benefit from the CAT therapy (e.g. motivation to cooperate, ability to think rationally, 'hearing voices' under control). Clients who are in Involuntary Outpatient Commitment (IOPC) tend to cooperate well because they are held accountable for their actions and do not want to return to jail. Good medication management, and the availability and ability to access outside resources are also important factors contributing to success. On the service side, CAT therapists have found that good communication and information-sharing among the multiple staff who interact with clients helps successfully monitor clients' outcomes and progress.

Additionally, success and improvement are continually monitored using the functioning and quality of life scales described in Chapter 3. The SOFAS, in particular, has been found by STAFF to be a good instrument to assess the overall quality of the social and functional aspects of participant's day-to-day lives.

5.4.6. Factors Associated with Lack of Success

A lack of success may be attributed to the following:

- psychiatric instability; a severe mental health diagnosis
- multiple hospitalizations; inability to control hallucinations and delusions
- lack of family and/or social supports
- a long history of homelessness and criminal justice involvement
- discontinuing medications
- an inability to function in the community

5.4.7. Intensity of Services

Service intensity is important to successful transition and independent living because it promotes trust and helps therapists identify and resolve problems more quickly. Due to the severity of mental health conditions, SASH clients need more intense treatment than other MFP clients in order to stay motivated, to continue to work on their goals, keep their appointments, and effectively manage medications. A program such as the SASH pilot that provides these types of high quality and consistent services is crucial to the success of these clients.

5.4.8. Most Important Activities of the Pilot

Caseworkers at SASH reported that the most important transition-related activities while still in the hospital include building trust and rapport in a very short time period to determine if a client would be appropriate for the pilot and encouraging them to become involved in it; empowering their own choice for involvement; and helping individuals get IDs and benefits by providing them with transportation.

Once in the community, the most important activities center on meeting their basic needs for food, shelter, clothing and communication; helping maintain good hygiene; medication management; and crisis intervention. All activities within the program that foster an individual's independence and self-sufficiency are equally important. An additional major focus is helping clients maintain housing stability, which is critical to their success in living in the community.

5.4.9. Alcohol or Drug Problems

Approximately 30% of SASH pilot participants have a secondary diagnosis of substance use disorder, although staff report that only 1 or 2 individuals have ever received substance abuse services through the pilot. Among those who use drugs, alcohol, marijuana and methamphetamines seem to be the most common substances. Misuse of prescription medications was not observed among pilot participants, except occasionally as a result of user error, and for those in assisted living, where medication is regulated and dispensed by staff, there is even less potential for misuse.

A real concern is that many clients quit taking their mental health medications because of perceived lack of efficacy and unwanted symptoms, such as brain fog, anesthesia of emotion, and impaired sexual performance. In these circumstances, participants may prefer to 'self-medicate' with alcohol or other drugs.

5.4.10. Staffing Needs

Since the CAT therapists perform all the activities once shared with COIL and the MCOs (i.e. in the BH pilot), they are unable to spend as much time on CAT therapy, particularly at the beginning, when clients first move out. A great deal of time is spent on locating housing, completing housing applications, getting household furnishings and food, setting up home health care, and helping clients complete the process of

getting IDs, social security numbers, and benefits through Medicare and Medicaid. Adding a housing specialist to the team would be very beneficial.

Additionally, the amount of time clients are allowed with a professional mental health therapist (two hours a week) appears insufficient to help them learn to understand, cope with and manage their extremely severe symptoms. Since they are trying to undo or manage a lifetime of poor reasoning and coping skills and manage unwanted thinking and behavior patterns, they need more time with such a therapist who can focus intensively on these issues. The CAT team felt it would be very helpful to have a mental health professional who could provide the intense level of counseling services needed for the clients to maximize chances for long term success in the community.

5.4.11. Ability to Live Independently

Clients with a long history of serious mental illness, with a history of poor medication management, prolonged homelessness, and multiple hospitalizations are likely to face additional challenges while living independently.

Note: Pilot staff interviewed for this report (and dates they began work with the pilot) were:

- Natalie Maples – Clinical Supervisor – UTHSCSA - 2011
- Judy Robinson – Research Specialist – UTHSCSA - 2013
- Jessica Rodriguez – CAT Therapist – CHCS - 2012
- Ana Perez-Ingram – CAT Therapist – CHCS - 2015
- Rosalinda Gomez – Caseworker – SASH - 2012
- Holly Burns – Caseworker – SASH - 2015

5.5 Recommendations for the SASH Pilot

Based on the conversations with SASH pilot staff and a pilot participant, a number of recommendations emerged to enhance the success of the pilot or similar programs that are part of Adult Mental Health services.

- Allow a longer pre-transition period so that clients are prepared to begin CAT therapy soon after they move out. The pre-transition period would allow for establishment of rapport and trust, as well as obtaining documents, evaluating housing options, etc.
- Allocate more money for better quality housing, and more choices. It would be helpful to have some type of transitional living facility with trained mental health staff that can adequately address the immediate needs of clients as they move out and become familiar with living in the community. Such a housing arrangement should be less restrictive than SASH and more accepting and helpful than assisted living. (One example is the Spindletop supported housing model in Beaumont, TX (Brooks, 2012)). Additionally, hire staff focused specifically on housing relocations and identifying more appropriate and affordable options.

- Assign flexible caseloads that could range from 6 to up to 13 per therapist, depending upon the level of disability and need of each client.
- Offer staff incentives to reduce turnover.
- Have the flexibility to extend the community services beyond one year to ensure that clients actually receive a complete year of CAT therapy (after accounting for the start-up time devoted to logistical issues and establishment of trust). Some clients with very severe mental illness may need up to two years of CAT services. Eliminate the 90-day eligibility rule, since many potential clients who don't meet those criteria could benefit from the pilot.
- Dedicate funds to enable clients to have more frequent psychiatrist visits.
- Guarantee rent coverage for at least two years after moving to the community.



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Appendix A

Treating Substance Abuse in the BH Pilot

The following report was presented to DSHS in February 2015.

Substance Use Disorder Among Nursing Facility Patients Moving to the Community

The Money Follows the Person-Behavioral Health Pilot

In 2008, the Texas Department of State Health Services began a Behavioral Health Pilot (BHP) program to provide services to individuals moving from nursing facilities (NF) to the community under the Money Follows the Person Medicaid managed care program. BHP is an innovative, evidence-based intervention that offers Cognitive Adaptive Therapy (CAT) and Substance Use Disorder (SUD) services for up to six months in the NF before transition, and one year after moving to the community. This Brief presents some lessons learned from the Pilot about addressing substance use issues among clients moving from NF to the community.

Addressing Substance Use Disorders in Nursing Facilities and Transition to the Community

Significant numbers of individuals in nursing facilities enter with a history of substance use disorder (Joseph, 1995; Lemke & Schaefer, 2010; Bernard, 2011; Klein & Jess, 2002). Others are at risk of developing problems due to dependence on drugs prescribed in the facility or lack of coordination of prescription medications once they move out (Viktil et al., 2006; Miller et al., 1991). At least one study has shown that NF patients with active alcohol use disorders continue to incur alcohol-related hospitalizations and institutionalizations following NF discharge and suffer earlier mortality as compared to their peers (Joseph et al., 1997). Substance use disorders can be especially problematic for individuals with a concomitant disorder, such as mental illness or a physical disability. SUDs may complicate their other conditions and, conversely, the mental or physical illness may make it harder for individuals to successfully engage in SUD treatment (Saisan et al., 2014; Drake et al., 1996; Xie et al., 2005).

All individuals admitted to the BHP had serious mental illness or another behavioral health condition with serious functional impairment. While only 2% were admitted with a primary diagnosis of substance use disorder, some 31% received SUD services in addition to CAT therapy through the BHP.

BHP participants with SUDs were similar to those without in race/ethnicity and in their other mental health diagnoses; however, (as in the general population) those with SUDs were more likely to be male and younger. Other studies (reported in Joseph, 1995) have found patients with alcohol problems admitted to NFs more likely to be male and younger, with fewer social supports and lower income, and more likely to suffer from depression, as compared to NF patients without alcohol problems.

How are SUDs identified among NF patients who move to the community? NF patients who move to the community under Money Follows the Person become clients of an MCO.¹⁵ Many MCOs conduct a client assessment at the time of community transition, which may include a screening question, such as “Have you ever received treatment for alcohol or drugs?” Some NF patients also have an indication in their medical records of a current or past SUD diagnosis or problems related to substance use. Other clients are identified at a later time by their CAT therapist. Clients may not initially disclose a history of SUD if they feel it may jeopardize or delay the transition process, whereas they may later confide in their CAT therapist after developing a relationship of trust. Additionally, some clients may believe they no longer have a problem because they have been “sober” in the NF, but the therapist may help them acknowledge their potential for continuing problems once they are living independently. Therapists may use a Motivational Interviewing approach (CSAT, 1999; Freeman et al., 2008) even at the “pre-contemplation” stage (i.e. before an individual is ready to acknowledge and seek help for their substance use) to help clients become aware of problems in their life that are plausibly related to their substance use.

Substance counselors in the Pilot suggest that a “whole person” wellness assessment is the most sensitive way to discover problems, including substance use, which may be interfering with clients’ success in the community. They find it most effective not to ask directly about a substance use “disorder” but rather to ask what a client’s alcohol or drug use is and whether it seems to be causing problems (e.g. “if you drink...” or “if you use drugs...”). Questions such as “How are you doing living in the community now? Is there anything (like alcohol use or drug use) that is hindering you from thriving, and would you like help addressing it?” can help elicit information about clients’ substance use in a non-stigmatized way. Joseph et al. (1995) found that the CAGE and MAST-G screening instruments are sensitive to identifying alcohol use disorders in NF populations. BHP counselors emphasize the importance of asking about substance use history as well as current use.

Clients should be periodically reassessed once in the community, since they may be more ready to disclose problems later or may have developed new ones.

How are individuals “engaged” in addressing their disorder? All BHP participants are assigned to a CAT therapist, either during their pre-transition period or once in the community. In addition, those who are identified as potentially having a substance-related problem are referred to a SUD counselor. The counselor carries out a comprehensive assessment of clients’ history and current use of substances and other life and health problems that could be related to SUD. The counselor emphasizes that they are concerned with a client’s overall wellness and their eligibility for various services that are available, and that asking about alcohol and drug use is part of this “whole person” assessment. Using a Motivational Interviewing approach (CSAT, 1999; Freeman et al., 2008), they begin by asking clients about their current concerns, and then may point out how these problems may be caused or aggravated by substance use. Since clients may tend to minimize the frequency or intensity of their problems, counselors probe by asking, “What it is like on your worst day?”

BHP counselors stress the importance of developing good rapport and trust with potential clients beginning at the screening stage. While the person who does the initial assessment need not be the same person who

¹⁵ Beginning in 2015, patients are also covered by an MCO while in the NF.

will provide the intervention, clients are more likely to talk frankly if they know this person will continue to be involved with them for the long haul, such as an ongoing case manager, counselor or care coordinator.

Counselors in the BHP have found that clients become motivated to engage in treatment once they understand how substance use may be aggravating their health conditions, interacting with their medications or creating other problems in their lives that may result in a need to return to an institution.

What kinds of substance use is seen in NF populations?

Among BHP participants with SUD, similarly to the general population, the most prevalent problem use involved alcohol, followed by marijuana, opiates and methamphetamines. Since substance use is generally not allowed in NFs, most individuals with SUD had developed these problems before entry in the NF. However, individuals in NF are also vulnerable to developing problems with prescription medications, particularly benzodiazepines, opiate pain relievers and anti-psychotics, as these are widely prescribed and often not well coordinated or managed in the NF or upon return to the community (Stevenson et al., 2010). Additionally, new problems with substance use may emerge after moving to the community, due to depression, stress, anxiety, self-medication of psychiatric symptoms, or difficulty coping with the challenges of independent living.

Sally's Story

I didn't think that I had a problem with SUD so I wasn't interested in the SUD services. The counselor kept coming around and talking to me and giving me information about SUD and how it can aggravate my health and other parts of my life. After 6-7 visits, I knew I could trust him, so I finally confided that substance use was a bit of a problem for me, and that I had been afraid to admit it. Over the next year he helped me to quit using, and my life has changed substantially for the better.

What kind of SUD services are provided? All BHP participants receive one year of Cognitive Adaptation Therapy (CAT), which addresses 26 areas of functioning and may include development of skills that have been compromised by SUD. Additionally, specific SUD services include individual counseling, family counseling, SUD education, and referral and transportation to AA & NA recovery groups or other community treatment resources.

Depending on need, individual counseling may focus on stressors, assertiveness, problem solving, cravings, recognizing triggers, and understanding the health consequences of substance use. Counselors meet with clients usually weekly or as needed. Techniques used include Motivational Interviewing and Cognitive Behavioral Therapy (NIDA, 2012). The counselor works together with the client to develop goals for the year, and reassess the appropriateness of and progress made towards these goals every few months. Clients who use prescription medications are educated about the risks of negative interactions with alcohol or other drugs or the risks of using their medications inappropriately.

Clients are also taught skills to help them better communicate with their physicians about their prescribed medications, to ensure they are not taking unnecessary meds or amounts that could lead to problems. Sometimes, the counselor or CAT therapist will review the client's medications with MCO staff to determine whether there are potential complications with multiple prescriptions or interactions with alcohol, if the client is drinking. If clients receive home health care, the visiting nurse may set up their meds for the week and monitor whether they are taking them appropriately. Developing communication skills and good

medication management are, of course, important considerations for all clients moving to the community, not exclusively those with SUDs.

For serious or acute SUD problems, the counselor may refer the client to inpatient treatment or detox and, if necessary, will transport them and help with their admission procedures. For clients with a co-occurring MH problem, the counselor may make a referral and/or transport the client to a Local Mental Health Authority or a private psychiatrist. Texas Medicaid funds comprehensive substance use disorder treatment services, including outpatient services (assessment, ambulatory (outpatient) detoxification, individual and group outpatient counseling, medication assisted therapy), and residential services (treatment and detoxification), as well as adult mental health services.

What outcomes are seen among SUD clients in the BHP? Among all participants who have completed

the BHP intervention, about 70% have remained in the community and not returned to a NF. This success rate is the same for those with SUDs and those without. While return to a NF is generally precipitated by a serious physical health issue, SUDs can aggravate existing physical disorders or cause new ones in already vulnerable individuals, so identifying and treating SUDs in populations transitioning from NFs can be crucial to keeping them in the community.

Don's Story

[After my stay in a NF], I recognized that my drug use had caused me huge problems in my life with work, relationships and health. I needed to do something about it. The SUD services offered by the BHP were important to my recovery. After a year, my minister and the BHP staff asked if I would help others with SUDs, so I started a Spiritual Recovery Support group for other BHP clients. We meet weekly to work on issues important to our ongoing recovery.

What unique challenges to community living are faced by SUD clients?

Housing. Individuals in the Money Follows the Person program who have SUDs may face additional challenges trying to relocate into the community. A past felony drug charge or being diagnosed with SUD and/or a serious mental illness can compromise eligibility for renting some housing units,

including public housing and section 8 (felony drug), or make private landlords wary. Having a physical disability, such as limited mobility, can also compound these housing challenges. Providing additional support, such as having a CAT therapist or care coordinator work together with the client and the housing relocation agency or individual landlords, can be helpful in overcoming these challenges.

Relapse. It is well-known and accepted that relapse is a common feature of recovery from SUD and should not be a basis for discontinuation of treatment or other sanctions, such as loss of housing. Research has shown that relapse rates are similar for drug addiction and other chronic illnesses, such as diabetes, hypertension and asthma (NIDA, 2008). Recovery is an ongoing process and current evidence demonstrates the success of treatment and supportive services (SAMHSA, 2014).

Harm Reduction vs Abstinence. It is also increasingly accepted that complete and lifelong abstinence from substances is not the only model for treatment, and that harm reduction may be an appropriate strategy if the client is not ready to commit to abstinence but willing to reduce their use or minimize the consequences (Marlatt et al., 2012; Harm Reduction Coalition, nd). The treatment approach should be flexible enough to be tailored to individual needs.

What about MCO clients with SUDs who remain in NFs? It is sometimes assumed that NF patients are abstinent from substances while in the facility. However, some do use alcohol, even to the point of binge drinking, for example while out on a recreational pass. Some NF have also been known to hold happy hours and smoke breaks (Joseph, 1995; Klein & Jess, 2003). NFs should be alert to the possibility that patients may have a history of SUD, which is not always indicated in admission data, and may need to do additional assessment to see whether visits with a psychiatrist or SUD counselor are warranted. Other strategies that have been reported in NFs include providing peer support (older volunteers from the community who have achieved stable sobriety) and facilitating alcohol education groups (Joseph, 1995). Clients may also develop dependence on prescription medications, particularly opiate painkillers, antidepressants, antipsychotics and anxiolytics/sedative-hypnotics, which are prescribed frequently (and sometimes inappropriately) in NFs (Stevenson et al., 2010; Joseph, 1995), and medications should be routinely reviewed and reduced as much as possible.

Recommendations

- Comprehensive psychosocial assessment of NF patients at the time of community transition and periodically while in the community. The assessment should include questions about previous and current substance use, as well as related health issues.
- For non-dependent drinkers, brief intervention following the SBIRT model (SAMHSA, nd; ATTC, 2014) may be useful. SBIRT, which is generally carried out in hospitals and health care facilities, includes screening, feedback on personal risk, advice on changing drinking behavior, self-help information and, if needed, referral to formal treatment. This could be done in the NF by staff or MCO care coordinators with some training in SBIRT. Client screening may be also repeated after the client has been in the community for a while to identify missed or new substance use behaviors.
- Good discharge planning to coordinate medications and services and ensure referral to appropriate SUD services.
- Good liaison with community agencies and warm hand-off of client once they move out of the NF.
- Referral to appropriate SUD treatment (outpatient, inpatient, detox and/or self-help groups), and facilitation of access (help with transportation). Ongoing follow-up with client to ensure they have successfully accessed these services.
- Utilization of peer support/recovery coaching as follow-up care (CSAT, 2009). The Texas Department of State Health Services funds 22 peer recovery support programs throughout the state, which use peer coaches to assist individuals in accessing SUD treatment and/or provide recovery support for up to a year after treatment. Peer counseling could also be adapted to support individuals while they are in NFs (Joseph, 1995).
- A single and consistent point of contact for the client, so that clients can develop good rapport and trust as well as knowing where to turn in case of an urgent issue.
- Possible use of telehealth (interactive audio-video, e.g. via Skype) or telephone (interactive audio) sessions for individuals in rural areas where few services are available or for those with mobility impairments or lack of transportation options (McKay et al., 2005). Such contacts are also useful for regular check-ins in between home or office visits.
- BHP staff emphasize that the bottom-line key to participant success is having the staff “really care about the clients.”

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Appendix B

Dissemination of Evaluation Findings

B.1 Poster presented at the Society for Social Work Research Conference, January 2015

Return to Community: Supporting Individuals As They Recover Their Lives Through the Money Follows the Person Program. Thomas M. Bohman, Lynn Wallisch, James Bradley, Dena Stoner. Presented at the 2015 Annual Conference of the Society for Social Work and Research, New Orleans, LA, January 14-18, 2015.

	<p>Return to Community: Supporting Individuals As They Recover Their Lives through the Money Follows the Person Program Thomas M. Bohman PhD, Lynn Wallisch, PhD, James Bradley, MSW Center for Social Work Research, The University of Texas at Austin School of Social Work Dena Stoner -- Texas Department of State Health Services</p>	 
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Money Follows the Person	Sample	Methods
<p>Money Follows the Person (MFP) is a federally-funded national demonstration program that helps Medicaid enrollees transition from institutional to community-based care. In 2008, Texas initiated a Behavioral Health Pilot (BHP) project to investigate whether individuals eligible for MFP who had mental health and/or substance abuse problems could successfully live in the community if offered appropriate targeted supports.</p> <p>Questions addressed in this presentation are:</p> <ul style="list-style-type: none"> • Do Pilot services improve functioning and quality of life? • Are improvements sustained over time? • What percentage of BHP participants eventually return to a nursing facility (NF)? • What factors predict the probability of return to NF? 	<p>Participants included individuals from two large Texas urban areas who have resided in a nursing facility for a minimum of three months, have expressed a desire to live independently and have a diagnosed mental health or substance abuse disorder.</p> <p style="margin-top: 20px;">Video was placed here</p>	<ul style="list-style-type: none"> • Participants were offered up to six months of services prior to community move-out and one year of services in the community. • BHP services included weekly visits by a case manager/therapist who offered specialized Cognitive Adaptation Training (CAT), a psychosocial treatment assisting participants with activities of daily living, and substance abuse treatment. • Participants also receive ongoing home and community-based services (HCBS) through their Medicaid HMO.

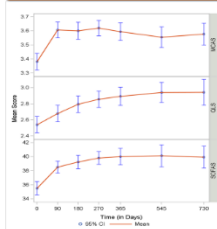
Poster presented at the Society for Social Work and Research 18th Annual Conference, New Orleans, LA, January 14-20, 2013. The Behavioral Health Pilot is supported by a grant from the Centers for Medicare and Medicaid Services through the Texas Department of State Health Services.



Methods

- Quarterly quantitative assessments of participants' functioning and quality of life using the Multnomah Community Ability Scale (MCAS) [Barker et al., 1994], the Social and Occupational Functioning Scale (SOFAS) [part of DSM-IV] and the Quality of Life Scale (QLS) [Heinrichs, Hanlon & Carpenter, 1984] during intervention and 6- and 12-months after intervention ended.
- Hierarchical Linear models tested for change across time in 270 participants' functional status and quality of life.
- Medicaid data was obtained to determine whether 256 participants returned to nursing home.
- Logistic regression used to identify predictors of return to nursing facility.

Participant Assessment Results



Participants' functional scores increased from baseline to 90 days with no change across time including one year post-intervention follow-up.

Quality of Life scores showed a similar pattern with additional change from 90 days to 180 days and more assessment timepoints.

Return to Nursing Facility Results

- 70% of participants remained in the community for up to 5 years to date: median tenure is 24 months; longest tenure is 65 months; and total community time is 314 group years. Over 50% of those who returned to nursing facility (n=63) were in community for 24 months or longer.
- Rate of in-patient hospitalization was the only reliable predictor of return to nursing facility. Participants experiencing 1 episode of in-patient care every six months (39% risk) were 1.93 times more likely to return compared with those experiencing 0 inpatient stays during six month periods (21% risk).

Video was placed here

Conclusions

- The high percentage of BHP participants remaining in the community up to 5 years shows that as individuals age and may need nursing facility care, they can successfully recover their lives in the community even if they have behavioral health problems in addition to physical health problems.
- If hospitalization can be prevented through enhanced ambulatory care, rates and length of community tenure could be even higher.
- After initial relocation expenses, the Pilot annually saves Medicaid money since community care costs about 40% less than nursing facility care.
- Long term services such as mental health rehabilitative services are now under capitated managed care organizations (MCO) and providing technical assistance to MCOs may help reduce their costs and improve client outcomes.

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Poster presented at the Society for Social Work and Research 18th Annual Conference, New Orleans, LA, January 14-20, 2013. The Behavioral Health Pilot is supported by a grant from the Centers for Medicare and Medicaid Services through the Texas Department of State Health Services.

B.2 Poster presented at the CHPR-St. David's Center for Health Promotion and Disease Prevention Research in Underserved Populations Conference, Austin, TX, April 1, 2015

Return to Community: Supporting Individuals As They Recover Their Lives Through the Money Follows the Person Program. Thomas M. Bohman, Lynn Wallisch, James Bradley, Dena Stoner. Presented at the CHPR-St. David's Annual Conference 'Preventing Chronic Disease Across the Lifespan', Austin, TX, April 1, 2015



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Center for Social Work Research, The University of Texas at Austin School of Social Work
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THE UNIVERSITY OF TEXAS AT AUSTIN
SCHOOL OF SOCIAL WORK

Money Follows the Person

Money Follows the Person (MFP) is a federally-funded national demonstration program that helps Medicaid enrollees transition from institutional to community-based care. In 2008, Texas initiated a Behavioral Health Pilot (BHP) project to investigate whether individuals eligible for MFP who had mental health and/or substance misuse problems could successfully live in the community if offered appropriate targeted supports.

- Questions addressed in this presentation are:
- Do participants show improved functioning and quality of life?
 - Are improvements sustained over time?
 - What percentage of BHP participants eventually return to a nursing facility (NF)?
 - What factors predict the probability of return to NF?

Sample

Participants included individuals from two large Texas urban areas who resided in a nursing facility for a minimum of three months, expressed a desire to live independently and were diagnosed with a mental health or substance misuse disorder.

Intervention Services

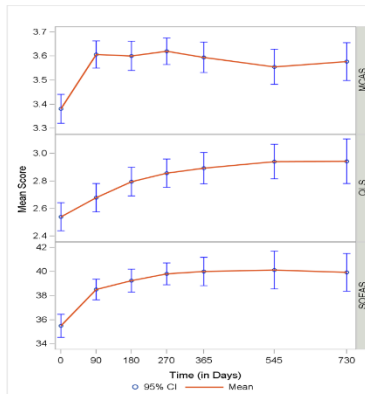
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- Participants also receive ongoing home and community-based services (HCBS) through their Medicaid HMO.

Methods

- Quarterly quantitative assessments of participants' functioning and quality of life using the Multnomah Community Ability Scale (MCAS) [Barker et al., 1994], the Social and Occupational Functioning Scale (SOFAS) [part of DSM-IV] and the Quality of Life Scale [QLS] [Heinrichs, Hanlon & Carpenter, 1984] during intervention and 6- and 12-months after intervention ended.
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- Logistic regression used to identify predictors of return to nursing facility.

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- Participants' functional scores increased from baseline to 90 days with no further change across time including one year post-intervention follow-up.
- Quality of Life scores showed a similar pattern with additional change from 90 days to 180 days.



Return to Nursing Facility Results

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- Long term services such as mental health rehabilitative services are now under capitated managed care organizations (MCO) and providing technical assistance to MCOs may help reduce their costs and improve client outcomes.

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Poster presented at the 2015 St. David's CHPR Annual Conference Preventing Chronic Disease Across the Lifespan, Austin, TX, April 1, 2015. The Behavioral Health Pilot is supported by a grant from the Centers for Medicare and Medicaid Services through the Texas Department of State Health Services.

Appendix C

Executive Summaries from Previous Evaluation Reports

Year 1 (2012)

The Money Follows the Person Behavioral Health Pilot is a demonstration program that offers Cognitive Adaptation Training (CAT) and enhanced substance abuse services to help individuals with mental illness and/or substance abuse leave nursing facilities for independent living. The Pilot is funded by a grant from the Centers for Medicare and Medicaid Services to the Texas Health and Human Services Commission/DADS, and is administered by the Department of State Health Services. The University of Texas Center for Social Work Research-Addiction Research Institute (UTARI) is conducting a long-term quality improvement evaluation of the Behavioral Health Pilot. In this first year of evaluation, interviews were conducted with 28 current and completed Pilot participants and 19 key informants to understand the program from diverse points of view. Findings and recommendations from these interviews are summarized below.

Success of the Pilot. A wide variety of outcomes may be considered to represent success, from being able to leave the nursing facility for any period of time to remaining in the community, functioning independently, being satisfied and enjoying a meaningful quality of life. From this viewpoint, key informants unanimously deemed the Pilot successful in that it offered each individual the chance to try to live independently, provided appropriate supports to do so, and moved each person forward from where they started. In turn, most of the participants interviewed seemed satisfied with program services and were in relatively stable living situations. Factors associated with the most successful outcomes included motivation, realistic expectations, prior independent living, controlled behavioral and physical health problems, cognitive capacity, social support, and the availability of community resources. While some of these factors represent personal characteristics, even they can be fostered and enhanced through program interventions. Significant barriers to success included dementia, advanced age, and complex or medically unmanaged health problems.

Most Effective Pilot Components. Participants and program staff suggested that the most effective services included advocacy, life skills training, emotional support, connection to community resources, substance abuse services (if needed) and the flexibility to be able to address individual needs as they arose. Many participants noted the high quality of their relationship with their CAT therapist – in particular, feeling respected, heard, and appreciated.

Which Services Can Be Improved? Recommendations included hiring staff to fill the hands-on case management-type functions that fell between HMO care coordination activities and more specialized CAT therapy (e.g. accompanying participants to obtain documents or visit housing options, or helping procure services and medical equipment); including an employment specialist on the services team; matching the amount and intensity of CAT services to participant need; more flexibility and funding for moving between the nursing facility, assisted living and independent living; improved relocation assistance; mental health

peer support; more effort to engage participants in social activities; and better integration of behavioral and physical health care.

Interaction Among Project Partners. Project partners reported good communication and interaction, and generally felt that their functions were complementary. The key informants suggested the need to strengthen informal relationships among themselves, closer interaction with the housing relocators, more face-to-face clinical discussions of clients between CAT and substance abuse therapists, having a Medicare liaison for dual-eligible clients, and creating an annual opportunity for all partners and the State to meet in person to dialogue and exchange ideas.

Integrating Pilot Services into Medicaid Long-Term Managed Care. Recommendations included tighter participation criteria (ensuring that participants are able and willing to engage with the services); more streamlined administrative and reporting requirements; manualization of the intervention; infrastructure for training and dissemination; wider housing options; and demonstration of budget savings or neutrality.

Year 2 (2013)

The Money Follows the Person Behavioral Health Pilot is a demonstration program that offers Cognitive Adaptation Training (CAT) and enhanced substance abuse services to help individuals with mental illness and/or substance abuse leave nursing facilities for independent living. The Pilot is funded by a grant from the Centers for Medicare and Medicaid Services to the Texas Health and Human Services Commission/ DADS, and is administered by the Department of State Health Services. The University of Texas Center for Social Work Research-Addiction Research Institute (UTARI) is conducting a long-term quality improvement evaluation of the Behavioral Health Pilot (Pilot). The evaluation is intended to answer the broad questions: How does the Pilot help participants in nursing facilities successfully transition to the community? How can the Pilot be improved and sustained? How can Pilot services ultimately be integrated into the Medicaid managed care system of long-term services and supports?

In this second year of evaluation, interviews were conducted with 23 current and completed Pilot participants and 10 collaterals (family members, CAT therapists, HMO providers), as well as with six Community Transition Teams and their members, to understand the program from diverse points of view.

Findings suggest that the Pilot could provide services more effectively and cost-effectively by better targeting appropriate participants, services, and length of service. Specific recommendations include:

- Further refine the admissions screening process and ensure that HMOs and other referral sources follow the recommended criteria.
- Further clarify which case management services should be offered by CAT and substance abuse therapists and which should be offered by partner agencies.
- Define and institute a more flexible approach to length and intensity of service.

- Consider including a “step up” or “step down” housing option. Extend housing options to include group homes, where appropriate.
- Evaluate the cost of transitioning inappropriate participants to the community who later return to a nursing facility, to determine whether it would be more efficient to exclude candidates up front who have a very low likelihood of success.

Overall, the Pilot interventions had a positive impact on participants’ lives. Participants showed increased functional status and quality of life across time, although quantitative measures showed some decrease toward the end of the intervention. Follow-up research with completed participants would be helpful to show whether this downward trend continues or whether participants stabilize or even improve after the end of the year-long intervention.

Finally, needs for training and education to enhance the process of community transition were identified for CTT members, family, HMOs, home health providers and the community. Information could be provided through in-person presentations, webinars, online modules, and the video project currently being conducted by UTARI. Furthermore, conference presentations and journal articles are proposed to extend knowledge about the Pilot to the broader community of researchers and policy-makers.

Year 3 (2014)

The Money Follows the Person Behavioral Health Pilot (BHP) is a demonstration program that offers Cognitive Adaptation Training (CAT) and enhanced substance abuse services to help individuals with mental illness and/or substance abuse leave nursing facilities for independent living. The Pilot is funded by a grant from the Centers for Medicare and Medicaid Services to the Texas Health and Human Services Commission/ DADS, and is administered by the Department of State Health Services. The University of Texas Center for Social Work Research-Addiction Research Institute (UTARI) is conducting a long-term quality improvement evaluation of the Behavioral Health Pilot (Pilot). The evaluation is intended to answer the broad questions: How does the Pilot help participants in nursing facilities successfully transition to the community? How can the Pilot be improved and sustained? How can Pilot services ultimately be integrated into the Medicaid managed care system of long-term services and supports?

In this third year of evaluation, UTARI conducted interviews with completed Pilot participants who were still living in the community and participants who had returned to a nursing facility after moving to the community under BHP. We also carried out data analyses of participant characteristics, functioning, quality of life, length of community residence and factors associated with successful community tenure. UTARI also produced a video that highlighted the challenges and successes of several of the BHP participants.

Findings from both the interviews and the data analyses demonstrate that the Pilot has a positive impact on participants' lives and enables most to remain successfully in the community. Overall, 72% of those who completed the BHP are still resident in the community. Participants showed increased functional status and quality of life across time, and gains achieved during the intervention persist for at least a year after the end of services. The most important factor associated with community tenure appears to be stability of physical health and timely receipt of health services, including home health care and outpatient visits.

Specific recommendations from the findings include:

- Continue participant contact with CAT therapists on an occasional or per need basis for at least a year after participants have completed the intervention.
- Incorporate tele-health interventions (care management, information and support) into the Pilot, as an adjunct to in-person services and particularly after services are over.
- Continue assessing completed participants' functioning and quality of life to see how long gains achieved during the intervention persist.
- Further investigate why a higher proportion of African American participants, as compared to whites and Hispanics, never leave the nursing facility after receiving pre-transition services from BHP.
- Continue conducting analyses of Medicaid and other data (e.g. MDS) to better understand factors associated with successful community tenure or need to return to a nursing facility.
- Conduct a study of the readiness and information needs of MCOs and community agencies to provide best practices in behavioral health services.
- Focus on wide dissemination of evaluation findings, including policy briefs, conference presentations, and targeted trainings.