2010 Allegheny County Community Treatment Teams Annual Outcomes Overview

Introduction

Community Treatment Teams (CTTs) in Allegheny County play a critical role in the behavioral health service system. They work with individuals with very complex needs that require a combination of unique supports to help keep them in the community. CTTs continue to be instrumental in providing intensive services to people discharged from Mayview State Hospital as part of its closure. Allegheny County CTTs follow the evidence-based practice model of Assertive Community Treatment (ACT).

CTTs receive oversight and support from the Allegheny County Office of Behavioral Health (OBH), Community Care Behavioral Health, and Allegheny HealthChoices, Inc. (AHCI). This includes regular monitoring and quality improvement activities as well as training and technical assistance to support the hard work of the CTTs and to assure that people are receiving services that follow the ACT model. In following the ACT model, teams are expected to meet key outcomes.

CTTs report outcomes data using a web-based application maintained by AHCI. This annual overview is intended to provide a summary of the year's trends in enrollment, and community integration and community tenure outcomes. AHCI also produces detailed quarterly reports to assist team leaders and supervisors with team management. These reports are also used by OBH, Community Care, and AHCI to monitor CTT performance. This report summarizes data from 2010, and provides some comparisons to 2009.

2010 Training and Technical Assistance Projects

Between November 2009 and July 2010, staff from AHCI, OBH, and Community Care conducted fidelity assessments to the ACT model with all nine teams. These assessments measure how well teams are following the ACT model. Teams develop individual plans to address unique areas of improvement and general themes are used to identify common technical assistance needs across teams.

The findings indicated CTTs are generally following the ACT model in the operations and structure, core team, and core practices areas. Some teams need to improve the frequency and intensity of services. Across teams, the provision of individualized, skill-based rehabilitation services can also be improved. Another common theme is the need to improve the provision of other evidence-based services within ACT, including integrated dual diagnosis treatment, supported employment, and wellness management services. Lastly, teams generally can improve their person-centered planning processes.

As a result of these and prior assessments, 2010 technical assistance projects focused on integrating the supported employment (SE) evidence-based practice with CTTs. Intensive training and technical assistance on incorporating the integrated dual disorders treatment (IDDT) evidence-based practice also began, and final plans were developed for training and technical assistance for team leader and team staff in person-centered planning.

Enrollment and Service Provision

2010 CTT Enrollment

- 764 people received CTT services during 2010, an increase of 11% from 2009.
- Nine teams were operating in 2010. Six teams were operating at or near capacity (approximately 100 people); the three newest teams are not yet at capacity.
- 60 people (8%) were discharged from CTT services; many discharges are voluntary as people move to less intensive services.
- On the eight adult CTTs, the most common primary diagnosis was schizophrenia (an average of 74% across teams).
- The WPIC Transition Team, primarily working with individuals 16-25 years old, had a mix of people with schizophrenia, bipolar disorder, major depression, and conduct disorder diagnoses.

Service Provision

- CTTs varied in their frequency of contact, from an average of 2 contacts per week to nearly 4 contacts per week.* The ACT model indicates CTTs should provide an average of 3 face-to-face contacts per week.
- CTTs also varied in the average number of hours of service per consumer per week, from 2.4 to over 5 hours per week.* The ACT model indicates CTTs should provide an average of 2 hours of face-to-face services per week.
- From 2009 to 2010, the same four teams met the contact frequency expectations using claims data. All teams met or exceeded the expected average number of hours of service per week using claims data.

** These calculations are based on claims data, which do not permit analysis of face-to-face vs. collateral vs. telephone contact. Fidelity assessments review the nature and frequency of contacts in detail using medical record reviews.*

Community Integration Outcomes

Table 1 includes outcomes for housing, natural supports, employment, and education.

Housing. At the end of 2010, teams averaged 33% of consumers living independently. Of the six established teams, only one team had a sizeable improvement from 2009 to 2010 in the proportion of people living independently (this team increased from 36% to 45% of people living independently). The two teams with a very high proportion of people discharged from Mayview State Hospital have the highest proportion of people living in congregate living arrangements.

Supports. A large proportion of people have some involvement with friends and family, and a much smaller proportion are involved in peer, recreational, or self-help activities outside of CTT. Teams with an older population who have state hospital histories have a higher proportion of people with no supports outside of CTT. These patterns are consistent with 2009.

Table 1. Community Integration Outcomes for People on CTTs, 2010

		Team Average	Team Range
Housing	% living independently	33%	13% - 45%
	% living with family	11%	1% - 21%
	% in semi-independent housing	12%	4% - 18%
	% in personal care homes	16%	2% - 32%
	% in community residential rehab housing	10%	1% - 20%
	% in long term structured residences	5%	1% - 7%
	% institutional (hospital or jail setting)	7%	1% - 14%
Supports	Friends/family	79%	60% - 90%
	Peer activities	18%	3% - 36%
	Recreational	8%	0% - 25%
	Self-help	7%	0% - 22%
	No supports outside CTT	15%	1% - 30%
Employment	Competitive employment	5%	0% - 10%
	Looking for competitive work	11%	1% - 19%
	Transition/shelter/ volunteer	4%	0% - 13%
Education: Secondary or post-secondary		6%	0% - 20%

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Community Integration Outcomes (continued)

Employment. Teams are at varying stages of implementing the SE model. Three teams have about 10% of consumers working competitively; there has been incremental improvement in competitive employment outcomes during 2010. All teams have few individuals working in sheltered environments or volunteering, potentially indicating an increased focus on finding competitive work.

Education. The WPIC Transition Team has the largest proportion of people pursuing education, as they work with a younger population. This team had an increase in the proportion of people involved in secondary education, from 3% at the end of 2009 to 10% at the end of 2010.

Community Tenure Outcomes

Table 2 includes outcomes for hospitalizations, jail, and hospital diversion programs.

Community, inpatient extended acute, and RTF-A. A very small percent of people on CTTs used these services in 2010. Many are new referrals, where CTTs begin working with people while they are in these facilities. This pattern is similar to 2009.

Psychiatric hospitalizations. The number of inpatient days used by CTT consumers, particularly those on established teams, continues to be of concern. While as many as 75% of consumers on a team did not have any hospital days during 2010, CTTs reported over 13,000 hospital days this year. After adjusting for the increased number of people using CTT services, the average hospital days in 2010 were the same as in 2009.

Respite and crisis bed usage. Consumers may benefit from formal or informal respite programs to help divert hospitalizations; 19% of people used these options during 2010, an increase over the 13% reported in 2009. This can be considered positive, as it suggests teams are assisting people in finding alternatives to hospitalizations.

Jail. Incarcerations continue to be a concern. While as many as 95% of consumers on a team were not in jail at any point during 2010, CTTs reported over 10,000 jail days this year. After adjusting for the increased number of people using CTT services, the average jail days in 2010 were very similar to 2009.

Table 2. Community Tenure Outcomes for People on CTT, 2010

	% of CTT consumers per team	Team range
Community extended acute	2%	0% - 9%
Inpatient extended acute	7%	1% - 21%
Residential treatment facility for adults (RTF-A)	4%	0% - 9%
Respite/crisis bed	19%	14% - 32%
Psychiatric hospitalization	33%	25% - 50%
Jail	11%	5% - 22%
Medical hospitalizations	22%	13% - 34%
Drug and alcohol detoxification	1%	0% - 4%
Drug and alcohol rehabilitation	3%	0% - 6%

Medical hospitalizations. A significant proportion of people have medical hospitalizations, indicating the continued importance of CTTs coordinating physical health needs in addition to behavioral health needs. The number of stays in 2010 was similar to 2009 after adjusting for the increased number of people who used CTT in 2010.

Drug and alcohol detoxification and rehabilitation services. Very few people on CTTs used these services. CTTs should be providing the great majority of substance abuse treatment services, so low utilization of these other services is not necessarily a negative outcome. This is consistent with 2009.

Summary and 2011 Plans

While CTTs continue to achieve many successes in supporting individuals with serious mental illness in the community, services can continually be improved through achieving greater fidelity to the ACT model. As seen in prior years, outcomes vary from team to team.

Teams vary in community integration and community tenure outcomes for several reasons. Differences in team populations account for some variation; for example, we may expect differences in certain outcomes for transition age youth compared to older populations with state hospital histories. Differences in how long the teams have been working with people also account for some differences. For example, teams with many people new to CTT may have higher inpatient utilization, as people are referred while in the hospital or still have readmissions until they are engaged in services. Variation in outcomes is also due to performance and model adherence issues. Overall, trends observed in 2010 were consistent with 2009.

This annual overview highlighted several areas to continue targeting for improvement in 2011:

- Decreasing inpatient utilization and jail days
- Increasing competitive employment
- Increasing housing independence
- Increasing natural supports.

Two key aspects of improving outcomes are improving supervision in implementing the ACT model and integrating the evidence-based practices of integrated dual disorders treatment and supported employment.

Technical assistance for integrating these practices will continue in 2011. Treatment planning workshops will also be required for all CTTs. These efforts, combined with team-specific quality improvement activities, are expected to build on current successes and increase both community integration and community tenure for the people the CTTs serve.

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AHCI's mission is to is to assure equitable access to quality, cost-effective behavioral health care that promotes positive clinical outcomes, recovery, and resiliency.

AHCI is a contract agency of the Allegheny County Department of Human Services' Office of Behavioral Health.