



A program of the Institute on Disability/UCED, University of New Hampshire

I-START: Data Summary

November 1, 2015- February 29, 2016

Referral Trends

Data below reflect all individuals accepted into I-START between November 1, 2015 and February 29, 2016. Caseloads will change over time as new individuals are referred and some are inactivated due to stability, moving out of the region or no longer requesting services.

Date of Referral: Date individual referred for START services; Coordinators begin tracking data related to an individual in SIRS.

Table 1: Current Caseload

Date of First Referral	August 12, 2015
Number at Start of Reporting Period	11
Accepted During Reporting Period*	20
Inactivated During Reporting Period	0
Total Served in Report Period	31
Current Caseload	31

Table 2: Caseload Size

Caseload Distribution	Number
Current number of START Coordinator FTE's	3
Active Cases	31
Average Active Caseload/FTE	10*

*Caseload size is slightly lower, since the Program Director and Clinical Director both maintain several active cases at this time and 2 of the START Coordinators also carry a targeted case management case load.

Table 3: New Referrals by Month (Report Period)

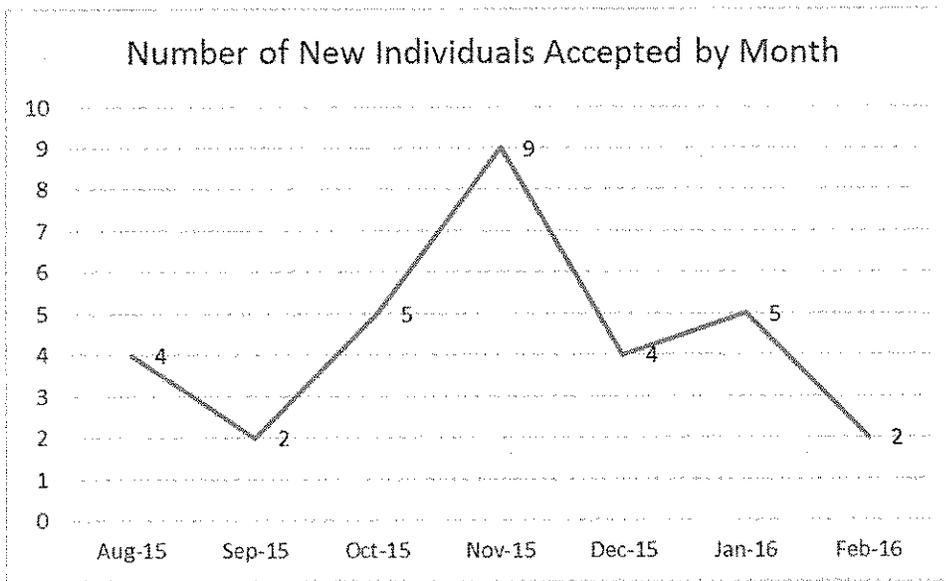
Month	Number
November 2015	9
December 2015	4
January 2016	5
February 2016	2
Total for Report Period	20



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Figure 1: Referral Trends

As we move forward we hope that referrals increase. We are hopeful each START Coordinator will have a caseload close to 30.



Referral Source

The following table shows the referral sources to I-START during this reporting period and for the program overall. The majority of referrals to date have come from case managers/care coordinators. As programs mature, sources of referral often become more diverse.

Table 4: Source of New Referrals

Referral Source	Reporting Period		Program Overall	
	Number	Percent	Number	Percent
Case Manager/Service Coordinator	14	70.00%	24	77.42%
Legal advocate	1	5.00%	1	3.23%
Other-DHS Worker	1	5.00%	1	3.23%
Residential provider - community	3	15.00%	3	9.68%
State operated I/DD center	1	5.00%	2	6.45%
Total Referrals	20	100.00%	31	100.00%



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Table 5: Current Caseload by County

County	8/2015-10/2015-	11/2015-2/2016-	Total by County
Allamakee	1	1	2
Black Hawk	3	9	12
Butler		1	1
Cerro Gordo	1	2	3
Chickasaw	2		2
Clayton	1	1	2
Fayette		1	1
Polk	1		1
Webster	1	4	5
Winneshiek		1	1
Wright	1		1
Total Accepted	11	20	31



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Characteristics of Persons Served

The following data points reflect the total number of individuals served at any point during the report period (N=31).

Age

The figure below shows the number and percent of individuals accepted into I-START in each age range, while Table 6 describes the population based on their current age.

Figure 2: Age at Enrollment

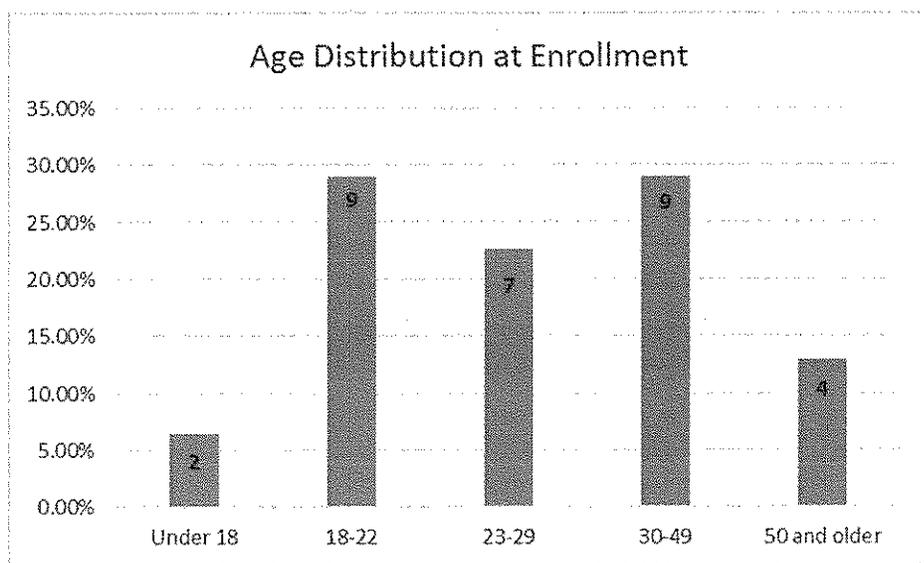


Table 6: Measures of Central Tendency (Current Age)

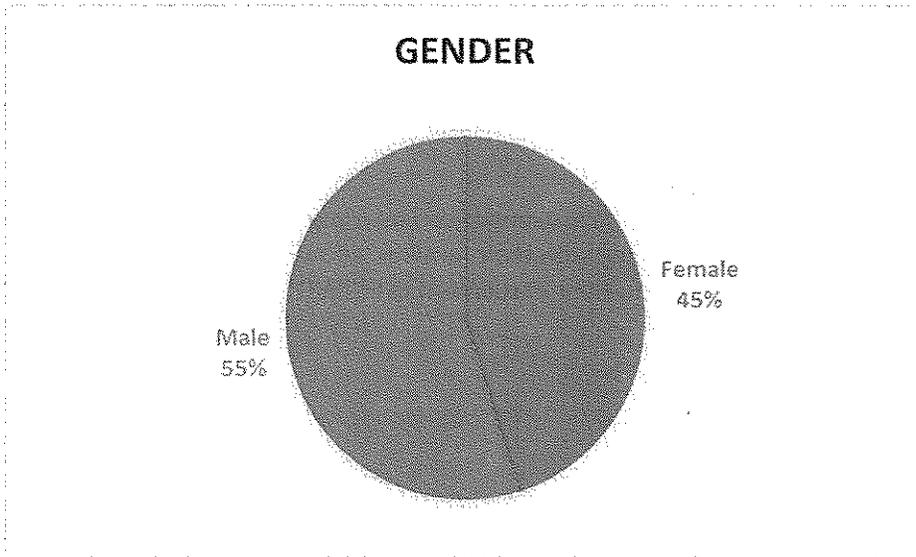
Oldest Age	56
Youngest Age	14
Mean Age	32
Median Age	28
Mode Age	18

Gender

The gender breakdown for I-START is consistent with most START programs nationally.

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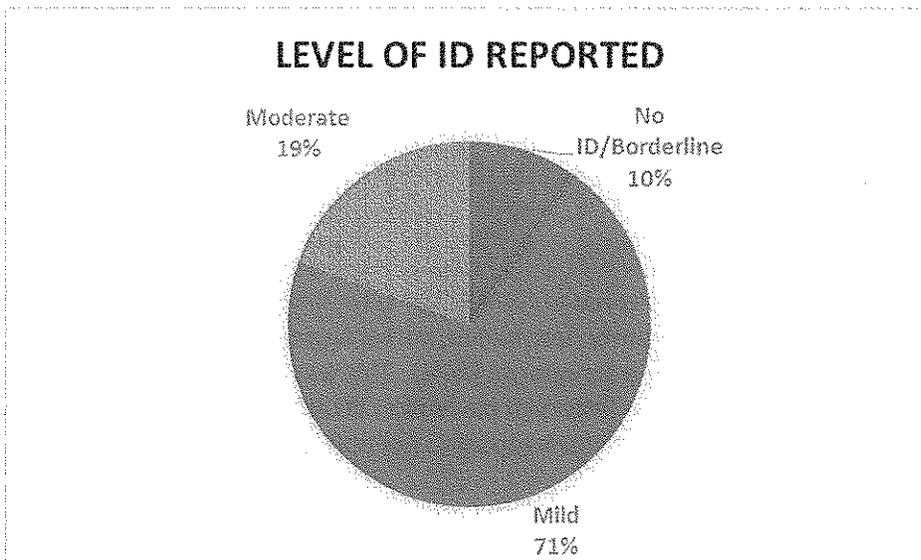
Figure 3: Gender



Level of Intellectual Disability

The majority of individuals served by I-START have a mild or moderate intellectual disability.

Figure 4: Level of ID





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Living Situation

The table below shows the living situation reported for individuals served by I-START. The majority of individuals enrolled in I-START live in paid residential settings. Currently less than 13% live with their families. This is significantly lower than national START trends in which approximately 43% of individuals supported live with their families, as Iowa historically has served more individuals than the national average as well.

In many instances, individuals supported by I-START have experienced multiple placement changes prior to their enrollment in START. For individuals not living with their families, about 60% have experienced multiple placement changes in the five years prior to their enrollment in I-START.

Table 7: Living Situation

Living Situation	Number	Percent
Community ICF/MR	1	3.23%
Family home	4	12.90%
Group home	4	12.90%
Homeless, sheltered	1	3.23%
Independent living	3	9.68%
Jail	1	3.23%
Psychiatric hospital	3	9.68%
State operated I/DD center	1	3.23%
Supervised apartment	2	6.45%
Supported living	8	25.81%
Other	2	6.45%
Unreported	1	3.23%
Total	31	100.00%

Primary Reasons for Referral

Data show that the majority of individuals were referred to I-START for externalizing behavioral challenges, which include physical aggression, property destruction, verbal aggression, and self-injurious behaviors. Overall, aggression is the primary reason for referral (74%). This was followed by the risk of losing placement (65%), which is consistent with the history of placement changes reported above and mental health symptoms (52%). The majority of individuals reported multiple concerns at time of enrollment with an average of 3.9 concerns reported.



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Table 8: Reasons for Referral

Presenting Problems	Number	Percent
Aggression (physical, verbal, property destruction, threats)	23	74.19%
At risk of losing placement	20	64.52%
Decrease in ability to participate in daily functions	6	19.35%
Diagnosis and treatment plan assistance	7	22.58%
Family needs assistance	10	32.26%
Leaving unexpectedly	5	16.13%
Mental health symptoms	16	51.61%
Other	6	19.35%
Self-injurious	7	22.58%
Sexualized behavior	6	19.35%
Suicidal ideation/behavior	7	22.58%
Transition from hospital	8	25.81%
Average # Reported	3.9	
Total Individuals	31	

Mental Health Conditions Reported

It is critical to understand each service recipients’ presentation in the context of their biological, psychological, and social strengths and concerns. In order to provide intervention and supports, we must know how these factors impact the person and his/her functioning, and specifically how they may contribute to or help prevent crisis and instability. An accurate understanding of both mental health and medical conditions is imperative in designing effective crisis prevention and intervention services. The number of individuals with a reported mental health condition in I-START is 84% which is slightly higher than other START programs nationally (76%).

Table 9: Reported Mental Health Conditions

Mental Health Conditions	Number of individuals reporting a MH condition	Percent of individuals reporting a MH condition
Individuals with reported mental health conditions	26	83.87%
Total individuals reporting no mental health condition	5	16.13%
Total	31	100.00%



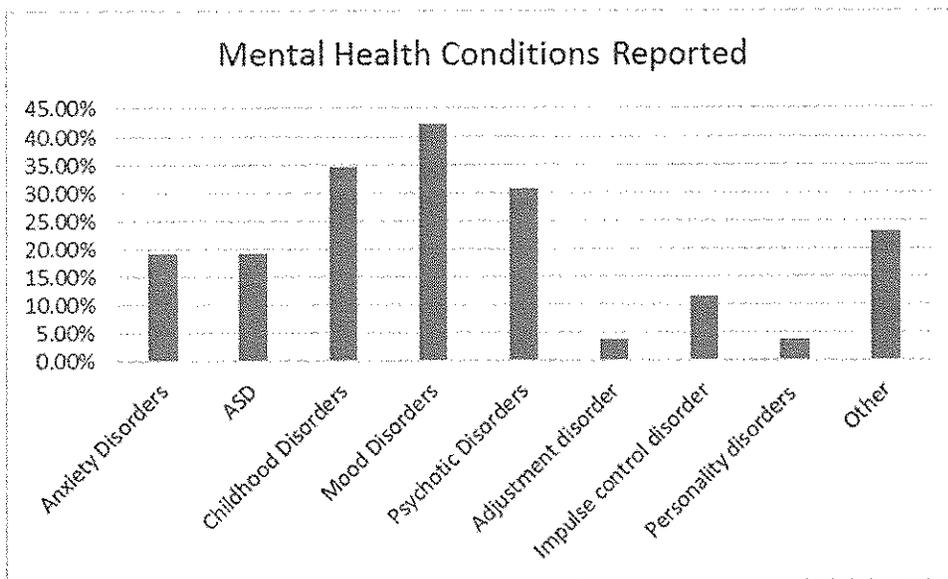
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Table 10: Number of Mental Health Conditions Reported

Number of MH Conditions Reported	Number of Individuals	Percent of individuals
Mean conditions reported	2.08	N/A
Mode conditions reported	2	N/A
1 conditions reported	7	26.92%
2 conditions reported	13	50.00%
3 conditions reported	4	15.38%
4 conditions reported	1	3.85%
5 or more conditions reported	1	3.85%
Total	26	100.00%

The graph below looks at the frequency of mental health conditions reported for individuals enrolled in I-START. While mood disorder is the most prevalent overall, there is also a high frequency of psychotic disorders and disorders diagnosed in childhood (ADHD) reported. The majority of conditions listed as other are intermittent explosive disorder and oppositional defiant disorder.

Figure 5: Frequency of Mental Health Conditions Reported





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Chronic Medical Conditions at Time of Referral

In addition to a mental health conditions, many of the people referred for I-START services present with co-occurring medical conditions. Medical conditions are important to address and research suggests that they are often under-diagnosed, underreported, or signs/symptoms of medical conditions misinterpreted as challenging behavior and/or psychiatric problems. Nationally, START programs report a medical condition in 52% of individuals accepted. For individuals referred to I-START, over 61% report a chronic medical condition at referral. In addition, 47% of these individuals report more than 1 chronic condition. This is important in a population whose average age is 32.

Table 11: Reported Chronic Medical Conditions

Chronic Medical Conditions	Number of individuals reporting a chronic medical condition.	Percent of individuals reporting a chronic medical condition.
Individuals with reported medical conditions	19	61.29%
Total individuals reporting no medical condition	12	38.71%
Total	310	100.00%

Table 12: Number of Chronic Medical Conditions Reported

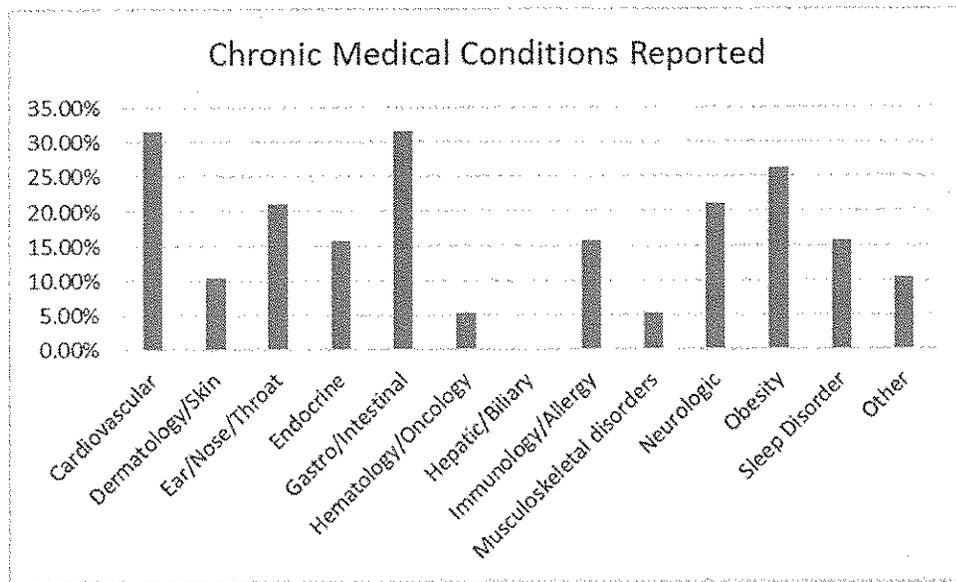
Number of Chronic Medical Conditions Reported	Number of Individuals	Percent of individuals
Mean conditions reported	2.11	N/A
Mode conditions reported	1	N/A
1 condition reported	10	52.63%
2 conditions reported	4	21.05%
3 conditions reported	3	15.79%
4 conditions reported	1	5.26%
5 or more conditions reported	1	5.26%
Total	19	100.00%

The graph below looks at the frequency of the most common chronic medical conditions for individuals enrolled in I-START. About 31% of individuals reporting a medical condition report GI problems and 31% report cardiovascular problems. Other conditions reported include obesity (26%) and diabetes or other endocrine disorders (16%), which are often associated with psychiatric medication side effects. 21% report a neurological disorder (seizure), which is common in this population.



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Figure 6: Frequency of Chronic Medical Conditions Reported



Emergency Service Trends

A number of I-START service recipients have a history of emergency service use prior to enrollment in START services. The following tables look at emergency service trends for individuals at entry into services as well as post-START. A target goal of the START program is to help avoid unnecessary emergency service use and reduce recidivism rates. Cross System Crisis Plans and team communication has helped to decrease this.

Table 13: History of Psychiatric Hospitalizations in year prior to START enrollment

Psychiatric hospitalizations during year prior to START enrollment	Number	Percent
Yes	16	51.61%
No	11	35.48%
Unreported	4	12.90%
Total	31	100.00%
Range	1 to 10	
Mean	2.87	



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Table 14: Psychiatric Hospitalizations following enrollment in START

Hospitalization Details	Program to Date
Total individuals with a psychiatric in-patient admission	9
Percent of Caseload	29.03%*
Total Number of Admissions	19
Average LOS (in days)	12.4
Number of individuals with more than 1 psychiatric in-patient admission	5
Percent of individuals with more than 1 psychiatric in-patient admission	62.5%

** Since the caseload changes, this number represents the percentage of all individuals accepted who have a hospitalization reported.*

Table 15: History of Emergency Department Visits in year prior to enrollment in START

ED Visits in year prior to enrollment	Number	Percent
Yes	18	58.06%
No	11	35.48%
Unreported	2	6.45%
Total	31	100.00%
Range	1 to 12	
Mean	4.22	



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Table 16: Emergency Department Visits following enrollment in START Services

Emergency Visits Detail	Program to Date
Total individuals with emergency department visits	6
Percent of Persons Supported	19.35%*
Total Number of Visits	11
Range of Visits	1 to 4
Number of individuals with more than 1 emergency department visit	2
Percent of individuals with more than 1 emergency department visit	33.33%

** Since the caseload changes, this number represents the percentage of all individuals accepted who have an emergency department visit reported.*

Service Trends

START services overall are incorporated into a tertiary care model to assess trends in service delivery for the quarter.

Based on a tertiary care approach to crisis intervention, START service measures are in three crisis intervention modalities: Primary (improved system capacity): clinical consultation, education, system linkage, and community training; Secondary (specialized direct services to people at risk of needing emergency services): intake and assessment activities, comprehensive service evaluations, outreach, Clinical and Medical consultation, and cross systems crisis prevention and intervention planning; and Tertiary (emergency intervention services): emergency assessments and mobile support as well as other emergency services such as hospitalizations and emergency room visits used by START recipients. The following analysis looks at utilization patterns in each of these services across both regions for the reporting period. The goal of START is to move the system from tertiary care (emergency level of crisis intervention services) to more primary intervention (able to assist when vulnerable) and secondary services (getting expert assistance without the use of emergency room or hospitalization). In particular, the goal is to build capacity across the service system in order to prevent and assist with potential problems rather than manage them as crises later.



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Primary Services:

Community Training

In addition to the services to individuals described below, the I-START program provides training and other services designed to build community capacity. The tables below show the number of community trainings provided in this reporting period as well as since program inception.

Table 17: Community Training-Region 1

Community Training	11/2015-2/2016	Program to Date
Community Education/linkage	11	13
Community-based training	3	3
Provided training to residential provider	1	1
Provided training to therapist/mental health providers	1	1
Time spent on affiliation and linkage agreements	5	5
Total Episodes of Community Training	21	23

Table 18: Linkage Agreements

County Social Services is redoing all of their contracts with providers which includes the Linkage Agreements.

Linkage/Collaboration Agreements	Number
Number Completed (Report Period)	17
Number Completed (Total)	17

Clinical Education Team: Preparing for and holding a Clinical Education Team meeting regarding the individual referred. Including reviewing and identifying relevant recommendations with START Clinical Director; and assisting system of support with implementing recommendations.

Table 19: Clinical Education Team (CET)

Clinical Education Team	Number
Number Completed (Report Period)	1
Number Completed (Total)	1



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Secondary Services:

START Planned Services

The chart below shows the percentage of time that was spent in each planned service area for the report period (11/1/2015-2/29/2016)

Clinical Education Team (CET): Preparing for and holding a Clinical Education Team meeting regarding the individual referred. Including reviewing and identifying relevant recommendations with START Clinical Director; and assisting system of support with implementing recommendations.

Clinical Consultation: START coordinators will present cases to their teams, and then share clinical consultations provided by the Clinical Director and Medical Director with community team members who support individuals, and work with the Clinical director to provide direct, on site clinical case consultations.

Comprehensive Service Evaluation (CSE): Completion of the Comprehensive Service Evaluation including receiving and reviewing records; interviewing the individual and system of support; writing the CSE; and reviewing recommendations through development of an action plan.

Crisis Follow-Up: Time spent following up after a crisis contact. This includes facilitating emergency service admissions and discharges, meetings with emergency service providers and follow-up on crisis plan recommendations.

Cross System Crisis Planning: Completion of the Cross Systems Crisis Intervention and Prevention Plan: collecting and reviewing relevant information; completing brainstorming form with team; developing/writing the plan and distributing; reviewing and revising the plan; and training on and implementing the plan with the system of support.

Intake/Assessment: Work done to determine the needs of the individual and their team, and the services to be provided. Includes: Information/record gathering; intake meeting; completion of assessment tools; and START action plan development.

Medical Consultation: This includes any consultation provided by the START Medical Director regarding medication and other medical issues, includes collaboration with prescribing doctor.

Outreach: Any time in which the START Coordinator provides education or outreach to the system of support related to general issues or those specific to the individual referred. Entities to which the START

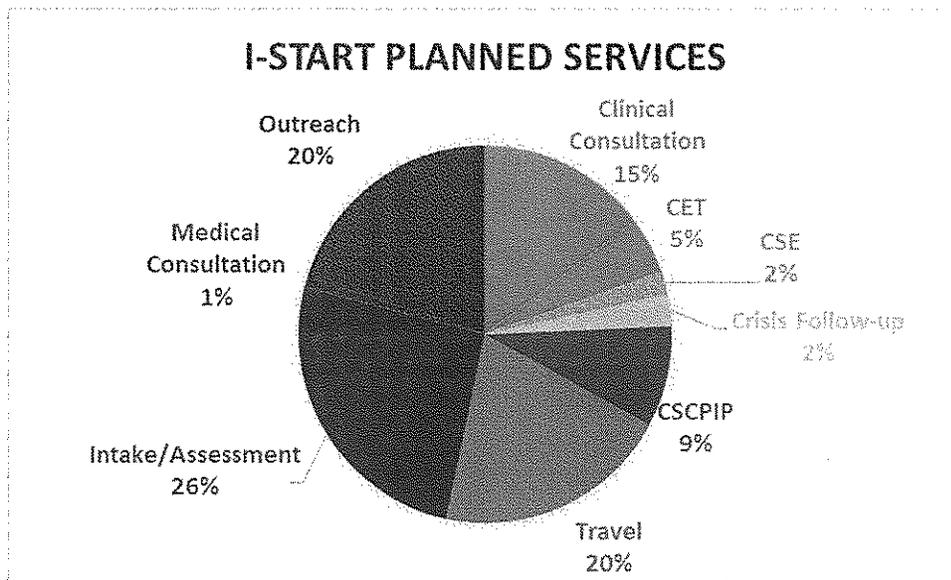


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Coordinator may provide outreach: families/natural supports, residential programs, day programs, schools, mental health facilities, or any entity that may seek or need additional support and education.

Therapeutic Supports: All of the work related to preparing for and facilitating planned Resource Center admissions.

Figure 7: I-START: Planned Services (Percentage of Time)



These planned service trends include data on services provided throughout the report period. Not all individuals who are active with I-START will receive services every month. Those cases that are of low intensity might have less than monthly contact until the time in which the case is made inactive. Even when a case is made inactive, outreach does occur occasionally. The tables below provide additional details on the number and percentage of individuals enrolled in I-START who received a particular START service during the months of November-February.

Table 20: Assessment Services (November-February)

Assessment Detail	I-START
Number of Individuals Receiving Assessment in Report Period	27
Percent of Caseload	87.10%
Range of Contacts	1 to 11
Average Contacts Per Person	4.78
Total ABC Assessments Completed	18



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Total RSQ Assessments Completed	19
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Table 21: Outreach Services (November-February)

Outreach Detail	I-START
Number of Individuals Receiving Outreach in Report Period	28
Percent of Caseload	90.32%
Range of Contacts	1-20
Average Contacts Per Person	6.75

Table 22: Cross System Crisis and Intervention Planning (November-February)

Crisis Planning Detail	I-START
Number of Individuals Receiving CSCPIP in Report Period	10
Percent of Caseload	32.26%
Range of Contacts	1 to 6
Average Contacts Per Person	2.90
Plans Completed (Total)	7

When required, individuals receiving START services also receive clinical and/or medical consultation, comprehensive service evaluations, in-home supports and crisis supports. The following tables provide detail on the number of individuals from I-START receiving these services.

Table 23: Clinical/Medical Consultation (November-February)

Clinical/Medical Consultation	I-START
Number of Individuals Receiving Consultation in Report Period	25
Percent of Caseload	80.65%
Range of Contacts	1 to 18
Average Contacts Per Person	4.72

Table 24: Comprehensive Service Evaluations

Comprehensive Service Evaluations	Number
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Number In Process	5
Number Completed (Total)	0

Tertiary Services:

Crisis Contact: An emergency call received by the START team that requires immediate triage and response, likely resulting in an emergency assessment. Assessment can be conducted in a number of settings including: family home, residential setting, day program, hospital emergency department, etc. In an emergency situation, this may be the mode in which the initial referral is received. We are still not live 24 hours and hopefully these increase as our capacity to respond increases.

Summary:

CSS I-START currently has 3 Coordinators-Felicia Bates, LeAnn Rosado, and Cassie Winters, we are hoping to fill a Coordinator position as well as a team lead. Our Clinical Director is Ashley Lutgen. Our Medical Director is Dr. Amanda Stumpf. Dr. Jesse Logue is our psychological consultant. Chalsea Carroll is our acting Director, but will be leaving the program the beginning of April. David O'Neal is our National Consultant along with Andrea Caoili.

CSS has been very supportive of the program and supports the continued growth and development of the program.

