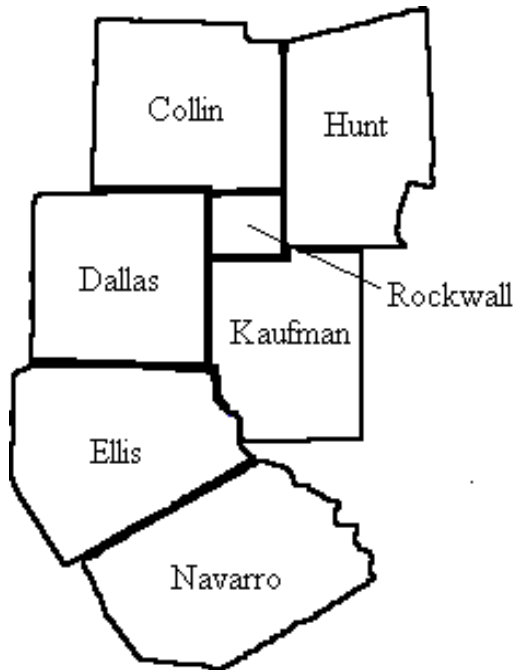


NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

...think populations...see individuals



STRATEGIC PLAN

SFY 2009 -2010

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Mission

*To Create a Well Managed, Integrated and Quality Delivery System of Behavioral Health Services
Available to Qualified Consumers in the NorthSTAR Region.*

North Texas Behavioral Health Authority

STRATEGIC PLAN

SFY 2009 – 2010

Executive Summary

The North Texas Behavioral Health Authority (NTBHA) is the Local Behavioral Health Authority (LBHA) as defined in Texas Law (Chapter 531, Section 3) for the “NorthSTAR” area which serves Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall Counties. The NorthSTAR Program is a unique public mental health/substance abuse treatment program serving indigent and Medicaid clients residing in the seven-county North Texas service area. In the NorthSTAR model, private providers work on contract to provide care. NorthSTAR is the publicly funded behavioral health delivery system in a seven-county area of North Texas. (See Appendix B SFY09 NorthSTAR Budget).

The NTBHA model separates the oversight, control, and financial management from the providers of service.

NTBHA is a governmental entity whose Board of Directors is appointed by the Commissioners’ Courts of each respective county. The distribution of Board members is based on population: Collin County has two appointments, Dallas County has four appointments, and the remaining five counties have one appointment each. In compliance with Texas State Statutes, the Local Behavioral Health Authority (NTBHA) shall, in conjunction with the Texas Department of State Health Services, Mental Health, and Substance Abuse Division, develop a strategic plan for public behavioral health services.

NTBHA conducted a *regional needs assessment* in the months of August 2007 – December 2007 to assist in the determination of service needs and gaps in services. NTBHA utilized the instrument from the previous needs assessment survey and added new questions to better understand consumer and provider needs. Consumers, family members, advocates, providers, policy makers and other stakeholders participated in the assessment. The most prevalent needs identified by consumers were housing and work assistance programs. These continue to be ongoing needs today. There is a critical

unmet need for housing for individuals with behavioral health issues. The need for work assistance serves to validate previous beliefs that the NorthSTAR population has been growing due to an increasing number of unemployed persons and a slow economy. There is also the increased risk from post-traumatic stress and other related disorders for returning veterans from Iraq and Afghanistan as well as the need for related support services for family members of returning veterans, increased drug usage among teens and older adults (60+) who are at risk for or are experiencing behavioral health problems.

Vision

The vision of the North Texas Behavioral Health Authority is a behavioral health care delivery system that provides appropriate care, in a timely manner to all individuals experiencing a mental illness and/or a substance use disorder.

The North Texas Behavioral Health Authority (NTBHA) seeks to promote a collaborative system of care for individuals with a behavioral health disorder. Partners in the collaboration process include consumers, family members, advocates, providers, county officials, local jails, schools, and other stakeholders. Collaborative Responsibility is the belief that the public health care system, which serves a community, is the responsibility of that community. Stakeholders, in cooperation with each other, develop, implement, evaluate and amend an integrated behavioral health service delivery system, which provides appropriate and timely services with significant and positive results. For the purposes of this report, *behavioral* health is defined as mental health, substance abuse and/or dual diagnosis. A public health service system built with Collaborative Responsibility is:

- Sustainable
- Supported by the community it serves
- Provides local oversight in conjunction with DSHS.

Collaborative Responsibility, in the behavioral health arena, is based upon the formation of partnerships with all stakeholders in the delivery of mental health and substance abuse services. Community partners collectively develop indicators for measuring the quality of care and for developing criteria for the prudent and responsible distribution of care. The resulting system of behavioral health care should be

designed to enhance the health of the entire community. This principle of Collaborative Responsibility provides the framework for the development of an envisioned system of care within the NorthSTAR Service Delivery Area (NorthSTAR SDA).

Principles Considered in Service Delivery and Service Design

1. All delivered services as well as service design must take into consideration the needs of the individual client and the needs of the communities.
2. All resources should be maximized.
3. Delivered services and program design must take into consideration how they directly and indirectly affect associated social service systems.
4. The cost or expense of operating existing and planned mental health programs must take into consideration all or total cost including those incurred by other or associated public service systems.
5. The local authority will be accountable to the communities.
6. The local authority will be accountable to the public it serves.
7. The local authority will be an integrated service system that maximizes the use of all available funds.
8. The system will match the levels of care to the levels of need, regardless of the individual's ability to pay.
9. The utilization of best practices to identify disease management principles when providing care.
10. The system will ensure a seamless continuity of care encompassing prevention, treatment, after-care and support services.
11. The system will utilize evidence-based practices and be outcome based.

12. The system will ensure access to recovery-based services that are responsive to the needs of the consumer.
13. The efficient use of funds and the prudent distribution of care will ensure eligible citizens receive the needed services from competent providers at a reasonable cost.
14. The local authority will be effective, fiscally efficient and sustainable over time.
15. The local authority will promote community and forensic education and anti-stigma programs designed to encourage the community to value people regardless of presenting illnesses or disabilities.
16. The local authority will provide an independent and impartial avenue (ombudsman) for consumers, family members, advocates, providers and stakeholders to seek resolution of complaints.
17. Services for all residents will include a safety net that provides emergency and crisis services.

Planning Process

NTBHA is unique in the State of Texas as a local authority in that it represents both mental health and substance abuse treatment services.

Ongoing planning is multidimensional with broad stakeholder participation. This process is continually being improved upon, as the agency adapts to changes in the regional system and legislative changes. Through previous planning efforts NTBHA is aware of systemic and organizational elements that can be improved upon. A significant part of this plan is to continue to strengthen the planning and development process to assure breadth and depth of stakeholder input. NTBHA has a solid base from which to build. This base includes the following vehicles for stakeholder input:

- Provider Advisory Council (PAC)
- Consumer Family Advisory Council (CFAC)
- North Texas Behavioral Health Authority Board – NTBHA Board – “Board”
- Commissioners Court Meetings – All Seven “CCM” Within Region

- Town Hall Meetings – A Total of Fourteen Town Hall Meetings were held in the NorthSTAR Region
- Survey/Needs Assessment - Includes NTBHA annual, issue specific (such as wait time survey), ValueOptions (VO) related (i.e. Utilization Management) and Universities (i.e. UNT School of Medicine)
- Outside Resources – Databook, VO data, other blended systems throughout the nation
- Hearing public commentary
- Analyzing complaint and call data
- Analyzing data gathered through NTBHA’s coordination of the Community Resource Coordination Groups (CRCG’s)
- Analyzing NorthSTAR data
- Participating in ValueOptions’ Quality Improvement program

Data and information for this plan was collected via a number of methodologies designed to maximize community input regarding priority services, unmet needs/service gaps, priority populations and the role of the LBHA.

Table 1 illustrates the data collection methods employed to assure ample opportunity for community input.

Table 1: Data Collection Methods for Community Input

Methodology		Consumers	Family/ Advocates	Providers	Policy Makers	Physicians	CRCG	General Public
		NorthSTAR Service Delivery Area	Advisory Councils	Yes	Yes	Yes	Yes	Yes
	Public Forums	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Surveys	Yes	Yes	Yes	Yes	Yes	Yes	Yes

*Includes all methods of input including face-to-face contacts, meetings, CRCG participation, Ombudsman complaints and grievances, etc.

The NTBHA Board fulfills a stakeholder input function as noted above, but is also the governing body for NorthSTAR and NTBHA. As such, the board is an active force in strategic planning. The plan will be reviewed by the above groups, and published for general community review. Input concerning the plan will be solicited during regular Town Hall meetings held in each County, community meetings, through direct contact with stakeholders, and through the NTBHA website. At the end of each fiscal year, several community planning sessions will be held to present overall input, and develop alternative community driven strategies if appropriate.

Review of 2006/2007 Strategic Plan

1. Long Term Solutions for Children (ages 12 and under). There are a disproportionate number of African American children represented in the child welfare system. Allegations/reports of abuse and/or neglect are made two to three times more often about African American children and families and African American children are four times more likely to be placed in care and less likely to receive in-home services. Wrap around services need to be evaluated and increased in these communities. Behavioral Expertise and Consultation will be made available to the Department of Family and Protective Services (Child Protective Services) agency and system that will help focus on solutions for our communities youth.
2. Development of a Request for Information (Proposal) for a Medical Model, Adult, Psychiatric, Emergency Evaluation and Crisis Stabilization (to include “alternative” services for 23-hour observation, etc) in counties surrounding Dallas county.
3. Enhanced mobile crisis will be implemented in SFY 2008 and will be continuously evaluated for increased outcomes.

Review of 2006/2007 Non Program Specific Activities and Goals

1. Local behavioral health functions will be continuously reviewed in an effort to improve the NorthSTAR Delivery System. The distribution of resources must be factored into this evaluation with the following recommendations:
2. Direct assistance needs to be provided to increase client enrollment in Medicaid, Medicare and Social Security to prevent decreases in Federally Matched Funds.
3. Information needs to be provided to legislative entities to increase funding for NorthSTAR.
4. Assistance needs to be provided to associated and other social services through the contribution of consultation, resource allocation, collaboration and other avenues so that the entire services provided to the public and at taxpayer expense are improved and coordinated.
5. The quality of mental health services will be evaluated with recommendations for improvements. Evaluations will be made to ensure that the recommendations are implemented.
6. Physician prescribing practices will be evaluated that will include recommendations for improved practices.
7. Utilizing existing resources, NTBHA will determine if it can provide “advisory groups” and develop and/or work with existing education groups for the various disciplines and stakeholders in the NorthSTAR delivery system.
8. There needs to be enhanced and increased utilization of the NTBHA Board Members as a resource in the strategic and political arenas.
9. There needs to be enhanced and increased activities, suggestions, recommendations and support of advocates, clients, mental health professionals and all other members of the various NorthSTAR communities in mental health.

External Assessment

Population

The NorthSTAR Service Delivery Area is comprised of Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall Counties. The region encompasses approximately 5,430 square miles, with a population of 3,543,193 based on 2007 estimates (U.S. Census Bureau).

The NorthSTAR region's population experienced a 12.1% increase in population between 2000 and 2006, 3,058,047 and 3,479,140 respectively. In several counties there were significant population increases. Collin County experienced a 42% increase in population, Ellis experienced a 22% increase in population, Kaufman experienced a 26% increase, and Rockwall saw its population increase 42%. Hunt and Navarro are the only two counties that meet the definition of a rural county. The State of Texas has experienced a 12.7% growth in the same period of time (U.S. Census Bureau).

As a result of this population change, NorthSTAR counties need to be continuously evaluated to identify unmet needs and identify NorthSTAR eligible individuals. This has been demonstrated through Town Hall Meetings, Commissioners Court Meetings and with various stakeholders (including consumers and families), satisfaction surveys in all counties. NTBHA has worked toward improving service delivery for the rural counties and has seen some success through telemedicine. NTBHA is currently working in conjunction with ValueOptions (See Appendix A) on enhancing mobile crisis outreach, creating crisis residential facilities, and establishing equitable rate structures that promote competition and enhanced service delivery.

Two sub populations with which NTBHA is equally concerned with are those with a dual Substance Abuse and Mental Illness diagnosis and children/adolescents. In the case of dual diagnosis, the NorthSTAR region must focus on integrated treatment of these disorders. Existing programs should be evaluated for improvement to expand this treatment to positively impact its consumers.

NTBHA must enhance its continuum of care for children/adolescents throughout the region with specific focus on outpatient community focused modes of care.

There is significant Hispanic population in all seven counties. There are only a few providers that are minimally bilingual. NTBHA will continue to participate and draw information from the NorthSTAR community to create a culturally competent system.

Internal Assessment

Crisis Intervention – Stabilization – Access to Services

A concerted focus needs to be made on NorthSTAR’s access to services. The overall goal is to locate emergency, psychiatric evaluation and behavioral health intervention services for adults, adolescents, and children.

Intermediate Residential Programs

Residential Programs need to be developed and implemented that provides intermediate level of care for children and adult. This includes program tracks for: Jail Diversion and Chemical Dependency De-Tox that are intensely supervised and provides both short-term and long-term program support. These programs need to consist of an employee program support and “short-term” competency restoration programs for transient and homeless support. Such facilities may include direct state funding.

Telemedicine Evaluation/Judicial Reviews

The utilization of telemedicine for the rural counties for crisis assessment and evaluation must be implemented. Additional telemedicine equipment is being distributed to all counties. Enhanced mobile crisis and transportation has improved service delivery to most counties of NorthSTAR.

340 (b) Atypical Expense

Through the implementation of the 340(b) pharmacy program, the region has realized a substantial savings in terms of atypical pharmaceutical expense. The waiting list for these medications has been eliminated.

It is the goal of NTBHA, working with ValueOptions, to reinvest the current savings to offset our region’s county jails in the cost of the purchase of this medication.

Development and Implementation of Rural Juvenile and Adult Diversion

The NorthSTAR System is not currently providing rural jail diversion activities for juveniles and adults due to limited resources. These services must be developed and implemented.

Development of Meaningful and Measurable Outcomes

Resiliency and Disease Management

Resiliency and Disease Management (RDM) is an effort to redesign the way public Mental Health services are delivered to adults with severe and persistent mental illness and children with severe emotional disturbance. It ensures the provision of interventions with empirical support to eliminate or manage symptoms and promote recovery from psychiatric disorders.

Key components include Uniform Assessments, Service Packages, Utilization Management, Quality Management, and Data Management. Some of the concrete goals of RDM include:

- Individuals will be regularly assessed using objective, valid assessment instruments.
- Individuals will participate in evidence-based services that are appropriate to address their unique individual needs.
- Individuals will participate in services of adequate intensity to aid in recovery from mental illness and the development of resiliency. Services will have fidelity to the key elements of evidence-based practices.
- Individual outcomes related to important indicators of quality of life will improve, providing progress toward the goal of recovery.

Provider Perspective

From the provider perspective, longer stays in treatment followed by transportation were the two most prevalent needs.

The following plan describes the delivery system, the target population and the methodology of the plan itself. In addition, the plan has identified multiple needs and includes recommendations to fill the needs while eliminating gaps in services.

Local Authority Assessment Components

NorthSTAR administrative and operational design focuses on cost effectively maximizing services and achieving customer outcomes.

Cornerstones of NorthSTAR's Distinctive Approach

- *Blended funding* – Federal, State and local sources contribute funds to purchase behavioral health insurance coverage for eligible consumers.
- *Integrated services* - Mental health and substance abuse treatment are coordinated under the umbrella of behavioral health, allowing integrated treatment in a single system of care. In SFY 2006 approximately 24% of NorthSTAR clients receiving services were dually diagnosed (Databook, March 2008).
- *Care management* - Individuals receive appropriate and cost-efficient care.
- *Data-based decision support* - A modern data warehouse and decision support software is used to evaluate and manage the system of care.

- *Behavioral Health Organization* - Services are provided through a contract with a licensed behavioral health organization (BHO).

Jail Diversion Plan

Mental Health and Criminal Justice

The Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) funds the project to implement jail diversion as outlined in HB 2292 through a contract with the local behavioral authority, North Texas Behavioral Health Authority (NTBHA).

The number of persons with mental illness in United States jails continues to grow. Currently the prevalence of active serious mental illness among inmates admitted to U.S. jails is about 7 percent, which means that nearly 700,000 persons with active symptoms of severe mental illness are admitted to jails annually. For those persons in prison, recent Bureau of Justice Statistics reports show approximately 16% or about 233,000 are also similarly diagnosed. About 75 percent of these people have a co-occurring alcohol or drug use disorder. Criminal justice and mental health professionals and advocates have called for diversion efforts to link offenders with mental illness to community-based services to break their continued cycling through the criminal justice, mental health, and substance abuse treatment systems and to reduce the number of people with mental illness in jails. Source: www.hhs.gov/asl/testify/t000921a.html. NTBHA Jail Match data at times have identified that as much as 33% of the jail population have a mental illness diagnosis. The percentage has run higher for the Dallas County jail.

Jail diversion services consist of two broad interlocking areas of intervention. First are the diversion mechanisms, or the means by which an individual is identified at some point in the arrest process and diverted into mental health services. This process for NorthSTAR is accomplished by the Jail Diversion Information Management (JDIM) system. Second is the system of integrated mental health and substance abuse services to which the client is diverted to a state mental hospital under a civil commitment or assigned to a provider as part of a 6-month misdemeanor or 12-month felony program.

Diversion as a primary goal leads individuals with mental illness or substance use problems away from criminal incarceration. Diversion services may either prevent incarceration or cut it short. Conceptually,

then, the definition of diversion could include many crisis services that are used to intervene after the onset of acute symptoms but before an individual has engaged in any criminal behavior, thus removing a basis for arrest.

Such a broad definition would make it very difficult to differentiate crisis services from jail diversion because one could never be sure that an arrest would otherwise have occurred. Diversion could also include any planning for release from jail, because a plan for community services after release often facilitates a faster release, thus preventing extended incarceration. Diversion programs can be operated by police, pre-trial service agencies, courts (as part of a Mental Health Court or otherwise), and from within the jail system.

What makes jail diversion unique is that this service positions itself within the criminal justice system as an immediate alternative to incarceration. Individuals with mental illnesses may be identified for diversion from the criminal justice system at any point, including pre-booking interventions (before formal charges are brought) and post-booking interventions (after the individual has been arrested and jailed).

Pre-booking diversion occurs at the point of contact with law enforcement officers and relies heavily on effective interactions between police and community mental health services. Most diversion efforts in the United States are post-booking programs, which can take place upon arraignment in the courts or in the jail.

A *post-booking diversion* program at either the arraignment court or the jail is one that screens individuals potentially eligible for diversion for the presence of mental illnesses; evaluates their eligibility for diversion; negotiates with prosecutors, defense attorneys, community-based mental health providers, and the courts to produce a disposition outside the jail in lieu of prosecution or as a condition of a reduction in charges (whether or not a formal conviction occurs); and links individuals to the array of community-based services they require.

Five key elements were associated with the programs that were perceived to be most successful when reviewing major jail diversion programs:

1. All relevant mental health, substance abuse and criminal justice agencies were involved from the start.
2. Regular meetings between key personnel from the various agencies were held.
3. Integration of services was encouraged through the efforts of a liaison person, or "boundary spanner," between the corrections, mental health, and judicial staff.
4. The programs had a strong leadership.
5. Non-traditional case management approaches were used. These approaches relied on staff that was hired less for their academic credentials and more for their experience across criminal justice, mental health, and substance abuse systems.

The bottom line was that program effectiveness depended on building new system linkages, viewing detainees as citizens, and holding the community responsible for the full array of services needed by the detainees.

Initial Program Objectives

- To reduce offender contacts with the criminal justice system by diverting eligible mentally ill offenders from jail;
- To stabilize mentally ill arrestees on medications, if necessary;
- To evaluate the mentally ill arrestee and make recommendations to the judge for alternative treatment;
- To transfer the arrestee to a transitional living environment for further treatment evaluation, if necessary;

- To develop a comprehensive treatment plan to include “new generation” medication therapy, rehabilitative services, and intensive case management;
- To provide coordination and collaboration with the criminal justice system through judicial monitoring.

Mental Health Diversion Program Admission Criteria

This process is accomplished through the JDIM-BOT.

- Adult defendants (17-years or older) charged with non-violent misdemeanor offenses A-B.
- Certain adult defendants on non-violent felony probation with technical violations.
- Defendants must be enrolled in the NorthSTAR program.
- Defendants must be identified as members of the Priority Population (Schizophrenia, Bipolar Disorder, and Major Depression).
- Defendants must not be severely mentally retarded, or otherwise be unable to participate in daily rehabilitation groups, keep monthly appointments, and take medications as prescribed.

Assumptions

- This strategy recommendation assumes a 6- to 12-hour diversion process;
- A messaging system that identifies the NorthSTAR enrollee, and other variables;
- A three to five day transitional placement for the diverted offender, if deemed clinically appropriate;
- A medication evaluation and “stabilization” at the jail.

Jail Diversion Plan

Until 2006, NTBHA employed a full time Jail Diversion Coordinator on its staff. This was a TCOOMMI funded position that eventually went to Dallas County, but continues to be funded by TCOOMMI.

Since 2006, under Dallas County the Jail Diversion program has been expanded greatly. The program consists of a full time Director of Criminal Justice and several key staff. Parkland Health replaced UTMB in the Lew Sterrett correctional facility.

Although NTBHA no longer employs jail diversion staff, NTBHA continues to provide support for the Jail Diversion Information System program and users. NTBHA employs a Jail State Liaison that serves as an interface for the county jails and the state hospitals. The Jail State Liaison plays an integral part in getting individuals diverted from the jails within the NorthSTAR service delivery area into a state hospital. The position is also important in promoting jail diversion activities for jails surrounding Dallas County that are in the NorthSTAR service delivery area. NTBHA staff provides training for parole, probation, fire departments and judiciaries which consist of recognition, interaction strategies and alternatives to incarceration.

NTBHA'S Plan for Surrounding Counties Jail Diversion

(Rockwall, Hunt, Kaufman, Navarro, Ellis, Collin)

There have been preliminary discussions with TCOOMMI to expand jail diversion programs to the outlying counties. Kaufman County has shown a strong interest in jail diversion. Steps are being taken to support a jail diversion program in Kaufman County. Dallas County has also offered assistance to Kaufman County to support jail diversion. NTBHA's long term plan expects to also expand some type of jail diversion software to all outlying county jails to assist with identifying inmates.

CRISIS INTERVENTION TRAINING (CIT)

- a. Training for municipal and county officers (Dallas Police Department is willing to provide this service—officers in outlying counties can attend training classes free of charge)
- b. Training for local fire departments (NTBHA staff also provides this training)

JAIL PRE-BOOKING SCREENING

- a. Health Care Professional provides mental health screening.
- b. NTBHA also facilitates a jail match process (CARE system) in conjunction with ValueOptions to identify individuals that have received previous MHMR services.

LOCAL HOSPITAL INVOLVEMENT

- a. Provide triage area for mental health professionals in safe environment.
- b. Establish local hospital involvement
- c. Provide continuing education (CEU) for hospital staff on Mental Illness

COUNTY AND MUNICIPAL JUDGES

- a. Provide education information regarding jail diversion process (NTBHA staff can provide this training).
- b. Offer treatment alternatives to incarceration (Assisted outpatient treatment).

MENTAL HEALTH PROVIDER INVOLVEMENT

- a. Intensive case management.
- b. Establish system for case management in home visits (to monitor medication compliance).
- c. Develop system for tracking.
- d. Develop reporting system for judiciary, parole and probation.

PROBATION/PAROLE INVOLVEMENT

- a. Educate staff on jail diversion.
- b. Offer treatment alternatives for violations.

TRANSPORTATION

- a. Case manager arrange transport to groups and clinic visits.
- b. Increase participation in rural transportation van (possible grant from TCCOOMI for transporting non-Medicaid clients).

COMMUNITY PARTICIPATION

- a. Engage local NAMI groups to educate community on safe and secure licensed boarding homes.
- b. Develop Municipal boarding home regulations in pilot city.

Outpatient Competency Restoration

NTBHA is committed to assisting with all efforts to transform the behavioral system in Texas. The 80th Legislature appropriated \$82 million for the FY 08-09 biennium, guided by the Legislature and in response to Rider 69. Funds were allocated to assist the state in making progress toward improving mental health and substance abuse crisis services.

NTBHA will coordinate efforts to extend Outpatient Competency Restoration (OCR) to outlying counties while supporting continuing efforts to improve Outpatient Competency Restoration in urban areas.

A successful OCR program will improve efforts to provide effective treatments to individuals in the legal system with mental illness and substance abuse disorders, with the goal of reducing burdens on the jails and state hospitals.

NTBHA supports education and outreach as a critical component of an OCR program.

NTBHA shall oversee strategies and procedures (as outlined in the DSHS contract) to divert individuals with mental illness from the criminal justice system to appropriate community services. NTBHA shall attend a least one quarterly meeting with TCOOMMI jail diversion staff to ensure that targets are being met, that data on those who have been diverted from the criminal justice system are being collected, and to resolve problems. NTBHA shall include a summary of these meetings, including any recommendations for change, in its quarterly report to DSHS.

Advantages of the NorthSTAR System

(from the LBJ School of Public Affairs assessment, 2003)

- *Guaranteed access to care:* The BHO is contracted to ensure a broad and accessible provider network, resulting in no waiting lists.

- *Cost effectiveness*: More people have been served under NorthSTAR without a decline in the quality of care.
- *Choice and Competition*: Competition has been infused into the system through the BHO contracting with a large array of providers, rather than block funding to traditional public providers. This competition adds incentive and accountability, and increases the number and type of available providers. Consumer choice of providers empowers the consumer and strengthens their investment in recovery and treatment.
- *Blended funding*: This supports better service coordination and continuity of care. This is clearly seen with the significant portion of consumers that receive both mental health and substance abuse care (24% in 2007 per March Databook, 2008). Under this system, consumers can receive integrated care with one provider network.
- *Data capabilities*: The data warehouse developed for NorthSTAR includes decision support software used for evaluating and managing the care system. This can be evaluated on both individual and aggregate levels through enrollment, encounter, and cost and assessment data tracking. Data allows focus on the most needed and effective services, as well as supports policy choices that strengthen the system of care.
- *Enforced efficiency*: The BHO is contractually limited in the amount of funding that can be used for administration and profit due to an at-risk contract. This guarantees that the vast majority of funds are expended on direct care, as well as providing a clear tracking device to ensure accountability.
- *Continuity of care*: Patients moving on or off Medicaid have access to the same care system. Consumers dually diagnosed with mental health and substance abuse issues may access integrated services within the same system. In addition, the structure of the system provides a firm base for maintaining continuity and tracking progress toward treatment goals.
- *Quality of care*: NorthSTAR has impacted the quality of care in providing more appropriate and less restrictive levels of care (Ex. 23 hour observation, outpatient detox, and ACT services), eliminating waiting lists, increasing accessibility to new generation medications, increasing post hospitalization follow up, and maintaining or improving consumer and provider satisfaction. An increased range of treatment options with care management and customer choice allows for the best clinically indicated treatment with the least restrictive level of care. Least restrictive care is generally consistent with less expensive treatment and better customer outcomes.

- *Separation of authority and provider functions:* NorthSTAR was the first initiative to completely separate the authority from the provider. Separation allows for objective focus on consumer needs and effective regional system design.
- *Communication/Collaboration:* Advocates, providers and consumers have continually been actively involved with the development of the NorthSTAR program. The NTBHA board has representation from all seven counties, as well as active provider, consumer and advocate forums. In addition, the private enterprise service delivery allows for significant flexibility and innovation.

NorthSTAR Behavioral Health Authority

In concert with stakeholder input, NTBHA has continued to refine its' role in the development and oversight of the NorthSTAR system of care.

NTBHA continues to strengthen its oversight capabilities to assure cost effective and customer centered service provision throughout the seven county region. NTBHA is also actively engaging in inclusive local and strategic planning toward system redesign that is beneficial for customers, stakeholders and the community at large.

Medical Director

NTBHA does not staff a full-time or part-time Medical Director in its SFY 09 budget.

Advice from a Medical Doctor may be beneficial to the Local Behavioral Health Authority (LBHA) when solicited, and may be requested by the LBHA on an ad hoc basis from physicians or groups of physicians who have expressed an interest in NorthSTAR. However, the LBHA must remain an independent agency not subject to undue outside influences.

Medical advice when requested should not represent or be limited to the interests of one particular stakeholder or group of stakeholders.

Medical advice when requested should be provided by a Medical Professional who is experienced in behavioral health issues and who has a working knowledge of NorthSTAR and the issue on which advice is solicited by the LBHA.

The Provider Advisory Council provides a forum for ALL doctors within the NorthSTAR community to present information on issues that are pertinent to the NorthSTAR community. This avenue should be utilized to present issues to the NTBHA Board of Directors.

Services and Supports

Support for resource development, allocation and increased service efficiencies needs to be increased. (Where does current funding come from, how can we access other funding and capitalize on current dollars such as funding from State (crisis, outpatient competency), partnerships with criminal justice for outpatient competency, developing TCOOMMI funding, expanded telemedicine, 340b, etc.)

SWOT Analysis

SWOT Analysis, is a strategic planning tool used to evaluate the **Strengths, Weaknesses, Opportunities,** and **Threats** involved in a project or in a business venture.

NTBHA utilizes an ongoing SWOT analysis model to identify key factors that may affect desired future NorthSTAR deliverables and outcomes. SWOTs are used as inputs to the creative generation of possible strategies, by asking and answering each of the following four questions:

- How can we **USE** each Strength?
- How can we **STOP** each Weakness?
- How can we **EXPLOIT** each Opportunity?
- How can we **DEFEND** against each Threat?

NTBHA's goal in utilizing SWOT Analysis is to identify key internal and external factors that are important to achieving NorthSTAR goals and objectives.

NorthSTAR Strengths

What NorthSTAR provides:

- Open access to treatment for the indigent and Medicaid clients.
- Consumer choices among multiple providers of care.
- 23-hour psychiatric crisis stabilization unit.
- A single pathway for treatment of mental illness and alcohol/substance abuse.
- A managed care system.

- Separation of authority and provider roles.
- Sound service provision infrastructure.
- Proven history of serving more consumers than other models.
- BHO has access to variety of tools to effect better care and higher efficiencies
- Established collaboration with local entities, criminal justice and primary care providers.
- Unified substance abuse and mental illness treatment access.
- 340b pharmacy to reduce costs and wait times for new generation medications.
- Established stakeholder involvement through the Provider Advisory Council (PAC), Consumer and Family Advisory Council (CFAC), town hall meetings, and NTBHA Board meetings.
- Productive relationship with BHO.
- Board representative of region.
- Commissioners Court support throughout region.
- Open lines of communication with providers.

NorthSTAR Weaknesses

- Insufficient funding to address effective continuum of care and diversion strategies
- Some areas lack resources that create barriers to optimal service access
- Stigma of mental illness and substance abuse
- Culturally competent services; a need for better services
- Collaboration with stakeholders needs improvement in all seven counties
- System access in all counties needs improvement

NorthSTAR Opportunities

- Stakeholders in all seven counties more interested – capitalize to increase collaboration toward more effective use of resources
- Community collaboration focused on system change. Integrated projects related to substance abuse
- Legislature statements for increased NorthSTAR funding
- New technology – increased efficiency of data collection

NorthSTAR Threats

- Funding cuts from Legislative action that impacts NorthSTAR.

Local Authority Goals, Service Priorities

GOAL I:

- Produce and Publish a NorthSTAR Delivery System Redesign – NorthSTAR Region Assessment which will be published on the NTBHA website, www.ntbha.org.

Process:

- Gather data from a variety of sources including Provider Assessments, meetings, etc. The data will then be analyzed to chart trends and determine user needs and services gaps. The results will then be presented to the NTBHA Board of Directors in the form of a Comprehensive Needs Assessment.

Outcome Measure:

- An annual published report will be produced and published on the NTBHA website.

GOAL II:

- The North Texas Behavioral Health Authority will develop educational/informational forums for the community, all levels of law enforcement, and judiciary courts on mental health and substance abuse.
- Increase awareness of the authority's role in the mental health/substance abuse spectrum as well as mental health/substance abuse resources to the public.
- Conduct town hall meetings every six months in various NorthSTAR service area locations to obtain community/stakeholder input and increase community access to board members.

Process:

- Continue to strengthen the relationship with ValueOptions towards cooperative solutions while maintaining stringent oversight. Continue to conduct provider and consumer needs assessment surveys, continue current meetings and increase data gathering/reporting.

Outcome Measure:

- Develop and submit strategic plan that is inclusive of community/stakeholders' (PAC/CFAC) observations.

GOAL III:

- The North Texas Behavioral Health Authority will collaborate with community Stakeholders to increase access to the behavioral health system throughout the NorthSTAR Region.

Process:

- Analyze data from needs assessment surveys, town hall meetings, estimate number of consumers to be served, and cost of lower level of care diversions utilizing best practices.

Outcome Measure:

- Evaluate access points in both rural and urban areas.
- Expand system to increase competition among providers, encourage "front line" development of programming toward better services for consumers. Increase consumer's choice of providers (having multiple providers run specific programs like outpatient competency restoration).
- Develop incentive program for providers in both rural and urban areas. Examine operational barriers (i.e. paper works, qualifications for entry into system, establish consistent reimbursement rates).
- Integrate co-occurring substance abuse/mental illness treatment. This will increase number of individuals diverted into lower level of care.

- Improve law enforcement coordination in all counties. Develop collaborative effort towards pre-booking diversion.
- Develop collaborative effort with criminal justice system toward post booking diversion to reduce recidivism rate.
- Expand cooperation with primary care sites (ER's, community clinics and emergency primary care clinics) to identify consumers and increase access to care.
- Coordinate with local municipalities and other organizations toward development of appropriate housing (NTBHA unable to provide housing; however the leverage of service dollars may provide incentives to other organizations to bear the brick and mortar cost).
- Continue to strengthen peer support in urban areas and develop in rural areas.
- Coordinate with rural providers to establish funding for transportation (Medicaid, TCOOMMI).
- Strengthen transportation availability in urban areas.
- Coordinate with local faith based and nonprofit groups to develop volunteer worker opportunities.
- Identify methods to reduce paperwork burden related to medication to increase number of consumers seen by physicians. Continue to develop 340B and other programs to reduce price of medication.
- Access to the NorthSTAR system will increase awareness of NTBHA and NTBHA's role will increase.

GOAL IV:

- North Texas Behavioral Health Authority will establish a system to provide mental health and substance abuse education to every county within the NorthSTAR region.

Process:

- Partner with other organizations (Mental Health America, Association of Persons Affected by Addiction) for community education toward reducing the stigma associated with mental illness/ substance abuse.
- Establish periodic education and town hall meetings with community groups in each of the seven counties addressing system access, crisis redesign services, and the role of NTBHA.

Outcome Measures:

- Increase education of individuals, community groups and public entities on signs and symptoms of mental illness and substance abuse through Education Advisory Committee.

GOAL V:

- North Texas Behavioral Health Authority will become more responsive to the diversity of the community.

Process:

- Develop a comprehensive plan to identify the diverse cultural needs within the community and assure appropriate behavioral health services provided based on that identified need.
- Develop a grassroots presence that will include stakeholders, families and consumers.

Outcome Measures:

- NTBHA will assist in the facilitation and coordination of systems that affect mental health. NTBHA will ensure that the NorthSTAR system has culturally appropriate programs that educate, support, and empower both individuals and groups in the community through the Education Advisory Committee.

GOAL VI: Network Planning

- NTBHA will oversee the development of service providers that allows consumers increased accessibility of services and continuous quality monitoring. With private providers providing services, it promotes the goal of NorthSTAR consumers being well-served and having more options with the services that are being provided.

Process:

- Offer an adequate number and type of contracted or participating providers to meet the health needs of NorthSTAR enrollees.
- Offer a network of participating providers that is geographically accessible to NorthSTAR enrollees.
- Describe the NorthSTAR participating provider availability and accessibility standards to state and/or federal regulators, accreditation agencies, benefit consultants, employers and other health care purchasers or prospective purchasers of NorthSTAR services, other payers of health care benefits such as Medicaid, Medicare, and CHIP offered in conjunction with NTBHA services, prospective or existing NorthSTAR enrollees and participating providers.

Outcome Measures:

- Provide a system that is adequate in numbers and types of providers to meet the full range of health care service needs of the enrolled population.
- Include within each county enough providers to allow enrollees provider choice.
- Continuously evaluate provider performance in conjunction with DSHS, VO to ensure that quality services are being provided and consumer needs are being met.
- Provide input and assist with facilitating provider contracting processes.

Education and Outreach

Action Plan for All Counties

Primary goal of plan should address NorthSTAR issues in all seven counties with a focus on the counties surrounding Dallas.

Two of the NorthSTAR seven counties meet rural population requirements: Hunt County and Navarro County. NTBHA, in conjunction with DSHS and VO, needs to assess population need for all seven counties.

Collin County enhanced mobile crisis response follow-up should be one hour for emergent and eight hours for urgent.

After-hour clinic to provide robust crisis services (for substance abuse and mental health) located in Collin County. Discussions have begun with two potential providers.

Education

ValueOptions needs to aggressively review provider performance (individual + the three major specialty network providers) in Collin County to determine whether the providers are meeting substance and mental health needs of the Collin County population.

Information including written literature should be provided to all jails, probate courts, providers, shelters, advocacy groups, grocery stores, etc. on how to engage individuals in NorthSTAR services.

There needs to be enhanced focus on Jail education. NTBHA can provide the initiative by forming an Education Advisory Committee. (NTBHA Quality Assurance staff position – September 1 SFY 2009).

Enhanced mobile crises services one-pager that specifically addresses each county (on what to expect) provided to every county jail. NTBHA along with VO need to address actual response times for enhanced mobile crisis. Perhaps a 50-minute response time is more realistic than a 30-minute response.

Ensure the following: NorthSTAR goals are aligned with the needs of Collin County; the system supports efforts to increase population service needs within NorthSTAR; the system provides measurable criteria to Collin County for the successful accomplishment of goals.

SFY 2009 NorthSTAR Crisis Services Redesign

Introduction/Background

NorthSTAR, a public behavioral health managed care initiative in the North Texas Region, submitted a Crisis Services Redesign Plan for SFY 2008 to the Department of State Health Services. The NorthSTAR regional plan was developed to address the immediate needs in the community for responsive and effective services for people in mental health and substance abuse crises. The expected outcomes of crisis services developed were designed to prevent hospitalization or incarceration as well as to effectively connect people with needed ongoing services following crisis resolution. The NorthSTAR plan was developed following a comprehensive process of gap analysis that was conducted through focus groups, review of all available data, stakeholder input, town hall meetings, surveys, and more. The participants and stakeholders represented all areas of community functioning e.g. law enforcement, physical and behavioral health providers, advocacy groups, families/consumers. There was representation from all areas of the service delivery area of Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall Counties.

The Crisis Redesign Plan submitted by NorthSTAR for SFY 2008 contained four components that were reflective of some of the core elements of a crisis system as outlined by Texas Department of State Health Services in 2006. The four areas included: AAS hotline certification, Enhanced mobile outreach, Crisis Residential, and Transportation offset. NorthSTAR engaged in a rigorous RFI process for the new and enhanced services in order to ensure equitable opportunities in all areas of the region and the selection of the most appropriate providers. The following pages will outline the NorthSTAR Crisis Redesign implementation progress and outcome measures to date, all of which are guiding and informing our ongoing gap analysis as we prepare to respond most effectively and efficiently with our Crisis Redesign Plan for SFY 2009. See Appendix C – FY 2009 Crisis Expenditure Projections for further information.

Status of SFY 2008 Crisis Redesign Implementation

AAS Hotline Certification

Adapt Community Solutions has operated a hotline in the NorthSTAR service delivery area since 2006. Over the past year, they have actively pursued their certification through American Association of Suicidology. The staff has undergone rigorous training and a desktop review of all policies and procedures has taken place. The final step is the scheduled on site visit that will take place on August 21st-22nd, 2008. Completion of AAS certification is expected by the end of SFY 2008.

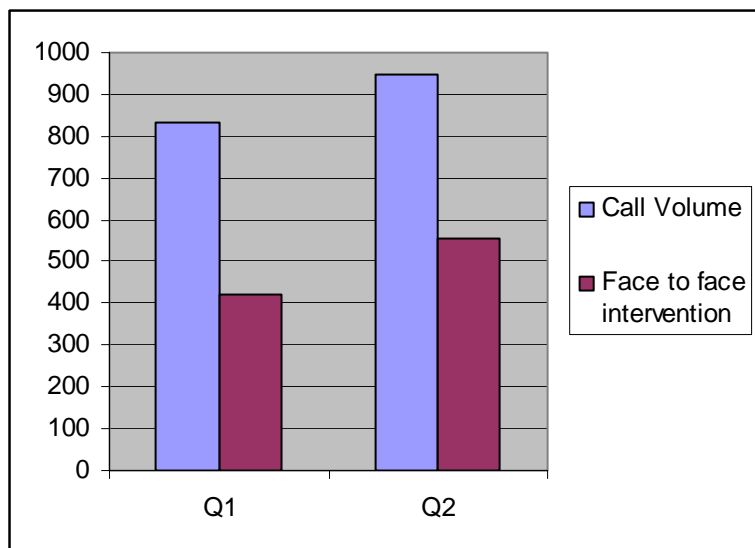
Enhanced Mobile Outreach

Mobile Crisis Outreach Teams (MCOTs) are clinically staffed mobile treatment teams that can provide prompt face-to-face crisis assessment, crisis intervention services, crisis follow-up and relapse prevention services for individuals in the community. These services are designed to reach individuals at their place of residence, school and/or other community-based safe locations, 24 hours per day, 365 days per year.

Mobile Crisis Outreach Teams provide services that are flexible, multi-faceted, and immediately accessible to individuals, both children and adults, at high risk for hospitalization or out-of-home placement. Services are provided in-vivo, primarily in the home but may be delivered at other community-based safe locations and are designed to be family-focused to include all members of the family affected by the crisis surrounding the individual, intensive, and time-limited.

In SFY 2008, we implemented 4 new teams to provide Mobile Crisis Outreach throughout the region which encompasses approximately 5,430 square miles. Three of the new teams are community based in the rural areas of the region while the fourth team is a specialized urban team focusing on the chronically homeless population that presents to The Bridge homeless assistance center and its' surrounding vicinity.

Table 1: Calendar Year 2008 First and Second Quarter
Mobile Crisis Activity in Outlying Counties



The Bridge is a state of the art homeless assistance center that currently serves over 700 people a day. Having just opened on May 22, 2008, they have already reported 32,000 overnight stays in the facility in the first 9 weeks of operation. It is an area where people with the most severe issues around mental health and substance abuse may present, as conditions of chronic homelessness exacerbate needs. In response, we have enhanced mobile outreach services through the utilization of liaison services. The liaisons are often first responders at The Bridge for behavioral health crises. They triage people to crisis intervention, on site psychiatric services, after hour urgent care, outpatient chemical dependency detox and treatment services. They provide transportation linkage to these crisis services. The liaison also coordinates the re-entry for people from jail or hospital back to The Bridge, ensuring that a treatment plan is received, a bed is held, and medications are on site. The liaison service served over 430 people from May 22-July 16, 2008.

Crisis Residential

Homeward Bound was selected to provide Crisis Residential Services with the first day of operation for this new service commencing on April 15, 2008. Crisis Residential Services are 24-hour facility based residential services that are usually short-term and offered to consumers who are demonstrating psychiatric crises that cannot be stabilized in a less restrictive setting. This level of care provides

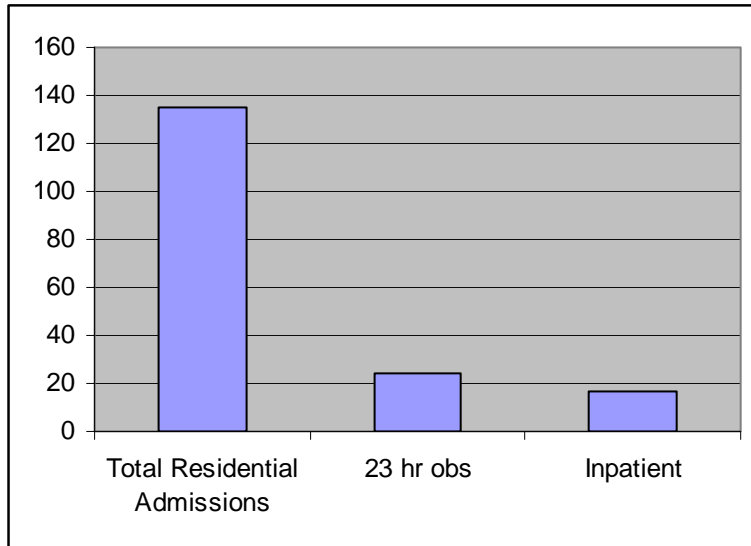
intensive behavioral health treatment in a licensed, highly structured residential program for consumers who do not require intensive clinical treatment in an inpatient psychiatric setting and would benefit from a short-term, structured stabilization setting.

This 24-hour, supervised, short-term treatment model serves as an alternative to inpatient hospitalization. In this facility-based program, consumers in urgent/emergency need can receive crisis stabilization services in a safe, structured setting, with continuous 24-hour observation and supervision. Services at this level of care include crisis stabilization, initial and continuing bio-psychosocial assessment, care management, medication management, and mobilization of family support and community resources.

The primary objective of the crisis residential service is to promptly conduct a comprehensive assessment of the member and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the member to a level of functioning which requires a less restrictive level of care. Duration of services generally is 1 - 14 days by which time a determination of the appropriate level of care will be made and facilitation of appropriate linkages coordinated by treatment team.

From April 15th through June 2008, we served 135 members in this setting. Each referral originated through an ER, hospital, or mobile crisis team intervention and reflected a diversion from higher levels of care. The preliminary outcome measures support this level of care as a diversion from hospitalization as 100% of the 135 would have been hospitalized without this level of care. The average length of stay has been 5 days; however, some members have remained in the treatment setting for 14 days. **Thirty day follow up** reveals that 87% of the members admitted to Crisis Residential remained stable in the community with no subsequent inpatient care while 82% remained stable in the community with no subsequent inpatient OR acute observation service (Green Oaks 23 hour observation).

Table 2: 30 Day Follow Up Measures After Crisis Residential Services



Transportation Offset

Transportation services are a critical part of the crisis response system within the NorthSTAR region which covers such a broad land mass. Daily transportation is provided through our specialized psychiatric transport company *TransiCare*, in facilitating appropriate member access between local ERs, Psychiatric Emergency Services, State Hospital, homeless centers, treatment centers, and more. This reduces the burden on local and regional law enforcement entities on transporting members for many psychiatric related court hearings, placement, etc.

Transportation through this specialized company is delivered by staff trained to respond to behavioral health emergencies, accompanied by nursing staff as conditions warrant, and available 24/7. The immediate availability of this type of transportation service can reduce the need for higher levels of care. For example, a chronically homeless person presenting in crisis at The Bridge may be quickly triaged and transported to Urgent Care After Hours Clinic in the evening where crisis intervention and medication management services are immediately available. During SFY 2008, capacity of transportation services increased in response to the identified needs. This is an ongoing area of need in SFY 2009. See Appendix C for further information.

Gap Analysis

The Crisis Redesign plans implemented in SFY 2008 have shown immediate positive results in the reduction of higher levels of care through stabilization and treatment at the least restrictive environments. Ongoing efforts to monitor the impact of new and enhanced services and to continuously evaluate remaining gaps, have guided our efforts in preparing recommendations to the NTBHA Board for SFY 2009 planning. Many of the core gaps identified in earlier planning stages were improved but have not yet been ameliorated. Some of the issues e.g. rural access, housing, and transportation are multi-faceted and will require a variety of strategies.

Recommendations to the Board for SFY 2009

Rural Access via Mobile Crisis and Transportation

The concerns regarding access to care and response times in rural areas are tied to the vast amount of land space in the region which is over 5,000 square miles. Many gains were made in SFY 2008 through the strategic placement of new teams in outlying areas, the use of technology e.g. global positioning software systems, laptops with air cards, and large monitors to support improved dispatch decision-making and management of mobile teams. We continue to review the data and determine the best placement and make up of rural teams. The funding and placement of the enhanced mobile teams did not occur until the second quarter of the calendar year 2008. **Table 1** referenced above shows the increased volume in both call volume and face to face interventions in the counties outside of Dallas County. There was a 12% increase in call volume and a 24% increase in face to face interventions compared to the service quarter preceding the new MCOT deployment. The recommendation is to add four additional Mobile Crisis Outreach Teams in strategic areas throughout SFY 2009.

Supported Housing Crisis Stabilization Program

Housing stability as a means of mitigating crisis has been identified as an ongoing area of need by members and providers in the NorthSTAR area for a number of years. Housing instability is an issue that is often causally related to ongoing instability and crisis in the lives of members with severe and

persistent mental illness. Housing instability is, at times, the *result* of continuous behavioral health crises and conversely may be a contributing factor to behavioral health crises. As people suffer from long term symptoms of mental illness and/or substance abuse, maintaining housing can become unmanageable. Furthermore, it is difficult for people to regain mental health stability after a period of crisis without stable housing to return to.

Research evidences the efficacy of supported housing programs for people with behavioral health disorders. Outcome studies show there is a direct impact on the reduction of shelter use/homelessness, hospital utilization, and correctional facility costs. Quality of life can be improved for many members with the opportunity for more long term community based crisis stabilization. These opportunities would be greatly augmented in the NorthSTAR area through the development of a *Supported Housing Crisis Stabilization Program* which concurrently addresses the psychiatric and prominent psychosocial factors that may be barriers to member stability e.g. lack of food, shelter, clothing, psychiatric medication, health care, etc.

The *Supported Housing Crisis Stabilization Program* could serve as a step-down from hospital, jail or crisis residential services. Services at this level of care include crisis stabilization, initial and continuing bio-psychosocial assessment, care management, medication management, and mobilization of family support and community resources.

The primary objective of this service is to provide stable housing while developing a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the member to a level of functioning including a more permanent housing situation. Duration of services generally is 30-60 days by which time a determination of the appropriate level of care will be made and facilitation of appropriate linkages coordinated by treatment team.

Services are short-term and offered to consumers who are demonstrating psychiatric crises with co-occurring or related housing needs. The program would include a dedicated cluster of apartments where consumers would live independently or with a roommate, depending upon their needs and availability of housing. A resident manager would be located at the same location and would be available 24/7 to support program participants. Each consumer in the program would be followed by a team of dedicated clinicians who would provide a minimum of 8 contact hours per month. Also included would be

physician services and group activity. Many of the contact hours would be provided in the consumer's home or in community rooms. Program consumers will participate in supervised socialization with their peers. Clinicians would provide Intensive Case Management utilizing a wraparound approach to ensure all of the consumer's needs are identified and included in the integrated treatment plan.

Increased Capacity at Facility Based Crisis Residential Services

Within the first few months of operation, the community and professionals within the system of care became more familiar with the new facility based Crisis Residential Services and began experiencing the positive outcomes. As more people began to understand the importance of this treatment option for members in crisis, we have maintained nearly full capacity. As a result of this limited capacity (average daily census of 10), people have to be referred to higher levels of care e.g. hospital, in order to meet the immediate needs.

Positive outcomes at Facility based Crisis Residential Services would support the expansion of this service in SFY 2009. Based on the volume that has been experienced over the past few months, the growing demand for this level of care, and the positive results that are being obtained, the recommendation would be to expand the capacity at this level of care to an average daily census of 20 during SFY 2009.

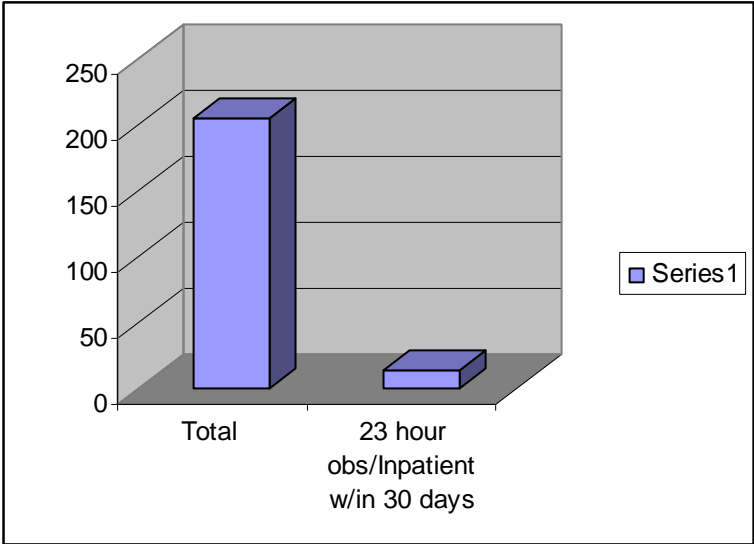
Urgent Care After Hours Clinic

Over the past 2 months, the NorthSTAR service delivery area has piloted an Urgent Care/After Hours Clinic in order to meet the needs of people within the community that may prevent the need for higher levels of care. Walk-in Crisis Services are immediately accessible services for adults, children, and adolescents that serve two purposes: ready access to psychiatric assessment and treatment for new individuals with urgent needs, and access to same-day psychiatric assessment and treatment for existing clients within the system when urgent needs arise. For persons whose crisis screening and/or assessment indicate that they are an extreme risk of harm to themselves or others in their immediate environment, rapid transfer to a higher level of care is facilitated. If extreme risk of harm is ruled out, brief crisis intervention services are provided on-site. Walk-in Crisis Services are designed to be intensive and time-limited, and are provided until the crisis is resolved or the person is referred to another level of care.

After the initial crisis assessment and intervention, continuing services may be provided in the office or in vivo (through mobile crisis outreach services) for up to 30 days until the individual is stabilized and/or transitioned to appropriate behavioral health services.

The Urgent Care/After Hours Clinic has served 205 unduplicated members from May 27-June 30, 2008. Our first outcome measure is available for this group of members which reveals that 93% have remained stable in the community without an inpatient or 23 hour observation visit within 30 days of their Urgent Care visit.

Table 3: Unduplicated Members seen at Urgent Care Walk In Clinic and subsequent Inpatient or 23 Hour Observation Service



The utilization of this pilot as well as the positive outcome measures support the need for this type of readily accessible outpatient crisis services for members of the NorthSTAR community. The recommendation is to continue providing crisis stabilization services through the Urgent Care Clinic and to expand to other locations to serve high need areas of NorthSTAR.

Comments and Suggestions

Stakeholder Comments on Strategic Plan are highly encouraged.

North Texas Behavioral Health Authority

Local Plan Stakeholder Survey

2008-2009

North Texas Behavioral Health Authority is the Local Behavioral Health Authority for Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall Counties.

Thank you for taking the time to complete this Local Plan Stakeholder Survey. This information will be used in preparing and or updating our Local Plan. The instructions for completing this survey are self-explanatory, and you can be assured of strict confidentiality. Please return your survey to:

Rhonda Davis - **Confidential**

NTBHA

10056 Marsh Lane, Ste. 210

Dallas, TX 75229

.....
or Fax **Confidentially** to

E-Fax Number: 469-523-0988

Please tell us who you are:

Check one:

1. Provider
2. Consumer
3. Parent
4. Advocate
5. Local Government Official or Employee
6. Law Enforcement
7. Other: _____
8. Affiliation: _____

WHAT ARE THE TOP **THREE** GAPS IN SERVICE IN THE NORTHSTAR SERVICE AREA?

SERVICE GAP OR NEED

BARRIERS TO MEETING NEED

1. _____

2. _____

3. _____

Additional Comments:

RANK ORDER THE TOP **THREE** CRITICAL SERVICES THAT ARE CURRENTLY PROVIDED IN THE NORTHSTAR AREA THAT MUST BE CONTINUED?

CRITICAL SERVICE

1. _____

2. _____

3. _____

Additional Comments:

WHAT ARE THE **THREE** MAJOR POLITICAL OR POLICY ISSUES FACING THE NORTHSTAR AREA THE NEXT BIENNIAL?

1. _____

2. _____

3. _____

Additional Comments:

RANK ORDER THE NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY'S **THREE** GREATEST STRENGTHS AND WEAKNESSES?

STRENGTHS:

1. _____

2. _____

3. _____

WEAKNESSES:

1. _____

2. _____

3. _____

Additional Comments:

APPENDICES

APPENDIX A

Estimated NorthSTAR Services Budget, September 1, 2008 - August 31, 2009

		Non-Medicaid Funds					Medicaid	Total Estimated	SH	Total	
		Local Funds	Substance Abuse Block Grant	Other DSHS Funds	TCOOMMI	OCR	Crisis Redesign funding	Projected PMPM Payment	Cash Payment (Premium)	Allocation	Funding
SFY 2009	Sep-08	383,333	854,392	2,746,245	145,833	48,231	371,784	4,304,023	8,853,841	2,874,083	11,727,924
	Oct-08	383,333	854,392	2,746,245	145,833	48,231	371,784	4,304,023	8,853,841	2,969,886	11,823,727
	Nov-08	383,333	854,392	2,746,245	145,833	48,231	371,784	4,304,023	8,853,841	2,874,083	11,727,924
	Dec-08	383,333	854,392	2,746,245	145,833	48,231	371,784	4,304,023	8,853,841	2,969,886	11,823,727
	Jan-09	383,333	854,392	2,746,245	145,833	48,231	371,784	4,304,023	8,853,841	2,969,886	11,823,727
	Feb-09	383,333	854,393	2,746,245	145,833	48,231	371,784	4,304,023	8,853,842	2,682,473	11,536,315
	Mar-09	383,333	854,393	2,746,245	145,833	48,231	371,784	4,304,023	8,853,842	2,969,886	11,823,728
	Apr-09	383,333	854,393	2,746,245	145,833	48,231	371,784	4,304,023	8,853,842	2,874,083	11,727,925
	May-09	383,333	854,393	2,746,245	145,834	48,231	371,784	4,304,023	8,853,843	2,969,886	11,823,729
	Jun-09	383,333	854,393	2,746,245	145,834	48,231	371,784	4,304,023	8,853,843	2,874,083	11,727,926
	Jul-09	383,333	854,393	2,746,245	145,834	48,231	371,785	4,304,023	8,853,844	2,969,886	11,823,730
	Aug-09	383,333	854,393	2,746,245	145,834	48,232	371,785	4,304,023	8,853,845	2,969,886	11,823,731
	Total	4,600,000	10,252,711	32,954,942	1,750,000	578,773	4,461,410	51,648,281	106,246,106	34,968,007	141,214,113
	Notes	1		2	3		4	5			

Notes:

1	Only Dallas, Collin, Rockwall, and Navarro counties are currently contributing funds. This estimate assumes participation of all counties at calculated matching amounts. Amounts will be paid out when DSHS receive the Local matching collections.
2	Less: GR Withhold for incentives (\$400,000) & Estimated GR match for Medicaid (\$6,630,983f or 12 mos./\$552,582 monthly). Includes New Generation Medication funds (\$6,693,468 annual).
3	Estimates TCOOMMI contribution of \$1,750,000, based on encounters in the DSHS data warehouse. Amounts will be paid out when DSHS receive the TCOOMMI collections.
4	Based on proposed FY09 crisis redesign allocation funding to NorthSTAR service area.
5	Based on Medicaid rates outlined in appendix 11, and most recent HHSC Medicaid Projections. Variable, depending on changes in Waiver rates and actual Medicaid enrollments. Includes federal funds, state GR match, and HHSC contribution.

APPENDIX B

FY 2009 Crisis Expenditure Projections

	FY 07 Baseline	FY 08 Crisis Spend	FY 09 Estimated Spend	Crisis Redesign Variance
<u>Current Programs</u>				
Community crisis services	\$ 19,236,807.00	\$ 21,595,995.90	\$ 22,095,995.90	\$ 500,000.00
Mobile Crisis	\$ 1,650,000.00	\$ 2,137,000.00	\$ 2,600,000.00	\$ 463,000.00
Transportation/Crisis Liasion	\$ 921,790.00	\$ 1,044,861.95	\$ 1,000,000.00	\$ (44,861.95)
After hours clinics	\$ -	\$ 142,258.00	\$ 887,340.00	\$ 745,082.00
Crisis residential	\$ -	\$ 277,500.00	\$ 1,000,000.00	\$ 722,500.00
<u>Proposed Programs</u>				
Crisis housing proposals			\$ 336,000.00	336000
Crisis center - North East NorthSTAR			\$ 800,000.00	800000
Crisis outreach/education			\$ 50,000.00	50000
FY 08 Crisis redesign funding		\$ 1,931,683.60		
FY 09 Crisis redesign funding			\$ 3,925,952.80	\$ 3,571,720.05
Total Crisis Target	\$ 21,808,597.00	\$ 23,740,280.60	\$ 25,734,549.80	
Total Crisis Spend		\$ 25,197,615.85	\$ 28,769,335.90	
over/(under) spend		\$ 1,457,335.25	\$ 3,034,786.10	

Please note: These figures are projections and are everything that was requested by the NTBHA stakeholders. It is still subject to DSHS approval.

References

www.ntbha.org

www.valueoptions.com

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U.S. Census Data

SFY 09 NorthSTAR Budget

NorthSTAR Data Warehouse

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LBJ School of Public Affairs assessment, 2003