Assessment of the
Community Behavioral Health Delivery System in Dallas County:
Detailed Report
Final Draft

Dallas County Behavioral Health System Redesign Task Force
September 30, 2010
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**Final Draft – Subject to Additional Peer Review**
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Introduction

Organization of the Report

This report is a companion document to the *Assessment of the Community Behavioral Health Delivery System in Dallas County: Main Report*. We refer to it as the *Detailed Report*, because it contains the longer, detailed analysis underlying our overall assessment.

This report results from a six-month engagement from April through September 2010 by a team of two consulting firms: TriWest Group, LLC (TriWest) and ZiaPartners, Inc. (ZiaPartners). Over that time, the principals conducting the assessment spent hundreds of hours on site and talking separately by telephone with clients and consumers, family members, parents, providers, advocates, funders, and other stakeholders in Dallas County, throughout the NorthSTAR region and across the state, including representatives from the Texas Department of State Health Services (DSHS).

These site visits ranged from talking with people waiting for appointments in provider waiting rooms to dozens of conversations with clinical managers and front line staff at a wide range of service delivery settings: primary care clinics, Specialty Provider Network (SPN) and other mental health providers, substance abuse services providers, leading community hospitals, residential facilities, the Lew Sterret Justice Center (Dallas County Jail and youth detention center), Henry Wade Youth Justice Center, The Bridge, the University of Texas Southwestern, and the Veterans Administration. We traveled beyond Dallas to Terrell State Hospital and Austin, and we talked with leaders from the North Texas Behavioral Health Authority (staff and board members), local mental health authorities outside of Dallas County, foundations (both local and statewide), governmental leaders, and researchers. We spent time with advocates from Mental Health America (MHA) of Greater Dallas, NAMI Dallas, NAMI Southern Sector, the Coalition on Mental Illness, and the Grant Halliburton Foundation. And we read hundreds of reports by others, and data extracts generously shared by DSHS, in particular and the many entities cited throughout this report and the more comprehensive 200-plus page Detailed Report that is a companion to it.

It is organized similarly to the Main Report, but it a stand alone document. The report is organized into three sections: this Introduction, Data and Policy Analysis, and The Twelve Steps: Areas of Recommendation.

The *Data and Policy Analysis* section includes detailed analysis of data on population trends, service needs, service provision, and funding, as well as an overview of national and state policy trends that inform strategic planning for the Dallas and NorthSTAR systems, and which inform our recommendations.
Within each subsection, there is a summary of major findings (in **bold and italics**), followed by more detailed data to support those findings and an analysis of the meaning of the data provided. These data elements frequently cross walk into the Recommendations section to support the findings and recommendations provided. However, it should be noted that in order to reduce duplication, there are additional findings and recommendations cited in the Recommendations section, many of which are more focused on the areas addressed in that section.

These analyses were shared in the form of a working draft of this report in August 2010, and significant additional feedback and input has been received and incorporated into this report.

**The Twelve Steps: Areas of Recommendation** section includes findings and recommendations that mostly coincide with the 12 Steps of Recovery for the Dallas County Behavioral Health System that were presented by the TriWest/ZiaPartners Team at the July 2010 meetings of the Coalition on Mental Illness (COMI) and the Dallas County Behavioral Health System Redesign Task Force, but their direction has been modified since then based on further data analysis and stakeholder input. In addition, we have attempted to align the general thrust of our recommendations with both the North Texas Behavioral Health Authority (NTBHA) Strategic Plan for 2010-12 and with Charting the Path: A Strategic Plan for Dallas County, which has five overarching Vision Statements to guide countywide planning, the first of which is that Dallas County is a model interagency partner, and the second is that Dallas County is a healthy community.

The Twelve Steps or Areas of Recommendation are as follows:

1. Creating and Implementing a Behavioral Health Leadership Team (BHLT) in Dallas County
2. Models for System Authority, Oversight, and Funding
3. Customer-Oriented Performance Improvement
4. Data Sharing for System Management
5. Primary Health/Behavioral Health Integration
6. Welcoming, Recovery-Oriented, Integrated Continuum of Crisis-Intervention and Acute-Care Services
7. Recovery-Oriented Integrated System of Care for Adults with Serious Mental Illness
8. Recovery-Oriented Integrated Continuum of Services for People with Substance Use and Co-occurring Disorders
9. Criminal Justice/Behavioral Health Service System for Adults
10. System of Care and Housing Services for People Who are Homeless
11. Development of a Children’s System of Care
12. Services for Cultural and Linguistic Minorities
Each of the 12 sections is organized with a brief background section, a list of major findings, and then a series of actionable recommendations. The recommendations themselves are divided into phases, usually with the first phase defining action steps to begin immediately and continue over the next 12 months (Year One), and the second phase referring to action steps or objectives for 12-36 months (Years Two and Three). The second phase is aligned with necessary time frames related to planning for future NorthSTAR contracting, health care reform, and Parkland’s new construction.

The first 11 of these areas of recommendation were shared with stakeholders in the form of a working draft in August 2010. A draft of the 12th area of recommendation (Services for Cultural and Linguistic Minorities) was shared with a smaller subset of stakeholders that provided input into that section. Significant additional feedback and input have been received and incorporated into this report.

**Background for the Report**

This is a very long and detailed report, and an understanding of how it was developed and the background that led to its development may help make best use of the findings.

First, we are very appreciative of the hours and hours of helpful input, discussion, and information that have been provided by clients and consumers, family members, parents, providers, advocates, funders, and other stakeholders in Dallas County, throughout the NorthSTAR region, and across the state, including representatives from the Texas Department of State Health Services (DHS).

Second, we have been very impressed with the engagement, involvement, and partnership that exist among various stakeholders, particularly within the Coalition on Mental Illness, ably coordinated by the Mental Health America (MHA) of Greater Dallas, in partnership with NAMI Dallas and NAMI Southern Sector. And each of those advocacy organizations has been of considerable help individually, as has been the Grant Halliburton Foundation.

Third, we clearly recognize that everyone in the system is laboring under very challenging circumstances with limited resources. Yet, what we discovered is that, almost without exception, Dallas County and the broader NorthSTAR area include systems of care with tremendous heart, where people are searching for ways to provide the best care possible to people with tremendous challenges, within whatever resources are available.

The fourth piece of background concerns our starting place for this report. When we (TriWest / ZiaPartners) entered the system in Dallas County, we were immediately provided sets of data and information with which many readers will already be quite familiar. These data sets are in many locations, but some of the best available compendia of this data are in the following presentations and documents:
Collectively, the starting place of information that we were provided made it clear that the first thing to examine within the Dallas County Behavioral Health System was the performance of NorthSTAR. Further, it is generally acknowledged that under NorthSTAR there has been access for greater numbers of individuals with Medicaid and no insurance, elimination of waiting lists for services, expansion and improved collaboration of the provider network, lower per capita cost per person served (compared to other Texas systems), and relatively comparable performance indicators compared to other systems in Texas as measured by DSHS (Resiliency and Disease Management/RDM tracking, Texas Recommended Assessment Guidelines/TRAG scores, readmission rates, and others). We clearly understand that stakeholders in the system are in many ways pleased with the expansion of access and the elimination of waiting lists, as well as being justifiably proud of service innovations in other areas of the system. There are many areas of strength and resources throughout the system, highlighted throughout this report.

At the same time, another part of our starting place was the knowledge (as most readers of this report will likely be aware) that the overall level of state public behavioral health funding in Texas is 48th in ranking of the 50 states,¹ that urban areas like Dallas are particularly challenged by that low level of state funding (and the low level of Medicaid penetration in Texas), that NorthSTAR is particularly challenged by serving increasing numbers of uninsured individuals without commensurate increases in funding from the state. There is clearly a sense that the system is moving toward overload, facing increasing needs and (relatively) shrinking resources, and that the system needs more resources in order to perform optimally. Part of our charge was not only to analyze the system as it is and provide recommendations for improvement, but also to help the system develop strategies for leveraging existing resources more effectively and attracting additional resources in the future, in order to reduce the sense of impending crisis and produce better outcomes for persons and families in need.

In order to accomplish this task, we have chosen not to start our analysis by simply repeating what you already know. Our goal is to take the data you are most familiar with and attempt to go deeper and wider to help readers “see” the Dallas County and broader NorthSTAR systems from a different perspective, and to help you to improve your system more effectively as a result. By going deeper, we mean that we have taken the initial sets of data provided and tried to analyze them in an integrated manner, with an eye toward what they can tell us about the service experiences of real people – not only the people who have successful experiences, but particularly those who are having relatively poor outcomes and high costs. By getting a picture of what is happening for those individuals, we are trying to provide you with a more accurate portrait of both the successes and limitations of how your system is using its existing resources.

By going wider, we mean that we are starting with the assumption that NorthSTAR is only a component of your system that most likely represents less than half of the total resources currently being expended in Dallas County for public behavioral health. Thus, evaluating only the NorthSTAR component of the Dallas County system does not provide an adequate representation of either the current state of the system or the potential to leverage broader resources across the system. Again, our goal is to help the reader see the fuller picture of all the resources in the system combined into an “integrated” package, so that you can begin to put them together in new ways to achieve better results and to attract even more resources for behavioral health care in the future.

As you begin to read this report, therefore, we would like you to join us in looking at both the Dallas County system, and the NorthSTAR regional system, through this new lens. We think there are many opportunities to build on your successes and to perform significantly better, even without a major increase in resources. We also think that there are potential new strategies for aligning with national and state priorities to leverage a broader array of resources most effectively (as well as strategies that we recommend that you avoid). We look forward to seeing how people within Dallas County and the broader NorthSTAR system use this report to inform efforts to improve the lives of real people over the years to come.

Data and Policy Analysis

Persons in Need

Overall Population Trends

Major Findings:

• **Impoverished populations in Dallas County (Medicaid, persons under 200% of the Federal Poverty Level [FPL]) grew more rapidly (16.6%) from State Fiscal Year (SFY) 2008 to SFY**
2010 than the overall population (2.0% in that same period).

- The percentage of impoverished adults who are covered by Medicaid in Dallas County (and Texas generally) compared to children, and compared to other states, is strikingly low. Only 11% of adults below 200% FPL, compared to the vast majority of children, have Medicaid or similar coverage.

<table>
<thead>
<tr>
<th>Overall Population</th>
<th>SFY 2009 Population²</th>
<th>Average Monthly FY 2009 Medicaid Members³</th>
<th>SFY 2009 &lt;200% FPL⁴</th>
<th>FY 2009 CHIP Enrollment⁵</th>
</tr>
</thead>
<tbody>
<tr>
<td>NorthSTAR Total (all counties)⁶</td>
<td>3,690,653</td>
<td>378,559</td>
<td>1,114,402</td>
<td></td>
</tr>
<tr>
<td>Dallas County</td>
<td>2,412,431</td>
<td>305,559</td>
<td>872,972</td>
<td></td>
</tr>
<tr>
<td>Dallas County – 0 to 18⁷</td>
<td>670,565</td>
<td>241,101</td>
<td>244,703</td>
<td>55,094</td>
</tr>
<tr>
<td>Dallas County – 19 and older</td>
<td>1,741,866</td>
<td>64,458</td>
<td>618,407</td>
<td></td>
</tr>
</tbody>
</table>

³ Texas Health and Human Services Commission. Final Count Reports for Medicaid Enrollment, Medicaid Enrollment by County, State Fiscal Year 2009. Retrieved from: http://www.hhsc.state.tx.us/research/MedicaidEnrollment/MedicaidEnrollment.asp. Average was computed across the 12 months of enrollment.
⁴ SFY 2009 figures for < 200% FPL will not be available from DSHS until October/November 2010. Therefore, we estimated these figures by using 2008 FPL figures and modifying them based on the change in average Medicaid enrollment between 2008 and 2009. Changes were increases of 6.8% for NorthSTAR Counties, 6.5% for Dallas County, 7.1% for Dallas County youth, and 4.6% for Dallas adults. We believe that the Medicaid increase is the best proxy, as it reflects both population growth and increases in the rate of poverty. SFY 2008 < 200% FPL estimates were obtained from the Texas Health and Human Services Commission, Strategic Decision Support Office, Copy of Estimated Population at-Below FPL in 2008 by Zip Code, via Personal Communication from M. Ferrara, August 16, 2010.
⁵ Texas Health and Human Services Commission. Texas CHIP Enrollment by County and Month, State Fiscal Year 2009. Retrieved from: http://www.hhsc.state.tx.us/research/CHIP/CHIP_EnrollbyCountyMonth/FY09.xls. Average was computed across the 12 months of enrollment.
⁶ Note that the SFY 2010 Quarter 1 NorthSTAR Databook reports an average of 384,130 for SFY 2009. NorthSTAR data was not broken down by county, so we used figures direct from the THHSC website. The numbers are comparable and likely differ due to different approaches to averaging counts across the year.
⁷ The average Medicaid eligibles include 2,201 children on average each month who are in foster care. These children are not included in NorthSTAR figures.
Overall, the Dallas County population is estimated by the census to have grown 1.0% (0.7% for children and youth and 1.1% for adults) between SFY 2008 and SFY 2009 and at the same exact rate again from SFY 2009 to SFY 2010 (1.0% overall, 0.7% for children and youth and 1.1% for adults). The Medicaid population in Dallas County grew more quickly, increasing 3.6% (4.0% for children and youth and 2.3% for adults) between SFY 2008 and SFY 2009. While SFY 2009 figures for the proportion under 200% FPL will not be available from the state until the fall, it seems likely, based on the financial challenges facing the region and the nation during that time period, that growth in this population was at least the same as growth in the Medicaid population.

Growth in Dallas County for Medicaid and the number of people under 200% FPL through early 2010 is on a trend to grow by even greater margins for the entire fiscal year. Growth from SFY 2009 to SFY 2010 (using confirmed eligibility figures through January 2010) occurred at a rate of 9.5% (11.0% for children and youth and 3.8% for adults), an increase of 28,899 Medicaid covered individuals in Dallas County alone (26,441 children and 2,458 adults). We expect a comparable rate of growth in the number of individuals under 200% FPL. Over the same period, the number of children covered by CHIP increased by 3.7%.

Of note is the difference in Medicaid coverage for children versus adults. While national trends show that Medicaid covers a higher proportion of children and youth in poverty than adults in poverty, the degree of difference in Dallas (and Texas as a whole) is greater. Nearly 93% of children under 200% FPL are covered by Medicaid, yet just under 11% of adults under 200% FPL have Medicaid coverage. Once CHIP is added in, nearly all of Dallas County children under 200% FPL are covered (the apparent number exceeds 100% because the two groups overlap as eligibility changes across the year, and because of possible errors in the SFY 2009 estimate of the number of children below 200% FPL).

**Overall Behavioral Health Prevalence Trends**

Most estimates of need for behavioral health services focus on the prevalence of behavioral health diagnoses. The consensus from studies in the 1990s centered on a 12-month prevalence rate of just over 20% (Regier and colleagues, 1993; Kessler and colleagues, 1996; U.S. Surgeon

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General, 1999\textsuperscript{10}), but in the last decade more refined 12-month prevalence estimates have been developed. Bilj and colleagues (2003) estimated much higher levels of need, approaching 29.1\%, including 11.5\% with substance use disorders (SUD). That study included estimates of severity, with 13.8\% of these conditions estimated to be mild, 7.0\% moderate, and 8.2\% serious.\textsuperscript{11} A study published in the same 2003 issue of Health Affairs questioned the validity of focusing too much on diagnosis as a measure of need, and recommended that levels of functioning, disability and distress also be considered in order to estimate clinical severity (Regier, 2003).\textsuperscript{12}

To provide more refined estimates, we obtained prevalence estimates for Texas and counties in the NTBHA catchment area directly from Holzer and Nguyen\textsuperscript{13} based on the Collaborative Psychiatric Epidemiology Surveys (CPES).\textsuperscript{14} The CPES were initiated in recognition of the need for contemporary, comprehensive epidemiological data regarding the distributions, correlates and risk factors of mental disorders among the general population, with special emphasis on minority groups. The CPES project joined together three nationally representative surveys: the National Comorbidity Survey Replication (NCS-R), the National Survey of American Life (NSAL), and the National Latino and Asian American Study (NLAAS).\textsuperscript{15} Holzer and Nguyen\textsuperscript{16} developed a synthetic (indirect) estimation model from CPES data that estimates need for mental health


\textsuperscript{13} Psychiatric Epidemiology and Services Research: Charles E. Holzer, III, Ph.D. and Hoang T. Nguyen, Ph.D. http://66.140.7.153/


\textsuperscript{15} The CPES surveys were developed under the sponsorship of the National Institute of Mental Health (NIMH), and the data collection was conducted by the Survey Research Center (SRC) of the Institute for Social Research at the University of Michigan from early 2001 through the end of 2003.

\textsuperscript{16} Chuck Holzer, Ph.D. and Nguyen, Ph.D. make 2007 state level estimates available on their web site: http://66.140.7.153/. 2007 county level estimates for NTBHA counties were purchased for this project. Estimates are for people who would be described as having a serious mental illness as defined by having one of a specified set of relatively severe mental health diagnoses, a high level of functional impairment, and, for adults, as having more than 120 days off work as a result of their mental illness in the last year.
services for specific demographic subgroups and then sums across all demographic subgroups to obtain an overall estimate of the numbers of people in need of mental health services. This approach enables them to develop estimates for any geographic area for which census data is available that meets the requirement of the model. The specific demographic variables used in Holzer’s synthetic estimation model were: age, sex, race/ethnicity, marital status, education and poverty, with adjustments for institutions and group quarters. The basic assumption underlying indirect needs assessment is that demographic characteristics have a consistent general relationship to psychiatric disorder throughout the U.S.

A similar synthetic estimation approach was used to estimate the prevalence of substance abuse in adults. Estimates were developed for specific combinations of conditions, including mental health and substance abuse separately, as well as co-occurring conditions. In order to ensure that the separate estimates tied together with the estimate for total mental health, we used an approach developed by Chuck McGee of the Western Interstate Commission for Higher Education (WICHE) Mental Health Program, in consultation with Dr. Holzer. Mr. McGee developed his approach in the process of completing the Colorado Population in Need 2009 report.\(^{17}\) We augmented this approach to refine the estimated breakout between persons with primarily SUD only and persons with co-occurring SUD and mental health (MH) conditions based on our team’s national experience across systems and our own synthesis of the results of the National Comorbidity Survey Replication (NCS-R), which conservatively estimates the 12-month overlap between severe and persistent mental illness and SUD at 60%.\(^{18}\)

**Persons with Severe Needs**

**Major Findings:**

- **The need for treatment of severe mental health (MH) conditions in SFY 2009 was 44,197 for Dallas County adults under 200% FPL and 28,508 for children under 200% FPL.**

- **68,871 adults under 200% FPL in Dallas County have severe substance use disorders (SUD).**

- **26,518 adults with severe MH conditions under 200% FPL in Dallas County have co-occurring SUD, and 41,323 adults with severe SUD conditions in Dallas County have co-**


\(^{18}\) Center for Substance Abuse Treatment. The Epidemiology of Co-Occurring Substance Use and Mental Disorders. COCE Overview Paper 8. DHHS Publication No. (SMA) 07-4308. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.
occurring MH conditions (not necessarily severe). These two co-occurring populations are partially overlapping.

The table below shows that the percentage of the adult population that is estimated to be in need of mental health services for severe conditions in Dallas County is 4.8%, or 82,913 of the 1,741,866 adults living in the county in SFY 2009. The level of need for other NorthSTAR counties is 3.8%. The State of Texas overall has a level of need comparable to Dallas County at 4.8%. For adults living below 200% FPL, the relative proportions between the state as a whole, Dallas, and the other NorthSTAR counties are similar.

<table>
<thead>
<tr>
<th>State or County Level</th>
<th>SFY 2009 18 and Over Population</th>
<th>Adults in Need for Severe MH Conditions (AIN)</th>
<th>Percent of Population</th>
<th>SFY 2009 AIN &lt; 200% FPL</th>
<th>Percent of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>State of Texas</td>
<td>18,362,951</td>
<td>885,094</td>
<td>4.8%</td>
<td>469,104</td>
<td>2.6%</td>
</tr>
<tr>
<td>NorthSTAR Counties*</td>
<td>2,705,038</td>
<td>120,645</td>
<td>4.5%</td>
<td>58,471</td>
<td>2.2%</td>
</tr>
<tr>
<td>Dallas County</td>
<td>1,741,866</td>
<td>82,913</td>
<td>4.8%</td>
<td>44,197</td>
<td>2.5%</td>
</tr>
<tr>
<td>Other NorthSTAR Counties</td>
<td>963,172</td>
<td>36,986</td>
<td>3.8%</td>
<td>14,273</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

* NorthSTAR Counties: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall

The Dallas County level of need figures can also be broken down by type of condition.\(^\text{19}\) Note that the percentage of severe need estimated by the Holzer and McGee methods is marginally higher than the national estimate of severe mental health and substance use disorders of 8.2% estimated by Bilj et al (2003).

\(^{19}\) Holzer and Nguyen make SFY 2007 state level estimates available on their web site (http://66.140.7.153/). County level estimates for each of the above mental health/substance abuse conditions for NTBHA counties were purchased for this project. SFY 2009 population < 200% FPL was estimated by applying the proportional relationship between the SFY 2007 < 200% FPL population and the SFY 2007 adult population to SFY 2009 adult population data. Estimate levels from SFY 2007 for mental health/substance abuse conditions were applied to SFY 2009 < 200% FPL estimates to obtain the estimates for the respective conditions in SFY 2009.
The prevalence of mental health need for youth in the population 0 to 17 years of age is in general higher than for adults, at 7.6% for the entire State of Texas, as shown below. The pattern of need for youth is similar to that for adults, with the NorthSTAR area level of need slightly below the overall state and with the need in Dallas County being higher than the other NorthSTAR counties as a group.

<table>
<thead>
<tr>
<th>State or County Level</th>
<th>SFY 2009 0 to 17 Population</th>
<th>Children / Youth in Need for Severe Conditions (CYIN)</th>
<th>Percent of Population</th>
<th>SFY 2009 CYIN &lt; 200% FPL</th>
<th>Percent of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>State of Texas</td>
<td>6,510,822</td>
<td>496,776</td>
<td>7.6%</td>
<td>271,577</td>
<td>4.2%</td>
</tr>
<tr>
<td>NorthSTAR Counties</td>
<td>985,615</td>
<td>72,936</td>
<td>7.4%</td>
<td>35,176</td>
<td>3.6%</td>
</tr>
<tr>
<td>Dallas County</td>
<td>670,565</td>
<td>51,164</td>
<td>7.6%</td>
<td>28,508</td>
<td>4.3%</td>
</tr>
<tr>
<td>Other NorthSTAR Counties</td>
<td>315,050</td>
<td>21,833</td>
<td>6.9%</td>
<td>6,659</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

20 The 200% FPL figures used by Holzer were based on SFY 2007 census data. As noted previously, there is evidence that the proportion of the Dallas County population under 200% FPL has increased since SFY 2007. However, the Holzer proportions from SFY 2007 were maintained in order to preserve the internal integrity of the Holzer model. Accordingly, there is some chance that the SFY 2009 need levels for persons under 200% FPL are higher than those noted here.
Estimates of the prevalence of severe SUD services use for children and youth were not available, as Holzer and Nguyen do not report them and national figures breaking out such use (Bilj et al, 2003) focus only on adult prevalence rates.

Persons Served

**Major Findings:**

- *NorthSTAR serves a figure that approximates 50% of adults and children in need of MH and SUD services. This is a relatively high penetration rate compared to other systems in Texas, and nationally.*

- *There is evidence to suggest, however, that this high penetration rate may be associated with insufficient services to those persons with the highest need of such services based on observable functional level.*

- *Over one-quarter (28.2%) of adults with the highest MH and SUD needs were served in the jail in County Fiscal Year (CFY) 2010 and received services from Parkland.*

- *Upwards of 40% of all children and youth with the highest needs were served through Dallas County Juvenile Services.*

- *African American youth are served in the juvenile justice system at twice their proportion of the population; African American adults are even more over-represented in the jail. Hispanic people comprise 40% of the population, but 24% of NorthSTAR persons served.*

- *There is evidence that - within the current amount and methodology of funding - NorthSTAR is serving too many persons without insurance compared to other similar managed care systems, at the expense of those with and without Medicaid who have the highest needs.*

- *There is evidence that suggests that in Dallas County a smaller percentage of persons with serious needs are receiving services in primary care settings than in comparable systems across the country.*
The 2003 national survey of prevalence (Bilj, et al, 2003) also estimated the proportion of persons served nationally. A breakdown of key national trends for the United States includes:

- 37.1% of those with serious needs receive treatment.
- Of those with serious needs receiving treatment, 62.9% receive care in specialty treatment settings and 37.1% receive care in primary care settings.

The table on the following pages looks at persons served across multiple care settings in Dallas County, comparing the number of persons served in SFY 2009 to the estimated need for services for severe MH and SUD conditions for adults and for severe MH conditions for children under 200% FPL.

<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Persons Served</th>
<th>Persons in Need (PIN) &lt;200% FPL</th>
<th>Percent of PIN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Behavioral Health System</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SFY 2009 NorthSTAR All Counties TOTAL</strong></td>
<td>62,075</td>
<td>124,628</td>
<td>49.8%</td>
</tr>
<tr>
<td><strong>SFY 2009 NorthSTAR Dallas County Total</strong></td>
<td>48,643</td>
<td>97,379</td>
<td>50.0%</td>
</tr>
<tr>
<td><strong>SFY 2009 NorthSTAR Dallas County Adults</strong></td>
<td>34,872</td>
<td>68,871</td>
<td>50.6%</td>
</tr>
<tr>
<td><strong>SFY 2009 NorthSTAR Dallas County Children</strong></td>
<td>13,771</td>
<td>28,508</td>
<td>48.3%</td>
</tr>
<tr>
<td><strong>SFY 2009 Medicaid Fee For Service / Primary Care Case Management Behavioral Health Services</strong></td>
<td>5,590</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

22 Combined Adults in Need (AIN) for both MH and SUD and Children / Youth in Need (CYIN) for MH from Holzer and Nguyen.
24 Breakouts for children and adults were not provided in the DSHS 11/23/09 “County Trends” report just cited. To compute these breakouts, proportions served from Dallas County for SFY 2009 from the NorthSTAR SFY10 Quarter 1 Databook were applied to the DSHS figures, as the Databook only reported averages of quarterly figures and the DSHS “County Trends” report provides unduplicated totals across all of SFY 2009.
<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Persons Served</th>
<th>Persons in Need (PIN) &lt;200% FPL&lt;sup&gt;22&lt;/sup&gt;</th>
<th>Percent of PIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult MH</td>
<td>2,595</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult SUD</td>
<td>617</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child MH and SUD</td>
<td>2,377</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SFY 2009 Medicaid Fee For Service / Primary Care Case Management Behavioral Health Services</strong>&lt;sup&gt;26&lt;/sup&gt;</td>
<td>2,024</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult MH</td>
<td>245</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult SUD</td>
<td>74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child MH and SUD</td>
<td>1,706</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SFY 2009 Additional Medicaid Vendor Behavioral Health Medications</strong>&lt;sup&gt;27&lt;/sup&gt;</td>
<td>7,390</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SFY 2009 Medicaid BH for Dallas County Children in Foster Care</strong>&lt;sup&gt;28&lt;/sup&gt;</td>
<td>360</td>
<td>28,508</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>SFY 2009 CHIP BH for Dallas County Children</strong>&lt;sup&gt;29&lt;/sup&gt;</td>
<td>2,755</td>
<td>28,508</td>
<td>9.7%</td>
</tr>
</tbody>
</table>

<sup>25</sup> Legislative Budget Board (LBB). (June 29, 2010). Draft data book for Legislative Budget Board comparative report: Comparative analysis of publicly funded behavioral health systems in Texas by HHSC service delivery area. Received via personal communication from I. Garza, August 31, 2010, in response to Open Records Request. LBB data included all NorthSTAR counties, so to estimate the proportion for Dallas County, the SFY 2009 NorthSTAR Dallas County proportions for persons served (78.4%) and expenditures (80.1%) were computed and applied to the LBB data.

<sup>26</sup> LBB. (June 29, 2010). As previously, SFY 2009 NorthSTAR Dallas County proportions for persons served (78.4%) and expenditures (80.1%) were computed using the November 23, 2009 DSHS data set cited above and applied to the LBB data.

<sup>27</sup> LBB. (June 29, 2010). The SFY 2009 NorthSTAR Dallas County proportion of overall NorthSTAR medication claimants (79.6%) was computed using the November 23, 2009 DSHS data set cited above and applied to the LBB claimant and expenditure data.

<sup>28</sup> Data on this population is not available through the state as of the date of publication; a conservative factor of 30% was used to estimate the proportion of the 2,201 average number of children in foster care with Medicaid per month in SFY 2009 who received services over the course of a year.
<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Persons Served</th>
<th>Persons in Need (PIN) &lt;200% FPL&lt;sup&gt;22&lt;/sup&gt;</th>
<th>Percent of PIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFY 2009 Additional DSHS-funded BH Services&lt;sup&gt;30&lt;/sup&gt;</td>
<td>2,585</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult MH</td>
<td>1,800</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult SUD</td>
<td>465</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child MH and SUD</td>
<td>320</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health System</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CFY 2009 Parkland Behavioral Health – Non-Jail&lt;sup&gt;31&lt;/sup&gt;</td>
<td>19,242</td>
<td>97,379</td>
<td>19.8%</td>
</tr>
<tr>
<td>Public Adult Correctional System</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CFY 2009 Parkland Behavioral Health – Jail&lt;sup&gt;32&lt;/sup&gt;</td>
<td>19,389</td>
<td>68,871</td>
<td>28.2%</td>
</tr>
<tr>
<td>Dallas County Jail Bed Use (CFY 2010)&lt;sup&gt;33&lt;/sup&gt;</td>
<td>522</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting for Bed (State Hospital)</td>
<td>105</td>
<td>68,871</td>
<td>0.2%</td>
</tr>
<tr>
<td>Waiting for Other BH Placement</td>
<td>417</td>
<td>68,871</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

---

<sup>29</sup> Data on this population is not available through the state as of the date of publication; a conservative factor of 5% was used to estimate the proportion of the 55,094 average CHIP enrollment for SFY 2009.<br>
<sup>30</sup> LBB. (June 29, 2010). As previously, SFY 2009 NorthSTAR Dallas County proportions for persons served (78.4%) and expenditures (80.1%) were applied to the LBB data.<br>
<sup>31</sup> Parkland computed a total, unduplicated persons served figure for behavioral health services in the emergency department, inpatient units, psychiatric clinic, and community oriented primary care clinics. This total of 14,424 was then reduced by 3,164 (the number of persons reported as served through NorthSTAR for all seven counties by Parkland Health and Hospital System in CFY 2009, as reported by the DSHS “NorthSTAR County Trends Report 11_23_09”) to reach an unduplicated annual total estimate of 14,424.<br>
<sup>32</sup> Personal communication from W. Ahmed, August 19, 2010.<br>
### Care Setting

<table>
<thead>
<tr>
<th></th>
<th>Persons Served</th>
<th>Persons in Need (PIN) &lt;200% FPL&lt;sup&gt;22&lt;/sup&gt;</th>
<th>Percent of PIN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dallas County CSCD – Services Delivered by Comprehensive Assessment and Treatment Services (CATS) Staff (SFY 2010)</strong>&lt;sup&gt;34&lt;/sup&gt;</td>
<td>1,090</td>
<td>68,871</td>
<td>1.6%</td>
</tr>
<tr>
<td><strong>Public Juvenile Justice System</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dallas County Juvenile Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Residential Contract Services (CFY 2010)&lt;sup&gt;35&lt;/sup&gt;</td>
<td>2,400</td>
<td>28,508</td>
<td>8.4%</td>
</tr>
<tr>
<td>Residential Contract Services (CFY 2010)&lt;sup&gt;27&lt;/sup&gt;</td>
<td>400</td>
<td>28,508</td>
<td>1.4%</td>
</tr>
<tr>
<td>County-Delivered Services (CFY 2009)&lt;sup&gt;36&lt;/sup&gt;</td>
<td>10,000</td>
<td>28,508</td>
<td>35.1%</td>
</tr>
<tr>
<td><strong>Other Systems</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent Supportive Housing (beds across various providers)&lt;sup&gt;37&lt;/sup&gt;</td>
<td>1,475</td>
<td>68,871</td>
<td>2.1%</td>
</tr>
<tr>
<td>The Bridge&lt;sup&gt;38&lt;/sup&gt;</td>
<td>1,850</td>
<td>68,871</td>
<td>2.7%</td>
</tr>
</tbody>
</table>

<sup>34</sup> Personal communication from G. Crumpton, June 11, 2010. Data was provided on the number of group (39,350) and individual counseling (2,723) units provided in SFY 2009 by staff. Data on persons served was not available for SFY 2009, so the number for the first six months of SFY 2010 (815) was multiplied by a factor derived from the number of SFY 2009 combined group and individual units (42,073) divided by the number of SFY 2010 combined group and individual units (31,465) to yield 1,090 (815 x 42,073/31,465).

<sup>35</sup> Personal communication from D. Kilcrease-Fleming on July 14, 2010.

<sup>36</sup> Dallas County Juvenile Department Clinical Services Division. Annual Report 2009.

<sup>37</sup> Data provided from the Metro Dallas Housing Alliance, via Personal Communication from Jay Dunn, July 21, 2010. Data is the number of beds available across units, and not all beds are filled by persons with severe behavioral health diagnoses.

<sup>38</sup> Personal communication from J. Dunn, July 21, 2010 for persons served and financial data for CFY 2010. Persons served data was reported unduplicated per day for CFY 2010. This was compared to a data set for the first four months of 2010 provided via personal communication from M. Faenza. Based on this, a four month turnover factor of 67% was calculated (1200 daily visits equates to 1,968 in four months); applying this factor three times resulted in a total annual estimate of 5,300; data from a personal communication from M. Faenza, April 19, 2010 on persons served data for CFY 2009 was then used to estimate that 35% of these persons had behavioral health needs, thus yielding the estimate of 1,850 persons with behavioral health needs served.
Public Behavioral Health System. Key findings for the formal behavioral health system in the preceding table include:

- **NorthSTAR serves a much higher proportion of adults in need under 200% FPL** than the estimate of national averages (Bilj et al, 2003) for adults with serious needs served (50.6% versus 37.1%).

- **Denver County comparison**: Another comparison looks at the Medicaid penetration rates for Dallas County and for Denver County, which also administers a 1915(b) mental health managed care waiver. **One important caveat for this comparison is that Denver (and Colorado as a whole) covers a broader proportion of its adult population in poverty through Medicaid, so there is less need to do so with state funding.** Despite this, the comparison illustrates the typical practice nationally of limiting services to people without Medicaid to priority populations only (rather than covering an entire population, such as those under 200% FPL (or any level of FPL, for that matter). Denver County’s CFY 2009
penetration rate for Medicaid adults was 20.4% and for Medicaid children was 8.6%.\textsuperscript{39} For Dallas County NorthSTAR Medicaid members that same year, the penetration rate was 15.4% for Medicaid adults and 4.6% for Medicaid children.\textsuperscript{40} Note also that Denver’s plan covers mental health services only, whereas 16.9% of Dallas County NorthSTAR consumers (Medicaid and non-Medicaid) are diagnosed primarily with SUD.\textsuperscript{41} Note also that funding rates in Colorado overall for mental health are much higher,\textsuperscript{42} but the most striking point of difference is this: NorthSTAR served \textbf{nearly four times as many} Dallas County uninsured residents (27,902 or 1.16% of its 2009 population) and Denver County only served 1,868 (0.31% of its 2009 population). Excluding the estimated 16.9% of persons served with SUD to make the data more comparable to Denver (which provides only mental health services), the Dallas County NorthSTAR rate is 0.96% of the population, more than three times as high as Denver’s. NorthSTAR in Dallas County is serving a much higher proportion of uninsured persons with its funds (compared to both its Medicaid population and the benchmark city of Denver), even though its funding allocation for uninsured persons is fixed, and its funding allocation for Medicaid is based on Medicaid enrollment. This is also seen in a simple comparison of the proportion of Medicaid funding out of overall non-state hospital funding for NorthSTAR as a whole (46.9% of the FY 2010 budget)\textsuperscript{43} to the overall proportion of persons treated who have Medicaid (42.6%).\textsuperscript{44}

- Over 17,500 additional persons are served through the STAR/STARPlus Medicaid managed care systems and additional services paid for by DSHS. The severity of need for those individuals served through the STAR and STARPlus systems likely ranges into moderate levels, given the service priorities of those HMO-based systems.

\textsuperscript{39} Personal communication, R. Bremer, ColoradoAccess, Access Behavioral Care.

\textsuperscript{40} Texas Department of State Health Services. (November 23, 2009). NorthSTAR County Trends Report 11_23_09. Provided in personal communication from M. Ferrara as a Microsoft Excel file on July 6, 2010. As noted above, breakouts for children and adults were not provided in this report. To compute these breakouts, proportions served from Dallas County for CFY 2009 from the NorthSTAR FY10 Quarter 1 Databook were applied to the DSHS figures, as the Databook only reported averages of quarterly figures and the DSHS “County Trends” report provides unduplicated totals across all of CFY 2009. These service figures were then divided by the average Medicaid members for SFY 2009, as cited in the table above.

\textsuperscript{41} Texas Department of State Health Services. (November 23, 2009). NorthSTAR County Trends Report 11_23_09.


\textsuperscript{43} See Appendix 30 of the 2009-2011 NorthSTAR contract. Medicaid funding accounted for $52,111,697, while the overall budget was $111,147,490.

\textsuperscript{44} Texas Department of State Health Services. (November 23, 2009). NorthSTAR County Trends Report 11_23_09. Method was described above.
Primary care settings. The data suggests that the percentage of individuals with severe needs below 200% FPL served in primary care settings (19.8%, considering any program in Parkland to be to some degree a primary care setting) is less than the national average (37.1%). However, it must be noted that we do not have access to data that would let us know all of the individuals served in primary care settings outside of Parkland. Nonetheless, given that Parkland is far and away the largest primary care provider for low-income populations in Dallas County, this finding is significant. Note further that this finding may be due to the fact that Parkland is not a NorthSTAR provider, and therefore some of the NorthSTAR population that might be successfully served in a primary health setting is referred to specialty MH providers. This referral process may also contribute to the dilution of available resources to provide higher intensity specialty MH services to those individuals with the highest needs (as defined by crisis contacts, homelessness, and incarceration).

Other child systems. There are also additional children served through the Medicaid foster care health plan (STARHealth, delivered by Superior HealthPlan Network, with behavioral health services managed by IMHS Behavioral Health [Cempatico]) and the three CHIP plans serving Dallas residents. We derived estimates of the numbers of persons likely to be served in those plans based on our experience with other parts of the country, but it is of interest to note the simple fact that our study has not been able to access data on the numbers of persons receiving behavioral health in these plans despite efforts with numerous statelevel informants over a two month period. The lack of ability to readily note the number of persons receiving behavioral health services in these plans underscores the difficulties facing clinicians trying to coordinate care across both funding streams. It should be noted that the June 2010 draft of the Legislative Budget Board (LBB) comparative analysis of behavioral health system funding was not able to report data on behavioral health services delivered through the STARHealth program for children in foster care.45

Adult corrections and juvenile justice settings. The number of persons in the jail waiting for behavioral health services was also computed, focusing on persons waiting as of the last month of the most recent county fiscal year (July 2010). These figures were used instead of CFY 2009 figures, given the dramatic increase in persons awaiting state hospital and community behavioral health resources. From CFY 2008 through CFY 2010, the average number of beds used has increased 25.1% (from 316 to 395 per month on average). The total in the last month

45 Legislative Budget Board. (June 29, 2010). Draft data book for Legislative Budget Board comparative report: Comparative analysis of publicly funded behavioral health systems in Texas by HHSC service delivery area. Received via personal communication from I. Garza, August 31, 2010, in response to Open Records Request.
of the fiscal year was even more concerning, over 63% higher (522 total). The increase for the
subgroup waiting for a state hospital placement was 138% higher that month than the CFY 2008
average (105 versus 44), and the increase for the subgroup awaiting community placements
was 54% higher (417 versus 272). The Dallas County Community Supervision and Corrections
Department (CSCD) delivers an impressive and growing array of services under contract and
through its Comprehensive Assessment and Treatment Services (CATS) unit. However, the
capacity for these services is under 5% of the capacity for behavioral health services in the jail,
suggesting a need for better flow through that system to other community behavioral health
services available through NorthSTAR.

Dallas County Juvenile Services has an impressive array of services that serve more than 40% of
all children and youth (of any age) in need of services, which represents a much higher
proportion of the youth eligible for its services (youth age 10 through 17). More on this below.

**Homeless services.** The Bridge and current permanent supportive housing (PSH) resources have
the capacity to serve about 2.5% of those adults with behavioral health needs who are
homeless each year. However, not all PSH resources are targeted to this population.

**Other systems.** It is important to note that the system currently has no way to track or even
effectively coordinate to receive data on persons served through other agencies, such as non-
NorthSTAR funded services through the Dallas Independent School District, City of Dallas
Substance Abuse Services, and services through the Texas Department of Criminal Justice,
Texas Department of Family and Protective Services, other state agencies, and the Veteran’s
Administration.

**Specific Indicators of Need**

**Diagnostic and Functioning Needs**

*Major Findings: Diagnostic and functioning data suggests that:*

· *Only a fraction of persons with primarily SUD needs (9.7%) are being served by NorthSTAR.*

· *Too few persons with co-occurring MH and SUD needs are being identified and served by NorthSTAR.*

· *Proportionally, NorthSTAR identifies fewer adults as in need of higher levels of care, as compared to other urban counties.*
Proportionally, NorthSTAR identifies fewer children as in need of intensive services, as compared to other urban counties.

One way to analyze needs is to consider the diagnosis of the person served. As noted above in the discussion of prevalence, diagnosis alone is generally not viewed as an adequate indicator of need (Bilj et al, 2003; Regier, 2003), but it is nonetheless an important indicator.

Diagnostic data was available for persons served through NorthSTAR. The following table provides a breakdown of percentages for primary diagnoses from submitted service encounters for NorthSTAR overall and Dallas County for SFY 2009. Note that these numbers exceed the number of persons served and therefore represent some duplication across persons served. Nonetheless, the numbers represent the best available distribution of primary needs across person served. ⁴⁶

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>All NorthSTAR Counties</th>
<th></th>
<th>Dallas County</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Persons</td>
<td>Percent</td>
<td>Persons</td>
<td>Percent</td>
</tr>
<tr>
<td>Affective Disorders – Major Depression</td>
<td>19,019</td>
<td>23.2%</td>
<td>14,513</td>
<td>22.5%</td>
</tr>
<tr>
<td>Affective Disorders – Bipolar</td>
<td>16,471</td>
<td>20.1%</td>
<td>12,573</td>
<td>19.5%</td>
</tr>
<tr>
<td>Affective Disorders – Other</td>
<td>2,755</td>
<td>3.4%</td>
<td>2,082</td>
<td>3.2%</td>
</tr>
<tr>
<td>Schizophrenia and Other Psychoses</td>
<td>11,166</td>
<td>13.6%</td>
<td>9,691</td>
<td>15.0%</td>
</tr>
<tr>
<td>Substance Use Disorders</td>
<td>13,028</td>
<td>15.9%</td>
<td>10,913</td>
<td>16.9%</td>
</tr>
<tr>
<td>Developmental Disabilities (ASD, MR)</td>
<td>209</td>
<td>0.3%</td>
<td>179</td>
<td>0.3%</td>
</tr>
<tr>
<td>Other Developmental / Behavioral</td>
<td>9,439</td>
<td>11.5%</td>
<td>7,539</td>
<td>11.7%</td>
</tr>
<tr>
<td>Dementia / Other Cognitive</td>
<td>92</td>
<td>0.1%</td>
<td>77</td>
<td>0.1%</td>
</tr>
<tr>
<td>Other MH Diagnoses</td>
<td>7,340</td>
<td>9.0%</td>
<td>5,684</td>
<td>8.8%</td>
</tr>
<tr>
<td>No Mental Disorder / Undiagnosed</td>
<td>2,445</td>
<td>3.0%</td>
<td>1,365</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

### Table 1: Diagnoses All NorthSTAR Counties vs. Dallas County

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>All NorthSTAR Counties</th>
<th>Dallas County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Persons</td>
<td>Percent</td>
</tr>
<tr>
<td>All Diagnoses</td>
<td>81,964</td>
<td>100%</td>
</tr>
</tbody>
</table>

Given the similarity between Dallas and the NorthSTAR overall, we will look at NorthSTAR as a whole for the remaining analyses in this section. NorthSTAR reports on a quarterly basis the proportion of persons served with primarily MH, primarily co-occurring MH and SUD, and primarily SUD. Proportions for SFY 2009 are reported in the table below.\(^{47}\) Note that services are skewed toward persons with MH only diagnoses, rather than persons with co-occurring MH and SUD or primarily SUD (column two), when compared to the distribution of need in the Dallas population (column three). Referencing back to the under 200% FPL persons in need figures (column four), less than 10% of the estimated persons with SUD (adults only\(^ {48}\)) are served (2,389\(^ {49}\) out of an estimated 24,674 in need), and less than 50% of the estimated persons with co-occurring MH and SUD (adults only) are identified as being served (12,426\(^ {50}\) out of an estimated 26,518 in need). Note that this finding could be the result of under-identification and under-documentation of the co-occurring SUD. However, under-identification has been shown in other state systems to be associated with less effective treatment matching and consequently poorer outcomes.

In comparison, nearly three-quarters (72.9%) of the estimated persons with MH disorders only (children and adults) are served (33,574\(^ {51}\) out of 46,187). It is likely both that the co-occurring SUD needs of many persons currently diagnosed with MH disorders are being missed and that there are too few persons with SUD only being served. This is consistent with national trends,

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\(^{48}\) We recognize that the NorthSTAR persons served proportions for SUD include both adults and adolescents, whereas the need estimates include only adults. We are still seeking a breakdown of persons with SUD served by age, which will allow this comparison to be refined. However, the overall trend is quite clear and is not expected to vary through more refined analysis.

\(^{49}\) NorthSTAR Data Book, 2\(^ {nd} \) Quarter, June 16, 2010. Retrieved at: http://www.dshs.state.tx.us/mhsa/northstar/databook.shtm#databook. The proportion from the Data Book for NorthSTAR overall was applied to the SFY2009 figure for the number of persons served in Dallas County, which was from the Texas Department of State Health Services. (November 23, 2009). Previously cited.

\(^{50}\) Same sources and methods just cited.

\(^{51}\) Same sources and methods just cited.
but represents two important opportunities to improve the effectiveness of services, especially when one considers the evidence from the preceding section that too few of the persons with the highest needs are being served, particularly among adults in the correctional system, among whom SUD needs (co-occurring and alone) are often the most pressing behavioral health concern.

<table>
<thead>
<tr>
<th>NorthSTAR Enrollees Served</th>
<th>SFY 2009 Average Proportion of Persons Served</th>
<th>Persons in Need (PIN) &lt;200% FPL Proportions</th>
<th>Proportion of &lt;200% FPL PIN Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD Primarily</td>
<td>4.9%</td>
<td>25.3%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Co-Occurring MH/SUD</td>
<td>25.5%</td>
<td>27.2%</td>
<td>46.9%</td>
</tr>
<tr>
<td>MH Primarily</td>
<td>69.0%</td>
<td>47.4%</td>
<td>72.7%</td>
</tr>
</tbody>
</table>

NorthSTAR also tracks cases by a mix of diagnosis and severity using Texas’s Resiliency and Disease Management (RDM) criteria. Diagnostic and functioning data is used to categorize a level of need for each person served. The table below compares data for NorthSTAR to the rest of the state and three other major urban counties (Bexar, Harris and Tarrant). Data from SFY 2009 is presented as percentages of levels of care reported (which is not 100% of persons served, but is assumed to be comparable in accuracy across regions). It should be kept in mind that NorthSTAR’s higher penetration rates complicate comparisons, but the findings below are consistent with other findings throughout this report that indicate that many high need enrollees do not receive sufficiently intensive services.

The table below summarizes data on assessed RDM for adults (that is, the level of care the person is assessed as needing, which may not be the same as the level of care received) in ongoing care. NorthSTAR identifies a lower proportion of persons at ACT – the highest level of care (SP4) – than do Bexar and Harris Counties, but a higher proportion than Tarrant County and a comparable proportion to the rest of the state. In later sections, we will see that, despite this variation, NorthSTAR provides a higher proportion of its overall population with ACT level (SP4) services. However, an urban area like NorthSTAR would be expected to identify a higher proportion of persons at this level of care than the state as a whole, suggesting that too few

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52 Holzer and Nguyen, previously cited. Figures are for Dallas.
53 Personal communication from I. Garza, July 12, 2010, in response to Open Records Request for LOC distributions for SFY2009 statewide. Percent calculations exclude not eligible cases.
persons may be having their needs assessed at this level (which is consistent with the findings above that persons with the highest needs appear to be being served at disproportionately lower levels). However, NorthSTAR’s proportion identified at SP3 is higher than all but Bexar County. Persons identified for SP1 are somewhat lower and for SP2 are somewhat higher.

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>Adult SP1 (Basic Services)</th>
<th>Adult SP2 (Depression Focus)</th>
<th>Adult SP3 (Team Based Treatment)</th>
<th>Adult SP4 (Assertive Comm. Tx.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NorthSTAR</td>
<td>62.5%</td>
<td>10.9%</td>
<td>23.8%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Rest of State</td>
<td>76.5%</td>
<td>8.3%</td>
<td>12.8%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Bexar County</td>
<td>61.0%</td>
<td>7.8%</td>
<td>27.0%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Harris County</td>
<td>68.1%</td>
<td>9.1%</td>
<td>18.4%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Tarrant County</td>
<td>78.4%</td>
<td>6.0%</td>
<td>13.7%</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

Data on assessed RDM for children and youth in ongoing care is summarized in the table that follows. NorthSTAR identifies a lower proportion of children and youth at the non-psychotic higher levels of care (SP2.1, 2.2, and 2.3) than do the other three urban counties and a lower proportion even compared to the rest of the state for SP2.1 and SP2.2. This suggests that children and youth without psychoses are being identified at a lower rate than in the rest of the state, particularly for externalizing disorders with involvement in the juvenile justice system, which is consistent with the very high proportion of youth receiving services through the Dallas County juvenile justice system. However, NorthSTAR’s proportion identified at SP2.4 is much higher than the rest of the state and the other three urban counties, suggesting more focus on this important subgroup of children than other parts of the state. Persons identified for SP1 and aftercare (SP4) fall toward the upper end of the range (suggesting a higher proportion of care going to children with lower level needs), though persons identified for SP1.2 fall in the lower part of the range (somewhat mitigating that trend, but not entirely). Overall, however, only 10.8% of NorthSTAR children are assessed as needing intensive services, whereas the proportions in the other three urban counties range from 14.7% (Tarrant) to 17.4% (Harris) to 22.5% (Bexar).

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54 Same citation and method as previous.
While diagnosis and diagnostically driven comparisons such as the assessed RDM levels are of interest, other indicators of need were also examined, as described in the next section.

Also of note is a possible gap, particularly in SP3 cases, between what is authorized and what is delivered. Authorized care is reviewed below.
Additional Needs

**Major Findings:**

- **The proportion of NorthSTAR members served in acute care settings (emergency departments, 23-hour observation, acute inpatient units) has grown dramatically (9.3%) from December of 2009 through May of 2010, an increase particularly driven by people without a current SPN and assigned level of care (LOCA). Data overall (including the “Top 200” data discussed below) suggest that people may be presenting in crisis settings and not getting attached to a SPN. Also, the broader system does not document providing much crisis care outside of designated emergency and crisis services providers.**

- **There is no data or tracking mechanism currently in place to monitor individuals who present in emergency departments or 23-hour observation, who are referred for follow up through the NorthSTAR Specialty Provider Network (SPN), and who do not show up. Consequently, a significant number of persons could readily “fall through the cracks” in a way that is “invisible” within the system.**

- **ValueOptions has identified a group of very high utilizing enrollees, termed the “Top 200,” who are using recurrent acute services. The cost of care for the “Top 200” in calendar year (CY) 2009 was just under $3.85 million. Further, the “high utilizer” cost data for this population is based only on NorthSTAR utilization, not on a cross walk of utilization of services funded by other sources. We have reviewed other data sets of high utilizers at Parkland, Green Oaks, and the Dallas County Jail, as well as of persons served at The Bridge, but within our data sets we are not able to determine the degree of overlap with the “Top 200” identified by NorthSTAR. Specifics about these populations are currently being gathered by the adult and child clinical operations teams that were formed during the course of our study.**

- **The rate of growth in the number of persons in the jail who are waiting for behavioral health placements was more than four times the rate of growth for the rest of the jail population from CFY 2008 through CFY 2010. What is more, the rate of increase in the last six months of CFY 2010 was more than double the rate of growth in either of the two preceding fiscal years.**

- **Dallas County’s growing Community Corrections behavioral health capacity reportedly is experiencing increasing difficulty moving persons through its service array (primarily at Wilmer) and back to NorthSTAR-funded community services (due to increased levels of**
denials for requested services).

- *Dallas County’s state-of-the-art juvenile justice system is largely dependent on county revenue (and to a greater degree than other parts of the country that more effectively leverage Medicaid funds) and is experiencing much larger cuts in service funding (upwards of 10% per year) than the rest of the behavioral health system.*

- *There is very little coordination with services delivered through the child welfare system at the system level. Most coordination linkages exist at the provider level.*

- *Important steps forward have been taken for persons who are homeless, but more remains to be done.*

**Acute Service Use.** In the CY 2010 data, we observed a trend of some concern in the number of persons presenting for care in emergency departments and crisis settings, a trend that correlates with the shift to case rate funding for NorthSTAR. The potential connection between the case rate and the increase in crisis utilization will be discussed later in this data analysis.

For the Parkland Emergency Department in 2009 and 2010, the first six months of 2009 versus the first six months of 2010 saw an increase of 9.5% (4,487 to 4,878 – see the table below).

<table>
<thead>
<tr>
<th>Parkland Psychiatric Emergency Department – Actual Number of Persons Presenting for Care in First Six Months of Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Month</strong></td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>January</td>
</tr>
<tr>
<td>February</td>
</tr>
<tr>
<td>March</td>
</tr>
<tr>
<td>April</td>
</tr>
</tbody>
</table>

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55 Personal communication, J. Floren, of data sets on 2008 through June 2010 visits and associated data.
Parkland Psychiatric Emergency Department – Actual Number of Persons Presenting for Care in First Six Months of Year

<table>
<thead>
<tr>
<th>Month</th>
<th>CY 2009</th>
<th>CY 2010</th>
<th>Percent Change CY 2009 to CY 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>800</td>
<td>862</td>
<td>8.0%</td>
</tr>
<tr>
<td>June</td>
<td>787</td>
<td>880</td>
<td>12.0%</td>
</tr>
<tr>
<td>Six Month Total</td>
<td>4,487</td>
<td>4,878</td>
<td>9.0%</td>
</tr>
</tbody>
</table>

The table below provides an overview of diagnoses seen in the Parkland Psychiatric Emergency Department in CY 2009.

Parkland Psychiatric Emergency Department: Frequency of Visit by Diagnosis in CY 2009

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affective Disorders – Major Depression</td>
<td>1,179</td>
<td>14%</td>
</tr>
<tr>
<td>Affective Disorders – Bipolar</td>
<td>1,100</td>
<td>13%</td>
</tr>
<tr>
<td>Affective Disorders – Other</td>
<td>289</td>
<td>3%</td>
</tr>
<tr>
<td>Schizophrenia and Other Psychoses</td>
<td>2,325</td>
<td>27%</td>
</tr>
<tr>
<td>Substance Use Disorders</td>
<td>1,428</td>
<td>17%</td>
</tr>
<tr>
<td>Developmental Disabilities (ASD, MR)</td>
<td>25</td>
<td>0%</td>
</tr>
<tr>
<td>Other Developmental / Behavior</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Dementia / Other Cognitive</td>
<td>57</td>
<td>1%</td>
</tr>
<tr>
<td>Other MH Diagnoses</td>
<td>1,274</td>
<td>15%</td>
</tr>
<tr>
<td>No Mental Disorder / Undiagnosed</td>
<td>25</td>
<td>0%</td>
</tr>
<tr>
<td>Physical Health Problems</td>
<td>808</td>
<td>9%</td>
</tr>
<tr>
<td>All Diagnoses</td>
<td>8,512</td>
<td>100%</td>
</tr>
</tbody>
</table>
Green Oaks Psychiatric Emergency Services use is also increasing,\(^{56}\) with the first six months of CY 2009 versus the first six months of 2010 showing an increase of over 17% in visits (4,940 to 5,797, with the sharpest rise in May and June – see the table below).

<table>
<thead>
<tr>
<th>Month</th>
<th>CY 2009</th>
<th>CY 2010</th>
<th>Percent Change CY 2009 to CY 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>728</td>
<td>908</td>
<td>25.0%</td>
</tr>
<tr>
<td>February</td>
<td>768</td>
<td>854</td>
<td>11.0%</td>
</tr>
<tr>
<td>March</td>
<td>840</td>
<td>954</td>
<td>14.0%</td>
</tr>
<tr>
<td>April</td>
<td>863</td>
<td>934</td>
<td>8.0%</td>
</tr>
<tr>
<td>May</td>
<td>876</td>
<td>1,047</td>
<td>20.0%</td>
</tr>
<tr>
<td>June</td>
<td>865</td>
<td>1,100</td>
<td>27.0%</td>
</tr>
<tr>
<td>Six Month Total</td>
<td>4,940</td>
<td>5,797</td>
<td>17.0%</td>
</tr>
</tbody>
</table>

One important trend occurring simultaneously with the increase in crisis use is an increase in the number of people not yet enrolled in the system presenting in crisis settings (individuals without an RDM assigned). The chart below\(^{57}\) shows an overall growth of 9.3% in the period of December 2009 through May of 2010 compared to one year earlier, but this includes an increase of 3.9% for persons with an RDM assigned and an increase of 13.0% for persons without an RDM assigned.

\(^{56}\) Green Oaks internal data reporting, G. Barnes, personal communication, July 14, 2010.

\(^{57}\) This chart is an update, with data provided in July 2010 by DSHS, of a chart developed by DSHS, shared in May 2010, and updated in June 2010, entitled “A Collaborative Review and Discussion of NorthSTAR System Performance and Trends.” The full original report is available online at: http://www.dshs.state.tx.us/mhsa/northstar/ppt/A%20Collaborative%20Review%20and%20Discussion%20of%20NorthSTAR%20Performance%206_2_10%20V3.ppt.
The figure below shows that this reverses the trend from the previous fiscal year. Between SFY 2008 and SFY 2009, all of the growth in the rate of acute users was among persons attached to SPNs. This trend reversed for SFY 2010, with all of the growth in acute users among persons without a LOCA assigned.\textsuperscript{58} This trend matches the overall increase in NorthSTAR users.

\textsuperscript{58} Texas Department of State Health Services. (September 20, 2010). NorthSTAR High Level Metrics 09_09_10. Provided in personal communication from M. Ferrara as a Microsoft Excel file on September 20, 2010. Data analysis by TriWest Group.
This trend appears to be related to population growth, as can be seen from the analysis of acute presentations for persons served by the Dallas County SPNs serving the largest proportion of NorthSTAR enrollees. Overall, rates of acute presentation by persons attached to SPNs have gone down in each year (even when overall acute presentations increased with population growth in SFY 2009). As seen in the two figures below, acute rates for adults and children attached to major SPNs in all instances but one (child rate at Centro de Mi Salud, which jumped to levels similar to other SPNs) showed downward trends in the proportion (average) of their members seen in acute settings over the first 10 months of each of the last three years.


60 Very few enrollees served through Centro de Mi Salud receive acute care, so an increase of just a few users (five) in a given month can increase the percentage substantially.

61 Analysis was completed on the first 10 months of each fiscal year since data for July and August 2010 were not complete at the time of the finalization of this report, and we wanted to control for seasonal trends.
**Jail Use.** The number of adults in the Dallas County jail waiting for state hospital and community behavioral health placements has also been increasing over the last three fiscal years (see the table below). While the overall jail population on average rose 5.9% between CFY 2008 and CFY 2010, the combined subset of the population waiting for state hospital beds (for competency restoration, primarily) and community (including residential) behavioral health placements (SAFPF and Special Programs funded largely by the Texas Department of Criminal Justice – TDCJ) has increased 25.1% (see the trend lines in the figure below). Without this increase, the rate of increase for the overall jail population would have been 17.7% lower (4.8% growth instead of 5.9% growth). Of even greater concern is the rate of growth in the last six months of CFY 2010. Note that in each CFY, the rate of persons waiting for these behavioral health placements increases. However, the rate of growth in the last six months of CFY 2008 and CFY 2009 (37.3% and 31.5%, respectively), was much lower than the rate in the last six months of FY 2010 (79.4%). This is a trend of extreme concern. The chart below extrapolates the 12-month growth figures out another year, but if the escalation seen in the last six months of CFY 2010 (February through July) continues, the rate of growth will be much higher.⁶²

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Community Corrections. The Dallas County Community Supervision and Corrections Department (CSCD) delivers an impressive and growing array of services, and it has been successful in increasing its funding through the Texas Department of Criminal Justice in recent years. Funding issues related to TDCJ allocations for Dallas County will be discussed later in this section. Of note, however, is that CSCD leadership reports that rates of denials for referral to NorthSTAR have increased, thus offsetting to some degree recent growth in service availability under Rider 48 funding.

Children’s Systems of Care. Trends in juvenile justice, child welfare and schools were examined:

- **Juvenile Justice.** The Dallas County Juvenile Justice Department has achieved many notable successes in rates of youth served over the past decade. While jurisdictions across the United States have seen reductions in juvenile offense rates over the past decade, according to data from the Department’s 2009 Annual Report, Dallas County has achieved remarkable reductions in referral rates across the board, with an overall 13.7% reduction from CY 1997 to CY 2009. Most of that reduction has been with younger youth, ages 10 to 15. Rates of detention have also fallen 19.5% since CY 2008 and 24.9% since CY 2005. However, during that same period of time (CY 2005 to CY 2009), annual average rates of residential referrals have risen 5.7%.

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63 Personal communication, T. Williams, August 19, 2010.
64 Juvenile Arrests 2008. (December 2009). U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. www.ncjrs.gov/pdffiles1/ojjdp. While the directionality of Dallas County’s overall rate trend matches the national trends, the magnitude of reductions in Dallas County have been much larger. While national statistics fell 3% from 2007 to 2008, Dallas County fell much more in the two time periods that covered 2007, falling 4.0% in CFY 2008 (compared to CFY 2007) and an additional 6.3% in CFY 2009 (compared to CFY 2008).
65 Personal communication from D. Kilcrease-Fleming on July 14, 2010.
Overall, the Dallas County Juvenile Justice system seems to have a strong array of best practices, backed up by rigorous outcomes tracking for the overall youth population and service providers. The challenges are two-fold. (1) These services are largely county-funded, and the county has endured substantial spending cuts over the past two fiscal years (CFY 2009 and CFY 2010) due to decreases in county revenue related to the economic downturn. Funding for contract non-residential community-based services, including evidence-based approaches like multisystemic therapy (MST), fell from $4.9 million in CFY 2009 to $3.7 million in CFY 2010, a nearly 25% cut. This was somewhat mitigated by an increase in county-provided services, with the county implementing functional family therapy (FFT). Contract residential services funding also fell from CFY 2009 to CFY 2010, from $6.2 million to a projected $4.9 million, an over 20% cut. The vulnerability of funding for juvenile justice services is a continued concern as the economic conditions continue to be a challenge. (2) The fact that nearly all intensive service availability for children is provided through the juvenile justice system is also of concern. For example, DSHS data shows that NorthSTAR authorized only one case of Service Package (SP) 2.1 in SFY 2009, even though 38 cases were assessed as needing SP2.1. During CFY 2009 (which overlaps SFY 2009 by 11 months), there were 230 discharges from in-home programs including MST through the juvenile justice system, out of over 2,300 overall youth served across their contract community-based service array (not counting youth served through county-run programs). During that same time period, there were over 330 admissions to residential programs, including 95 admissions to substance abuse treatment programs. Limiting most intensive service use to the juvenile justice system therefore increases funding vulnerability (by limiting access to federal Medicaid reimbursement for services that could be covered) and adds the stigma of justice system involvement for youth and families seeking intensive services. It also underscores that the opportunity for collaborative partnership between county-funded juvenile justice services and NorthSTAR-funded community behavioral health services (and services funded by any other sources) is currently under-leveraged.

• Child welfare. The main finding related to the needs of children in the child welfare system was that no behavioral health system stakeholder talked with has yet been able to provide our study with data on numbers of children in the child welfare system who need behavioral health services. The LBB draft databook did not even include data on children receiving behavioral health services through STARHealth. Medicaid services for children in

66 Personal communication from D. Kilcrease-Fleming on July 14, 2010. Financial information was provided through an interview and utilization data was provided through internal data tracking reports for contract renewals and community provider outcome tracking provided by Dr. Kilcrease-Fleming.
the foster care system are not included in NorthSTAR, and we have found no evidence of coordination between benefits for transitions involving children served through NorthSTAR and children in foster care served through STARHealth. Eligibility data available through the Texas Health and Human Services Commission notes that there are nearly 2,000 children eligible in the Medicaid foster care category at any one time and that these numbers are more stable than the broader children’s Medicaid eligibility figures (which have increased consistently in the most recent fiscal years). It is likely that many of these children need behavioral health services. An estimated 50 to 75% of children in foster care need MH services and many of those do not receive such services in a timely manner, if at all. For the purposes of this study, we conservatively estimated that 30% of the just over 2,200 children eligible for Medicaid in the foster care category receive behavioral health care each year. The primary concern for this population is that services are so fragmented at the system level that no data on their needs or service use was identified. While individual providers such as Child and Family Guidance Center and Phoenix House serve children across the behavioral health, juvenile justice, and child welfare systems, system-level data on needs and service use trends is lacking. As noted above, even the LBB report did not include data on Medicaid behavioral health services through the STARHealth program for children in the foster care system.

Schools. NorthSTAR served 1,861 persons through the Dallas Independent School District (DISD) in SFY 2009, and DISD ranked 9th in persons served among NorthSTAR providers. The DISD served over 4,400 children overall and its Youth and Family Centers. This is an example of a particularly effective partnership in the system, with NorthSTAR and Parkland to implement its Youth and Family Centers, which integrates services for students in all three systems (NorthSTAR, Parkland, and non-NorthSTAR). It can serve as a base upon which to build, as discussed under Step 11 in the recommendations section.

Homelessness and Housing. Dallas County has taken great strides to reduce chronic homelessness from 2004 to 2009, effectively cutting in half the total number of chronically homeless people from 1,181 to 601 (a 49.1% reduction). The Metro Dallas Homeless Alliance

\[\text{\textsuperscript{67}}\text{Texas Health and Human Services Commission. Final Count Reports for Medicaid Enrollment, Medicaid Enrollment by County, State Fiscal Year 2009.}\]
\[\text{\textsuperscript{69}}\text{Persons served data provided via personal communication on October 4, 2010, by L. Smith.}\]
\[\text{\textsuperscript{70}}\text{All data provided from the Metro Dallas Housing Alliance, via personal communication from Jay Dunn, July 21, 2010.}\]
(MDHA) attributes this to the development of permanent supportive housing (PSH), increased access to MH and SUD services, and the opening in 2008 of The Bridge. While much of the drop in the numbers of people who were chronically homeless predated the opening of The Bridge, the fact that numbers of chronically homeless individuals have stayed relatively stable through 2008 and 2009 despite the economic downturn correlates with The Bridge’s opening. The development of PSH is seen as particularly critical to the drop, with 1,222 units of PSH available throughout the metro Dallas area. An additional 350 units were in development as of a 2010 MDHA report, but neighborhood acceptance of new developments remains a challenge, as does the need to address the broader group of individuals who are homeless but who do not qualify as chronically homeless. More detailed discussion of issues related to housing and homelessness will be found in Step 10 of the recommendations.

71 Updated figures provided via personal communication on October 5, 2010, by J. Dunn.
**Racial and ethnic cultural groups.** Data from NorthSTAR, Parkland, and Dallas County Juvenile Services shows some distinct overall service trends that stakeholders we interviewed confirmed as true. These are presented in the following table.

<table>
<thead>
<tr>
<th></th>
<th>SFY 2009 Dallas Census</th>
<th>SFY 2009 Dallas NorthSTAR Served(^72)</th>
<th>Parkland - All OP (BH and PH)</th>
<th>Parkland Behavioral Health(^73)</th>
<th>CFY 2009 Dallas County Juvenile Dept.</th>
<th>2009-10 Dallas Jail Census(^74)</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>20%</td>
<td>40%</td>
<td>30%</td>
<td>34%</td>
<td>43%</td>
<td>53%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>40%</td>
<td>24%</td>
<td>52%</td>
<td>30%</td>
<td>42%</td>
<td>20%</td>
</tr>
<tr>
<td>White</td>
<td>33%</td>
<td>33%</td>
<td>14%</td>
<td>62%</td>
<td>14%</td>
<td>27%</td>
</tr>
<tr>
<td>Asian American / Pacific Islander</td>
<td>5%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>0.3%</td>
</tr>
<tr>
<td>All Other</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Speak Spanish at Home</td>
<td>33%</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>Speak Spanish at Home, English Less Than Very Well</td>
<td>19%</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

\(^72\) These percentages exclude the 23.7% of SFY2009 Dallas County NorthSTAR service recipients for whom data on race and ethnicity was not available and show the breakdown only for those persons for whom data was reported.

\(^73\) This data includes inpatient, emergency department, hospital outpatient clinic, and community-oriented primary care clinic (COPC) visits, but does not include a subset of COPC care coordination activities that involve additional people. Percentages equal more than 100% because Hispanic status is tracked separately from the other categories, and it was not possible to unduplicate the count. The percentages reported do not subtract Hispanic individuals from the racial subcategories they also endorse (such as, African American, White, multiracial and other).

\(^74\) July 1, 2009 through June 30, 2010.
Several trends can be observed:

- NorthSTAR serves African American members at a higher rate than their proportion of the overall Dallas population and Hispanic members at a much lower rate.

- The rate of services to African American members makes sense given the emphasis of NorthSTAR on lower income populations and the higher rates of poverty among African American communities in Dallas County.

- The rate of services to Hispanic members to some degree fits with national trends in which Hispanic populations tend to seek care in primary care settings rather than specialty behavioral health settings, but the rates seem even more disproportionately low.

- Furthermore, the NorthSTAR data is as revealing for what it does not show as for what it shows. First of all, data on race/ethnicity was not reported for a full 23.7% of Dallas County NorthSTAR members in SFY2009. Second, as has already been observed, information on language is not collected.

- Data from Parkland shows a greater proportion of Hispanic people served overall (column four in the previous table), but available data specific to behavioral health shows a disparity in access (column five above) smaller than that through NorthSTAR, but still marked. Parkland also does not have data on primary language spoken.

- Most concerning, data from the Dallas County Juvenile Department (DCJD – column six above) shows African American youth involved in the juvenile justice system at twice the proportion of African Americans in the overall Dallas County population.

- Data from the Dallas County Jail behavioral health services was not available, but data on the overall jail population shows African American adults even more over-represented than in the juvenile justice system.

Discussions with system stakeholders including providers serving racial and ethnic minority populations and consumers, families, and youth of color, reinforce these findings. Key issues identified include:

- A lack of attention to people who speak primarily Spanish. In addition to the lack of Spanish programming materials or enrollee-specific communication around denials, providers also report a lack of Spanish public service announcements or other promotional materials for NorthSTAR involvement. This is of concern especially in light of the low rate of Hispanic service delivery in NorthSTAR. Providers reported that they believe very few Hispanics even know that NorthSTAR exists.
A lack of outreach at the system level to minority populations overall was noted. While specific providers have tried to locate in neighborhoods and areas of the county where specific minority communities reside, the system as a whole has not addressed such planning.

Our conversations with African American and Hispanic parents and youth emphasized a perceived need for more community-based interventions, such as community/school education and stigma reduction, access to youth/teen peer groups, and home-based services. Providers noted that current reimbursement methods do not support home-based service delivery or outreach. Conversations with adult consumers and family members emphasized higher levels of stigma in minority communities for behavioral health needs and particular difficulties with transportation and wait times.

The RDM categories are seen as particularly problematic and unwieldy for minority populations whose symptom presentation does not always readily fit the “Big Four” diagnoses for adults. While there is a process for access based on other diagnostic needs, providers describe it as cumbersome and a barrier to care in itself. Providers noted particular concern when using tools associated with the RDM with children, and Spanish-speaking providers noted that the Spanish translation of the Ohio scales is not accurate. This was seen as particularly problematic for refugees and other immigrants with trauma-related needs, since post-traumatic stress disorder (PTSD) is not prioritized within the system and complicates accurate diagnosis in many cases (particularly with non-English speaking people). In addition, providers do not perceive that there is support for adjustment to the RDM recommended service mix when necessary to respond to culturally-related needs. The process was uniformly described as complicated, time-consuming, unclear, and, overall, a barrier to care.

Providers report that there are no efforts to systematically assess for differential needs across minority groups. They also noted a lack of system-wide training related to cultural diversity and differential clinical approaches for diagnosis and treatment.

Access to services in Spanish was noted as a severe problem. Providers noted in particular a lack of SUD services for Spanish-speaking populations, and even more difficulty accessing psychiatrists than the system as a whole. The idea of allowing access to Spanish-speaking psychiatrists across SPNs was suggested. Pharmacy access in evenings and on weekends was also noted as lacking in predominantly Hispanic communities.

**Needs of sexual minorities.** System stakeholders serving sexual minority populations reported minimal resources for the lesbian, gay, bisexual and transgender (LGBT) community. The only focus for planning, needs assessment, and targeted service delivery noted was Ryan White funding for persons affected by HIV, which, while a critical set of funding and programs,
addresses only a subset of the larger LGBT population and focuses on HIV and AIDS, which also includes a broader range of individuals. Dallas County Health and Human Services oversees funding for a 12-county area through the Ryan White Planning Council of the Dallas Area, and key agencies in Dallas delivering behavioral health supports within the broader array of Ryan White funding include Parkland, the AIDS Arms Peabody Health Center, Legacy Counseling, and the Greater Dallas Council on Drug and Alcohol Abuse. Stakeholders noted that services were generally available if a person qualified for Ryan White or other funding, and that many of the Ryan White funded providers also serve a broader range of needs for LGBT groups, but otherwise LGBT-specific resources were lacking.

Based on our review, the broader needs of sexual minorities beyond those addressed through the Ryan White planning process can be best described as invisible at the system level. While there are some community-based providers addressing the needs of LGBT people (for example, the counseling center at the Dallas Cathedral of Hope), there is no planning focus of which we are aware for the broader population beyond the HIV/AIDS-affected groups served through Ryan White funds. Data on sexual orientation is not collected within the system, and persons knowledgeable about the needs of the LGBT community are not intentionally involved in system planning efforts. This was seen as especially true for transgendered people. Also noted was a broader lack of awareness and sensitivity for LGBT persons, and even of specific issues such as AIDS/HIV treatment, in the broader system outside of specialty programs. One example of an attempt to address this was a recent collaboration between the AIDS Education Training Center and DSHS to provide staff training in state hospitals regarding HIV testing and psychiatry. We are aware of no efforts to address the broader needs of LGBT populations.

**Other needs.** It is clear that Dallas County residents with MH and SUD service needs also experience a range of other needs, including those related to developmental disabilities, other disabilities and impairments, traumatic brain injury, dementia-related disorders, and other challenges. Individuals with these conditions are particularly at risk for extended incarceration, particularly when in need of competency restoration. Dallas Metrocare Services is the local authority for developmental service delivery, and has made noticeable efforts to partner in outreach to engage individuals who have both MH and developmental disabilities, but there is more attention that could be paid to this complex population.
Analysis of Behavioral Health Care Coverage

Major Findings:

- **The State of Texas covers relatively few adult residents who are impoverished, compared to other states.**

- **Rates of coverage for adults under 133% FPL through Medicaid and for adults from 133% to 400% through subsidies to purchase care through the federal health insurance exchange are expected to increase dramatically for adults in 2014 under Health Care Reform, presenting an opportunity for enhanced services.**

- **Under Health Care Reform, the public sector can expect more (mostly federal) funding, but also more competition from other insurers, to provide behavioral health care.**

- **Mental health parity regulations will increase the competitive edge for integrated health plans in the nearer term.**

One variable underlying the funding and expenditure mix just described is behavioral health care coverage. Trends in Medicaid and CHIP coverage for SFY 2008 through SFY 2010 were described in the initial section of this report; the table from that section is repeated below.\(^75\)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NorthSTAR Total (all counties)</strong></td>
<td>3,690,653</td>
<td>378,559</td>
<td>1,114,402</td>
<td></td>
</tr>
<tr>
<td>Dallas County</td>
<td>2,412,431</td>
<td>305,559</td>
<td>872,972</td>
<td></td>
</tr>
<tr>
<td>Dallas County – 0 to 18(^76)</td>
<td>670,565</td>
<td>241,101</td>
<td>244,703</td>
<td>55,094</td>
</tr>
<tr>
<td>Dallas County – 19 and older</td>
<td>1,741,866</td>
<td>64,458</td>
<td>618,407</td>
<td></td>
</tr>
</tbody>
</table>

\(^75\) Please see previous table for citations.

\(^76\) The average Medicaid eligibles include 2,201 children on average each month who are in foster care. These children are not included in NorthSTAR figures.
The bullets below provide an overview of which persons are currently eligible for which coverage. Currently, behavioral health care coverage for persons served in Dallas County public behavioral health systems is broken out as follows:

- **Adults with Medicaid** – Currently, relatively few adults have Medicaid coverage, with just under 11% of adults below 200% FPL having Medicaid coverage (64,458 confirmed count on average in FY 2009; 66,916 on average in SFY 2010 through January 2010). Those that qualify under the Aged, Disabled/Blind, and Medically needy categories are only eligible up to 74% of the FPL and TANF Parents are only eligible up to 14% of the FPL. NorthSTAR covers the behavioral health needs of these persons. In addition, many adults with lower level needs also receive services through the STAR and STARPlus Medicaid HMOs.

- **Adults with Medicaid and Medicare (Dual Eligibles)** – For adults with both Medicaid and Medicare, inpatient hospital services and some outpatient services delivered by physicians and licensed clinicians are paid for by Medicare. As a result, the costs of these services are not accounted for within the NorthSTAR program. For example, in CFY 2009, Parkland billed over $1.8 million in Medicare services for persons with dual Medicaid and Medicare eligibility, many of whom were NorthSTAR members.

- **Children with Medicaid** – A much higher proportion of Dallas County’s impoverished children are eligible for Medicaid, with nearly 93% of children under 200% FPL covered by Medicaid (241,101 confirmed count on average in SFY 2009; 267,542 in SFY 2010 through January 2010).

  - **NorthSTAR eligible** – Most of these children (all but 2,201 in SFY 2009 on average and 2,113 on average through January 2010 for SFY 2010) receive their services under the NorthSTAR program.

  - **STARHealth eligible** – Children in foster care receive their behavioral health services through STARHealth, a Medicaid managed care plan for foster children in Texas delivered by Superior HealthPlan Network, with behavioral health services managed by IMHS Behavioral Health (Cempatico).

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77 Per the 2009-2011 NorthSTAR contract, “Individuals in Medicaid Category 2, program type 55 are eligible for enrollment in NorthSTAR only if substance abuse/chemical dependency services are clinically indicated.” These individuals receive services under the non-Medicaid eligibility provisions of NorthSTAR.
o **Medicaid Fee-For-Service** – A surprisingly high number of Medicaid services for children continue to be paid through the fee-for-service program, including a few services delivered by community providers for children in the Dallas County juvenile justice system.

o **Medicaid STAR / STARPlus** – Many children with lower level needs also receive services through the STAR and STARPlus Medicaid HMOs.

• **Children with CHIP** – Just over 55,000 children on average were eligible for behavioral health services delivered through CHIP plans in SFY 2009, and the average increased to over 57,000 per month in SFY 2010. Three CHIP plans deliver behavioral health services in Dallas County, including Amerigroup Texas, Inc., Parkland Community Health Plan, and UNICARE Health Plan of Texas, Inc.

• **Adults and children without insurance** – Because of the limitations of Medicaid coverage, most adults and many children in Dallas County are covered by the following health plans:

  o **Behavioral Health for Select Moderate to Severe Conditions**: NorthSTAR covers the behavioral health needs for adults up to 200% of the FPL if those behavioral health needs meet the diagnostic and severity guidelines of the NorthSTAR system. This is limited to:

    ▪ **All covered mental health services** only for individuals that meet the DSHS mental health priority population requirements, which include:78

      • “Adults who have severe and persistent mental illness, such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.” This is routinely implemented as qualification under one of the DSHS Resiliency and Disease Management (RDM) for Adults categories. It is of interest to note that “the availability of resources” is noted as a factor (along with level of functioning and the needs of the individual) when determining the “choice of and admission to services.” We are not aware of any current limitations on access related to resource availability, despite apparent contractual flexibility to enact such limits. Providers reported substantial authorization hassles and administrative barriers that discourage such attempts when trying to access

services for adults for diagnoses beyond the “Big 3,” even though such access would be permissible. This has raised the concern among many stakeholders that people in need of services may be inappropriately diagnosed, particularly with “bipolar disorder,” in order to receive access to services.

- “Children and adolescents ages 3 through 17 years with a diagnosis of mental illness who exhibit emotional, behavioral, or mental disorders” and who also have a serious functional impairment (defined as Children’s Global Assessment Score of 50 or less in the past year), who are at risk of out-of-home placement due to psychiatric symptoms, or who are enrolled in a school system’s special education program due to a serious emotional disturbance. Note that, again, there is a requirement “that services be offered first to those most in need.” Again, this is routinely implemented as qualification under one of the DSHS Resiliency and Disease Management (RDM) for Children categories.

- **All covered SUD Services for any abuse or dependence diagnosis** for any youth, pregnant women with dependent children, parents of children in foster care, persons with HIV, and persons who use needles to take drugs.\(^{79}\)

- **SUD Services Only for dependence diagnoses only** for all other adults.\(^{65}\)

  o **Behavioral Health Services for Other Conditions**: Behavioral health services for persons who are uninsured that fall outside the limits of NorthSTAR coverage (both those under 200% FPL who do not meet diagnostic and functioning requirements for NorthSTAR service provision and those above 200% FPL who are not eligible for NorthSTAR services) are met by safety net providers in the community who provide services to persons without insurance coverage. Parkland’s community oriented primary care (COPC) clinics are a major source of service delivery for these persons, serving over 6,000 adults and children in CFY 2009. Parkland also provides the bulk of health services for these individuals, as well.

**Projected Impact of Health Care Reform.** By 2014, health care reform is expected to increase the number of Medicaid eligibles statewide by 25% (1,000,000 more eligible persons, in addition to the projected 4,000,000 that would otherwise be covered then). Statewide costs for the expansion are projected at $1.7 billion in state funds and over $12 billion in federal funds, in federal fiscal year (FFY) 2014. The primary eligibility groups expected to grow are childless

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\(^{79}\) 2009-2011 NorthSTAR Contract. Main body.
adults under 133% FPL (currently they have no coverage), parents under 133% FPL (currently covered up to 14% of PPL), SSI/Aged/Disabled up to 133% FPL (currently covered at 74% of FPL), and children age 6 to 18 under 133% FPL (currently covered at 100% of FPL). This could increase available funding to NorthSTAR proportionately (more detailed analysis is in process), with a potential 15% to 25% increase in available funds (20% to 30% increase in Medicaid coverage for persons already eligible for NorthSTAR under the 200% FPL limit, with the new federal funds covering much of that expansion).  

While persons under 133% FPL are expected to be eligible for Medicaid in 2014, persons over 133% FPL up to 400% FPL will be eligible to receive premium credits to purchase insurance through a health insurance exchange. Texas has opted to participate in the federal health insurance exchange.

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System Providers

Major Findings:

- Dallas County has less community hospital capacity than the average in the rest of Texas and the nation, though capacity is comparable to that of Denver, Colorado. In SFY 2009, NorthSTAR provided additional acute care through its dedicated state hospital resources (12% of acute care users, 64% of acute care days, and 41% of acute care spending) and 23-hour observation capacity (40% of acute care users, 11% of acute care days, and 23% of acute care spending).

- Furthermore, acute inpatient lengths of stay (LOS) are only one-half to one-third as long as LOS in comparison cities (Denver, Pittsburgh, Philadelphia, and Seattle). If acute care in Terrell State Hospital and 23-hour observation use is factored in, the LOS is 6.2 days, which is much more comparable.

- ADAPT Mobile Crisis has been a useful addition to the crisis service array, but its capacity is insufficient to meet the range of needs that continue to present in emergency room settings.

- Early indications are that the introduction of the case rate correlates with an increase in persons presenting for services in acute care and correctional settings. While this is consistent with the financial incentives of the case rate, it appears that the performance incentives of the case rate may not be sufficient to align service delivery with those most in need.

- SUD service delivery trends show a fixed capacity for residential care that has effectively capped delivery of that service for multiple years, as well as a trend since November 2009 of sharply decreased numbers of persons accessing outpatient SUD services.

- Overall, NorthSTAR has a strong core of providers able to provide intensive services, but their mix of service delivery authorized fits the overall pattern observed previously of a bias toward less intensive service delivery. Despite this, NorthSTAR compares well to other urban counties in Texas and is only exceeded by Bexar County in its delivery of intensive services. This is not surprising given the low funding for behavioral health services in Texas overall.
Hospitals

The table below presents CY 2009 summary data for hospitals serving NorthSTAR members for whom NorthSTAR tracked the LOS.\(^{81}\) It should be noted that many more NorthSTAR members with dual Medicaid / Medicare coverage were likely served at other hospitals, and, since Medicare was the responsible payer, these admissions would not necessarily be tracked in the ValueOptions UM data.

![Table with data]

<table>
<thead>
<tr>
<th>Provider</th>
<th>CY 2009 Estimated NorthSTAR Admissions(^{82})</th>
<th>FY 2009 Estimated Percent Dallas County(^{83})</th>
<th>CY 2009 Estimated ALOS (Days)(^{84})</th>
<th>CY 2009 Total Inpatient Days(^{85})</th>
<th>CY 2009 Avg. Daily Census(^{86})</th>
<th>SFY 2009 Total Dallas County Persons Served(^{87})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green Oaks Hospital</td>
<td>1,240</td>
<td>79.5%</td>
<td>2.9</td>
<td>3,657</td>
<td>61.6</td>
<td>5,284</td>
</tr>
<tr>
<td>Timberlawn Mental Health System</td>
<td>395</td>
<td>84.9%</td>
<td>4.0</td>
<td>1,628</td>
<td>21.9</td>
<td>1,213</td>
</tr>
<tr>
<td>Child</td>
<td>229</td>
<td>n/a</td>
<td>4.6</td>
<td>1,054</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Adult</td>
<td>166</td>
<td>n/a</td>
<td>3.5</td>
<td>574</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Medical Center of McKinney</td>
<td>298</td>
<td>62.8%</td>
<td>3.2</td>
<td>951</td>
<td>8.0</td>
<td>344</td>
</tr>
</tbody>
</table>

\(^{81}\) Inpatient use trends had to be estimated using various data sources for calendar year (CY) 2009 and SFY 2009, as actual data requested from ValueOptions was not provided.

\(^{82}\) ValueOptions, NorthSTAR. (December 2009). Utilization management (UM) report: Trend analysis December 2009. Internal report provided via personal communication from F. Spaulding, May 14, 2010. All in network admissions were estimated by dividing total days by an average of 12 one-month average length of stay (ALOS) statistics, so these should be treated as estimates only. Out of network admissions were actual.

\(^{83}\) Texas Department of State Health Services. (November 23, 2009). NorthSTAR County Trends Report 11_23_09. Percentage was estimated dividing all unduplicated Dallas County members served by the provider overall (inpatient plus any other services provided) by all NorthSTAR members served by the provider overall.

\(^{84}\) ValueOptions December 2009 UM Report. Average lengths of stay (ALOS) were estimated using an average of 12 one-month ALOS statistics, so these should be treated as estimates only.

\(^{85}\) ValueOptions December 2009 UM Report. These were actual days for in network providers. For out of network providers, days were estimated by multiplying the ALOS estimate in the previous column by actual admissions.

\(^{86}\) ValueOptions December 2009 UM Report. Average daily censuses (ADC) were estimated using an average of 12 one-month ADC statistics, so these should be treated as estimates only.

\(^{87}\) Texas Department of State Health Services. (November 23, 2009). NorthSTAR County Trends Report 11_23_09. Actual unduplicated Dallas County members served by the provider overall (inpatient plus any other services).
Data from the Texas Hospital Association looking at CY 2008 psychiatric hospital capacity\textsuperscript{88} was analyzed by TriWest and then compared with data gathered by Parkland staff from the Texas DSHS Annual Survey, State Licensing Database as of 6/1/2010. These analyses were then supplemented by telephone interviews with facility representatives conducted in June and September 2010. The results are summarized in the table below and show total inpatient behavioral health and specialized capacity in the Dallas Metro Area.

<table>
<thead>
<tr>
<th>Provider</th>
<th>CY 2009 Estimated NorthSTAR Admissions\textsuperscript{82}</th>
<th>FY 2009 Estimated Percent Dallas County\textsuperscript{83}</th>
<th>CY 2009 Estimated ALOS (Days)\textsuperscript{84}</th>
<th>CY 2009 Total Inpatient Days\textsuperscript{85}</th>
<th>CY 2009 Avg. Daily Census\textsuperscript{86}</th>
<th>SFY 2009 Total Dallas County Persons Served\textsuperscript{87}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glen Oaks Hospital, Inc.</td>
<td>36</td>
<td>10.3%</td>
<td>4.2</td>
<td>155</td>
<td>1.9</td>
<td>15</td>
</tr>
<tr>
<td>Hickory Trail</td>
<td>37</td>
<td>86.1%</td>
<td>2.9</td>
<td>108</td>
<td>1.1</td>
<td>99</td>
</tr>
<tr>
<td>Out of Network</td>
<td>87</td>
<td>n/a</td>
<td>6.4</td>
<td>560</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Looked at on a per 100,000 population basis, this capacity is below the national average. Several comparisons can be made:

- Total beds (476) as a proportion of the 2009 NorthSTAR counties population (3,690,653) yield a per 100,000 population figure of 12.9 (compared to Texas overall figures from 2006 of 26.4 and the national average in 2006 of 25.2\textsuperscript{89}).

- The situation is somewhat better for adults than for children in the NorthSTAR counties on a per 100,000 population basis, with 13.7 beds per 100,000 for adults (371 beds for 2,705,038 adults ages 18 and over) and 10.7 beds per 100,000 for children (105 beds for 985,615 children ages 0 to 17).

- If the NorthSTAR region were a state, it would have ranked 47\textsuperscript{th} among states in 2006.\textsuperscript{90}

\textsuperscript{88} Personal communication, R. Schirmer, Texas Hospital Association, June 23, 2010.\textsuperscript{89} Capacity analysis by MCPP Healthcare Consulting, Inc., (09-2009), analysis conducted for Washington State using American Hospital Association Annual Survey Database. Personal communication, D. Jarvis.\textsuperscript{90} The 2006 comparisons likely overstate to some degree the relative lack of beds in the Dallas Metro Area, as the overall United States population has grown 2.8% since 2006 and psychiatric bed capacity overall has likely declined. Even if all of the rankings from 2006 were adjusted for population growth, the national average would still be 24.6 beds, and the Dallas Metro Area’s ranking would not change.
• However, metro areas range widely in their capacity, with Pittsburgh, PA, having 49.3 beds per 100,000 population in 2009 and Denver, CO, having 12.7.  

• In addition, NorthSTAR uses a large proportion of Terrell State Hospital beds to provide acute care (which we define as an average stay of 21 days or less). Looking at one sample month (April 2010), the census across all units with an average LOS of under 21 days averaged 135 out of an average daily census of 312.5 (43.2% of use). If these 135 days are added to the NorthSTAR acute capacity total, the overall number of beds per 100,000 increases to 16.6.

• In addition, Green Oaks Hospital provided an average of 866 units of 23-hour observation per month (10,394 total for CY 2009 and 8,508 to Dallas County enrollees in SFY 2009), with an average daily census of 28.5. For the last eight months of CY 2009, there were on average 60 persons per month staying multiple nights in 23-hour observation.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Beds</th>
<th>Total Behavioral Health</th>
<th>Psychiatric Beds</th>
<th>Alcohol / Drug Beds</th>
<th>Dual Diagnosis Beds</th>
<th>Dedicated Child / Adolescent Psychiatric Beds</th>
<th>Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodist Richardson</td>
<td>205</td>
<td>42</td>
<td>30</td>
<td>12</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Green Oaks **</td>
<td>106</td>
<td>106</td>
<td>78</td>
<td>–</td>
<td>20</td>
<td>8*</td>
<td>–</td>
</tr>
<tr>
<td>Hickory Trail **</td>
<td>86</td>
<td>86</td>
<td>28</td>
<td>14</td>
<td>–</td>
<td>30*</td>
<td>14</td>
</tr>
<tr>
<td>Timberlawn **</td>
<td>144</td>
<td>144</td>
<td>56</td>
<td>16</td>
<td>–</td>
<td>55*</td>
<td>17</td>
</tr>
<tr>
<td>Parkland</td>
<td>672</td>
<td>18</td>
<td>18</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Children’s Medical Center</td>
<td>487</td>
<td>12</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>12*</td>
<td>–</td>
</tr>
</tbody>
</table>

91 Data provided to TriWest in July and August 2010 by county and state behavioral health authority contacts in these counties and states for the time periods covered.

92 Data from TSH internal census tracking document for April 2010 provided by TSH via personal communication, T. Claxton in May 2010.
### Hospital Bed Capacity

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Beds</th>
<th>Total Behavioral Health</th>
<th>Psychiatric Beds</th>
<th>Alcohol / Drug Beds</th>
<th>Dual Diagnosis Beds</th>
<th>Dedicated Child / Adolescent Psychiatric Beds</th>
<th>Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTSW University Hospital</td>
<td>422</td>
<td>18</td>
<td>18</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>THR Presbyterian Dallas</td>
<td>895</td>
<td>50</td>
<td>50</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Totals</td>
<td>–</td>
<td>476</td>
<td>278</td>
<td>42</td>
<td>20</td>
<td>105</td>
<td>31</td>
</tr>
</tbody>
</table>

Note that NorthSTAR currently delivers most of its acute inpatient care through two free-standing psychiatric hospitals (Green Oaks and Timberlawn). Inpatient LOS are very low compared to other public managed care areas. The table that follows compares LOS from the two primary NorthSTAR facilities to LOS averages from Denver County, CO, Philadelphia County, PA, Allegheny County, PA (Pittsburgh), and King County, WA (Seattle) for Medicaid members in managed care plans in SFY2009. As can be seen, in all areas except Philadelphia, LOS are two to three times longer than for the two NorthSTAR facilities.

<table>
<thead>
<tr>
<th>County / Region</th>
<th>Child LOS (Under 12)</th>
<th>Adolescent LOS (13 to 17)</th>
<th>Adult LOS (18 to 64)</th>
<th>Older Adult LOS (65 and older)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timberlawn</td>
<td>4.6 days</td>
<td></td>
<td>3.5 days</td>
<td></td>
</tr>
<tr>
<td>Green Oaks</td>
<td>n/a</td>
<td></td>
<td>2.9 days</td>
<td></td>
</tr>
<tr>
<td>Denver County</td>
<td>9.7 days</td>
<td>10.1 days</td>
<td>8.8 days</td>
<td>8.1 days</td>
</tr>
<tr>
<td>Philadelphia County</td>
<td>6.9 days MH</td>
<td>11.3 days SUD</td>
<td>3.9 days MH</td>
<td>11.1 days MH</td>
</tr>
</tbody>
</table>

93 Comparison count data provided to TriWest in July and August 2010 by county and state behavioral health authority contacts in these counties and states for the time periods covered.
<table>
<thead>
<tr>
<th>County / Region</th>
<th>Child LOS (Under 12)</th>
<th>Adolescent LOS (13 to 17)</th>
<th>Adult LOS (18 to 64)</th>
<th>Older Adult LOS (65 and older)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allegheny County (Pittsburgh)</td>
<td>10.3 days MH 10.8 days SUD</td>
<td>8.9 days MH 8.1 days SUD</td>
<td>17.3 days MH 22.1 days SUD</td>
<td></td>
</tr>
<tr>
<td>King County (Seattle)</td>
<td>13.4 days</td>
<td></td>
<td>11.6 days</td>
<td></td>
</tr>
</tbody>
</table>

As noted above, NorthSTAR delivers a substantial portion of acute care through Terrell State Hospital and the Green Oaks Hospital 23-hour emergency observation unit. The table that follows shows the distribution of acute care delivery for Dallas County NorthSTAR enrollees in SFY 2009.

<table>
<thead>
<tr>
<th>Acute Service Type</th>
<th>SFY 2009 Unduplicated Persons Served (% of Total Acute Service)</th>
<th>SFY 2009 Days of Service (% of Total Acute Service)</th>
<th>SFY 2009 Days Per Person</th>
<th>SFY 2009 Expenditures (% of Total Acute Service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Inpatient</td>
<td>6,061 (48.1%)</td>
<td>19,609 (25.2%)</td>
<td>3.2</td>
<td>$9,917,967 (36.0%)</td>
</tr>
<tr>
<td>23 Hour Observation</td>
<td>4,985 (39.6%)</td>
<td>8,508 (10.9%)</td>
<td>1.7</td>
<td>$6,412,482 (23.3%)</td>
</tr>
<tr>
<td>State Hospital – Acute</td>
<td>1,552 (12.3%)</td>
<td>49,732 (63.9%)</td>
<td>32.0</td>
<td>$11,236,544 (40.8%)</td>
</tr>
<tr>
<td><strong>Total Acute Services</strong></td>
<td><strong>12,598</strong></td>
<td><strong>77,849</strong></td>
<td><strong>6.2</strong></td>
<td><strong>$27,566,993</strong></td>
</tr>
<tr>
<td>State Hospital – Long Term</td>
<td>279</td>
<td>65,438</td>
<td>234.9</td>
<td>$14,785,145</td>
</tr>
</tbody>
</table>

In addition, three hospitals – Green Oaks Hospital, Parkland Health and Hospital System, and Timberlawn Mental Health System – provide psychiatric emergency services. Data was provided by:

94 Personal communication, T. Claxton.
by Green Oaks Hospital and Parkland Health and Hospital System on emergency department services for calendar year 2009:

- Green Oaks Hospital emergency department served 6,799 NorthSTAR members across 10,124 visits. A total of 1,593 (23.4%) of those served had more than one visit.\textsuperscript{95}

- Parkland’s psychiatric emergency department served 5,824 people across 7,048 visits. Of those served, 77% of charges were for Medicaid payers.\textsuperscript{96} NorthSTAR data shows 3,164 total unduplicated NorthSTAR members served by Parkland, with total visits of 4,610. Of these, 95.4% were Dallas County members.\textsuperscript{97}

- Timberlawn Mental Health System has been designated as the primary place for police to bring children and adolescents in need of emergency mental health services.

Parkland Health and Hospital System also provides a wide range of outpatient treatment, including in CFY 2009:\textsuperscript{98}

- Outpatient services through its Psychiatric Outpatient Clinic to 2,740 unduplicated persons,

- Outpatient services through its Community Oriented Primary Care clinics to 5,766 unduplicated persons, and

- Jail-based psychiatric services to 19,389 unduplicated persons.

**Mobile Crisis**

ADAPT Mobile Crisis services in CY 2009 provided the following:\textsuperscript{99}

- There were a total of 39,523 total phone calls (88.6% involving adult NorthSTAR members and 11.4% involving children) with an average speed of answer of 6.0 seconds and an abandonment rate of 0.86% overall. The pace of calls in the last two months of the year (November and December) averaged 4,326 per month, 66% higher than the average of the

\textsuperscript{95} Green Oaks internal data reporting, G. Barnes, personal communication, July 14, 2010.  
\textsuperscript{97} Texas Department of State Health Services. (November 23, 2009). NorthSTAR County Trends Report 11_23_09.  
\textsuperscript{98} Fichtel, M. (August 18, 2010).  
\textsuperscript{99} All data from ValueOptions December 2009 UM Report.
first two months of CY 2009 (2,607 average in January and February).

- 6,374 crisis calls (16.1%) were responded to with face-to-face interventions. Of those:
  - Only 906 resulted in a hospitalization (14.2%),
  - Only 10 resulted in a call to the police (0.2%),
  - 1,924 (30.0%) resulted in a SPN appointment (including 130 emergency appointments),
  - 1,082 (17.0%) resulted in an urgent care clinic appointment,
  - 769 (12.1%) resulted in a non-NorthSTAR outpatient referral,
  - 400 (6.3%) resulted in a chemical dependency referral,
  - 392 (6.1%) resulted in a medical referral, and
  - 698 (11.0%) resulted in the client not being able to be located (in 53 of these cases, a collateral of the client was provided with services).

Outpatient and Residential Mental Health (MH) and (SUD) Providers

One major accomplishment of the NorthSTAR system has been the expansion of the provider network. In SFY 2009, NorthSTAR utilized 291 facility and individual providers to serve members from Dallas County. The table on the following page looks more closely at those MH and SUD providers serving more than 1,000 persons per year. Together, these 13 providers served over 47,000 persons (with some duplication across providers), accounting for over 78% of the duplicated persons served count for Dallas County in SFY 2009.\(^{100}\) The table includes the distribution of authorized RDM levels of care (LOC) for persons in ongoing care as of December 2009 to illustrate the different population subgroups with which each provider tends to specialize.\(^{101}\) Note that all three ACT providers for Dallas County are included.

\(^{100}\) Texas Department of State Health Services. (November 23, 2009). NorthSTAR County Trends Report 11_23_09.

\(^{101}\) Personal communication from I. Garza, July 12, 2010, in response to Open Records Request for LOC distributions for SFY2009 statewide. Percent calculations exclude not eligible cases.
## Facility Providers Serving >1,000 Dallas County NorthSTAR Members

<table>
<thead>
<tr>
<th>Mental Health Providers</th>
<th>Persons Served</th>
<th>Provider Type</th>
<th>Percent Served Adult</th>
<th>Percent Served Child</th>
<th>Adult Service Mix</th>
<th>Child / Adolescent Service Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adult SP1 Basic (% of All Adult)</td>
<td>Adult SP2 Depression (% of All Adult)</td>
</tr>
<tr>
<td><strong>All NorthSTAR for SFY 2009</strong></td>
<td><strong>48,643</strong></td>
<td><strong>All Providers</strong></td>
<td>72%</td>
<td>28%</td>
<td>70%</td>
<td>5%</td>
</tr>
<tr>
<td>Dallas Metrocare Services</td>
<td>25,535</td>
<td>MH Outpatient</td>
<td>80%</td>
<td>20%</td>
<td>60%</td>
<td>12%</td>
</tr>
<tr>
<td>LifeNet Behavioral Healthcare</td>
<td>2,801</td>
<td>MH Outpatient</td>
<td>96%</td>
<td>4%</td>
<td>60%</td>
<td>2%</td>
</tr>
<tr>
<td>ADAPT Of Texas, Inc.</td>
<td>2,474</td>
<td>MH Outpatient</td>
<td>89%</td>
<td>11%</td>
<td>78%</td>
<td>0%</td>
</tr>
<tr>
<td>Child And Family Guidance Center</td>
<td>2,175</td>
<td>MH Outpatient</td>
<td>32%</td>
<td>68%</td>
<td>47%</td>
<td>39%</td>
</tr>
<tr>
<td>ABC Behavioral Health, LLC</td>
<td>1,836</td>
<td>MH Outpatient</td>
<td>100%</td>
<td>0%</td>
<td>77%</td>
<td>0%</td>
</tr>
<tr>
<td>Centro De Mi Salud, LLC</td>
<td>1,109</td>
<td>MH Outpatient</td>
<td>64%</td>
<td>36%</td>
<td>81%</td>
<td>17%</td>
</tr>
<tr>
<td>University of Texas Medical Branch</td>
<td>1,009</td>
<td>MH Outpatient</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Facility Providers Serving &gt;1,000 Dallas County NorthSTAR Members</td>
<td>Persons Served</td>
<td>Provider Type</td>
<td>Percent Served Adult</td>
<td>Percent Served Child</td>
<td>Adult Service Mix</td>
<td>Child / Adolescent Service Mix</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>----------------</td>
<td>------------------------</td>
<td>----------------------</td>
<td>----------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Homeward Bound, Inc.</td>
<td>2,547</td>
<td>SUD Residential / Outpatient</td>
<td>100%</td>
<td>0%</td>
<td>Detox, Residential Recovery, Outpatient</td>
<td></td>
</tr>
<tr>
<td>Solace Counseling Associates, PLLC</td>
<td>1,887</td>
<td>SUD Detox / Outpatient</td>
<td>100%</td>
<td>0%</td>
<td>Outpatient Detox, Outpatient</td>
<td></td>
</tr>
<tr>
<td>Nexus Recovery Center, Inc.</td>
<td>1,213</td>
<td>SUD Residential / Outpatient</td>
<td>95%</td>
<td>5%</td>
<td>Residential Recovery, SFR, Outpatient – Specializing in women and children programs</td>
<td></td>
</tr>
<tr>
<td>Association of Persons Affected by Addictions</td>
<td>1,066</td>
<td>SUD Outpatient</td>
<td>100%</td>
<td>0%</td>
<td>Peer support and recovery coaching</td>
<td></td>
</tr>
<tr>
<td>Specialty OP Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dallas Independent School District</td>
<td>1,861</td>
<td>School-Based</td>
<td>0%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADAPT Community Solutions, Inc.</td>
<td>1,740</td>
<td>Mobile Crisis</td>
<td>88.6%</td>
<td>11.4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Trends in Levels of Care Served

Acute care trends since the case rate. The data discussed above on the increasing proportion of persons presenting for service in acute care settings over the first seven months of 2010 is of concern, suggesting that (1) more people are being seen initially in acute care settings and (2) more people overall are in crisis and not able to have their needs managed in a routine outpatient setting, both those in care and those not in care. This is a concerning trend that correlates with the introduction of the case rate payment method.

The case rate was implemented following a sharp rise in the numbers of people served and reportedly a corresponding unsustainably high rate of service expenditure through NorthSTAR. In order to bring spending more in line with available funds, the case rate was implemented. The case rate payment method creates a clear financial incentive for providers to (1) serve approximately the same number of people over time, with limited growth in numbers served (since the payment per case drops substantially as numbers exceed past utilization trends), and (2) provide as little service as possible to each person (as the amount of funding per case is low and is received as long as any level of service, no matter how low, is provided). While NorthSTAR attempts to balance this incentive by tracking outcomes, the only available outcome measures are the Texas Recommended Assessment Guidelines (TRAG) variables.

As will be seen in our discussion below regarding performance measures, it is our experience that metrics developed for statewide and national reporting can be useful for very broad comparisons at the state level, but typically they are not concretely grounded enough to serve as clinically meaningful performance standards at the local level. While useful for tracking trends across local areas focusing on different priorities, a measure of the number of individuals who improve in functioning broadly defined is not as useful as would be a performance target such as reducing the actual number of people whose functioning leads to presentation in an acute care setting. Similarly, improvement in criminal justice involvement of any kind is not as useful a local system performance measure as would be a reduction in the number of individuals with behavioral health needs who are arrested or who are waiting in jail for a behavioral health placement. Therefore, it is understandable that performance incentives tied to TRAG scores have not been sufficient to prevent Dallas County NorthSTAR members from presenting more often in emergency room and jail settings over the first seven months of 2010, at rates of increase in both settings more than double the rates in prior years. Furthermore, overall measures of persons served and units of service provided have stabilized under the case

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102 It should be noted that case rate implementation also has reportedly reduced funding to some SPNs and has been associated with layoffs – more on this below.
rate (and in July and August dropped substantially\textsuperscript{103}). While this is not necessarily problematic (in fact, analyses of persons served suggested that the system had previously been focusing too much on serving as many people as possible rather than those most in need), it seems that those most in need may be being served even less well in 2010 under the case rate than in prior years. DSHS has not as of mid-September concluded that this is the case,\textsuperscript{104} and it will be important to track this to see how the trend evolves over time. In June 2010, we specifically requested data from NorthSTAR on the reconciliation of the case rates, RDM levels, and services received, but had not received that information as of the finalization of this report.

**SUD service delivery trends over time.** The chart below shows trends in the number of residential and non-residential SUD services used over the last 46 months (data is included from September 2005 through June 2010), focusing on the number of unduplicated enrollees using both sets of services each month.\textsuperscript{105} For SUD services, trends in NorthSTAR services show that the number of enrollees using residential services has been kept flat, suggesting that capacity is used to its maximum and has not kept pace with growth in the overall population. The trend for non-residential SUD services is quite different, showing consistent growth over time that sharply increased in 2009 (consistent with growth in the number of enrollees), but that dropped off dramatically beginning in November 2009 (a 23.6% drop in users in one month) as ValueOptions instituted increased controls on use.

\begin{center}
\includegraphics[width=\textwidth]{chart.png}
\end{center}

\textsuperscript{103} Texas Department of State Health Services. (September 17, 2010). TriWest-Zia comments on August 2010 draft report. Provided in personal communication from M. Ferrara as a Microsoft Word file on September 17, 2010.

\textsuperscript{104} Texas Department of State Health Services. (September 17, 2010).

\textsuperscript{105} Texas Department of State Health Services. (September 6, 2010). TriWest Data 09_06_10. Provided in personal communication from M. Ferrara as a Microsoft Excel file on September 7, 2010. Data analysis by TriWest Group.
Both trends indicate that SUD service use has been tightly controlled, a finding that makes sense given NorthSTAR’s limited funding, but that is concerning given the overall prevalence of severe SUD needs in Dallas County and the severe needs in the correctional system.

**Comparisons to other Texas counties.** As described in the needs section, NorthSTAR tracks MH cases by a mix of diagnosis and severity using Texas’s Resiliency and Disease Management (RDM) criteria. The table below compares data for NorthSTAR to the rest of the state and three other major urban counties (Bexar, Harris and Tarrant). The table presents data from SFY 2009 as percentages of levels of care reported (which is not 100% of persons served, but is assumed to be comparable in accuracy across regions), and data on authorized LOC for adults (that is, the LOC the person is authorized to receive, which may or may not be the same as the LOC received) in ongoing care.\(^{106}\)

It is important to note that an analysis of services actually received would be more useful than the assessment we carried out below based on service packages authorized (or the earlier analysis of recommended LOC). At present, we do not have data that informs us how many people in NorthSTAR who were assessed as needing SP3, for example, actually did or did not receive services at that level, what the outcomes were of those who did not receive the assessed level, and whether individuals may have received only a minimum level of services in the service package but actually required more. We also do not have comparable data from other LMHAs that could inform us how those figures might compare to other urban counties in Texas. Based on data on the number of people in jails or presenting in crisis settings discussed above, as well as the many descriptions we have received from providers, consumers, and family members of individuals who fall through the cracks due to long waits in the clinics, lack of assertive follow up capacity for individuals in crisis who do not keep appointments, and transportation challenges, it is our impression that this is a significant issue in the system. The comparison of NorthSTAR data to other LMHAs is also complicated by the higher number of persons served by NorthSTAR, which may obscure trends among persons served when viewed in comparison to other counties.

Despite these limitations, it is noteworthy that while NorthSTAR authorizes a lower proportion of individuals at the highest level of care (SP4) than does Bexar County, it does so at a higher proportion than Harris and Tarrant Counties and the rest of the state. Further, the gap between SP4 recommended and authorized is narrower for NorthSTAR than for all the comparison counties (NorthSTAR authorized a higher amount of SP4 as a proportion of the number

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\(^{106}\) Personal communication from I. Garza, July 12, 2010, in response to Open Records Request for LOC distributions for SFY2009 statewide. Percent calculations exclude not eligible cases.
recommended overall than did the comparison counties). Data from the draft version of the data book for the LBB comparative analysis of behavioral health system funding showed that the NorthSTAR region provided a higher level of SP4/ACT services in SFY 2009 than comparison counties (2.1% of overall population in NorthSTAR versus 0.7% of overall population in the combined Tarrant, Harris and Bexar service areas). However, NorthSTAR’s proportion authorized at SP3 is higher and at SP1 is lower than all but Bexar County. Persons identified for SP2 fall into the middle range, but are at a rate much lower than the proportion identified as in need of that level (4.6% authorized versus 10.9% recommended).

Note however that the comparability of authorization mix to other urban counties does not lead to the conclusion that the authorization mix in any of these counties is one that is maximally effective for the population, given the available resources. Our study did not review overall system performance in the other counties regarding acute care and crisis utilization trends, penetration rates, substance use service delivery, and so on. Our study, as noted below, was also unable to determine the connection between authorization of services and services received. Finally, none data on SPN crisis service package use (such as SP0 and SP5) for individuals who may not yet have been determined eligible for an RDM or assigned to a SPN for continuing care shows little such care provided. Finally, comparison data with other counties does not address the issue of whether individuals are assigned to service packages that might better be served in primary care settings, and how that affects comparisons between counties.

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>Adult SP1 (Basic Services)</th>
<th>Adult SP2 (Depression Focus)</th>
<th>Adult SP3 (Team Based Treatment)</th>
<th>Adult SP4 (Assertive Community Treatment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NorthSTAR</td>
<td>70.0%</td>
<td>4.6%</td>
<td>22.8%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Rest of State</td>
<td>81.9%</td>
<td>2.6%</td>
<td>13.9%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Bexar County</td>
<td>64.2%</td>
<td>5.2%</td>
<td>27.4%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Harris County</td>
<td>82.2%</td>
<td>2.4%</td>
<td>14.4%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Tarrant County</td>
<td>82.8%</td>
<td>0.9%</td>
<td>15.1%</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

107 Legislative Budget Board. (June 29, 2010). Draft data book for Legislative Budget Board comparative report: Comparative analysis of publicly funded behavioral health systems in Texas by HHSC service delivery area. Received via personal communication from I. Garza, August 31, 2010, in response to Open Records Request.
The table below summarizes data on assessed LOC for children and youth in ongoing. Patterns overall are similar to those for the LOCs identified and recommended, the only exception being that the proportion served at the aftercare level (SP4) is much higher than the proportion identified (28.2% authorized versus 17.8% recommended) and the proportion served at the brief levels (SP 1.1 and 1.2) are much lower than the proportion identified (65.8% authorized versus 71.4% recommended). It should be noted that this “gap” is comparable to the “gap” for Bexar County and much lower than the “gap” for Harris and Tarrant Counties.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NorthSTAR</td>
<td>47.7%</td>
<td>17.7%</td>
<td>0.0%</td>
<td>4.2%</td>
<td>1.1%</td>
<td>1.2%</td>
<td>28.2%</td>
</tr>
<tr>
<td>Rest of State</td>
<td>53.0%</td>
<td>11.7%</td>
<td>0.3%</td>
<td>6.7%</td>
<td>1.5%</td>
<td>0.5%</td>
<td>26.3%</td>
</tr>
<tr>
<td>Bexar County</td>
<td>33.8%</td>
<td>20.3%</td>
<td>1.5%</td>
<td>14.4%</td>
<td>6.2%</td>
<td>0.3%</td>
<td>23.5%</td>
</tr>
<tr>
<td>Harris County</td>
<td>54.0%</td>
<td>17.2%</td>
<td>0.0%</td>
<td>7.9%</td>
<td>2.4%</td>
<td>0.0%</td>
<td>18.4%</td>
</tr>
<tr>
<td>Tarrant County</td>
<td>43.2%</td>
<td>6.7%</td>
<td>2.9%</td>
<td>8.6%</td>
<td>1.7%</td>
<td>0.0%</td>
<td>37.0%</td>
</tr>
</tbody>
</table>

System Funding and Expenditures

**Dallas County Behavioral Health Expenditures**

**Major Findings:**

- System funding is highly fragmented, with NorthSTAR behavioral health funding at the system level essentially uncoordinated with other Medicaid (foster care, fee for service), CHIP, county agency (jail, juvenile justice), state agency (community corrections, child welfare, other agencies), federal (Veteran’s Administration), and local (schools) funding. Fragmentation is so pronounced that the system does not even have readily accessible data on persons served or amounts spent on behavioral health services in these systems.

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NorthSTAR accounts for just over 50% of current identified system funding for public behavioral health services and supports. It is very likely well under half of all public funding for behavioral health services and supports.

Other significant partners in terms of system funding include: Dallas County (jail, juvenile justice) / Health District, the homeless services continuum, and the local correctional continuum (jail, CSCD, and juvenile justice).

The table that follows gives an overview of funding for behavioral health services and related supports by the major providers in Dallas County. This table includes positive supports such as housing and homeless services, as well as the costs of identified negative impacts on the community such as jail days used waiting for a behavioral health placement. The table also notes a wide variety of funding sources that are known to serve persons with behavioral health needs, but for which data on behavioral health funding for people in Dallas County or the NorthSTAR region is not known at present. While some sources may be able to report data between now and when the report is finalized in September 2010, most of the sources for which funding levels are not known represent systems whose service delivery is particularly fragmented from the rest of the Dallas County behavioral health system.

<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Persons Served</th>
<th>Expenditures</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Behavioral Health System</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2009 NorthSTAR All Counties TOTAL 109</td>
<td>62,075</td>
<td>$134,028,649</td>
<td>Various</td>
</tr>
<tr>
<td>FY 2009 NorthSTAR Dallas County TOTAL 110</td>
<td>48,643</td>
<td>$107,395,201</td>
<td>Various</td>
</tr>
<tr>
<td>Local Funds</td>
<td></td>
<td>$3,065,547</td>
<td>County</td>
</tr>
<tr>
<td>Substance Abuse Block Grant</td>
<td></td>
<td>$7,506,231</td>
<td>Federal</td>
</tr>
</tbody>
</table>

---


110 Expenditure data for Dallas County comes from the NorthSTAR County Trends Report 11_23_09 just cited. Breakouts by spending category were computed by applying the FY 2010 budget proportions from Appendix 30 of the NorthSTAR 2009-2011 contract to the actual FY 2009 expenditures reported by DSHS. These estimates should be treated as approximations only, and are used only because actual expenditures for Dallas County were not provided by the NorthSTAR contractor.
<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Persons Served</th>
<th>Expenditures</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSHS Funds</td>
<td></td>
<td>$24,535,782</td>
<td>Approximately 89% State / 11% Federal MH Block Gant</td>
</tr>
<tr>
<td>TCOOMMI Funds</td>
<td></td>
<td>$1,281,211</td>
<td>State</td>
</tr>
<tr>
<td>Outpatient Competency Restoration Funds</td>
<td></td>
<td>$423,732</td>
<td>State</td>
</tr>
<tr>
<td>Crisis Redesign Funds</td>
<td></td>
<td>$3,266,295</td>
<td>State</td>
</tr>
<tr>
<td>Rider 65 for Transitional Services and Intensive</td>
<td></td>
<td>$3,142,596</td>
<td>State</td>
</tr>
<tr>
<td>Ongoing Services Funds</td>
<td></td>
<td>$3,266,295</td>
<td>State</td>
</tr>
<tr>
<td>Medicaid Per Member Per Month Payments</td>
<td></td>
<td>$38,152,119</td>
<td>State (30.15%) / Federal (69.85%)</td>
</tr>
<tr>
<td>Terrell State Hospital Funding</td>
<td></td>
<td>$26,021,689</td>
<td>State</td>
</tr>
<tr>
<td>SFY 2009 Medicaid Fee For Service / Primary Care</td>
<td>5,590</td>
<td>$3,631,109</td>
<td>State (30.15%) / Federal (69.85%)</td>
</tr>
<tr>
<td>Case Management Behavioral Health Services¹¹¹</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult MH</td>
<td>2,595</td>
<td>$1,372,458</td>
<td></td>
</tr>
<tr>
<td>Child MH</td>
<td>2,180</td>
<td>$1,966,182</td>
<td></td>
</tr>
<tr>
<td>Adult SUD</td>
<td>617</td>
<td>$240,184</td>
<td></td>
</tr>
<tr>
<td>Child SUD</td>
<td>197</td>
<td>$52,285</td>
<td></td>
</tr>
</tbody>
</table>

¹¹¹ Legislative Budget Board (LBB). (June 29, 2010). Draft data book for Legislative Budget Board comparative report: Comparative analysis of publicly funded behavioral health systems in Texas by HHSC service delivery area. Received via personal communication from I. Garza, August 31, 2010, in response to Open Records Request. LBB data included all NorthSTAR counties, so to estimate the proportion for Dallas County, the SFY 2009 NorthSTAR Dallas County proportions for persons served (78.4%) and expenditures (80.1%) were computed and applied to the LBB data.
### Care Setting

<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Persons Served</th>
<th>Expenditures</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFY 2009 Medicaid Fee For Service / Primary Care Case Management Behavioral Health Services&lt;sup&gt;112&lt;/sup&gt;</td>
<td>2,024</td>
<td>$550,615</td>
<td>State (30.15%) / Federal (69.85%)</td>
</tr>
<tr>
<td>Adult MH</td>
<td>245</td>
<td>$68,339</td>
<td></td>
</tr>
<tr>
<td>Child MH</td>
<td>1,552</td>
<td>$379,130</td>
<td></td>
</tr>
<tr>
<td>Adult SUD</td>
<td>74</td>
<td>$34,087</td>
<td></td>
</tr>
<tr>
<td>Child SUD</td>
<td>154</td>
<td>$69,060</td>
<td></td>
</tr>
<tr>
<td>SFY 2009 Additional Medicaid Vendor Behavioral Health Medications&lt;sup&gt;113&lt;/sup&gt;</td>
<td>7,390</td>
<td>$20,654,097</td>
<td>State (30.15%) / Federal (69.85%)</td>
</tr>
<tr>
<td>SFY 2009 Medicaid BH for Dallas County Children in Foster Care (STARHealth)</td>
<td>360</td>
<td>Not Available (N/A)</td>
<td>State (30.15%) / Federal (69.85%)</td>
</tr>
<tr>
<td>SFY 2009 CHIP BH for Dallas County Children</td>
<td>2,755</td>
<td>N/A</td>
<td>State (28.39%) / Federal (71.61%)</td>
</tr>
<tr>
<td>SFY 2009 Additional DSHS-funded BH Services&lt;sup&gt;114&lt;/sup&gt;</td>
<td>2,585</td>
<td>$3,110,644</td>
<td>State</td>
</tr>
<tr>
<td>Adult MH</td>
<td>1,800</td>
<td>$2,329,438</td>
<td></td>
</tr>
<tr>
<td>Child MH</td>
<td>255</td>
<td>$169,722</td>
<td></td>
</tr>
<tr>
<td>Adult SUD</td>
<td>465</td>
<td>$429,577</td>
<td></td>
</tr>
<tr>
<td>Child SUD</td>
<td>65</td>
<td>$181,907</td>
<td></td>
</tr>
</tbody>
</table>

---

<sup>112</sup> LBB. (June 29, 2010). As previously, SFY 2009 NorthSTAR Dallas County proportions for persons served (78.4%) and expenditures (80.1%) were computed using the November 23, 2009 DSHS data set cited above and applied to the LBB data.

<sup>113</sup> LBB. (June 29, 2010). The SFY 2009 NorthSTAR Dallas County proportion of overall NorthSTAR medication claimants (79.6%) was computed using the November 23, 2009 DSHS data set cited above and applied to the LBB claimant and expenditure data.

<sup>114</sup> LBB. (June 29, 2010). As previously, SFY 2009 NorthSTAR Dallas County proportions for persons served (78.4%) and expenditures (80.1%) were applied to the LBB data.
<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Persons Served</th>
<th>Expenditures</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Health System</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2009 Parkland Behavioral Health – Non-Jail Sources</td>
<td>19,242</td>
<td>$8,518,207</td>
<td>Hospital District (County)</td>
</tr>
<tr>
<td>CFY 2009 Parkland Behavioral Health – Non-Jail</td>
<td></td>
<td>$13,714,141</td>
<td>Hospital District (County)</td>
</tr>
<tr>
<td>Operating Loss to Health District</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Public Adult Correctional System</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CFY 2009 Parkland Behavioral Health – Jail</td>
<td>19,389</td>
<td>$7,391,763</td>
<td>Hospital District (County)</td>
</tr>
<tr>
<td>Operating Loss to Health District</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dallas County Jail Bed Use (SFY 2010 Averages)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting for Bed (State Hospital)</td>
<td>63</td>
<td>$1,144,578</td>
<td>County</td>
</tr>
<tr>
<td>Waiting for Other BH Placement</td>
<td>313</td>
<td>$5,652,990</td>
<td>County</td>
</tr>
<tr>
<td>Dallas County CSCD-CATS</td>
<td></td>
<td></td>
<td>State / County</td>
</tr>
<tr>
<td>84a Outpatient SUD Treatment Grant (SFY 2009)</td>
<td>N/A</td>
<td>$521,383</td>
<td>State</td>
</tr>
<tr>
<td>84c Residential SUD Treatment Grant (SFY 2009)</td>
<td>N/A</td>
<td>$2,252,314</td>
<td>State</td>
</tr>
</tbody>
</table>

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116 Fichtel, M. (August 18, 2010). Parkland computed its net loss, paid for through county funding of the health district for all costs attributed to a behavioral health encounter. This does not include any payments received from NorthSTAR or any other funding for non-jail clinical services.
117 Fichtel, M. (August 18, 2010).
119 Texas Department of Criminal Justice. (December 1, 2009). Report to the Governor and Legislative Budget Board on the monitoring of Community Supervision Diversion Funds.
<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Persons Served</th>
<th>Expenditures</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services Delivered by CATS Staff (SFY 2010)</td>
<td>1,090</td>
<td>$2,200,000</td>
<td>State</td>
</tr>
<tr>
<td><strong>Public Juvenile Justice System</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dallas County Juvenile Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Residential Contract Services (FY 2010)</td>
<td>2,400</td>
<td>$3,700,000</td>
<td>County / State</td>
</tr>
<tr>
<td>Residential Contract Services (FY 2010)</td>
<td>400</td>
<td>$4,800,000</td>
<td>County / State</td>
</tr>
<tr>
<td>County-Delivered Services (FY 2009)</td>
<td>10,000</td>
<td>$2,000,000</td>
<td>County / State</td>
</tr>
<tr>
<td><strong>Other Systems</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent Supportive Housing (beds across various providers) – FY 2010</td>
<td>1,475</td>
<td>$12,500,000</td>
<td>City / County / State / Federal / Private / Other</td>
</tr>
<tr>
<td>The Bridge</td>
<td>1,850</td>
<td>$8,200,000</td>
<td>City / County / State / Private</td>
</tr>
</tbody>
</table>

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120 Texas Department of Criminal Justice. (December 1, 2009).
121 Personal communication from G. Crumpton, June 11, 2010. Data was provided on the number of group (39,350) and individual counseling (2,723) units provided in SFY 2009 by staff. Costs were estimated by multiplying the number of group units by $33.33 an hour and the number of individual units by $100 an hour, rounding down to the nearest $100,000. Data on persons served was not available for SFY 2009, so the number for the first six months of SFY 2010 (815) was multiplied by a factor derived from the number of SFY 2009 combined group and individual units (42,073) divided by the number of SFY 2010 combined group and individual units (31,465) to yield 1,090 (815 x 42,073/31,465).
122 Personal communication from D. Kilcrease-Fleming on July 14, 2010.
123 Dallas County Juvenile Department Clinical Services Division. Annual Report 2009. This funding estimate is derived from calculating an estimated cost of $100 per unit for 20,000 units delivered in FY 2009.
124 Data provided from the Metro Dallas Housing Alliance, via Personal Communication from J. Dunn, July 21, 2010. Persons served data is the number of beds available across all units, and not all beds are filled by persons with severe behavioral health diagnoses. Financial data is an estimate based on the annualized budget for 1,098 PSH (772) and Shelter+Care beds (326) included in an annualized budget table provided by J. Dunn. This covers only 1,098 of the 1,475 beds available, so funding reported for the 1,098 was increased by factor of 1,098/1,475 (25.6%) and rounded from $12,554,827 to $12,500,000 to derive this estimate.
125 Personal communication from J. Dunn, July 21, 2010 for persons served and financial data for FY 2010. Persons served data was reported unduplicated per day for FY 2010. See table in Persons Served section for methodology.
## Care Setting

<table>
<thead>
<tr>
<th>Persons Served</th>
<th>Expenditures</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>City</td>
<td>City of Dallas Substance Abuse Services 126</td>
</tr>
<tr>
<td>2,500</td>
<td>$1,500,000 to $3,000,000</td>
<td>Local / State / Federal</td>
</tr>
</tbody>
</table>

### Other Systems Not Yet Reporting Data

<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Persons Served</th>
<th>Expenditures</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments Leveraged by Other Public System Hospital and Outpatient Providers</td>
<td>N/A</td>
<td>N/A</td>
<td>Medicare, Self-Pay, Commercial</td>
</tr>
<tr>
<td>Other Grants</td>
<td>N/A</td>
<td>N/A</td>
<td>Private / State / Federal</td>
</tr>
<tr>
<td>Texas Department of Criminal Justice</td>
<td>N/A</td>
<td>N/A</td>
<td>State / Federal</td>
</tr>
<tr>
<td>Texas Department of Family and Protective Services</td>
<td>N/A</td>
<td>N/A</td>
<td>State / Federal</td>
</tr>
<tr>
<td>Other State Agencies</td>
<td>N/A</td>
<td>N/A</td>
<td>State / Federal</td>
</tr>
<tr>
<td>Veteran’s Administration</td>
<td>N/A</td>
<td>N/A</td>
<td>Federal</td>
</tr>
</tbody>
</table>

### Totals

<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Expenditures</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Expenditures for Behavioral Health Services and Supports for Sources Reporting</td>
<td>$210,792,206 (100%)</td>
<td>Various</td>
</tr>
<tr>
<td>NorthSTAR Dallas County Expenditures (% of Total)</td>
<td>$107,395,201 (50.9%)</td>
<td>Various</td>
</tr>
<tr>
<td>Other Medicaid (FSS, PCCM, HMO)</td>
<td>$24,835,821 (11.8%)</td>
<td>Federal / State</td>
</tr>
<tr>
<td>Other Dallas County Expenditures (% of Total)</td>
<td>$72,595,376 (34.4%)</td>
<td>Various</td>
</tr>
</tbody>
</table>

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126 Personal communication, key informant interview.
127 Data provided via personal communication on October 4, 2010, by L. Smith
This total does not include a wide array of behavioral health funding from other sources, including:

- Payments leveraged by other major hospital and outpatient providers serving public sector consumers, including Medicare, self-pay, and commercial;
- Private, state and federal grants leveraged by other major hospital and outpatient providers serving public sector consumers;
- Additional services through the Dallas Independent School District;
- State and federally funded services through the Texas Department of Criminal Justice (prisons, parole, probation and related services incurred by persons with severe behavioral health needs);
- State and federally funded services through the Texas Department of Family and Protective Services (foster care, kinship care, services provided in addition to those funded under the STARHealth Medicaid plan);
- State and federally funded services through other state agencies (other divisions within DSHS, Texas Department of Assistive and Rehabilitative Services, Texas Department of Housing and Community Affairs, Texas Juvenile Probation Commission, Texas Youth Commission, and others);
- Federally funded services through the Veteran’s Administration system; and
- Other private, commercial and grant funded initiatives.
The implications of this analysis are many and include:

- Only 51.4% ($107.4 million) of the over $204 million in currently identified behavioral health system funding in Dallas County comes from NorthSTAR. Assuming that at least another $5.9 million is spent through the dozens of agencies and organizations for which data was not available, NorthSTAR funding represents under half of total public behavioral health system funding in Dallas County.

- The next largest funder of behavioral health services and supports is Dallas County, inclusive of the hospital district (Parkland), which manages 22.5% of funding ($46.9 million).

- Medicaid FFS and HMO funding for behavioral health services through integrated health plans comprises 11.9% of funding ($24.8 million), plus an unidentified amount of additional spending through the STARHealth plan for children in foster care. Combined with CHIP funding and spending through Parkland, behavioral health delivered through integrated funding streams is currently a significant component of the system and likely to grow over time, as will be seen in the policy analysis later in this report.

The diagram on the following page shows the broad and fragmented array of funding streams currently paying for behavioral health services and related supports in Dallas County.
Comparisons to Other Texas Counties and Other Systems Nationally

**Major Findings:**

- Advocacy for additional state funding based on the efficiency of the system has not been successful historically. Advocacy for increased state funding by other agencies, such as the Texas Department of Criminal Justice, based on differential, population-based need has been successful in recent years.

- On a per capita basis across all funding streams identified by the LBB in its June 2009 draft data book, NorthSTAR is funded for MH services at a level comparable to the Bexar County service area ($34.05 versus $36.20 per capita, respectively, though Bexar County spends much more on psychiatric medication) and at a level much higher than Harris and Tarrant Counties’ service areas ($23.62 and $21.24 per capita, respectively). Per capita spending for SUD services is essentially equal ($4.54 to $4.95 per capita, with NorthSTAR at $4.63).

- The NorthSTAR area receives less TCCOMMI funding per capita (the other three counties received 19% to 65% more funding in SFY 2009).

- NorthSTAR and/or Dallas County should begin to focus more on differential needs-based data (much of which is summarized in this document) to begin to advocate for additional, targeted funds based on those needs. Partnership with TDCJ and other agencies with successful track records in such advocacy may also be warranted, as would alignment with the current and future state policies (such as health care reform) discussed in the next section.

- Dallas County and NorthSTAR are the only full-risk managed care systems of which we are aware in which funding for the uninsured is capped and the expectation of service access and service provision is unlimited.

One of the goals of this study has been to compare funding levels in Dallas County to comparable counties in Texas. It is well established that Dallas’s level of overall mental health funding is very low nationally.\(^\text{128}\)

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**Funding per person served.** It has been frequently observed that NorthSTAR funding is much lower than the rest of Texas on a per person served basis.\(^{129}\) This latter observation has been used in numerous efforts to argue for increased funding for the NorthSTAR region.

The difficulty with this argument is two-fold. First, state-level funding decisions tend to be driven more by overall population dynamics (such as size of population, population needs) rather than delivery system efficiency. It is well established that no behavioral health system in the country and most certainly no behavioral health system in Texas has sufficient funding to serve all persons in need. Emphasizing the ability of NorthSTAR to serve more people on a per capita basis than other regions may actually undermine the argument that North Texas has more unmet needs than other parts of the state. Contrast this with the successful arguments by the Texas Department of Criminal Justice that have led to increased funding under Rider 48 for Dallas County based on Dallas’s higher proportion of felons than other parts of the state (that is, Dallas County has a higher proportion of the state’s felons in its system, so it needs a higher proportion of Rider 48 funding).

Second, Texas has no excess funding available for behavioral health given its low national ranking in per capita funding, and it is facing the potential of dramatic future cuts in state spending. This compounds the difficulty in using an efficiency-based argument to justify increased funding. While such an argument is being weighed currently by the LBB as a possible rationale for expanding the NorthSTAR model to other parts of Texas (an argument that is at least logically based on efficiency), efficiency has yet to be a sufficient argument for increased spending through NorthSTAR. Instead, the history of NorthSTAR has been dominated by repeated funding cuts over the past decade as “efficiencies” were taken out of the system.\(^ {130}\)

However, a per person served analysis vs. a per capita analysis clearly underscores the relative decrease in funding for NorthSTAR as a whole (and Dallas County, as well) per person served in NorthSTAR over the last decade. The cumulative impact of these cuts over time has been dramatic, representing nearly a one-third reduction in available funds per person served (not even accounting for inflation, which means that the reductions are an order of magnitude greater in terms of services purchasing power). The table below uses data from DSHS to illustrate the per person funding reductions for NorthSTAR enrollees from SFY2000 through SFY2010. Note however that this data only applies to comparisons within NorthSTAR and other


LMHA funding. It does not take into account dollars and persons served in other settings, including, in particular, primary health settings. In addition, data cited earlier indicates that in Dallas, the percentage of available public (Hospital District) primary health care resources that are actually utilized for behavioral health may be less than the national average. Further, there is no comparison data with other Texas urban counties regarding use of county hospital district primary health resources for behavioral health services. Therefore, comparisons of available funding and persons served through all sources cannot be readily analyzed.

<table>
<thead>
<tr>
<th></th>
<th>SFY 1999-00</th>
<th>SFY 2009-10</th>
<th>Percent Increase / Decease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollees Served (MH and SUD)</td>
<td>30,742</td>
<td>65,052</td>
<td>111.6%</td>
</tr>
<tr>
<td>Funding</td>
<td>$78,787,144</td>
<td>$116,570,300</td>
<td>48.0%</td>
</tr>
<tr>
<td>Funding per Enrollee Served</td>
<td>$2,563</td>
<td>$1,792</td>
<td>- 30.1%</td>
</tr>
</tbody>
</table>

**Funding per capita.** To broaden the perspective on how Dallas County and NorthSTAR funding compares to the rest of the state, our study has sought to access comparison data on funding sources that looks at the broader population in the three comparison counties previously cited, and their related service delivery areas (SDAs): Bexar, Harris and Tarrant Counties. This has been complicated by the fragmentation of funding described in the previous section, so not all data was available. Available data included:

- Comparison data on Medicaid FFS, PCCM and HMO (STAR/STARPlus) and indigent behavioral health expenditures from the draft LBB data book\(^{132}\) and
- Comparison data by county for the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) program.\(^{133}\)

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\(^{131}\) Texas Department of State Health Services. (September 17, 2010). TriWest-Zia comments on August 2010 draft report. Provided in personal communication from M. Ferrara as a Microsoft Word file on September 17, 2010. SFY 2009-10 funding amount includes an assumed $300,000 retroactive increase in payments for later months in 2010 (to be paid in subsequent months).

\(^{132}\) LBB. (June 29, 2010). Draft data book for LBB comparative report: Comparative analysis of publicly funded behavioral health systems in Texas by HHSC service delivery area. Received via personal communication from I. Garza, August 31, 2010, in response to Open Records Request.
Comparison data for other funding streams, particularly Medicaid funding for children in the foster care system through STARHealth, CHIP expenditures, and local county mental health spending, was not available to our study (nor was such data included in the LBB analysis).

The draft LBB data is the most comprehensive and it shows a wide range of funding across Medicaid and indigent, as well as MH and SUD funding streams, as shown below.

<table>
<thead>
<tr>
<th>Service Delivery Area (SDA)</th>
<th>SFY 2009 Medicaid MH Services</th>
<th>SFY 2009 Indigent MH Services</th>
<th>SFY 2009 Medicaid SUD Services</th>
<th>SFY 2009 Indigent SUD Services</th>
<th>Total SFY 2009 BH Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>NorthSTAR</td>
<td>$65,226,304</td>
<td>$82,634,681</td>
<td>$6,960,937</td>
<td>$10,135,116</td>
<td>$164,957,038</td>
</tr>
<tr>
<td>Bexar County SDA(^{134})</td>
<td>$114,796,048</td>
<td>$40,762,003</td>
<td>$5,704,304</td>
<td>$4,302,047</td>
<td>$165,564,401</td>
</tr>
<tr>
<td>Harris County SDA(^{135})</td>
<td>$181,759,944</td>
<td>$81,188,764</td>
<td>$13,822,855</td>
<td>$14,176,195</td>
<td>$290,947,757</td>
</tr>
<tr>
<td>Tarrant County SDA(^{136})</td>
<td>$75,401,332</td>
<td>$36,731,934</td>
<td>$6,467,279</td>
<td>$6,459,310</td>
<td>$125,059,855</td>
</tr>
</tbody>
</table>

\(^{133}\) TDCJ data on contracts related to each county during SFY 2009 received via personal communication from D. Collins, September 9, 2010, in response to Open Records Request.

\(^{134}\) Bexar County SDA includes Atascosa, Bexar, Comal, Guadalupe, Kendall, Medina, and Wilson Counties.

\(^{135}\) Harris County SDA includes Brazoria, Fort Bend, Galveston, Harris, Montgomery, and Waller Counties.

\(^{136}\) Tarrant County SDA includes Denton, Hood, Johnson, Parker, Tarrant, and Wise Counties.
Analysis on a per capita basis using the SFY 2009 population projections in the LBB draft data book reveals some interesting trends, as shown in the table below.

<table>
<thead>
<tr>
<th>SDA</th>
<th>SFY 2009 Population</th>
<th>BH $ Per Capita</th>
<th>MH $ Per Capita</th>
<th>Non-Medication MH $ Per Capita</th>
<th>SUD $ Per Capita</th>
<th>Medicaid $ Per Capita</th>
<th>Indigent $ Per Capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>NorthSTAR</td>
<td>3,690,653</td>
<td>$44.70</td>
<td>$40.06</td>
<td>$34.05</td>
<td>$4.63</td>
<td>$19.56</td>
<td>$25.14</td>
</tr>
<tr>
<td>Bexar</td>
<td>2,021,692</td>
<td>$81.89</td>
<td>$76.94</td>
<td>$36.20</td>
<td>$4.95</td>
<td>$59.60</td>
<td>$22.29</td>
</tr>
<tr>
<td>Harris</td>
<td>5,663,845</td>
<td>$51.37</td>
<td>$46.43</td>
<td>$23.62</td>
<td>$4.94</td>
<td>$34.53</td>
<td>$16.84</td>
</tr>
<tr>
<td>Tarrant</td>
<td>2,849,024</td>
<td>$43.90</td>
<td>$39.36</td>
<td>$21.24</td>
<td>$4.54</td>
<td>$28.74</td>
<td>$15.16</td>
</tr>
</tbody>
</table>

The comparison of behavioral health (BH) spending per capita reveals the following:

• Bexar County SDA has the highest per capita BH spending ($81.89), but this difference is driven almost entirely by the $59.60 spent per capita on Medicaid MH medications. If that spending is removed, Bexar County MH spending is less than 10% higher than NorthSTAR.

• Bexar County and NorthSTAR SDAs have much higher per capita MH funding than Harris and Tarrant County SDAs.

• All four SDAs have comparable levels of per capita SUD funding.

• Indigent funding is presented in *italics* because the validity of this data is compromised by the lack of reporting of community-based acute and other non-state hospital indigent expenditures in non-NorthSTAR SDAs, given the lack of a managed system for those expenditures.

This analysis underscores the dilemma faced by NorthSTAR’s funding approach – funding levels are comparable to, if not somewhat higher than, comparable areas of the state, but far more persons are served, spreading these limited funds more thinly than other SDAs. While

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137 The LBB data book notes that emergency room, inpatient, and observation costs for indigent people, as well as other “Non-State Hospital costs for indigent persons,” are understated outside of the NorthSTAR region, so the apparent higher level of NorthSTAR indigent funding is not valid.
NorthSTAR can certainly make a strong efficiency claim based on costs per person served, this argument has not been successful in closing the efficiency gap.

Analysis of TCOOMMI funding shows a different set of relationships. Data was provided in response to an Open Records Request by the Texas DCJ for all contracts pertinent to the counties below. For similarity of comparison, the LBB report’s SDA population figures are used for the per capita comparisons. All three comparison areas receive much more funding per capita, ranging from 19% (Harris) to 65% (Bexar).

<table>
<thead>
<tr>
<th>TCOOMMI Service Area</th>
<th>SFY 2009 LBB SDA Population</th>
<th>SFY 2009 TCOOMMI Funding</th>
<th>TCOOMMI $ Per Capita</th>
<th>Percent of NorthSTAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>NorthSTAR</td>
<td>3,690,653</td>
<td>$2,208,715</td>
<td>$0.60</td>
<td>100%</td>
</tr>
<tr>
<td>Bexar County</td>
<td>2,021,692</td>
<td>$1,995,919</td>
<td>$0.99</td>
<td>165%</td>
</tr>
<tr>
<td>Harris County</td>
<td>5,663,845</td>
<td>$4,032,031</td>
<td>$0.71</td>
<td>119%</td>
</tr>
<tr>
<td>Tarrant County</td>
<td>2,849,024</td>
<td>$2,224,930</td>
<td>$0.78</td>
<td>130%</td>
</tr>
</tbody>
</table>

The Texas Department of Criminal Justice (TDCJ) has recently been successful in advocating for Rider 84 funding for expanded SUD treatment for persons in community corrections, as summarized in the table below. Note that although this new funding was awarded competitively and reflects the higher need in Dallas, it does not fully correct for the historical imbalance in TDCJ allocations for Dallas County as described in the TCOOMMI data just reviewed. Total TDCJ allocations for Dallas County “per felon” are reportedly one-third of the total allocation for Harris County.\(^\text{138}\)

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\(^{138}\) Personal communication, T. Williams, July 23, 2010.
<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>SFY 2009 Felony Population</th>
<th>Percent of State Felony Population</th>
<th>Total SFY 2009 Rider 84 Funding</th>
<th>Percent of Overall Rider 84 Funding</th>
<th>Percent Funding Vs. Percent Felony Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dallas County</td>
<td>32,235</td>
<td>13.4%</td>
<td>$2,773,697</td>
<td>12.5%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Bexar County</td>
<td>13,724</td>
<td>5.7%</td>
<td>$1,056,019</td>
<td>4.8%</td>
<td>83.5%</td>
</tr>
<tr>
<td>Harris County</td>
<td>25,456</td>
<td>10.5%</td>
<td>$821,706</td>
<td>3.7%</td>
<td>35.3%</td>
</tr>
<tr>
<td>Tarrant County</td>
<td>12,456</td>
<td>5.2%</td>
<td>$1,334,773</td>
<td>6.0%</td>
<td>115.7%</td>
</tr>
</tbody>
</table>

It should be noted that TDCJ was able to allocate funding for all counties other than Tarrant as a substantial proportion of their relative need, based on percent of the state felony population. In addition to facing the reality of needing to serve more within the limits of existing funds, NorthSTAR and/or Dallas County may also look for needs data (much of which is summarized in this document) to begin to advocate for additional, targeted funds based on those needs. Partnership with TDCJ and other agencies with successful track records in such advocacy may also be warranted. And alignment with the future policy directions discussed in the next section, such as those associated with health care reform, may also be of use.
Policy Analysis

**Major Findings:**

- County, regional and state policies are in alignment with recommendations that promote more effective interagency service delivery to populations with the most severe health and safety risks. Priorities at the regional level have begun to shift in this direction, but a stronger shift is needed to align with state priorities and funding opportunities.

- Any discussion of system organization and authority must be informed by an understanding of the known and unknown potential changes related to health care reform and the implementation of mental health parity.

- While Dallas County benefits from a regional behavioral health authority to facilitate shared planning with surrounding counties and blended behavioral health funding streams, it lacks the county-level structure (dedicated leadership, staffing, and organization) necessary to coordinate interagency efforts within Dallas County and participate effectively within the regional structure.

- As Dallas County plans ways to organize its county-level behavioral health services more effectively, it needs to develop more effective partnerships with managed care organizations, providers, consumers, families, and other stakeholders. These partnerships need to occur routinely within the county system of care, as well as through specific collaborative projects with diverse stakeholders.

- In contemplating changes, Dallas County should keep in mind that there is no silver bullet. All of these options face the same, sometimes grim, challenges, and require collaboration with the same system partners. With that being said, some structures align incentives and collaborative opportunities better than others, which are key to success.

**County Level Policy**

*Charting the Path, A Strategic Plan for Dallas County, 2007-2017*[^139] lays out five goals referred to as “visions” for the county to pursue over the decade that ends in 2017. In 2010, one third of the way through that decade, the first three of those visions nicely frame the path forward to resolve the challenges and take advantage of the opportunities noted in the preceding sections. These include:

• **Vision 1: Dallas County is a model interagency partner.** The path out of the morass of funding fragmentation and competing needs described in the preceding sections depends on Dallas County agencies – both those in county government like the Dallas County Jail, Dallas County Community Supervision and Corrections Department, Dallas County Juvenile Services, Dallas County Health and Human Services Department, and the Dallas County Hospital District (otherwise known as Parkland Health and Hospital System), as well as their partners in state government, surrounding counties, the broader behavioral health services provider community, and the consumers, parents, family members and advocates who use and work to improve their services – coming together to articulate a common path forward and a common commitment to model interagency collaboration.

• **Vision 2: Dallas County is a healthy community.** Behavioral health is integral to health, and the behavioral health burdens documented in this document require a commitment to the broader health care delivery system, particularly in light of impending health care reform.

• **Vision 3: Dallas County is safe, secure, and prepared.** Too many of the people whose needs are not currently well met in the broader behavioral health system find themselves involved in the criminal justice, juvenile justice, child welfare, and crisis systems, too often due to a lack of better alternatives and sometimes because of the risk they pose to safety and security. Reorienting the goals and priorities of the existing system and its funding to better serve these individuals is an essential component of this vision to maximize the effectiveness of the County’s safety net crisis system, and facilitate the use of criminal justice resources, not just to protect the peace, but to build it.

**Regional Policy**

The *North Texas Behavioral Health Authority Strategic Plan, SFY 2010-2012*, \(^{140}\) lays out eight goals from the perspective of the seven-county regional behavioral health authority. The first of these refers to this assessment and underscores the need to build a regional plan by broadening participation in planning to all seven counties. More specifically, the remaining seven goals are all pertinent:

- Goal II centers on enhancing the authority’s role, both through transfer of authority from the state and increased involvement of county-level board members. While the process with the state is well underway, the findings of this report underscore the need for county-level authorities to take a greater role within NTBHA and organize themselves and their human service agencies to coordinate more effectively and with greater clarity with NTBHA. In short, the strength of NTBHA as a regional structure is directly dependent on the strength

\(^{140}\) NTBHA. (2010). North Texas Behavioral Health Authority Strategic Plan, SFY 2010-2012.
and resources of the contributing county behavioral health leadership structures that are collectively represented by NTBHA. As participating counties put their authority behind NTBHA, NTBHA’s authority will increase.

• Goal III focuses on maintaining adequate funding, a goal which this report seeks to broaden to also include better leveraging non-NTBHA behavioral health resources, pursuing targeted new funds based on needs that are congruent with state and local priorities, and more effectively using existing NorthSTAR funds to align with those priorities.

• Goals IV and V focus on broadening access to education and counseling services, efforts that can be part of a coordinated set of strategies to provide persons in need with the right supports, rather than simply the existing array. The data in this report would argue that this needs to be part of a broader strategy to also link persons who are in all county service programs more quickly and effectively with the right mix of ongoing supports in the right service setting supported by the right funding stream. These recommendations are detailed in the next sections of this report.

• Goals VI and VII prioritize key supports to empower individual consumers, including increased collaboration with the Department of Assistive and Rehabilitative Services to enhance access to vocational supports and promote employment and enhanced transportation supports. Both are critical to help people move out of the public behavioral health system and promote both individual wellness and recovery, as well as improve system-level flow.

• Goal VIII commits to strengthening the housing continuum, a goal which fits exactly with our recommendations in Step 10.

We contend across the recommendations that follow this section that this regional strategy can only be successful to the extent that individual county-level strategies align with it. The first Step we offer in our recommendations section is the step of beginning to organize a locus of county-level authority within Dallas County that will allow Dallas both to better manage its own resources, as well as to better exercise its responsibilities within NorthSTAR. The ability of Dallas County to organize itself and determine how NTBHA’s regional priorities can be supported in the pursuit of the county’s own critical goals is inextricably linked with the success of those goals and with the broader mission of NTBHA to Create a Well Managed, Integrated and High Quality Delivery System of Behavioral Health Services Available to Qualified Consumers in the NorthSTAR Region. This gap in current county-level organization and authority is explored further below.
State Level Policy

It is well established that Texas has a long history of inadequately funding behavioral health services. NorthSTAR has helped the state achieve significant cost-savings over the past decade, including rate reductions in March 2001, October 2001, and January 2004; benefit reductions in September 2004 and further benefit changes in December 2005; experiments with prepaid models for select SPNs from 2005 to 2008; and the latest blended case rates for RDM in late 2009 through early 2010. Many providers report that the effect of these case rates has been to reduce their funding, leading in some cases to layoffs and in many cases to ongoing financial strain and risk of further reductions. These repeated moves over the past decade, along with many other innovations and the development of a wide array of excellent and responsive service models, have allowed NorthSTAR to maintain solvency and achieve its success in dramatically reducing costs per person served.

The findings of this report raise the question as to whether this focus primarily on “cost-efficiency” (serving more people with fewer dollars) needs to be reconsidered. Cost efficiencies achieved by broadening the number of persons across whom costs are averaged, while leaving behind key populations with severe behavioral health needs in correctional and crisis settings, threatens both the validity of cost-efficiency claims and the ongoing financial viability of the broader system. The rate at which persons with behavioral health needs languish in jails and present in emergency rooms has escalated in the past eight months to more than double prior rates of increase.

Furthermore, the findings and recommendations of this report fit with current state priorities, including:

- Addressing the competency restoration crisis that is affecting not just Dallas County, NTBHA, and Terrell State Hospital but local MH authorities and state hospitals across the state, necessitating new approaches to continuity of care (as addressed in our Steps 6 and 9 below). The state’s priorities were be published at the end of August 2010, and the importance of this initiative to DSHS is visible in the considerable time and energy invested in the Continuity of Care Task Force.

- Continuing the work of crisis redesign, building on past efforts initiated with state funds to establish and, over time, expand supports such as Mobile Crisis. Note that ADAPT’s Mobile Crisis services, which responded in person to just over 530 cases per month with a hospitalization rate of under 15% of those cases in CY 2009, were targeted to bend the

141 See http://www.dshs.state.tx.us/mhsa/continuityofcare/ for final report.
curve on increased presentation in emergency rooms, two of which (Green Oaks and Parkland) together account for more than three times that many cases per month (1,779 for the first six months of CY 2010), a rate that is increasing by double-digits and which results in a far higher percentage of 23-hour observation and inpatient episodes (over 40% at Green Oaks), as addressed in our Step 6 below.

- Broadening partnerships with TCOOMMI and TDCJ to reduce probation and parole violations related to unmet behavioral health needs, divert individuals with behavioral health needs from correctional settings, and help people successfully and safely reenter the community from community corrections, jail and prison settings (as addressed in our Step 9 below).

- Preparation for health care reform by enhancing capacity to serve people with behavioral health needs in primary care settings (as addressed in our Step 5 below); integrate care delivery across tertiary settings (hospitals), secondary specialty care (behavioral health), and primary health (as addressed in our Step 5 below); increase the collaboration of providers through better access to the data needed for effective care management (as addressed in our Step 4 below); and align financial incentives with performance incentives responsive to county, community, and person-level needs (as addressed in our Step 3 below). The state’s emerging priorities in this area are outlined well in the draft HHSC report to the legislature of the Integration of Health and Behavioral Health Services Workgroup.

- Potential expansion of behavioral health managed care to other parts of Texas, provided that current models prove to be exportable and sufficiently accountable, as reflected in the current work of the LBB. Of note in relation to our findings and recommendations is that a significant barrier to managed care rollout in Texas is its perceived association with the loss of meaningful local authority over the delivery system.

- Building recovery oriented systems of care for both individuals with MH (Transformation State Incentive Grant – TSIG) and SUD needs (Texas Recovery Initiative – TRI), including increasing emphasis on peer support, recovery coaching and self-directed care.

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142 Green Oaks internal data reporting, G. Barnes, personal communication, July 14, 2010. TriWest analyzed all 2009 psychiatric emergency department and inpatient admissions and found that 40.7% overlapped.


144 Personal communication, S. Shore (TSIG) and J. Powell (TRI).
National Policy Trends

The strong convergence between county, regional, and state policy priorities with the findings of this report and the recommendations that follow are further reinforced by national policy trends in three areas: health care reform, mental health parity, and behavioral health system governance. Trends must be understood across all three areas in order to determine the next steps for governance of Dallas County’s county-level behavioral health systems and the broader NTBHA regional plan of which it is a part (and which is but a part of it). Each of these is addressed below.

Health Care Reform. There are several structural factors related to health care reform that need to inform planning in Dallas County and NTBHA regarding future governance, oversight, and policy. These include:

Need for Local Initiatives that Integrate Health and Behavioral Health. The structure and financing of health care delivery is in flux at the national, state and local levels. It is clear that no single model will predominate, and that the critical variable over the next four years will be the local level. In his overview of accountable care organizations (ACOs), Harold Miller observes that “the structure of healthcare providers differs dramatically from state to state and region to region.”\(^{145}\) As elaborated in the next point, it is a truism that “all health care is local,” and local systems will need to position themselves to both respond to the federal and state reforms that will culminate in 2014, as well as survive in the difficult financial situation that will continue to unfold and likely worsen between now and then.

Local factors are key to controlling complex, co-morbid behavioral health costs, which are a central driver of overall health costs. As Mauer and Jarvis point out in a key paper informing the State of California’s Medi-Cal reform efforts:\(^{146}\)

\[\text{Leadership at both state and county levels will be critical to success. Because all healthcare is local, Boards of Supervisors, county administrators, health plans, county MH [mental health] /SU [substance use] and community-based provider organizations, county organized}\


health systems, community health centers, consumers and advocates must work together craft a set of local solutions that take advantage of the opportunities that will unfold under healthcare reform.

Mauer and Jarvis are not just promoting a value-based principle – they cite key behavioral health cost drivers in the current health care delivery system and the likely health care delivery future that can only be addressed by integration of health, behavioral health, and broader county human services, including:

- Mental disorders were one of six key drivers of increases in overall Medicare spending from 1987 to 2006. Along with diabetes, arthritis, hyperlipidemia, kidney disease, and hypertension, they accounted for more than a third of the rise in Medicare spending.\(^{147}\)

- The Faces of Medicaid III documents that 49% of Medicaid beneficiaries with disabilities have a psychiatric condition (52% of dual eligibles) and psychiatric illness is represented in three of the top five most prevalent disease dyads among the highest-cost 5% of beneficiaries with disabilities. See the figure below (an excerpt of the top 10 conditions from the Faces of Medicaid report).\(^{148}\) Mauer and Jarvis (June, 2010) estimate conservatively that as many as 25% of these high cost beneficiaries also have a co-morbid SU condition.\(^{149}\)

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\(^{147}\) Thorpe, K.E., Ogden, L.L., Galactionova, K. (April, 2010). Chronic conditions account for rise in Medicare spending from 1987 to 2006. Health Affairs. Vol. 29 No. 4.


\(^{149}\) Mauer, B., and Jarvis, D. (June 30, 2010). The business case for bidirectional integrated care: Mental health and substance use services in primary care settings and primary care services in specialty mental health and substance use settings.
A recent study conducted by JEN Associates for the California Medi-Cal system found that individuals with Serious Mental Illnesses (SMI) account for 10% of the fee-for-service population, but payments for their total health care costs (not just behavioral health) represented 37% of payments. Of the almost 250,000 enrollees with SMI in the sample, a subset of almost 10,000 individuals received approximately $500 million worth of care ($50,000 each). See the figure that follows.

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A 2007 federal report found that nearly one in four adult hospital stays in 2004 in U.S. community hospitals involved MH or SUD disorders. Three-quarters of these admissions were for a non-MH/SUD disorder, with a secondary MH/SUD diagnosis. About 33% of all uninsured stays, 29% of Medicaid stays and 26% of Medicare stays were related to MH/SUD disorders, compared to about 16% of privately insured stays.151

A review of 1999 claims data for adult Medicaid beneficiaries in six states (Arkansas, Colorado, Georgia, Indiana, New Jersey, and Washington) found that people with diagnosed SUD had significantly higher expenditures overall and that half of the additional care and expenditure was for treatment of co-morbid physical health conditions. The six states “paid $104 million more for medical care and $105.5 million more for behavioral health care delivered to individuals with SUD diagnoses than for care given to persons with other behavioral health disorders but no SUD diagnosis.”152

A Washington State study of Medicaid medical expenses prior to and following specialty SUD treatment compared Medicaid expenses for this group to the untreated population.

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Average monthly medical costs for persons receiving SUD treatment were $414 per month higher for those not receiving treatment. In the Medicaid population, 66% of frequent users (those with 31 or more visits in a year) of emergency departments (EDs) had SUD diagnoses.\textsuperscript{153}

The bottom line is that, whatever happens in the future with health care reform, “bending the cost curve” for overall health care will require effective strategies for addressing co-morbid behavioral health costs within a better integrated delivery system. Clearly, these findings have enormous implications for Parkland in its strategic planning regarding health care reform and primary care / behavioral health integration, as well as the broader behavioral health system as it positions to support the health care reform efforts of the community as a whole.

**Partnerships between health care delivery systems and county human services.** A 2009 overview of accountable care organizations (ACOs – one possible structure that may emerge as health care reform proceeds) describes four different levels of ACO organization. The fourth level and most comprehensive ACO brings together health care providers and the broader human services delivery system to address the needs of those with the most complex conditions, including people who are homeless, people in the criminal justice system, and others, as depicted in the figure below.\textsuperscript{154} Efforts across the country are starting to move in this direction. At the state level, Colorado and Washington have both initiated ACO demonstration projects that will attempt to demonstrate such collaboration. However, because health care delivery is fundamentally local, we believe that it is the county and multi-county delivery systems where a new level of collaboration, risk-sharing, and joint effort are needed to translate the promise of health reform into a reality. Without such arrangements, better integrated delivery systems that center only on health services will simply be better positioned to shift the costs for the most vulnerable onto locally funded county services. With a full partnership between county human services and integrated health plans, not only can the incentives to shift costs be minimized, but counties will be positioned to share with integrated health delivery systems in the realization of cost savings through better integrated care, savings that can hopefully fill gaps in service, address disparities in access to health care, and promote opportunities for prevention that will otherwise continue to go unmet.


Changes in existing funding streams. As outlined in the previous health care coverage section, many currently uninsured individuals will have health coverage under health care reform in 2014. Partially to fund this expansion of coverage through Medicaid eligibility and subsidies to purchase insurance through health exchanges, and partially in response to the expected reductions in the uninsured and their impact on hospital providers, reductions in Upper Payment Limit (UPL) and Disproportionate Share (DSH) payments to hospitals to cover uncompensated care are expected. Other funding changes related to integrated health purchasing by states are also anticipated.

Mental Health Parity. In response to the promulgation of rules addressing behavioral health parity for the private group health market, managed behavioral health organizations are positioning themselves across the country to integrate their carved-out lines of business. While we are still waiting on similar such rules for plans funded through the Centers for Medicare and Medicaid Services (CMS), the public sector is also beginning such dialogue. TriWest and ZiaPartners are currently involved in such regional positioning in other states and are aware of similar regional positioning work in numerous states, and we believe that such discussion is happening behind the scenes in most locales across the county. One example is from rural
Oregon, where a coalition of three counties, local Medicaid health plans, health and behavioral health providers, and the state have formed a local, integrated health authority to share oversight and risk. The state health and behavioral health purchaser sits on the governance board. However, we are not aware of any local region that has as of yet assembled all the pieces.

**Behavioral Health System Governance.** The implications of health care reform and MH parity must be considered in any planning for future system governance and oversight. Structures developed over the past decade across the country will face the need to reorganize in order to respond to the opportunities of health care reform, as well as the “threats” to their existing lines of public health business. As formerly uninsured service recipients now have coverage, market entities (insurance companies, integrated health plans, large provider groups) may seek entry into markets that were previously limited to a single county. Combined with the press of parity away from separate purchasing and finance arrangements for behavioral health services, any efforts to organize a distinct “behavioral health authority” should consider how such an authority will co-exist in an immediate or potential partnership with any local “health authority” in a post-reform, post-parity environment.

That being said, in any future model it will be necessary for behavioral health service delivery to be better organized at the provider, county, and regional levels. This is exemplified by the many moves by health insurers in recent years to “integrate” their behavioral health lines by absorbing managed behavioral health companies or hiring their staff. Many “integrated” plans continue to subcontract with managed behavioral health companies because of the specialized competencies required in managing behavioral health delivery systems. Dallas County should consider the following “partnership options” when weighing organizational models for organizing Dallas County behavioral health services and participating in the broader NTBHA region.

There are five critical gaps (one related to staffing and four related to levels of partnership) that are key to successful integration and that Dallas County and the broader NTBHA region do not yet have in place. These include the following:

1. **Dedicated County-Level Behavioral Health Leadership** – Most of the successful single and multi-county models in which we have worked and which we observe nationally (Colorado, Kansas, Pennsylvania, Washington, and numerous others), have a dedicated lead and supporting staff resources for coordinating county-level behavioral health services. This is generally a high-level manager, backed up by administrative, contract, clinical, and (most importantly) data analytic resources. These resources do not need to be expansive --, two to five full-time equivalents are sufficient, depending on the degree of shared support from
other county departments (and the degree of actual access to that support, as opposed to formally structured access that is never acted upon).

2. **County-MCO Partnership** – In Washington and Pennsylvania, county and multi-county partnerships directly manage and bear risk for managed behavioral health carve-outs. Counties in these states have a right of first refusal to either operate directly full risk behavioral health carve-outs or contract in shared risk arrangements with either private or public managed care organizations (MCOs). The common factor in both states and their numerous plans is that effective urban counties (King County – Seattle, Allegheny County – Pittsburgh) have a designated county-level behavioral health lead, with clear lines of responsibility to county government leaders. Dallas County and the other six NTBHA counties, while they have involvement through seats on the NTBHA board, are not effectively participating in NTBHA. Counties are not organized well enough individually to be able to come together to empower and direct NTBHA adequately to either oversee the managed care operation fully or to braid and possibly seek additional federal Medicaid match for services currently funded solely (or at least largely) through county funds. What is more, counties do not appear to be driving NTBHA – they instead appear to be working to identify ways to help NTBHA take more of the lead, most recently through attempts to devolve state authority to NTBHA. The lesson from effective Washington and Pennsylvania counties is that those counties **organize themselves** to effectively use their managed care infrastructure. The key factor is not whether the counties bear risk or hold the contract (in our opinion, the majority of Washington and Pennsylvania counties do not effectively use their managed care infrastructure, regardless of where the risk is borne). The key instead is effectively using the available infrastructure (managed care tools) to use resources flexibly to maximize quality outcomes at any level of resourcing.

3. **Provider-MCO Partnership** – The accountable care organizations of the future will blend many functions traditionally associated with MCOs (integrated systems to manage data across levels of care, utilization trending and management, quality initiatives) with the care delivery capacity of providers. Some models even call explicitly for health plan / provider organization integration.\(^{155}\) In the figure that follows, Jarvis has summarized the options

available to behavioral health organizations as they confront the integrated care future in terms of their potential relationships with MCOs.\textsuperscript{156}

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Provider</td>
<td>Become a preferred provider of the health plan</td>
<td>Provider Network: Form a consortium of BH providers and contract as a provider network</td>
<td>Co-Owner: Form a consortium of BH providers and become co-owners of an integrated health plan</td>
</tr>
<tr>
<td>Integrated Healthcare System</td>
<td>Preferred Provider: Create a preferred provider relationship with the IHS</td>
<td>Co-Owner: Merge with the IHS, becoming part of their BH Division</td>
<td>Co-Owner: Merge with the IHS, becoming part of their BH Division</td>
</tr>
<tr>
<td>Accountable Care Organization</td>
<td>Preferred Provider: Become a preferred provider of the ACO</td>
<td>Co-Owner: Become a participating partner of the ACO</td>
<td>Co-Owner: Become a founding member/owner of the ACO</td>
</tr>
<tr>
<td>Primary Care Capitation</td>
<td>Preferred Provider: Become a preferred provider of the medical home</td>
<td>Partner: Become a bidirectional partner of the medical home</td>
<td>Merger: Merge with a medical home, become a person-centered healthcare home</td>
</tr>
<tr>
<td>Hybrid Model</td>
<td>Preferred Provider: Become a preferred provider of the health plan</td>
<td>Partner: Become a bidirectional partner of the medical home</td>
<td>Merger: Merge with a medical home, become a person-centered healthcare home</td>
</tr>
</tbody>
</table>

After reviewing these options, Jarvis concludes:

\textit{It’s very important for MH/SU providers to understand that in most situations, they are going to need to focus on more than clinical integration and strengthening their capacities as a high performing, recovery and wellness-oriented CBHO [community behavioral health organization]; they are going to need to examine how the management systems might change and be ready to proactively respond in order to not fall to the bottom of the food chain, or worse, to prevent being cut out of the game altogether. As noted above, this may range becoming a preferred provider to becoming a co-owner of a health plan to merging with an integrated healthcare system. . . . Like it}

\textsuperscript{156} Jarvis, D. (March, 2010). How are we going to get paid tomorrow? Emerging models for health and behavioral healthcare. Working draft. Provided by the author via personal communication and cited with permission.
or not, the mental health and substance use systems are going to end up embedded in these new structures.¹⁵⁷

Many local behavioral health managed care plans today are founded on provider-MCO partnerships. Most Colorado counties and all regions in Florida with Medicaid managed care carve-outs are currently managed by provider-MCO partnerships that share risk and responsibility for management, often with a 50-50 governance model and tailored risk sharing arrangements that reflect the financial resources of the members. Florida’s separate behavioral health carve-out for children in the foster care system involves a similar partnership between a MCO and a coalition of local child welfare agencies (Florida’s child welfare system is managed by local non-profit collaboratives involving one or multiple counties).

The potential for provider participation in NTBHA is also underleveraged. Providers report to us that they feel marginalized and increasingly under pressure from decisions made outside of their control (the most recent major example being the move to case rates). Physicians as a group also report dissatisfaction. However, the clinical operations groups and the reconstituted Physician Leadership Group initiated in the last two months also show that providers are eager and ready to participate in system-level management. They also have successful track records as individual agencies and in partnership with others (for example, the Metro Dallas Homeless Alliance) in addressing system management issues.

4. Broader Partnership through Collaboratives – There are many different models for local interagency partnerships to create a locally-empowered behavioral health collaborative decision making process (e.g., Tarrant, Bexar, Travis, Denver). For example, the Denver area Metro Crisis Services, Inc. (MCSI) is an independent, community-owned, non-profit corporation that provides a continuum of psychiatric urgent care, stabilization and support services for people in crisis as a result of MH/SUD issues across the seven county metro Denver region (Adams, Arapahoe, Broomfield, Boulder, Denver, Douglas and Jefferson Counties). Mental Health America of Colorado served as the project coordinator, manager, and fiscal agent for MCSI during the initial research, planning and development phase through a 27-person community collaborative process. MCSI is in the process of obtaining 501(c)(3) status and is governed by a board comprised of chiefs of police (one representative for all municipalities in the region), sheriffs (one representative for the seven county sheriffs), all metro hospitals with acute inpatient or emergency rooms (represented

by the Colorado Hospital Association), the Denver City Council, area county commissioners (one representative for the other six counties), community mental health providers (one representing the six county-based providers), MH MCOs (one representative for the three MCO regions), the regional SUD managed care organization, a family member of a person served, a consumer, and an advocacy organization. The treatment model was informed by the Bexar and Travis county crisis diversion systems. The five leading local hospitals funding psychiatric care for the uninsured committed nearly $1 million a year in operating expenses to match additional funds from local foundations and commitments to fund member claims from local managed care organizations.

While this effort includes many of the same levels of collaboration as past Dallas County initiatives (for example, establishment of The Bridge), the scope of participation, the direct participation of law enforcement and local governmental officials, and joint governance and funding by local hospitals (including county, university-affiliated, and for-profit) take the level of collaboration to a deeper level.

5. **Partnership in Performance Management** – Contractually-based performance incentive targets are currently used in multiple states to tie MCO performance to financial rewards and penalties (Connecticut, Kansas, and Massachusetts are good models). NTBHA counties currently have the potential to make better use of performance incentives. The current contract (in Appendix 4b) sets financial penalties for the MCO (ValueOptions) in multiple areas, including up to nearly $270,000 in penalties for adult services and over $94,000 in potential penalties for child services related to compliance with Resiliency and Disease Management (RDM), $50,000 in potential penalties related to TIMA compliance, $50,000 in potential penalties related to system access, up to $90,000 in potential penalties related to claims and data reporting (including up to $5,000 per month for uncorrected data issues, $17,000 for claims processing, and $17,000 for data reporting), and over $100,000 a year in potential monthly penalties related to call center performance. In addition, the financial incentives are only in the form of penalties, not rewards. Reward in the NorthSTAR system is purely based on “efficiency,” rather than positive quality incentives. While the current “penalties” are only a small part of the overall NorthSTAR funding, these incentives (or, rather, disincentives) correlate with much of the system performance dialogue we have been exposed to during the assessment period. The key point here is that current system financial incentives related to RDM and state-level data and performance requirements are driving much of the system performance effort, even though these issues are not among the most critical reported to us by system stakeholders or the most critical in driving the clinical and financial outcomes of the individuals most in need. For example, what might happen if these same performance incentives were tied to provider willingness to divert
people from acute care and psychiatric emergency department settings? Or to engagement in continuity of crisis services from the point of initial contact? While these performance standards are set by the state, DSHS has expressed a willingness to incorporate guidance from NTBHA (as determined by the participating counties) into performance incentive contracting, should the NTBHA counties be able to speak with a common voice on such matters. Furthermore, NTBHA itself already has the authority to work with counties, providers, the MCO (ValueOptions) and DSHS to set performance management incentives for providers in the areas of inpatient, 23 hour observation, and emergency room utilization. The language is very broad and permissive, but requires effective partnership among the parties:

The total incentive value is: To be determined by ValueOptions . . . Incentive dollars for this contract have been given to ValueOptions. It is the expectation that ValueOptions work with NTBHA, and the provider and stakeholder community on development of provider incentives. Not all need be/should be incorporated in the incentive plan, but rather what the group feels is most meaningful.  

Two Areas of Strength for Dallas County and NTBHA. While Dallas County and the North Texas area are underleveraged in our view in the four areas just summarized, it is just as important to emphasize two ways in which the area is ahead of other jurisdictions:

1. **Regional Infrastructure** – While the area is under-positioned in terms of county-level behavioral health leadership infrastructure, North Texas is unique in our experience in having an urban, multi-county collaborative purchasing structure. While many states have statewide (e.g., Connecticut, Kansas, Nebraska, Massachusetts, New Mexico) structures that include major urban areas and other states have multi-county structures for smaller towns and rural counties (e.g., Colorado, Florida, Pennsylvania, Washington), we are not aware of a locally-governed infrastructure for an urban county and its surrounding metro area. As noted above, the current NorthSTAR contract gives NTBHA more authority over performance incentives than it is currently taking. Furthermore, the structure of NTBHA is often criticized for lacking the authority over the NorthSTAR contract that the state holds. However, it is nonetheless a strength to have a multi-county framework in which to address regional concerns, given that all major cities tend to attract a disproportionate share of both persons in need and service delivery infrastructure within their broader multi-county metro areas.

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2. **Inclusion of Multiple Behavioral Health Funding Streams** – By integrating funding for multiple payers (Medicaid and state-funded uninsured) and for both MH and SUD service funding, NorthSTAR enjoys a level of braided funding rivaled only by the State of New Mexico’s statewide entity. Other states’ efforts to address the needs of the uninsured broadly have foundered (e.g., Tennessee), and most states tend to (1) limit funding for state-funded uninsured to the limit of available funds, and (2) separate management of MH and SUD services (only Arizona and Pennsylvania among the states we reviewed combine them). While the level of funding for NorthSTAR is widely seen as inadequate, the fact that an infrastructure exists for braiding these funds is a distinct advantage.

The Biggest Gap – Behavioral Health and Primary Care Funding Integration. The national movement toward behavioral health carve-out funding was largely driven by the failure 20 years ago of previously “integrated” funding systems to adequately address and manage behavioral health services. Today, Medicaid behavioral health services are often carved out and managed separately, allowing increased attention to this subset of needs, but in the view of many at least preventing resolution of (and potentially even contributing to) the terrible health outcomes of many vulnerable populations, most notably those of adults with serious MH/SU disorders.  

There is No Silver Bullet. The bottom line of this analysis is that no state or region has all the necessary pieces in place to meet the needs today of those with the highest needs in our communities, nor the future opportunities of health care reform. The table that follows gives an overview of the current strengths and gaps across multiple urban areas.

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<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>County-MCO Partnership</th>
<th>Provider-MCO Partnership</th>
<th>Regional County Partnership</th>
<th>Broader Collaborative Partnerships</th>
<th>Performance Management Partnerships</th>
<th>Includes MH / SUD Funds</th>
<th>Includes Medicaid / State Funds</th>
<th>Includes Physical Health / BH Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dallas Metro Area</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes***</td>
<td>No</td>
</tr>
<tr>
<td>Denver Metro Area</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Other Texas Metro Areas (Bexar, Tarrant, Travis)</td>
<td>Yes*</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Philadelphia Metro Area</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pittsburgh Metro Area</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Seattle Metro Area</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

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160 Only Dallas manages braided state funding for uninsured persons; other metro areas (other Texas areas, Seattle) include these funds in their local authorities, but they are only provided to the limit of available funds.

161 Counties oversee local mental health authorities, but these are not managed care organizations.
The Twelve Steps: Areas of Recommendation

Step 1: Creating and Implementing a Behavioral Health Leadership Team (BHLT) in Dallas County: A Step-by-Step Approach

Overview

This recommendation grows out of the central finding that Dallas County lacks a county-level structure (dedicated leadership, staffing, and organization) necessary to (1) coordinate interagency efforts within Dallas County and (2) participate effectively within the regional structure. This finding is the basis of the recommendations in Steps 1 and 2. There is no single person or entity responsible for coordinating planning across behavioral health services funded by Dallas County, including the jail, juvenile justice, community corrections, the hospital district, and the broader human service array. There is also no collaborative process through which Dallas County can coordinate its behavioral health activities with its critical system partners for Dallas County – other human service agencies, state agencies such as child welfare, juvenile justice, schools, Medicaid STAR / STARPlus / STARHealth HMOs, behavioral health providers, homeless services agencies, advocates, consumers, and families – to assess county needs and develop plans to address them, both within NTBHA and NorthSTAR, and through other partnerships.

In July 2010, the TriWest/ZiaPartners Team presented our initial system development recommendations, titled “Twelve Steps of Recovery for the Dallas County Behavioral Health System” (attached), to representative stakeholders from Dallas County and from counties in the NorthSTAR region. Based on feedback from the July presentation, and in preparation for our team’s return visit in August 2010, we prepared the additional detail in this section to help guide initial activities to implement Step 1. At the August 2010 meeting of the Dallas County Behavioral Health System Redesign Task Force, the initial organizing activities were carried out, and throughout September 2010 the Dallas County Behavioral Health Leadership Team (described in this section) was organized and initially chartered.

The goal of Step 1 is to strengthen the functional decision-making capacity of the Dallas County Behavioral Health System by creating an empowered horizontal and vertical partnership of representatives who collectively own responsibility for the design, implementation, and oversight of a true system of care within Dallas County, as well as in relationship to the other counties participating in the NorthSTAR Region.

This section illustrates practical and manageable steps that are recommended in the creation and implementation of a Behavioral Health Leadership Team for Dallas County. While these steps are intended to stimulate a more organized and effective capacity within Dallas County,
we further recommend that once organized, the Dallas County Behavioral Health Leadership Team will quickly need to represent itself in the NorthSTAR regional collaborative as a significant partner with the other six counties in the regional network of care.

Purpose of the Behavioral Health Leadership Team

The purpose of creating the Dallas County Behavioral Health Leadership Team is twofold.

1. To identify and formalize a partnership process and structure for Dallas County in which all significant stakeholders can come together to organize and oversee planning, decision-making, resource sharing, and implementation strategies for the behavioral health needs of the residents of Dallas County.

2. To help Dallas County be organized as a more effective partner with other counties within the NorthSTAR region, enabling the North Texas Behavioral Health Authority (NTBHA) as a whole to more effectively oversee the managed care component of the system that is currently contracted by the Department of State Health Services (DSHS) to ValueOptions.

The creation of a Behavioral Health Leadership Team for Dallas County is predicated on the recognition that:

- The populations served by NorthSTAR, and the resources provided through NorthSTAR, are only a portion of the total resources allocated for behavioral health care (and the total public behavioral health population, both adults and children) in Dallas County.

- Dallas County, like other large urban counties in Texas, needs to have a locus of organized partnership in order to make decisions and optimally leverage all resources (county-funded and from other federal, state, and county sources) in a coherent and cost-effective manner across all behavioral health populations.

Getting Started in August and September: First Meeting and Formal Chartering of the Behavioral Health Leadership Team

Our initial recommendation – already carried out in August and September 2010 – was that the Behavioral Health Leadership Team (BHLT) be organized and formally chartered by the County Commissioners. This recommendation also highlighted that a partnership between the BHLT and the Hospital District (Parkland) would be ideal in aligning the major sources of county-funded behavioral health spending and positioning the BHLT to coordinate longer-term health care reform activities with primary care. The point of these activities was to designate a formal structure within the county that would be accountable to the Commissioners for the planning, oversight, and coordination of behavioral health system resources and services for adults and
children in Dallas County. This structure would not have, in and of itself, formal spending authority over all the resources as if they were blended in a common pot. Each set of resources brought to the table would be formally overseen and managed through current mechanisms.

However, under the auspices of the BHLT, there would be a formal framework within the county for transparent oversight and coordination of all the resources for a common purpose and vision, with a single point of collective accountability to county leadership. While the decisions made by the BHLT would not be binding on any entity, the BHLT would include leaders able to make binding decisions on the part of each funding stream so that the consensus forged by the BHLT could guide those decisions. As described above in the policy analysis section, other large Texas counties have begun to develop similar types of partnership activities (though each county is unique in the way that this has unfolded), and nationally, county health and human service funding streams are increasingly positioning themselves in such a way, sometimes in regional partnerships, in order to prepare for health care reform. Dallas County can learn from, but should not specifically copy, what other counties have done; the Dallas County structure needs to be driven by the unique combination of behavioral health system stakeholders that comprise it.

Note also that the BHLT should (and did) begin to form prior to being “formally chartered” as described above. It is easier for county leadership to formally recognize a group if it exists and is beginning to demonstrate that it has the collective energy and capacity to engage in the partnership-driven decision-making process that the county needs and that the County Commissioners would want.

**Therefore, we recommended that the first formative meeting of the BHLT occur on August 26, 2010, in lieu of – or as a transition from – the current Behavioral Health System Redesign Task Force.** This occurred, work groups to organize the BHLT were initiated, and the BHLT met in lieu of the Behavioral Health Redesign Task Force at the September 23, 2010 meeting. At that meeting, the BHLT built upon recommendations provided in the earlier version of this report regarding chartering and membership, and began to take steps to emerge as an enduring structure within Dallas County. (Note that we did not modify our recommendations in this report regarding chartering, membership, workgroups, and so on to take into account the work done by the emerging BHLT. We applaud the steps taken by the BHLT to adapt these recommendations into its own autonomous process.)

**Recommendations for Membership and Structure of the BHLT**

Unlike the Behavioral Health System Redesign Task Force, the BHLT needs to be a formally representative entity, with designated and committed participation by specific constituencies within Dallas County. It is not necessary for the “perfect” representative structure to be
determined prior to the group beginning to form and meet. In most groups like this, the most effective representative structure evolves over time, usually over a period of six to 12 months. Developing a shared framework and by-laws that formally define the ongoing structure can be one of the early tasks of the BHLT, as assigned by the County Commissioners.

Based on the TriWest/ZiaPartners evaluation of the Dallas County system, we have recommended an initial structure that looks something like this (the actual group agreed to by the Redesign Task Force generally follows this approach, but with differences agreed to by that group in September 2010):

<table>
<thead>
<tr>
<th>Proposed Initial BHLT Member Organizations</th>
<th>Initial Proposed Representation¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advocates</strong></td>
<td></td>
</tr>
<tr>
<td>Association of Persons Affected by Addiction (APAA)</td>
<td>1 representative</td>
</tr>
<tr>
<td>Coalition On Mental Illness</td>
<td>1 representative (preferably a consumer)</td>
</tr>
<tr>
<td>Mental Health Association of Greater Dallas</td>
<td>1 representative</td>
</tr>
<tr>
<td>NAMI Dallas</td>
<td>1 representative</td>
</tr>
<tr>
<td>NAMI—Southern Sector Dallas</td>
<td>1 representative</td>
</tr>
<tr>
<td>Additional advocate focused on child/family services</td>
<td>1 representative</td>
</tr>
<tr>
<td><strong>County and City Service Programs</strong></td>
<td></td>
</tr>
<tr>
<td>Dallas County Jail Psychiatric Unit</td>
<td>1 representative</td>
</tr>
<tr>
<td>Dallas County Sheriff’s Department / Jail</td>
<td>1 to 2 representatives</td>
</tr>
<tr>
<td>Community Supervision and Corrections Department – Probation / CATS</td>
<td>1 representative for Adult, 1 representative for Youth</td>
</tr>
<tr>
<td>Dallas County Juvenile Services</td>
<td>1 representative</td>
</tr>
<tr>
<td>Dallas County Public Defender’s Office—Mental Health Public Defender</td>
<td>1 representative</td>
</tr>
</tbody>
</table>

¹ Each organization would have the recommended number of representatives plus designated alternates in order to ensure high-level participation in all meetings.
<table>
<thead>
<tr>
<th>Proposed Initial BHLT Member Organizations</th>
<th>Initial Proposed Representation¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro Dallas Homeless Alliance (MDHA)</td>
<td>1 representative</td>
</tr>
<tr>
<td>Specialty Court Judge</td>
<td>1 representative</td>
</tr>
<tr>
<td><strong>Inpatient Hospital and Emergency Services Providers</strong></td>
<td></td>
</tr>
<tr>
<td>Parkland Health and Hospital System</td>
<td>1 representative</td>
</tr>
<tr>
<td>Green Oaks Hospital</td>
<td>1 representative</td>
</tr>
<tr>
<td>Timberlawn Health Services</td>
<td>1 representative</td>
</tr>
<tr>
<td><strong>Outpatient Providers</strong></td>
<td></td>
</tr>
<tr>
<td>Alcohol and Other Drug (AOD) Providers</td>
<td>2-3 representatives from currently participating larger AOD providers:² Homeward Bound, Nexus, Phoenix House, etc.</td>
</tr>
<tr>
<td>The Bridge</td>
<td>1 representative</td>
</tr>
<tr>
<td>Specialty Provider Network (SPN)</td>
<td>1 representative each from currently participating SPNs: ABC, ADAPT, Child and Family Guidance Center, LifeNet, Metrocare, Centro de Mi Salud, etc.</td>
</tr>
<tr>
<td>Other Non-SPN Providers</td>
<td>At least 1 child-serving and 1 adult-serving representative</td>
</tr>
<tr>
<td>Parkland Health and Hospital System (Outpatient Clinic, Community Oriented Primary Care)</td>
<td>1 representative</td>
</tr>
<tr>
<td>Psychiatrist Leadership Group / North Texas Society of Psychiatric Physicians</td>
<td>1 representative</td>
</tr>
<tr>
<td>UT Southwestern Department of Psychiatry</td>
<td>1 representative</td>
</tr>
<tr>
<td><strong>Payers / Funders</strong></td>
<td></td>
</tr>
<tr>
<td>Representative of the Dallas County Commissioners³</td>
<td>1 representative</td>
</tr>
</tbody>
</table>

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² Initially, at least, fewer AOD providers than SPN providers will be represented given the greater number of SPNs, but the BHLT may decide to rebalance this over time.
This initial group of about 35 members may (or may not) be a little larger than the ultimate size of the leadership group. However, this list is reasonably representative of the collective voice of the whole system, and inclusive enough to get started in the process with the initial activities described below. We would fully expected that the initial BHLT group (as indeed did occur on September 23, 2010) may decide to add or subtract members as it better understands what structure and what representation will allow it to be most effective. Also, as discussed further in Step 12 below, the ability of the group to represent cultural minority groups should be explicitly developed and maintained over time.

In addition to identifying an initial representative group, there are three other early “structure” activities that can be helpful for getting the group started.

1. **Temporary Chair and Co-Chair.** One of these activities is the early identification of a temporary chair and co-chair to help provide some initial guidance for the formation of the group. Most such groups with whom we have worked appoint the temporary chair and co-chair to be in place for about three to six months, until the group is able to make a more organized decision about the role of the chairpersons and who they should be (often through the development of formal by-laws). The Task Force did select two temporary co-chairs at its August 26, 2010 meeting.

2. **Facilitation and Staffing.** Early on, many such groups also identify a person (or persons) who will function as a “staffer” for the group, that is, someone to maintain a membership list, distribute meeting information, take and distribute minutes, and so on. This should not be one of the chairpersons. In addition, in some large systems, the group will decide to identify a small pool of resources in order to hire a facilitator for the group. The facilitator would usually be someone who is well-respected in the system as a neutral meeting facilitator. The facilitator should not be someone who is a representative of the group, a “content expert or consultant,” or someone who is a stakeholder in the process. Having a facilitator is optional, however.

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3 We recommend that this not be a Commissioner, but instead be a high-level county staff person able to coordinate closely with the Commissioners.
3. **Formal Connection with Existing Workgroups and Teams.** Early on, the BHLT should have a formal relationship with existing and emerging system structures, allowing it to begin functioning as the single point of coordination and collaboration it is intended to be. Three such existing structures are: **Adult Clinical Operations Team; Child and Family Clinical Operations Team, and Psychiatrist Leadership Group.** These groups have already begun to form for the purpose of organizing problem solving and information sharing capability within a clinical quality improvement framework to guide system performance. Consistent with Step 12, an additional structure to address operational issues related to cultural minority groups may be added over time, either as a stand-alone team or a subgroup to another team. Each of these workgroups is likely to have members who are also on the BHLT. Also, these teams are likely to overlap in their membership with consumer, provider, and physician groups convened by NTBHA for the broader NorthSTAR region, further facilitating coordination at the regional level. Thus, it will be relatively simple to create a more or less formal reporting and communication mechanism between the BHLT and these other teams and workgroups. Other existing groups (for example, COMI, Jail Coordination Group, MDHA) or new ones may be connected or developed in relation to the BHLT. Examples may include a Consumer/Family Advisory or Peer Support Team, Cultural/Linguistic Competency Team, Data Sharing Team, Recovery-oriented Integrated System Change Agent Team, Housing Operations Team, Criminal Justice Team, AOD Service System Team, Crisis System Development Team, Children’s System of Care Team, and so on. These can be enduring groups or they can be workgroups that are “commissioned” for a specific time-limited purpose. Again, there is no pressure to determine all of the groups that might be formed or to clarify relationships with all of the existing groups at the beginning of the process. It is better to start with the available people, and develop the structure over the initial several months to a year.

**Initial Activities for the BHLT**

There are very concrete and specific initial activities, listed below, that help a group like the BHLT form successfully. The TriWest/ZiaPartners team participated in the August 26, 2010 meeting to help guide the group through some of these initial steps.

It should be noted that, in addition to the activities listed below, there are other activities that it is very important **not** to engage in. The purpose of the group is to form successfully in order to provide a partnership process, structure, and locus of collaboration for Dallas County. It is important to focus on activities that support this objective and that do not detract from it. Specifically, this group should **not** begin by trying to figure out a new managed care structure or arrangement, getting stuck again on how the system cannot make progress until it obtains more resources, seeking “the answer” or “quick fix” for the system’s multiple issues, or serving
as a sounding board for helping NTBHA and ValueOptions address their system-specific concerns. This is simply not possible, and will lead to frustration and barriers for the group. Furthermore, the mandate of the group is broader than any of these tasks. The goal is to develop a workable structure and process within which all of these types of decisions, and many more, can be made over time and made for the right reason—with the needs, hopes, and dreams of Dallas County residents who have behavioral health conditions in the center of the conversation.

Here are the initial activities we recommend: (NOTE – these activities were successfully accomplished at the September 23, 2010 meeting.)

- **Begin with the existing Behavioral Health System Redesign Task Force Membership as the starting place of the BHLT.**
- **Invite all potential members to the table.** Within the above framework, the meeting in August was an opportunity to invite anyone who is interested in joining the BHLT to come to the table. In addition to the recommended representatives, the invitation to the meeting over time was open to anyone willing to take the time to participate over time. This is an inclusive process.
- **Group formation, part 1.** Identify who is present, why they came, and who they believe they might represent. Identify who is missing and who might need to be invited.
- **Group formation, part 2.** Discuss the mission and purpose of the meeting. Emphasize that the success of the BHLT would be developing a culture of partnership in which the group wins, and the system wins, only if everyone at the table believes that there is more value in operating within the partnership than operating competitively and separately. This is a difficult cultural change that will occur over time, not in a single meeting. Conduct of the meeting will need to reinforce partnership as a critical mission of the group.
- **Group formation, part 3.** As an assignment for the September meeting, each attendee should identify who they represent and commit to go back to their existing or potential constituency and determine whether that “representation” can be formalized. Each constituency should know that it has a responsibility for identifying a representative who actually represents and designating an alternate to ensure continuous participation over time.
- **Initial mission statement.** The group might consider an initial objective of writing a draft mission statement and assigning a workgroup to create such an initial draft.
- **Communication and minutes.** At the outset of the meeting, the group should identify who will take minutes, how they will be distributed and what mechanism will be used for
internal and external communication. In particular, the group might want to communicate information related to its initial formation and expected next steps to the County Commissioners and the Hospital District.

- **Chair and co-chair.** As described above, the group should identify initial chair/co-chairs for temporary leadership of the group and make a decision about whether or not to bring in outside facilitation.

- **Meeting schedule.** A schedule for the next meeting—or, ideally, several meetings—should be identified.

Here are some subsequent activities:

- **Communication.** It is critical for the group to communicate widely about its activities and goals, including communication with other counties in the NorthSTAR region, the legislative delegation for the county, the County Commissioners, and the county stakeholders listed above. **It is also very important to invite DSHS to be a “partner” in the process, allowing representatives of DSHS to visit or attend the meetings, even though they are not “formal members.”**

- **Using the TriWest/Zia Partners Report as a road map.** A working draft of this report was provided to the BHLT in August for initial review and comment, and their collective feedback was incorporated into this report. As an empowered partnership representing the Dallas system, the BHLT is an important vehicle for taking action on the steps in this report. Consequently, the BHLT will be able to use these recommendations and the report as a road map to guide initial activities. In turn, these initial efforts at successful decision-making will help the group form and create increasing political “will” to formally charter the group to have an enduring role. One subset of the recommendations in this report involves options for system restructuring. Examples from other states were presented at Commissioner Dickey’s forum on August 27, 2010 and, following that forum, specific recommendations are already being discussed and informing the recommendations in this final report. However, these recommendations will require careful consideration by system stakeholders over a period of several months. Prioritizing and assigning responsibility for the many recommendations in this report will be a major focus over the rest of 2010 and early 2011. In addition, the BHLT has an opportunity to use its emerging structure, and the recommendations in this report, as a framework for working with ValueOptions on its September 8, 2010 redesign proposal to the NTBHA Board, regarding how to address anticipated challenges in meeting its medical loss ratio targets. This represents an early opportunity for the BHLT and its workgroups (such as, the clinical operations teams) to engage in a proactive process during the next several months that will offer a more thoughtful direction for making changes in the system, and to provide its input in a
coherent and organized way to NTBHA and ValueOptions. We hope that those several months will allow the BHLT to develop into the forum where such major decisions about the future of Dallas County’s behavioral health system can be made openly and in coordination with all the major system partners within the county, the region, and the state.

- **Early wins.** The group should organize itself around identifying some early successes that demonstrate value and capacity. These early activities could be related to some of the quality improvement activities or projects that are being undertaken by the Operations Teams (for example, data sharing, looking at the Top 200 high utilizers, etc.). It is important at this juncture to “stay within the serenity prayer of system change.” The group should not start by locating the hardest problem to solve or by identifying problems that can only be solved by outside intervention that is beyond county and regional control. Further, it is helpful if the early wins are connected to immediate improvements in real clinical care for real people.

- **Evaluation.** The group could consider whether they would like to include planning for an evaluation process at the early phase of formation.
Step 2: Models of System Authority, Oversight and Funding

Background

This section addresses Step 2 in the Twelve Steps of Recovery for the Dallas County Behavioral Health System: Developing a county-based locus of authority and decision making within Dallas County to organize and coordinate the delivery of county-funded behavioral health services within the broader array of regional behavioral health, health care and human services.

The recommendations in this section, as in the others, are organized according to phases of implementation, with the assumption that the Dallas County BHLT will partner with other NTBHA counties, NTBHA, providers within the NorthSTAR regional behavioral health system, the NorthSTAR MCO, broader regional health systems, and the full array of system stakeholders to oversee the implementation process.

Findings

The recommendations in this section are based on a series of findings in our study, listed below.

Finding 1: While Dallas County benefits from a regional behavioral health authority to facilitate shared planning with surrounding counties, it lacks the county-level structure (dedicated leadership, staffing, and organization) necessary to (1) coordinate interagency efforts within Dallas County and (2) participate effectively within the regional structure. This finding is the basis of our recommendations in Step One, and is critical for any further development of more sophisticated funding models or managed care arrangements. There is no single person responsible for coordinating planning across behavioral health services funded by Dallas County, including the jail, juvenile justice, community corrections, the hospital district, and the broader human service array. There is also no collaborative process through which Dallas County can coordinate its behavioral health activities with its critical system partners for Dallas County – other human service agencies, state agencies such as child welfare, juvenile justice, schools, Medicaid STAR / STARPlus / STARHealth HMOs, behavioral health providers, homeless services agencies, advocates, consumers, and families – to assess county needs and develop plans to address them, both within NTBHA and NorthSTAR, and through other partnerships.

Finding 2. Other urban behavioral health systems across the country are aggressively developing various types and levels of partnership with MCOs, providers, and diverse stakeholders. These partnerships provide an organized mechanism and structure by which local county executives and County Commissioners can identify a single point of accountability and exercise local authority over a behavioral health system comprised of multiple diverse funding streams, populations, intermediaries, and providers, all of which
**need to be coordinated.** The Data and Policy Analysis section of the report noted examples across the country that include Medicaid managed care components. An authority model in Texas that does not require a managed care waiver is Mental Health Connections in Tarrant County, an excellent example of a strong partnership structure in Texas. County-based authorities in other states with managed care components have developed effective partnerships at multiple levels, including:

- Partnerships with MCOs to leverage county funds (sometimes by matching them to new federal Medicaid funding for eligible community-based services), develop performance incentives, and share information to manage care.

- Closer alignment between providers and payers (MCOs, counties). This is key to many of the opportunities under health care reform. Health homes and ACOs both devolve financial risk and responsibility for care management to providers. Steps to bridge the provider/payer gap help prepare for these new structures and approaches.

- Partnership through project-specific collaboratives to develop necessary parts of the service continuum and share both risk and responsibility with all parties that have a stake in the process. Denver Metro Crisis Services, Inc., is one such example, sharing financial risk for crisis care for all adults with severe behavioral health needs across multiple counties, hospitals, law enforcement agencies, sheriffs, and courts.

In Dallas, such a structure may include partnerships between and among the county and behavioral health providers, local hospitals, other county agencies, other NTBHA counties, state agencies (DSHS, TDCJ, TDARS, Youth Services Commission), Medicaid HMOs, foundations, and other parties. By acting in a more organized manner internally, Dallas County can become a better and more effective partner to others. Partnership in performance management by sharing risk and responsibility for care with other agencies that have a stake in the outcomes, as well as structuring reimbursement to align incentives with shared county priorities, would be another set of opportunities. The range of possibilities is summed up well in the diagram (found on the following page) that is currently being used for planning by an integrated regional health authority in Oregon.⁴

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⁴ Crook County Court, Deschutes County Board of Commissioners, and Jefferson County Board of Commissioners. (July 20, 2010). Central Oregon Meeting “Regional Health Authority” Discussion Powerpoint Presentation.
Finding #3: Parkland Health and Hospital System is just beginning the process of identifying an internal locus of authority and decision-making for its behavioral health service line. At the beginning of our consultation, Parkland’s behavioral health services did not have a mechanism for routine internal coordination of behavioral health services, reported up through multiple senior managers, and had no identified single point of accountability for planning, implementation, coordination and external communication. In recent months, however, this has begun to shift substantially, with an identified Parkland lead, both internally and in the Dallas BHLT development, and representatives of all Parkland behavioral health programs beginning to meet regularly to create an internal Parkland behavioral health leadership team.

Finding #4: There are multiple funding models that are used by public managed behavioral health systems in designing contractual relationships and allocating risk. For the past 12 years stakeholders in the Dallas/NorthSTAR region have become familiar with one such model: hiring a for-profit MCO in a capitated, full risk contract, with a relatively small percentage of funding utilized for performance incentives and penalties. There are other models that are increasingly common, particularly in more mature managed behavioral health plans. These include:

- **A range of risk arrangements**, including:
  - Partial risk or shared risk corridors, where the risks and rewards of care delivery are shared and less potentially volatile, and
  - No risk or administrative services organization (ASO), in which the MCO is hired to provide managed care functions on a fixed budget with a set fee.

- **A balanced investment of resources in performance incentives (both positive and negative)** that range from:
  - An amount equal to the amount of profit that can be earned through managing utilization (within a shared risk contract) or through the fixed management fees (in an ASO-based contract), or
  - Specific positive and negative performance incentives to reward progress toward system quality improvement targets.

These various funding models can be implemented in any of the different types of structures described in this section. Examples of specific performance incentives and performance indicators are included in the recommendations in Step 3.

Finding #5: Dallas/NorthSTAR has a unique funding model for managing behavioral health care for uninsured individuals, one that we have not observed in any other public managed behavioral health system. In the NorthSTAR contract funding model, individuals who are eligible as uninsured are served on par (and without limit) to individuals who have Medicaid,
even though state funding for services to individuals without insurance is capped, whereas Medicaid funding increases per each additional enrollee. This funding model has clearly been very helpful since the initiation of NorthSTAR in facilitating access for people without insurance, improving service efficiency, and eliminating a two-tiered system. At this point, however, the funding model may be actually having a reverse effect on quality, in that overall resources are diluted, and individuals with the highest needs (with or without Medicaid) may be less able to get the services they need to prevent severely adverse outcomes (like hospitalization and incarceration). Note that in every other public managed care arrangement that we have observed, the managed care entity is responsible for defining the limits of service provision based on the per capita allocation of resources. For example, county-governed MCOs in Washington State are responsible for emergency and inpatient services for people without insurance. Over and above that, they set priorities for the use of state general revenue for people without insurance (such as people with inpatient use in the past year or criminal justice system involvement), up to the limit of availability and often supplemented with additional county sales tax revenue funding.

Finding #6: The lack of an organized partnership structure in Dallas for coordinating funding from multiple sources (such as Dallas County funding, NorthSTAR funding, and other state funding) creates a likelihood that opportunities are being missed to utilize county dollars to leverage Federal Medicaid matching dollars, and thus increase total available county behavioral health funding. This is especially true for children and youth, given their higher level of coverage under Medicaid. One likely area where this appears to be the case is funding for community-based juvenile justice services such as FFT and MST, but our team has not had access to sufficient data to determine the potential scope of such funding. Furthermore, such braided and leveraged funding opportunities require a higher level of cross-system collaboration and trust than prevails under current arrangements (see Step 11 of this report, regarding children’s systems of care).

Finding 7. Any discussion of system organization and authority must be informed by an understanding of the known and unknown potential changes related to health care reform and the implementation of mental health parity. The implications of health care reform and mental health parity must be considered in any planning for future system governance and oversight. Structures developed over the past decade across the country will face the need to reorganize in order to respond to the opportunities of health care reform. Combined with the press of parity away from separate purchasing and finance arrangements for behavioral health services, any efforts to organize a distinct “behavioral health authority” must consider how such a model must be adapted in order to be viable in a post-reform, post-parity environment.
Finding 8: There are multiple models by which county behavioral health systems organize and oversee “managed care structures” and contract with MCOs. This discussion is a partial condensation of the more comprehensive discussion of managed care structures from the Policy Analysis section of this report. As noted above, stakeholders in Dallas County and the broader NTBHA area have been familiar with a model in which there is a contractual relationship primarily between the state Medicaid authority (DSHS) and a single private MCO (ValueOptions), with a local authority (NTBHA) that has some advisory, planning, and oversight functioning, but little direct authority and only minimal resources for accomplishing these functions. There are several other types of structures, and, of course, variable iterations within those structures. To identify a few:

• **One model is to develop a local authority structure in which the state Medicaid authority (or similar funding body) delegates through a direct contract to the local county (or an organized group of counties) substantial authority in turn directly contract with an MCO.** This model is utilized in a number of Pennsylvania counties, for example, and is related to the model that is being discussed in relation to the transfer of authority to NTBHA, though the arrangement is between a version of NTBHA that is chartered directly by the county or county group, and the contractual delegation comes through the county governmental structure. This model requires, however, that there is a substantial local authority and capacity at the county level, independent of the MCO arrangement, which is one of the reasons for the development of the Dallas County BHLT.

• **Another alternative is to develop locally-controlled (usually by provider/stakeholder partnerships that can involve counties), non-profit MCOs that are designated to hold the contract with the local authority, in accordance with state requirements.** This model is being utilized in cities like Philadelphia, Detroit, Seattle (county-operated), and Pittsburgh. In this arrangement, local “ownership” is reinforced and any “fund balances” are more directly used for local re-investment. In some cases, the local, non-profit MCO may contract or partner with a traditional for-profit MCO for the purpose of consultation, select functions, or to provide ASO capabilities.

• **More complex arrangements can occur in systems in which the local authority oversees and coordinates multiple managed care entities, each responsible for distinct populations (so they are not fundamentally competitive), some of which may be for-profit MCOs, while others may be locally controlled non-profits.** Current examples of this arrangement include Miami and Tampa, where, for example, Medicaid funding for mental health care is managed by one set of MCOs (or managing entities) and state substance abuse funding is managed by another.
Another arrangement is one in which the behavioral health managed care function is held as a carve-in, or sub-contracted within a carved-in arrangement as a carve-out, within a large managed health care organization. This is familiar in Texas in the STAR / STARPlus model, and is most common in similar HMO models in other states. Although well-functioning models are still only rarely seen on a large system scale (Group Health Cooperative in Washington, Intermountain Healthcare in Utah, and Kaiser in many states are notable in the private sector), it is likely that versions of this arrangement will be promoted in the movement toward ACOs and health care reform, as described in more detail in our Policy Analysis section. In fact, expansions of these models are currently being funded as demonstration projects in other states and are likely under consideration to some degree in Texas.

When contemplating changes in its managed care structure, Dallas County and the NTBHA region should keep in mind that there is no silver bullet. All local authority options face the same, sometimes grim, challenges and require collaboration with the same system partners. Most important, the decision about which model to choose not only depends on system partnership and politics, but also very much depends on local system capabilities. Developing an MCO can certainly be done, but it requires learning new skills, developing new capacities, dedicating substantial administrative resources, and reorganizing local structures and relationships. In most local systems, the payoff appears to be worth it, but the initial effort is great. With that being said, some structures align incentives and collaborative opportunities better than others, and this is one key to success. Those that do are the ones in which local decision-makers decide together upon goals and steps to achieve them, translating into action the adage that “all health care is local.”

Recommendations

As in previous sections, the recommendations in this section are divided into phases. The first phase should begin immediately and extend over approximately 12 months. The second phase will focus on implementation activities that would go on line no earlier than two years from now, and probably later. Note again that we are viewing the Dallas County BHLT, working in partnership with Dallas County agencies, and with NTBHA and the state as appropriate, as the vehicle through which the Dallas County authority would be developed.

**Phase 1: Organize a Dallas County authority to work within the existing NTBHA structure to maximize performance of the NorthSTAR MCO, NorthSTAR providers, and NorthSTAR funding opportunities to achieve Dallas County behavioral health system goals, in collaboration with other NTBHA counties.** This is the essential focus of the recommendations in Step 1. For Step 2,
we build upon those recommendations to analyze how they lead to further development of specific approaches to organizing system authority and funding models.

1. **Manage more effectively within Dallas County (now through the end of 2010).** One of the most glaring gaps in the current authority structure for Dallas County is the lack of county-level alignment between county-funded services and NorthSTAR. Dallas County has the opportunity in the next three months to take significant steps to organize oversight of its many behavioral health funding streams and service delivery systems. Through the vehicle of the Behavioral Health Leadership Team, Dallas County should coordinate planning, data analysis and decision-making so that its four representatives on the NTBHA board can speak with one prepared and informed voice. This is a readily achievable and critical step toward developing a more expanded capacity in a multi-county local authority and to implement more sophisticated structures and models in the future.

2. **Ensure involvement and empowerment of significant stakeholder constituencies through the Dallas BHLT and across the broader regional authority.** Recently initiated public behavioral health managed care systems commonly create formal structures and processes to ensure representation and empowerment of key stakeholders. Examples include a defined oversight role for psychiatric leadership (through a Psychiatrist Leadership Group and/or a Medical Director), a clinical quality oversight function (through a Clinical Quality Management Committee), as well as specific committees or teams for various populations (Adult Operations, Child/Family Operations, Cultural Minorities, Addiction Services, etc.), and a designated role for consumer / family / stakeholder oversight through a formal advisory committee with meaningful authority.

3. **Parkland Health and Hospital System needs to continue making progress in organizing and empowering its own internal behavioral health services line, and dedicate staffing to support this line of business.** Within Dallas County, Parkland Health and Hospital System, a large, complex organization, is the major health care delivery entity. If it is going to manage its own behavioral health services effectively and be an effective partner to other county agencies, it will need to dedicate leadership and staff resources to lead this process internally and to represent Parkland consistently in county and regional collaborative processes. Given the critical necessity of behavioral health and health care integration to improve the delivery, effectiveness and economic feasibility of both sets of services (as described previously in our Policy Analysis section), the behavioral health service line will need ties across the organization and the support of top hospital leadership to make decisions and allocate resources to accomplish them. We formally recommend that Parkland continue the evolution of its internal leadership team for behavioral health, identifying an interim lead and planning assertively to create
an official Behavioral Health Service Line Manager position (similar to the arrangement that has been implemented at John Peter Smith Hospital in Tarrant County). The next few years represent a time of rapid change, so Parkland’s behavioral health service line, as a distinct component within its overall leadership team, will need to be organized, staffed and poised to manage that change and respond to opportunities for collaboration and performance improvement.

4. **Dallas County funded agencies will need to organize their own behavioral health services decision-making process in order to collaborate with the new authority, represented through the BHLT.** Dallas County Juvenile Services, the Dallas County Community Supervision and Corrections Department, Dallas County Courts, the Dallas County Jail, Dallas County Health and Human Services, and the Dallas County Hospital District all organize themselves effectively and deliver an impressive array of services. However, they are not organized currently to make joint behavioral health policy and, ultimately, purchasing decisions collaboratively. This will require not just dedicated behavioral health staff resources, but also an organizational shift within each county human services agency toward improved interagency collaboration.

5. **Begin to manage more effectively within the existing NTBHA authority structure (first three months of 2011).** There are two primary reasons for this recommendation. First, too much early emphasis on restructuring NTBHA is likely to distract from the hard work of improving services within the existing structure. Second, plenty of opportunity exists right now to improve management of the system within the current NTBHA structure. Currently, NTBHA counties have the potential and ability to better align their own services with those of NorthSTAR, leverage local funds through NTBHA, work with DSHS to set performance standards and incentives for the MCO (ValueOptions), and work with ValueOptions to set performance incentives and improve current risk-sharing arrangements (i.e., the case rate) with providers. Progress in these efforts may be necessary to continue expanding regional authority within NorthSTAR, prepare for the development of more sophisticated structures, and possibly for NorthSTAR even to survive as a viable managed care arrangement. The success of these efforts during the coming year will inform the next steps that are outlined below, as well as lead to short term improvements in system quality and effectiveness. For example, by adding more meaningful outcomes and performance incentives to the case rate, such as incentives for moving individuals out of county-funded jail, community corrections, and juvenile justice services and into the community with the support of NorthSTAR services, and for reducing recidivism and violations of release conditions, NorthSTAR may be able to help Dallas County face the challenges of increasing jail use and decreasing county funds.
6. Work with the other NTBHA counties to the extent possible, and independently to the extent necessary, to improve the effectiveness of the next NorthSTAR contract (first six months of 2011). DSHS is currently developing the 2011-2013 NorthSTAR contract with input from NTBHA counties and stakeholders. Dallas County can position itself to be informed and to positively influence the development of the next contract through more coherent action, in collaboration with other NTBHA counties wherever possible, but independently when necessary. Examples of potential contract provisions are provided throughout all of these recommendations (most notably the performance management discussion in Step 3), but some governance related items include:

   a. **Improve reporting through NTBHA.** According to DSHS, NTBHA has the same access to data as does the MCO and DSHS. Dallas County should work with NTBHA to enhance its data reporting capacity and help NTBHA frame questions and reports pertinent to county-level concerns (for example, regular reports on the percent of intakes coming out of the Dallas County Jail and reports on the effectiveness of service delivery to those discharged inmates). The county should obtain and review these reports well in advance of NTBHA board meetings so that the county can work with the Behavioral Health Leadership Team to analyze and plan based on their data, and thereby exercise authority in NTBHA board meetings more effectively.

   b. **Implement MCO performance incentives.** By partnering with DSHS, Dallas County can help the state and NTBHA develop performance incentives that improve MCO responsiveness to priorities set by the county in partnership with local providers, agencies, and stakeholders, as well as other counties.

   c. **Negotiate more contractual flexibility regarding how to align services to the uninsured with the limited available funding levels provided by DSHS to NorthSTAR.** As noted above, the NorthSTAR system has been stretched thin by contracting for a service package for uninsured individuals that is comparable to the Medicaid package, where the uninsured funds are fixed and the Medicaid funds can increase on a per capita basis. At this juncture, we recommend that the county increase flexibility in designing services for people without insurance by focusing on improving quality of care for the population rather than continuing to reduce the cost per person served. Examples of such realignment include maximizing diversion of individuals with relatively less severe conditions to primary health services, prioritizing resources to ensure that individuals who are at highest risk (for hospitalization, homelessness, and incarceration) are not underserved, and creating more fluid service delivery models with increased access to drop in services and peer support. Further, defining a benchmark
minimum “cost per person served,” below which there is a reasonable consensus that quality will suffer, could provide leverage for “need-based” advocacy for additional resources. Our recommendation would be to set that benchmark no lower than the current figure; ideally it would initially be set somewhat higher.

d. **Identify county-funded community-based services that are eligible for Medicaid reimbursement.** The rate setting process for the next NTBHA contract will be carried out in early 2011. It may be possible to use county funds for services provided to people with Medicaid through NTBHA to leverage additional federal matching funds over and above the otherwise possible Medicaid rates. Another option might be to use state hospital funds to leverage a federal match, if they can be shifted to the community (see recommendations in Step 6.)

e. **Support organization and development among providers to develop the capacity – both independently and collaboratively – to share greater financial risk and responsibility within the NorthSTAR system.** The future of care management seems likely to move more towards provider-level activity through the implementation of structures such as health homes and ACOs. Developing provider data infrastructures, financial stability when needed, care management structures, and fiscal management capacity will help Dallas County providers and other stakeholders prepare for these new opportunities and challenges. Some MCOs are formally required by contract to provide training and technical assistance to help their providers build these capacities. The goal is to ensure that providers have the knowledge, technical capability, and collective empowerment to analyze proposed risk sharing arrangements (such as case rates), and determine whether the funding and incentives are both actuarially sound and appropriately aligned (the latter of which clearly has not been true with the current case rate structure). Such skills are necessary precursors to more sophisticated development of locally-controlled MCO arrangements, as described below. Within this process, building on discussions over the next six months and using MCO-level data in partnership with other NTBHA counties to learn from the experience of the case rate, Dallas County can partner with providers, MCOs, and NTBHA to take important steps toward developing a comprehensive array of flexible provider funding arrangements and incentives.

f. **Involves DSHS as a partner at the table.** Continued participation by DSHS in partnership with the BHLT (and NTBHA) will allow Dallas County to be more aware of the concerns and priorities of their state partner, share Dallas County priorities and data, and collaboratively problem solve to address shared priorities. DSHS leadership has directly informed the TriWest/ZiaPartners team.
that they would strongly welcome such a partnership, and that a closer ongoing relationship would not only facilitate transfer of more state authority to the local region, but also permit much more creativity in the development of MCO contracts, oversight mechanisms, performance indicators, and so on.

g. **Develop a needs-based advocacy strategy for improved funding.** Advocacy for additional state funding based on the efficiency of the system has not been successful historically. Advocacy for increased state funding by identifying local needs that coincide with state priorities can be more successful. Dallas County can work with NTBHA even in the short term to identify opportunities for funding advocacy, but these efforts should increase in intensity and in their ability to reflect consensus at a county and regional level throughout 2011. The NTBHA counties and the organizations within them can build cumulative political leverage to promote discrete projects that tie to the strategic priorities of the state (see the Policy Analysis section for examples) and other funders, such as local foundations. Partnership with TDCJ and other agencies with successful track records in such advocacy may also be warranted, as would alignment with other current and future state policies (such as behavioral health/primary health integration and health care reform).

**Phase Two (late 2011 and 2012): Collaboratively plan for the 2013 NorthSTAR procurement to further position NorthSTAR and Dallas County for the implementation of more creative and sophisticated authority structures and funding models, and for the implementation of health care reform in 2014.** DSHS currently plans to re-procure NorthSTAR in 2012 for the SFY 2013-2015 biennium. Collaborative planning, building on the success of working more effectively within Dallas County and NTBHA (through the Phase One recommendations above), can help the future NorthSTAR model employ more artful strategies for local resource management, and to be better positioned for integration with physical health care, more responsive to anticipated CMS parity regulations, and more prepared for health care reform. By 2012, the path toward health care reform should be much clearer and both local stakeholders and DSHS will be in a better position to collaboratively restructure and refocus the NorthSTAR procurement to address that future.

1. **Work with DSHS, NTBHA, and the other NTBHA counties to explore a full range of options for the next NorthSTAR procurement.** As the state prepares for health care reform, there will be increasing clarity about the opportunities available and challenges posed through mental health parity, Medicaid expansion, implementation of the federal health insurance exchange, and development of new rules governing innovative structures such as health homes and accountable care organizations. In addition, the beginning steps in Phase 1 will provide both a learning process and an opportunity for
capacity building in order to develop more creative models for local behavioral health management. A regional behavioral health management infrastructure that combines the resources of the emerging Dallas County BHLT with the six other metro area county human services arrays (and other counties that may be interested in joining, if the model is attractive enough) will have a critical role to play in the development of new structures and the evolution of the local health care market, as will the resources of each individual county within NTPBA.

2. **Evolve and realign the NorthSTAR funding model to be a better match for the service system.** As noted above, there are many models for creating managed care contracting packages and incentives. It would be premature to recommend a specific model at this time, as this is something the BHLT and NTPBA will need to address over time, developing consensus and defining possible limits through the demonstrated capacities of the partners. We do recommend, however, that the BHLT and NTPBA begin to look ahead toward using either a risk-sharing performance based contract or a performance-based ASO contract for the next re-procurement. In addition, as noted above, by Year Two the BHLT will be in a better position to consider how to integrate other state or local resources (for example, Terrell State Hospital or Hospital District) into the managed care arrangement, to the extent that that increases flexibility, partnership and funding leverage. The degree to which such steps will make sense will be proportionate to the degree to which the local Dallas County (and broader NTPBA) partners have developed the capacity to be truly empowered to operate their own system. (See recommendation 5).

3. **Create a template for an inter-county behavioral health regional collaborative agreement.** The current NTPBA arrangement is far less formal than other examples of multi-county managed care oversight collaboratives. Furthermore, other areas of the country formally establish such organizations as extensions of county government (not state government), which in turn subcontract with the state. The BHLT could review these model collaboratives (such as in Pennsylvania) with its NTPBA partners over the next 12 months and begin to engage any willing regional partners in the development of a formal agreement for the evolving collaborative, in preparation for the re-procurement process.

4. **Collaboratively plan and restructure for health care reform (2012 and 2013).** To prepare for the implementation of health care reform in 2014, planning among all the key parties to develop a collaborative structure (potentially even an entity like an ACO that shares risk and governance between counties, health systems, and providers) should proceed, addressing the key areas of partnership outlined in this section.
5. **Most importantly, evolve more creative and empowered models for local managed care authority, oversight, and performance management.** As noted in the Policy Analysis section, and earlier in this section, there are many different structures used by urban systems across the country, almost all of which could have potential application in Dallas County and NorthSTAR. It is impossible, however, to recommend one “correct” structure at this time. In order for Dallas County and the NorthSTAR region to decide over time which will be the best structure, the system has to go through a series of developmental phases and build the capacity to create more sophisticated structures, and, frankly, to determine whether there is sufficient commitment in the Dallas County system (first and foremost) to do the work to develop that capacity. Our recommendation is that the system visualizes three levels of potential development, as follows:

NOTE: These “3 Levels” are only intended as suggestions to help stakeholders envision possibilities. There are many possible variations and permutations that can emerge as the system evolves, including possibilities that are not even mentioned in these 3 levels. **Our goal in this report is to open up ideas for future consideration and encourage other creative approaches that may emerge during the process.**

**Level 1:** Developing an empowered Dallas County structure (and to the extent possible, an empowered regional authority) to gradually expand local oversight and performance management of NorthSTAR (as well as other components of the Dallas County system) within the remainder of the current and during the next contract cycles. This, of course, is the process we have mostly focused on in our Phase 1 recommendations above, and in other steps in this report.

**Level 2:** We recommend deliberate consideration of the prospect of developing a locally controlled non-profit MCO that could be in place to “compete” for the 2013 re-procurement. We recommend that the starting place for this development begin in Dallas County and then involve other county partners as they are interested and willing (perhaps within a matter of months, to the extent they are interested). It is essential, however, NOT to get distracted by starting this process too soon at the expense of building the Dallas County BHLT and fully engaging in all the Phase One activities over the next year. The local partnership needs to build its capacity for action, decision-making, and responsibility first. Note also that such an arrangement does not necessarily either exclude or compete with ValueOptions. In fact, ValueOptions can be positioned to be a key partner to provide ASO functions, consultation, and even shared risk within the new entity (although we recommend that this be under a clear contract that is periodically re-procured), and thereby maintain a significant future role. Note also that the locally-controlled MCO must still be accountable to a true local authority.
grounded in county government and distinct from the MCO. However, within such a structure it may be easier to braid resources from other Dallas County sources and facilitate community reinvestment of any “profits” (as is currently the case in Colorado, Washington, and Pennsylvania counties and regions). Finally, although the advantages of this arrangement should be fairly clear (and can in actuality be launched relatively quickly, i.e., within 12 months), it is important to note that there is a lot of initial developmental work required to help such a brand new organization function effectively. However, there are many such organizations from around the country that would be more than willing to share their experiences and provide consultation.

**Level 3: The boldest, and most sophisticated model, and the one that would potentially best align with health care reform, is also the most challenging. In this arrangement, a coalition of providers inclusive of the Dallas County Hospital District would develop as an ACO (with multiple levels of person-centered health care homes) and could specifically incorporate a carved-out behavioral health managed care entity that would then “compete” for the NorthSTAR contract.** There are many reasons why a carve-out works better to provide services to very complex public behavioral health populations than does a carve-in. These issues would need to be addressed in such a model, and they generally are not addressed well in most versions of this model that we have seen implemented across the country. A notable exception, that could evolve more fully in this direction under health care reform, is Colorado Access in Denver. Note that it is entirely possible to operate a county-specific ACO for Dallas County that also incorporates a regional behavioral health (or even broader) managed care entity. Further, this approach not only builds on the developmental activity in Level 1, it also can build upon the developmental activity in Level 2. The ACO could carve-out its behavioral health line and subcontract it in turn to a locally controlled non-profit behavioral health MCO that is also working in an ASO or consultative partnership with a behavioral health managed care vendor.

The advantage of this latter arrangement would be obtained on multiple levels. It would bring together health and behavioral health, local ownership and accountability, and sophisticated MCO technology to address the concerns and realize the potential clinical and economic outcomes outlined in our Policy Analysis section. More importantly, it is an arrangement that demonstrates a very compelling vision and capacity that would establish Dallas County as a true leader in developing innovative care systems in the era of health care reform, and correspondingly have the potential to attract both state, federal, and private foundation development funding to support and evaluate the model.
However, we are not recommending this structure at this time. The reason for this is not because we do not think it is a good idea, but because we cannot predict (as stakeholders in the Dallas system cannot predict) whether all of the partners in Dallas will be able to commit to carrying out the preparatory work, as outlined in this and other recommendations, necessary to develop such a structure, with all its complexity and risk, to the point that it could be made operational within three years. There is an enormous learning curve and a need to invest considerable resources in building all the structures necessary to make such an ambitious arrangement successful. Most importantly, the experience of other jurisdictions across the country argues that this approach will succeed ONLY if it evolves out of the BHLT partnership leadership structure we have described in Step 1 of these recommendations, and which we have made fundamental to our recommendations across this report. On the other hand, if everyone pulls together and commits to the necessary work and risks, the Dallas County system has the true potential to create something unique and powerful on behalf of its most vulnerable people.
Step 3:
Customer-Oriented Performance Improvement

Background

This section of the report describes a step-by-step approach to designing and implementing a customer-oriented, performance improvement-driven system of care, identifying potential performance indicators and outcomes for such a system, and illustrating the potential for connecting those indicators to performance incentives that are built into funding mechanisms, including managed care contracting.

Before going into these issues in detail, it is important to provide background related to our findings about performance outcomes, performance improvement, and performance incentives in the current system.

Findings

Finding 1: Although the NorthSTAR system has had a positive impact on the regional behavioral health system during the past 10 years, the current methodology for measuring system performance does not provide an adequately accurate picture of how the system is truly performing to meet the needs of its “customers”—the individuals and families with SUD and MH disorders who are in need of services.

Finding 2: The NorthSTAR system has relied primarily on state-defined performance measures. These measures may have been valuable for guiding the initial design of the managed care system, and may continue to serve a role for state and federal monitoring of the program, but they do not substitute for locally-defined and locally-relevant performance measures that reflect the experiences and needs of people served in Dallas County (and NorthSTAR more broadly). There needs to be a more sophisticated process of developing, monitoring, and incentivizing an expanded approach to performance measurement and performance improvement that is grounded in local priorities and meaningful indicators.

Finding 3: System performance, either for Dallas County or for the NorthSTAR region, cannot be evaluated only by looking at NorthSTAR. The success of the entire system in serving the population as a whole has to be measured by indicators and outcomes beyond those specifically governed by NorthSTAR funding. Specifically, the NorthSTAR system is utilizing system performance measures and incentives that were designed to “see” the NorthSTAR system as being successful in a certain way and allow it to be readily compared to other systems using indicators standardized by DSHS. Focusing only, or primarily, on these measures, however, obscures other areas where system improvement is needed (in many cases, urgently). It also impedes the implementation of performance improvement activities that can improve
system and client outcomes within existing resources, and may in fact contribute to more effective use of existing resources.

For example, the NorthSTAR system has demonstrated success in eliminating waiting lists, increasing access to initial service contact, and serving a higher number of people (adults, children) per capita. Consequently, it is described as a “more efficient” system. Further, because the total amount of funds is limited, and “efficiency” is presumably maximized, additional improvements in the service delivery system are presumed to require more funding. Unfortunately, this creates a false dichotomy.

The important question that needs to be asked is not only how many people the system is seeing, but also what is happening to the people that the system sees. For example, if the system “sees” 62,000 people per year (and 48,000 in Dallas County), how do we know whether the service that was offered or provided was most effectively matched (clinically or financially) to what people actually needed? Furthermore, how do we know whether the service that was offered or provided occurred in a setting that would be “smartest” from the broadest system perspective? There are many variations to this discussion, but here are several of the many specifics that will be addressed in this report:

- To what extent are individuals who present in crisis, or who are at high risk for incarceration or homelessness, not only “seen,” “diverted from hospitalization,” and “given an appointment,” but also connected to continuing care of adequate intensity to stabilize them, prevent future crises, and promote progress toward recovery?

- To what extent are adults or children with less acute or severely disabling behavioral health conditions, who are provided more routine services (whether uninsured or on Medicaid), being appropriately served with an adequate number of visits, and to what extent are they most appropriately served in a specialty behavioral health setting (SPN), as opposed to a primary health setting or other generic support setting? (Note that diagnosis alone is not a sufficient determinant of where an individual would be most effectively matched to service, either clinically or financially).

- To what extent is the system organized to routinely identify individuals or cohorts of individuals who are doing poorly, and plan appropriate improvements in services to better meet their needs?

Our first observation is that the data to answer any of these questions is currently not easy to obtain by persons outside of DSHS or the MCO. While data is readily available for many of these questions, empowerment and expertise to access and analyze the data is limited outside of DSHS/MCO. Our second observation is that measures of performance that are too broad, or with too large a denominator (such as the rate of hospital readmission per person served), may
obscure the presence of a smaller but significant cohort of individuals who may not be doing very well (clinically or financially), such as the recently identified group of the “Top 200.” Our third observation is that, as in other local mental health authorities (LMHAs) across Texas, there are many people being served in primary health settings that are not tracked within the LMHA data because they are billed separately. In Dallas and NorthSTAR, there is currently no measure in place to determine if there is a population that would be better served in another setting or in another funding stream. Our fourth observation is that there are no specific performance indicators that require focus on these currently hidden populations, and on the potentially important improvement opportunities associated with them.

The purpose of this section is to answer the question: **What can be done differently about performance monitoring and performance improvement, either in Dallas County or in NorthSTAR as a whole?**

**Recommendations**

Our recommendations include three different phases, all of which are to be carried out under the auspices of the BHLT. They should be carried out in partnership with NTBHA when they involve regional oversight, and with DSHS at all possible opportunities. The first phase, which can begin immediately, involves building a customer-oriented performance-improvement culture. The second phase, which can arise out of the first over the course of the next year, is to develop more sophisticated system performance measures and indicators that can be applied within the current system. The third phase, which needs to come into play within about two years, involves creating better performance incentives and alignment within the managed care contract and other funding streams.

**Phase One (1 to 6 months): Building a customer-oriented performance-improvement culture**

1. **Define the vision:** The success of a behavioral health system is defined by what happens to the people in the system who need care. It is important to begin by articulating the vision that the experience of each and every customer is important and will be a target for success and improvement, even when resources are limited (as they always are). In addition, the vision for Dallas County cannot be articulated by entities outside of the county, such as DSHS, NTBHA, or ValueOptions. Dallas County has to define its own vision for how it wants its behavioral health system to perform. Articulating this vision is one of the early functions of the Dallas County BHLT. In our experience with other state and county behavioral health systems around the country, articulating the vision is the first step to defining how to make progress in relation to that vision, both in utilizing existing resources more effectively and in strategically attracting additional resources. A sample vision statement might read as follows:
Dallas County’s vision is to design and implement a behavioral health system that is welcoming, recovery- and resiliency-oriented, integrated, trauma-informed and culturally competent, in which each individual and family presenting for care can be welcomed as they are, inspired with hope, and helped over time to address their mental health, substance use, health, and other complex needs in order to achieve the most happy, hopeful, and productive lives they possibly can.

2. **Begin the process by looking at the stories of real people in the system.** A critical element of a customer-oriented performance-improvement system, as utilized in other customer-oriented industries, is to begin by looking at the stories of real people in the system and then using that information in an organized way to develop better ways of helping them, and designing performance indicators and incentives accordingly. In Dallas County (and in NorthSTAR generally), many people are doing quite well; many people are also falling through the cracks and doing quite poorly. The first step in system improvement is to identify the second group of people and find out what they need that would be more effective. Note that the process begins by understanding the people, not just a list of their problems or deficits. If the system starts looking at the individuals who are having the hardest time as desirable customers, and thinks about how to provide them a more welcoming and hopeful experience, this will usually be the first step toward producing better outcomes.

3. **Begin with easier targets for improvement.** In Dallas County, the group of individuals known as the “Top 200” is a good starting place. These individuals are not only doing poorly, they are also costing the system millions of dollars in high-end care. Furthermore, the “Top 200” is likely to represent the “tip of the iceberg” of a much larger group of individuals who are not fitting well into current services and are not able to effectively utilize the current system. Because they are already a high-cost group, improvements in services can be accomplished more easily within existing resources and are likely to save the system money. Starting with this type of population would be a good “learning opportunity” for Dallas County, and ultimately NorthSTAR as a whole, to begin to redesign the system from a customer-oriented performance-improvement perspective.

4. **Use a systematic performance-improvement approach.** In Dallas County, the adult clinical operations team has just begun organizing to develop the capacity to use a systematic approach to look at this high-need population. The group has decided to broaden its perspective to include individuals who are having poor outcomes and high costs in sectors of the Dallas County system that are funded outside of NorthSTAR, such as Parkland, the Bridge, or the jail. The group has also decided to begin by systematically putting the stories of real people in the middle of its conversation. This is a formal and systematic performance-improvement approach that permits the group as a whole to look at the
problem “out of the box,” if you will, and come up with ideas and solutions that are much more likely to be successful. Note that such an approach is a marked contrast to what has been happening in NorthSTAR during the past few years, in which funding crises are met with reactive system interventions based on limited aggregate data sets, without attention to understanding the experiences of real customers, monitoring the impact of any changes on those customers, and utilizing a formal continuous quality improvement “Plan-Do-Check-Act” structure and process to evaluate and modify the interventions.

Here is an example from another county system in Michigan:

This system (a client of ZiaPartners) was working on a system transformation process and began to look at the highest utilizers of services in the system. In this system, the county had developed a functional managed care entity to manage Medicaid and state/local dollars for mental health and substance abuse services. When they began looking at the highest utilizers in their system, they identified a group of approximately 50-60 individuals that had cost them over $2 million dollars in the previous year, mostly through recurrent hospitalizations. They discovered that a majority of them (approximately 80%) had co-occurring mental health and substance use conditions. They also discovered that, contrary to their expectations, most of these individuals did not meet criteria for priority mental health services, according to state definitions. When they reviewed their “stories,” they found that there was a mismatch between the services they were being offered (for example, addiction treatment) and what they actually needed or wanted (usually a fairly flexible and moderately intensive ongoing treatment relationship to help with a variety of crises and life problems, along with ongoing mental health and substance use issues). The high intensity “case management” that was needed, however, was not routinely authorized or offered for this group of people because they were not “eligible.” As a result, they kept cycling back through expensive acute care. Once the county’s performance improvement process was able to “see” the high need people and have a more accurate understanding of how to help them, they were able to re-allocate some acute dollars to pilot and then implement a specialized wrap-around case management intervention (in partnership with four different provider agencies) targeted at this group of individuals, and were able to demonstrate that this intervention was both clinically successful and more cost-effective.

5. **Pilot suggested solutions and evaluate outcomes.** It is difficult to predict exactly what the clinical operations teams in Dallas County will develop. One possibility would be a mechanism to flag members of the “high-risk pool” and to pilot a high-intensity case management wrap-around approach, perhaps including peer support and mobile outreach, funded with acute-care dollars that are likely to be saved if this approach is more successful.
This process would need to be addressed in partnership with members of the clinical operations team, and then referred to the BHLT for implementation support.

6. **Translate pilot interventions into more systematic changes and associated performance indicators.** For example, in the situation described above, performance indicators might include:

a. Early identification of individuals who are at risk of becoming high utilizers.

b. Attachment of those individuals to appropriate care, with demonstration of continuing engagement.

c. Improvement in outcomes, as demonstrated by reduction in acute events and lower cost.

Based on baseline data collection for the original target population, the above indicators could be defined with more specificity as targets. Example: During the first three months, 50% of identified high-risk individuals are connected to continuing care as evidenced by twice-weekly contact; during the second three months, the target is 70%; during the next three months, the target is 80%.

**Phase Two (6 to 12 months): Develop more sophisticated indicators for performance-improvement activities**

1. **Establish the role of the BHLT in overseeing performance: defining performance indicators, identifying improvement targets, and monitoring and incentivizing progress.**

   This has to be seen as a practice opportunity, the result of which would be increasing sophistication in the ability to oversee the performance of any funder in relationship to the system vision. It is a process that is proactive, not reactive, and it would take a lot of practice. Although the NorthSTAR system has been in place for a decade, we have not observed that the local system (for example, NTBHA in this instance) has developed a great deal of sophistication in knowing how to identify and monitor performance indicators and to oversee a performance-improvement-driven system. For Dallas County, this process has not even begun. Consequently, as the BHLT begins to form, it needs to begin to identify what meaningful indicators for system performance would look like. We envision this activity taking place during the next 12 months.

2. **Design indicators based on what people actually need and want, and where improvement needs to occur.** Do not have the indicators be governed only by what is measured by DSHS (for example, TRAG scores) or what has been measured historically (for example, access without a waiting list). Do, however, practice identifying indicators that are measurable and significant. Most important, every significant area of system development should be
associated with measurable indicators of progress that can be connected to system-wide performance monitoring and performance improvement. Twenty-five examples are listed below. There are many others.

a. Number of individuals or families who are seen in crisis who have a non-crisis follow up contact within three days, seven days, and then continue to be seen for the following month.

b. Percentage of individuals/families in crisis who are seen voluntarily (without a hold) versus those who are seen involuntarily.

c. Percentage of individuals and families who are at risk for crisis who have a voluntary after-hours crisis plan that they know how to use and that will actually work.

d. Increase in the percentage of individuals/families in crisis who have crisis resolution and continuing engagement in care without either 23 hour observation OR inpatient stay.

e. Number of individuals and families who are connected to services as a diversion from a crisis or emergency room stay.

f. Number of individuals and families who are connected to peer support (one contact, ongoing contact; acute crisis; routine services; adult MH, adult SUD, child/family).

g. Targeted reductions in the percentage of active clients who are arrested; who are booked; who are incarcerated.

h. Increase in the percentage of individuals with MH and/or SUD issues who are involved with the criminal justice system and are diverted into community-based MH/SUD services (adults, juveniles; pre-booking, post-booking; post-incarceration; with or without specialty court, etc.).

i. Increase in the percentage of individuals with MH and/or SUD issues who are involved with the criminal justice system and who leave the justice system (jail, community corrections, juvenile services) without waiting for a subsequent placement.

j. Reduction in the percentage of individuals with MH and/or SUD issues who are involved with the criminal justice system and under community supervision who violate the conditions of their probation.

k. Increase in the percentage or number of individuals with SUD or MH disorders who are homeless and present in any setting, who are connected to any kind of supportive housing or to any kind of continuing treatment support (with or without housing).

l. Increase in the number of units of sober housing that will accept people with co-occurring MH issues.
m. Increase in the number of units of supportive housing that will accept people (with or without mental illness) who are actively using substances.

n. Increased percentage of diversion of individuals who need longer-term (longer than seven days) inpatient or residential psychiatric care into sub-acute community residential settings, with reduction in both state hospital utilization and acute inpatient utilization.

o. Increased percentage of diversion of individuals needing competency restoration into community-based settings (including residential settings) in lieu of state hospital or jail.

p. Update of psychopharmacology formulary guidelines to reduce the percentage of denials without increasing costs.

q. Decrease in clinic wait times for urgent walk-in clients presenting for care in SPNs.

r. Reduction of the percentage of individuals who present requesting substance abuse treatment who never receive it; reduction of percentage of individuals who receive detox or residential treatment who do not engage in outpatient care; reduction in outpatient care drop-out rate.

s. Reduction in the percentage of individuals/families who come for one appointment and do not return.

t. Improvement in the engagement of individuals in crisis who have co-occurring issues but who do not have one of the “Big 3” diagnoses at initial presentation.

u. Improvement in the rate of data collection on the prevalence of individuals with co-occurring MH and SUD issues from 25% (current) to 35% in the next year.

v. Increase in the number of individuals with MH and/or SUD issues recognized and treated in the Parkland system (by 10%, 25%, etc.). Target service in both behavioral health outpatient services and in primary health services by primary health providers.

w. Increased rates of service availability in Spanish; increased rates of involvement by Hispanic individuals in specialty behavioral health settings.

x. Increase in proportion of outpatient behavioral health services provided at Parkland by social workers.

y. Reduction in death rates within the behavioral health population.

3. **In a regional system, some of the indicators should be reflective of individual county priorities.** For example, if Rockwall County wants to target an increase in “telemedicine” interventions for individuals in crisis held by the sheriff, this could be identified as an
important performance indicator for Rockwall, even though other counties might not consider it to be of equal priority.

4. Development of indicators should not depend on knowing how to solve the problem or having resources allocated to the problem. Most systems (including historically the NTBHA/NorthSTAR system) tend to focus on measuring performance in areas in which they either know they can succeed, are specifically funded, or are externally mandated (for example, Medicaid or other state requirements). Further, most systems (again including NTBHA/NorthSTAR) continue monitoring certain measures long after that monitoring has outlived its usefulness. It is important, in successful system oversight, to make an effort to choose indicators that expose important clinical performance issues that might otherwise be invisible, even though the solution or the funding is not initially apparent. If you can’t “see” the problem, you will not be able to improve it, let alone solve it.

Another factor in developing indicators is that the system needs to learn how to negotiate and set attainable improvement targets. For example, if the “system vision” includes eliminating homelessness for individuals and families with behavioral health issues, the initial improvement target may be “creating 50 new units” or “reducing homelessness by 5%.” For increasing access to specialty behavioral clinics for Hispanic individuals, initial efforts might focus on offering paperwork and public service announcements in Spanish. These “small steps” are not insignificant if applied in a structured process of continuous improvement over a period of time.

5. Utilize in-depth root cause analyses for high-profile issues, critical incidents, or serious adverse outcomes. A major source of data for serious system-improvement activity comes from having a routine and transparent quality improvement process for addressing a broad range of “critical incidents.” A customer-oriented system philosophy establishes that NO critical incidents are acceptable and, consequently, all will be reviewed systematically. The most important purpose of the review is not to assign blame and punishment, (though this may be necessary) but to look for systemic issues that need to be addressed to make it less likely that critical incidents (for example, deaths) will occur in the future. We have observed that there is contract language requiring some kind of adverse incident and death review process in NorthSTAR. This data is tracked at the state level and shows (through a methodology we did not review) that levels in NorthSTAR (just over seven deaths per 1,000 population) comparable to some other urban areas (Bexar and Harris Counties) and lower than others (Tarrant is over 10 deaths per 1,000). However, we have not been able to discern how findings are connected to performance improvement monitoring processes (death reviews) that are organized to make it less likely that the next person dies.
6. Develop organized mechanisms for prioritizing indicators for attention. Within the framework of the BHLT for Dallas County (and similarly on the regional level within the framework of the NTBHA Board, as currently constituted) there exists a potential mechanism for identifying and then prioritizing performance indicators for system attention, as well as for developing and overseeing performance improvement activities. Note that at the Dallas County level, only some of this activity would specifically relate to NorthSTAR.

The process for doing this involves identifying priority areas of concern for the community (Dallas County, for example), identifying potential performance indicators for each area of concern, considering reasonable improvement targets and plans, considering/negotiating how to prioritize which to actually put into action, and then designating or delegating specific workgroups or subcommittees to “do the work.” This activity is a core function of any behavioral health “authority” in any system. There is no such organized function at present within Dallas County and it urgently needs to be developed.

Phase Three (2011 through 2012): Incorporate performance improvement indicators, targets, and incentives into behavioral health oversight functions, including MCO contracting

1. Develop a working knowledge of how to use performance-improvement incentive contracting for all system funding streams. The capacity to purchase system-improvement activities in behavioral health care contracting is often overlooked. Most of the purchasing process emphasizes defining “units of service” and associated reimbursement criteria, without specifying or clearly incentivizing system-prioritized improvement targets that can be negotiated in partnership with the service provider or funding intermediary. This dramatically diminishes the potential leverage of the expended dollars to produce desired results, even in a system with very limited resources. Further, even where there are improvement targets and incentives included in the contract, the incentives may not be properly aligned to produce the desired results.

   a. Example of a potential incentive: NorthSTAR performance incentive contracting in the current contract is both limited and out of balance. The total contract is $146,000,000, and the opportunity for the MCO (ValueOptions) to make a profit is primarily focused on its ability to limit expenditures within the Direct Services Claims Target (DSCT) of 88%. In this scenario, ValueOptions can expend up to $17.53 million to cover administrative expenses and has a potential profit margin for the difference between the DSCT and what it spends on administration. By contrast, the amount of money invested in performance-improvement contracting is very limited. In addition, the specific items that are identified are mostly derived from larger state performance-improvement targets in other LMHAs (for example, TRAG scores), have not changed much over the
years, and are not primarily reflective of identified local (county-specific) or regional priorities. Consequently, the total package of performance-improvement leverage is relatively low (under $700,000, as defined in Appendix 4b of the contract), as enumerated previously in the policy section above. From this data, it can be seen that whether or not ValueOptions adheres to its performance targets is only a small contributor to its bottom line. Further, many important issues do not have incentive dollars attached, and therefore if they are not accomplished there is little leverage, one way or the other, in the oversight process. See the next example for an alternative approach.

b. **Example of potential incentive:** Massachusetts Behavioral Health Partnership is a statewide Medicaid managed care arrangement in which, coincidentally, ValueOptions has been the vendor for almost 15 years. However, the relative weights of the various elements of the MCO contract with the Commonwealth of Massachusetts are quite different. First, there is a narrower limitation on how much money can be earned in the contract through managing utilization. Second, the amount of money “at risk” for performance-improvement activity is equal to or greater than the amount of money that can be earned through restricted utilization. Each contract cycle includes approximately two dozen performance targets that are negotiated with a variety of state, provider, and advocacy stakeholders. Most targets include both an “up-side” incentive, a “zero” reward, and a “down-side” incentive. An example (which is not in the current contract) would be as follows: The indicator might be the percentage of individuals seen after hospital discharge within seven days in an outpatient clinic; if MBHP achieves 90% it could earn $250,000; 75-90% earns $0; below 75% leads to a pay back of $200,000. Clearly, a collection of two dozen indicators, carefully and smartly negotiated, can exert powerful leverage on the performance of the managed care contractor. The policy section underscored how much attention the current contract is able to focus on RDM compliance and overall access targets. In turn, the MCO intermediary may pass along related incentives, or other incentives, to its providers in collaboration with NTBHA, as defined in Appendix 4a of the NorthSTAR contract.

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5 The current contract (in Appendix 4b) sets financial penalties for the MCO in several areas, including up to nearly $270,000 in penalties for adult services and over $94,000 in potential penalties for child services related to compliance with Resiliency and Disease Management (RDM), $50,000 in potential penalties related to TIMA compliance, $50,000 in potential penalties related to system access, up to $90,000 in potential penalties related to claims and data reporting (including up to $5,000 per month for uncorrected data issues, $17,000 for claims processing, and $17,000 for data reporting), and over $100,000 a year in potential monthly penalties related to call center performance.
2. **Strong recommendation**: By the next contract cycle, Dallas County, the other NTBHA counties, and NTBHA should be prepared to negotiate – and monitor – a managed care contract with much more performance improvement leverage. The entire sequence of activities in Phases 1 and 2 leads in this direction. The system has to have a process for developing indicators, setting local priorities, understanding how to engage in systemic performance improvement, and learning the approximate pace of progress. Further, there has to be a developed consensus on the right balance of financial risk attached to utilization versus risk attached to performance-improvement incentives. We recommend that the goal should be that more of the money at risk (or potential profit) should be tied to performance-improvement incentives than to utilization restriction.

3. **In Dallas County, similar strategies can be applied to contracts utilizing other funding sources.** Dallas County CSCD and Juvenile Services already incorporate outcomes monitoring into their contract oversight and renewal process. They therefore already have indicators in place that could be tied to similar performance incentives. This could also be extended to collaboration between the county and NorthSTAR. For example, if the Hospital District pools funds with NorthSTAR to leverage improvement in behavioral health integration within the Parkland COPCs, then the funding could be passed to each COPC with specific financial incentives attached to achieving attainable performance-improvement targets. If the system moves forward in developing a residential crisis-stabilization unit with pooled resources, part of the provider contract for the CSU could include specific performance indicators and incentives.
Step 4:  
Data Sharing for System Management  

Background  
This section addresses Step 4 in the Twelve Steps of Recovery for the Dallas County Behavioral Health System. One of the most significant findings in the study is that both clinical and financial management information in the Dallas County and NorthSTAR systems is not as developed as it should be, nor is it used as successfully as it could be to oversee and manage a complex behavioral health care system. This is true at two different levels:  

• The data elements currently being collected by DSHS to monitor the performance of the NorthSTAR system provide an incomplete and only partially accurate picture of NorthSTAR’s performance, both in and of itself, and in comparison to other Texas LMHAs. This point was discussed in greater detail previously in the data analysis and the performance improvement sections of this report, but it is relevant to the recommendations in this section as well. To reiterate: the vast majority of information collected is used to promote specific performance areas that do not necessarily support local efforts to create an effective recovery- and resiliency-oriented system, because the current indicators are too broad and “miss the target” of depicting the true quality of service delivery.  

• Beyond NorthSTAR, the depth and breadth of information shared across all system partners, service types, levels of care and funding arrangements is not adequate to ensure that the Dallas County (or regional) behavioral health system of services and supports functions effectively as a total system of care. Although considerable volumes of clinical and financial data do exist, the data elements are not as comprehensive, systematic, or accessible as they are in similar county systems. Probably of more concern, however, is that, with only a few very good exceptions, this data is not routinely shared across service and funding partners, nor is it routinely used to make strategic policy decisions affecting the design, delivery and resources of the county system of care within a total population management framework.  

In addition to the immediate need for an improved system for identifying and sharing relevant data, the emergence of health care reform and the pressure to develop uniform and integrated electronic health record (EHR) capacity is a major opportunity and will drive administrative data collection in the system for years to come.  

Consequently, there is tremendous advantage to establishing a functional framework now for system-wide targeted data-driven outcomes, data production and shared use, as will be described in more detail below.
The recommendations in this section, as in the others, are organized according to phases of implementation and with the assumption that the Dallas County BHLT (and representatives of the BHLT working in partnership with other counties in the NTBHA region) will be empowered and responsible for overseeing the implementation process. The recommendations in this section are based on a series of findings in our study, as well as some hypotheses derived from these findings. In addition to the major findings cited above, more specific findings related to data collection and data sharing are listed below.

Findings

Finding 1: There is no single point of accountability for using data as a system management tool that encompasses the comprehensive purview of the total system of care. The need for an entity such as the BHLT to take such responsibility is essential for the management of priority populations in need within the total system’s available aggregate financial resources.

Finding 2: Current initiatives exist, such as the ValueOptions “Top 200” initiative and the seven-year-old Jail Data Instant Messaging Initiative (JDIM), that highlight the willingness and capacity of the system to use clinical and financial data to improve services. Clinical Operations Team members, including representatives of many providers and ValueOptions, are already looking at new and more effective ways to share data. For example, ADAPT has a cutting-edge system that can easily link multiple data sets and make them searchable by system partners in a way that protects clients’ and providers’ privacy rights.

Finding 3: Even when data is available in Dallas County and NorthSTAR, it takes a great deal of effort to retrieve the types of system information sets that other counties routinely use to manage their behavioral health systems. The partners in this system have an underdeveloped internal use of data. While there are a range of discrete initiatives to promote data sharing and analysis for improving partnered activities (JDIM being the best example), the system as a whole has limited prowess for smartly using its collective data, primarily because there is no collective responsibility for using comprehensive data sets to drive decision-making that spans any individual funding or data partner’s responsibility. For example, DSHS reports that NTBHA has access to the same level of system data they do, but nearly all data used for this report came from DSHS, not NTBHA.

Data sharing is essential for management of large systems; the premise in public behavioral health and health systems is that using system-wide clinical and financial management information is both the purview and the responsibility of the designated total system leadership structure.
Recommendations

As in previous sections, the recommendations in this section are divided into phases. The first phase should begin immediately and extend over approximately 12 months. The second phase focuses on implementation activities that would begin in year two. Note again that we view the Dallas County BHLT, working in partnership with NTBHA partners when appropriate and DSHS, as the “place” where the design and implementation of the data policies for the system will be set, informed by operational teams that have knowledge and experience of implementing data projects and initiatives and which have wisdom from the field about the impact on services and clients.

*Phase One (late 2010 through 2011): Initial implementation.* Formulate a policy framework related to system-wide data production and sharing to prepare to improve data targets, production and analysis by and between all funded entities, including MCOs and direct-service operators. The BHLT should begin to look at this as a major opportunity to establish a policy framework for the data targets, production and shared use across the total system to design, operate and improve all aspects of service delivery. This would begin with the BHLT identifying a data group and tasking it to oversee the process of development in this area. It would be logical to engage and enlist people who are already working on aspects of data development, but should surely include representation from both the Adult and Child Clinical Operations Teams.

1. Begin examining the available information about the experiences of the clients who traverse multiple systems and data sets as they try to enter and navigate the current array of services, building on analysis of the “Top 200,” but including other information and data sources, as well as additional “high utilizers” beyond the NorthSTAR/ValueOptions data set. Note that this activity has started to come together under the newly formed system-wide clinical operations teams during the course of this study. Enhanced sharing and analysis of data will help the system’s partners “see” the experience of its customers more clearly, recognize and improve client flow patterns, identify opportunities to improve services, and identify strategies to pool and coordinate resources to gain funding efficiencies and greater leverage from these resources. Members of the system-wide operations teams have begun to present and discuss their understanding of what experiences high-risk/poor-outcome individuals are having within and between various service settings and partnership activities. This is a critical building process for these groups to establish a system-wide purview and to identify a common focus for the teams.

2. Using clinically-driven data sharing to “discover” the experiences of clients with poor outcomes can then lead to identifying systemic improvement opportunities that require a
system partnership to improve, thereby reinforcing shared responsibility for production and use of data.

3. These data-generated improvement opportunities can be held by the BHLT as targeted outcomes for system-wide improvement that foster broader collaboration and partnership. Examples might include: reducing criminal justice engagements of all kinds in both NorthSTAR and non-NorthSTAR service populations, successful engagement at lower levels of care for complex clients, improved access for high-risk/highly vulnerable populations, improved access to core services like SUD treatment for high-risk and highly affected individuals, and so on. Many of these targeted indicators are listed in other sections of this report.

4. Finally, as an early implementation recommendation, we strongly suggest that the JDIM team of clinical and technical experts begin to work with the BHLT and the clinical operations teams to evaluate the potential of JDIM or JDIM-like capacity to “cast a wider net” in order to incorporate more populations and more provider partners. There is a tremendous lesson to be learned from partnered activities like the JDIM experience. The JDIM process has improved outcomes for behavioral health clients coming into contact with the criminal justice system by producing a real-time, coordinated-response capacity between community and criminal justice partners. The JDIM Initiative should be highlighted as a model approach to creating effective data partnerships for the benefit of the broad populations served. Of note is that this conversation has begun in the Clinical Operations Team discussion, and both Parkland Hospital and The Bridge have expressed interest in developing this capacity more systemically.

**Phase Two (1 to 3 years): More-detailed implementation**

1. By year two, the information and experiences emerging from data-sharing partnerships as described above can evolve sufficiently to inform the design of performance requirements for MCO re-contracting, both in terms of data content and data-sharing requirements. It is very likely that the BHLT and the operations teams will have developed some representations of data-sharing activities and partnerships that cast a wider net across the system, and will have clearly illustrated some actionable opportunities to improve population flow, ease of access to lower threshold engagement for clients, smoother transitions between levels of care and types of services, and other clinical improvements. These data-sharing experiences will allow the system leadership to get “over the top” of all the system resources in Dallas County, and all the programs in Dallas County, in order to better leverage existing resources to engage and serve people and families with high-risks and poor-outcomes. This discovery is fundamental to the initial design of the performance monitoring activities of any MCO (and any other funding intermediary in the system,
including the Hospital District), as well as the provider partnership, in order to continuously improve the functioning of the system of care for its customers. DSHS has expressed support of the development of shared databases, either as part of expanded funding integration through NorthSTAR or as a separate initiative.

2. **These data development and data-sharing objectives must be held in the framework of Continuous Quality Improvement.** The goal is to ensure that the outcomes continue to evolve in the direction of prevention, early intervention, early access to care for people at lower thresholds to avert higher need and poor outcomes, support for the recovery and resiliency of individuals and communities, a decrease in the crisis tone of the system, promotion of the integration of services, and other system measures (as described in other sections of this report) that are demonstrated to produce better health and social outcomes.

3. **The development of overall system data performance indicators and effective, broad data-sharing strategies should be designed to meet the needs of important external policy and funding partners, most notably DSHS and the state legislature.** Good data systems create the ability to attract resources by demonstrating accurate outcomes and honest improvement activities. The ability of a system to create and manage data to set policy, design, service delivery and oversight protocols for the system is a key marker of that system’s capability to effectively manage its resources. Consequently, by the beginning of year two, it is desirable not only that the internal partners in the system will be more effective, but also that external policy and funding partners will view the system of care as more able to manage its resources, and therefore able to attract both more autonomy, and more resources. **Note that this is not only an essential precondition to shifting as much local control over the managed care system as possible to the local authority.** It also requires that both the county and regional authority demonstrate that they are managing data and resources beyond what is connected only to the managed care component of the system.
Step 5: Primary Health/Behavioral Health Integration

Background

This section addresses the integration of behavioral health into the full spectrum of primary health services. The recommendations in this section, as in the others, are organized according to phases of implementation, and with the assumption that the Dallas County BHLT (and representatives of the BHLT working in partnership with NTBHA, DSHS, and other counties in the NorthSTAR region) will be empowered and responsible for overseeing the implementation process. The recommendations in this section are based on a series of findings, listed below.

Findings

Finding 1: As discussed in detail in the initial data and policy analysis section, the economics of health care reform depend on successful bi-directional integration of behavioral health and health care. Preparation for health care reform will require enhanced capacity to serve people with behavioral health needs in primary care settings and integration of care delivery across tertiary settings (hospitals), secondary specialty care (behavioral health), and primary health. The state’s emerging priorities in this area are outlined well in the HHSC report to the legislature from the Integration of Health and Behavioral Health Services Workgroup. In addition, health care reform will bring more people into the health care service delivery system. By 2014, health care reform is expected to increase the Medicaid eligibles statewide by 25% (1,000,000 more eligible persons, in addition to the projected 4,000,000 that would otherwise be covered then).

Finding 2: Parkland’s Community-Oriented Primary Care (COPC) clinics and broader ambulatory health resources offer an initial primary care and broader health delivery infrastructure upon which to build, but that capacity needs to be increased substantially even to address current needs. The COPCs served over 5,700 unique individuals in County Fiscal Year (CFY) 2009; Parkland as a whole served over 11,000 persons with behavioral health needs. Increasing integrated behavioral health capacity in the COPCs is a current priority and it is likely that this number has grown, perhaps significantly, in the past fiscal year. Behavioral health services in the COPCs reach a very diverse population (39% are Hispanic, 30% White, 29% African American and 2% Asian American / Pacific Islander). However, the system could be serving a much higher capacity of persons in primary care settings. Nationally, 54% of mild

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cases and 37% of severe cases of behavioral health need are treated in primary care settings. The proportion served in the COPCs represents less than 6% of the 97,379 adults and children under 200% of the Federal Poverty Level (FPL) that have severe behavioral health needs in a given year, and a much smaller percentage of the broader population of persons with mild to moderate needs under 200% of FPL.

Parkland’s primary care resources can also support the delivery of primary care in specialty behavioral health settings. Mauer (April, 2009; March, 2010) underscores the importance of embedding primary care resources in community behavioral health settings to increase access for individuals with severe and persistent mental illness and severe SUD in order to address the serious morbidity and mortality risks in this population. SAMHSA just awarded 43 grants to expand primary care in specialty behavioral health settings, and there are many additional grant opportunities through SAMHSA and even more under the Patient Protection and Affordable Care Act (PPACA) available now and over coming months.

**Finding 3: A wide variety of evidence-based approaches are available to support behavioral health integration, but they require a fundamental reorientation of both behavioral health and primary care clinical practice.** The Parkland COPCs have made a focused initial commitment to moving toward evidence-based models of integrated care. The Frew Settlement funded the Services Uniting Pediatrics and Psychiatry Outreaching to Texas (SUPPORT) project targeting Medicaid children with behavioral health needs. The project is small in scope and growing (as a research project, it has substantial protocols for informed consent that project staff see as an unfortunate barrier to care), yet it has reached nearly 900 children by the end of August 2010 (start up was in late 2008, but did not ramp up substantially until June 2009). The project has adapted for children the IMPACT protocol of collaborative care (more on this below). It has been especially successful in engaging Hispanic children and families (over 72% of persons served are Hispanic). Most conditions addressed are moderate in intensity (mostly ADHD) and there has been an ability to have early intervention for many emerging behavioral health needs (parent/child relationship problems). The project has separate, dedicated funding under the Frew Settlement (Medicaid is not billed), but targets only Medicaid enrollees, so it adds substantial value to the system. There are plans (reportedly supported by the state) to build on the model and add behavioral health codes to primary care practices in Medicaid, which have been excluded in Dallas County (and most Medicaid waiver programs like NorthSTAR) because of the carve-out model. Parkland has also just completed a Hogg Foundation pilot of the IMPACT model for adults (which did not continue after grant funding ended). The project served nearly 1,200 people in 18 months and provided many learning opportunities, in addition to the expansion of care delivery during the project period. These projects give Parkland and the broader system a strong base of experience to work from, and they also demonstrate the need for administrative and physician leadership to help clinical
staff make the difficult changes in practice required by these models, as described below. Parkland has also sent staff to receive training from Intermountain Health in Utah, which is one of a handful of model integrated ACO models in the country, adding further to the expertise base at Parkland available for future development.

A separate project funded under the Frew Settlement through Children’s Medical Center provides a telephone referral and consultation service for primary care pediatricians focusing on diabetes, gastrointestinal, cardiology, and psychiatric consultation. There is a website with resources and pediatricians can call a centralized number and get a telephone consultation within 30 minutes. As with other similar programs in the country (such as Washington State’s psychiatry-only service), the project is underutilized, but it provides an important base to build on.

The national literature emphasizes a multiplicity of approaches that are (1) tailored to the need level of the person served (embedding behavioral health in primary care settings for lower need individuals and primary care resources in community behavioral health settings for persons with more persistent and complex disorders)\(^2\) and (2) grounded in an evidence-based shift away from traditional office-based models. For example, the IMPACT (Improving Mood: Promoting Access to Collaborative Treatment) model of collaborative care is designed to: (1) treat the individual where he or she is most comfortable; (2) build on the established relationship of trust between a doctor and consumer; (3) better coordinate mental health and medical care; and (4) reduce the stigma associated with receiving mental health services.\(^3\) Two key principles that form the basis of the model include: (1) Mental health professionals or allied health professionals with mental health expertise are integrated into primary care settings to help educate consumers, monitor adherence and outcomes, and provide brief behavioral treatments according to evidence-based structured protocols; and (2) Psychiatric and psychological consultation and supervision of care managers is available to provide additional

\(^2\) See:

mental health expertise where needed. Key components of the model include screening, consumer education and self-management support, stepped up care (including mental health specialty referrals as needed for severe illness or high diagnostic complexity), and linkages with other community services such as senior centers, day programs or Meals on Wheels. Several randomized studies have documented the effectiveness of collaborative care models to treat anxiety and panic disorders, depression in adults, and depression in older adults. For example, a study with older adults found higher satisfaction with depression treatment, reduced prevalence and severity of symptoms, or complete remission as compared to usual primary care.

Common features of all of the primary care integration models include: co-location, use of validated screening tools for both behavioral health and physical health risks, integrated information technology support (including patient registries to track/monitor appointments, preventive care, chronic care interventions, patient preferences), shared electronic health records (EHR), and routine outcomes tracking with emphasis on brief, widely used protocols.

There is also a need to address challenges, such as billing protocols that may not allow for same-day primary care provider (PCP) and BH visits, implementation of the Screening, Brief Intervention and Referral to Treatment (SBIRT) codes, the need to pay for case management and the cost of coordination, and movement away from a fee-for-service funding arrangement.

But the biggest challenges center on the PCP and behavioral health consultant (BHC) work force. Collaborative care requires a different set of skills, knowledge and attitudes. The program needs to recruit for PCPs comfortable with BH issues and leadership must buy into and promote the model, both through support and assertive promotion and supervision. The role of the PCP is much different, as the PCP and BHC collaborate to develop and implement the treatment plan.

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See also President’s New Freedom Commission on Mental Health Final Report at 66.
The role of the BHC is also quite different in the collaborative care model from a traditional clinical role. The BHC can be supported by a peer support specialist instead of a case manager, as a variation of the model. The BHC and peer specialist can work together to provide education to increase awareness and support self-management so that the person served is actively engaged in their treatment. The BHC provides medication support, brief counseling, treatment response monitoring, and relapse prevention planning. The psychiatrist acts as consultant to the team for individuals who are not responding to the BHC and PCP.

There is a heavy focus on clinical integration via care coordination, team meetings, “warm handoffs,” and informal coordination “in the hallway.” The alternate approach to delivering services involves:

- Short, targeted BH consultations versus standard 50-minute hour,
- Longer primary care sessions to conduct adequate screening,
- Joint sessions when appropriate,
- A view that sessions are “interruptible” as key members are either brought in to respond to emerging issues or are consulted on other cases, and
- Group delivery of medication management and other services that both enhances efficiency and promotes mutual support among persons served.

The recent Hogg Foundation pilots and differences in practice identified through our review of Parkland’s COPC and broader outpatient system currently underscores the need for a commitment of medical and management leadership to the integration agenda. The existing relationship between Parkland and the University of Texas Southwestern may be a potential resource for new partnerships to retool training and refocus physician leadership in this area.

**Finding 4.** Reimbursement for integrated behavioral health and primary care can occur through a variety of methods, and there is emerging consensus that they are best reimbursed by methods other than direct fee for service billing by behavioral health clinicians who happen to be located in primary care settings. Furthermore, they can be paid for from a variety of funding streams. The essential strategy (short-term and long-term) is to view behavioral health as an integral component of the services provided by the primary health team and as part of primary health care billed under a health benefit. This ranges from integrating attention by PCPs to behavioral health conditions within medical visits for a co-occurring medical condition, addressing co-occurring behavioral health issues as part of routine team-based disease management efforts (as for diabetes, obesity, and so on), creating a collaborative consultation in which services are delivered by the primary care team supported by the
Consultant, and direct billing for services like SBIRT which are reimbursable specifically within primary health.

Recommendations

As in previous sections, the recommendations in this section are divided into phases. The first phase should begin immediately and extend over approximately 12 months. The second phase focuses on implementation activities that would begin in 2011. The third phase will begin in late 2011 through 2012. Note again that we view the Dallas County Behavioral Health Leadership Team, working in partnership with NTBHA when appropriate, as the “place” wherein the design and implementation of the broader behavioral health and primary care integration strategy will be led, informed by the operational teams. We also expect Parkland and its COPC leadership to have a central role in this development.

Phase One (2010 through first half of 2011): Develop a planning framework to guide multi-level behavioral health and primary care integration

1. Initiate planning to expand capacity to provide behavioral health care in Parkland’s COPCs, with a goal of (1) expanding access to current COPC patients and (2) developing a step-down capacity for persons ready to exit NorthSTAR’s specialty provider network. This should build on lessons learned through the Frew/SUPPORT and Hogg Foundation studies, but should also include a process for formally coordinating bidirectional movement between the COPCs and NorthSTAR. Integrating Parkland’s outpatient system more fully with the broader NorthSTAR system has the potential to take pressure off the specialty provider network (SPN) by engaging more individuals with less severe mental health and substance use issues in primary health settings. This would involve a step-wise shift from a payer-centered level of coordination (for example, NorthSTAR eligible individuals are served by a SPN and non-NorthSTAR diagnoses and payer types are served by COPCs) to coordination driven by level of need (for example, lower need persons served by COPCs and higher need by SPNs). The Children’s Medical Center referral/consultation service and the broader resources of its pediatric department should also be incorporated into planning efforts in order to improve support for a broader array of pediatric practices.

2. Initiate planning to place primary care capacity within select SPNs as a pilot. Embedding primary care resources in SPNs is also needed. SAMHSA released a series of federal grants last year to support such development and this planning may include an option to pursue such funding should it be available in the next federal fiscal year.
3. **Initiate planning within Parkland and with the University of Texas Southwestern (UTSW) (and Children’s Medical Center, as appropriate) to build physician leadership within primary care with a vision for behavioral health integration in primary care settings.** The importance of the buy-in and support of physician leadership within an institution like Parkland is essential, and it is critical that physician recruitment and training within Parkland as a whole and the COPCs in particular be supported by active physician leadership that understands and supports best practices in the delivery of behavioral health in primary care settings. Partnering with UTSW (and potentially Children’s Medical Center) could potentially attract visionary leadership with a tie to ongoing research and residency training.

4. **Develop creative models for using existing funding to support the expansion of behavioral health capability in primary care.** For example, in the short term, NorthSTAR could work with Parkland to develop a contract to reimburse capacity (as opposed to a fee for service contract) to expand behavioral health integration within its COPCs and within medical clinics already partnered with its OPC. For a modest initial amount, Parkland could set a goal of expanding the number of individuals with serious behavioral health needs served in community health settings by 5,000 per year, and then building that as a sustainable feature of the clinics. That would serve both NorthSTAR’s need to divert lower need (though still meeting targeting criteria as “serious”) individuals with behavioral health needs away from the directly funded provider network, and would support Parkland’s goal of developing integrated behavioral health care delivery capability as part of building health care homes.

5. **Initiate and expand current hospital wide initiatives for improving screening and intervention for co-occurring behavioral health conditions.** In addition to activities in the community clinics, Parkland has begun to look at the issue of screening and identification (and intervention) for substance use disorders as a medical quality improvement (QI) initiative hospital wide, including improving that capability in current MH service settings. This type of hospital wide QI project is exactly the right approach to beginning to make progress toward leveraging better integration and outcomes within existing resources, and should be built upon and leveraged more broadly.

6. **Incorporate planning regarding the future of the 340B Drug Pricing Program into the process.** Currently, ValueOptions is working with a few system stakeholders to review the cost-effectiveness of the current 340B Drug Pricing Program and its potential to be better leveraged within both NorthSTAR and the broader behavioral health system. This would be
a natural point of collaboration and discussion within the broader BHLT and clinical operations teams.

Phase Two (second half of 2011 through 2012): Begin to implement multi-level behavioral health and primary care integration

1. Hire a physician lead within Parkland to ground the shift in physician and other primary care provider practice (early 2011). It will be critical to implement the grounding of physician leadership noted above as soon as possible. Early 2011 represents a near term, but achievable goal.

2. Begin to systematically convert each COPC from a traditional behavioral health delivery model to a collaborative care model (begin mid-2011). The only way to realize the needed efficiencies in behavioral health delivery within the COPCs is to shift from a traditional model of parallel service delivery (in which BH clinicians and PCPs see patients separately in traditional models) to a model of collaborative care such as IMPACT. While there are multiple models, all of the successful ones involve a shift in practice such as that described above. This will require a commitment and potential retraining and targeted hiring of new staff within the COPCs. While Parkland will need to have ownership of its own resources and workforce redesign, the role of the BHLT will be critical as NorthSTAR resources offer a potential funding source for this shift. Parkland will need to hire and retrain new staff; the value for NorthSTAR is to provide a setting to serve its members in a more cost effective manner and still promote access.

3. Begin to implement primary care in a pilot set of SPNs (begin late 2011). Parkland or other primary care resources can also begin to be implemented within SPN settings in 2011. We recommend that this also be executed in a step-wise fashion, but ideally with as many SPNs as are interested.

4. Begin planning for more sophisticated methods of tracking cost-savings from primary care/behavioral health integration in Parkland. As demonstrated in the policy analysis section related to health care reform, both immediate and long range savings can accrue from improved health outcomes stemming from behavioral health / primary care integration for high need individuals in primary health settings managed under arrangements that are essentially at risk for emergency and catastrophic medical care within a fixed budget (like that of Parkland). Although data technology is not yet in place for studying the impact on health costs of improved attention to co-occurring mental health
and substance use conditions in health settings, by Year Two this technology can and should be developed, so that the Hospital District can be reassured that primary health/behavioral health integration is not only clinically sound, but cost effective.

5. **Shift the 340B Drug Pricing Program to a sounder footing.** Based on the analysis and planning in Phase One, the 340B program should be shifted to a more consensus-based and cost-effective setting sometime in 2011.

**Phase Three (begin as soon as possible, but expect primary planning to occur in 2012 and later): Incorporate behavioral health integration planning into plans for a potential accountable care organization (ACO) structure (or structures)**

The future of health care will depend on the success of multi-specialty, integrated care delivery systems, whether they organize as ACOs or otherwise. As noted in the recommendations in Step 2, Parkland and other partners within the BHLT may have the option to integrate behavioral health management within the larger development of a county or regional ACO. The BHLT should begin as soon as possible to plan with Parkland (and potentially other health care delivery systems, as appropriate) to determine how best to achieve behavioral health integration within each model. Eventually, each STAR/STARPlus Medicaid and CHIP MCO will need to address this issue, and the BHLT will need to decide how to position the Medicaid behavioral health system with each one. One thing seems certain: At some point in the future, the NorthSTAR system will need to integrate better with the STARPlus/STAR system. To the extent that leaders in Dallas County and NTBHA can prepare for and help guide that transition, the less likely that decisions made at the state level will be disruptive to ongoing care delivery. DSHS and HHSC will be key partners in this planning process.
Step 6:
Welcoming, Recovery-Oriented, Integrated Continuum of Crisis-Intervention and Acute-Care Services

Background

This section addresses Step 6: developing a proactive crisis response continuum and a continuum of crisis stabilization and crisis residential services. The recommendations in this section, as in the others, are organized according to phases of implementation and assume that the Dallas County BHLT (and representatives of the BHLT working in partnership with NTBHA and other counties in the NorthSTAR region) will be empowered and responsible for overseeing the implementation process. The recommendations in this section are based on a series of findings in our study, as well as some hypotheses derived from these findings, as listed below.

Findings

Finding 1: The Dallas County system (and NorthSTAR) is designed in such a way that it has become highly crisis-reactive, and as a result significant resources are invested in what we would call “back-end,” more expensive crisis response (for example, psychiatric emergency services [PES] and 23-hour observation [OBS]), rather than lower-cost proactive crisis response that would reduce the “crisis tone” (and crisis cost) in the system over time. Historically, the current system of PES at Parkland and Green Oaks, with OBS bed capacity at Green Oaks, evolved as an urgent stopgap measure to control hospital utilization. In this regard, it has been successful. However, both PES and OBS are relatively expensive, highly medicalized services, and individuals often access these services involuntarily. Although some do walk in for help, neither service is designed to make that a rewarding experience. The volume of PES and OBS, and the cost of these services, outstrip the current capacity of the Mobile Crisis services provided by ADAPT. Consequently, if someone requires a “crisis intervention,” particularly someone who is not already engaged successfully with an SPN and particularly “after hours,” there is little recourse other than to call the police.

Finding 2: Unlike many other urban systems, including some other LMHAs in Texas, Dallas County does not have a 24/7, welcoming, hopeful, integrated crisis walk-in site that provides an easy entry point for individuals and families who are needing crisis help, and where they can easily receive continuing short-term crisis intervention. One of the principles for reducing higher-end crisis response is to build the crisis response system around the needs of the “customers.” It is expected that individuals and families will have multiple complex conditions – such as co-occurring health, MH, and SUD issues – and will not have an easy time keeping appointments, asking for help, and so on. In Dallas and other urban areas, many may have their needs complicated by poverty and cultural and linguistic backgrounds that, separately or
together, impede ready access to care, as discussed further in our Step 12 below. For those people who are at highest clinical and financial “risk” in the system, there is a very fine line between being able to ask for help in crisis voluntarily (and therefore being able to respond to a much lower-cost intervention) and needing an involuntary hold, a trip to PES or OBS, or inpatient treatment. Ideal system design purposefully creates mechanisms to make it easier and more rewarding for individuals and families to ask for help sooner, particularly in after-hours crisis situations.

Examples include:

- In Tarrant County, John Peter Smith Hospital (JPS) has a separate space for a walk-in crisis center, distinct from the entrance used for involuntary admissions by police.

- In Bexar County, one aspect of their system is a “welcome center” where people can walk in, or police can drop off, for a welcoming crisis response. This site has peer support personnel and is conceived as a “recovery recruitment center,” in which the individuals who come in are viewed as “recovery prospects.” This site is connected to the higher-end involuntary crisis services, but provides a lower threshold of engagement.

- In the Boston area, there are multiple “crisis teams” that are staffed primarily with master’s level clinicians. The teams have a “location” but are also mobile. They get involved in evaluating individuals for both voluntary and involuntary hospitalization, and have access to crisis beds. In addition, each team is available to provide initial intervention and short-term follow-up for anyone, on request, 24 hours a day, seven days a week. For most teams, the majority of their clients are voluntary, not involuntary.

**Finding 3:** The current crisis response system has a significant follow-through gap. Although it is easy for individuals leaving PES or OBS to get “referred” to a next-day appointment at an SPN, there is no tracking to determine if they actually got there, and no continuity of responsibility for assuring follow-up if they literally “fall through the cracks.” This hand-off is a period of very high vulnerability in a crisis situation. A proactive crisis system has to be designed to reduce to near zero the likelihood of an individual falling through the cracks. Data collection, tracking, reporting, and capacity to act on results of tracking is essential.

**Finding 4:** There has been a recent increase in PES utilization at both Parkland and Green Oaks, the majority of which is related to individuals who have not been “assigned” to an RDM. However, it is not clear if these are individuals who were never seen before, versus individuals with prior contact in the system who never got assigned to an RDM for a variety of other reasons (lack of follow up, unclear eligibility, etc.). It is possible that some of this increase is related to service reductions consequent to the SPN case rate. While we have been able to frame the major contours of this trend, we have not been able to gather enough clinical
information about the individuals presenting in crisis settings to fully understand this phenomenon, nor have we been able to access data from ValueOptions’ reconciliation of the case rates to encounter data. The fact that this data is so hard to find is worrisome in itself, as this would be an obvious performance-monitoring target to evaluate case rate implementation, as discussed previously in Step 3. We are expecting that some of the “Top 200” and other cases reviewed by the Adult Clinical Operations Team will illustrate some of the “stories” behind this data, and thus provide more detailed information about potential response. Over 34% of the claims from the “Top 200” fell into the crisis continuum (PES, OBS, inpatient), comprising nearly two-thirds (64%) of their $3.85 million in costs and suggesting strongly that their experience has much to teach us about possible improvements. Another 13.4% of costs are related to SUD services (42.5% received at least one CD service), and the remaining 23.2% of costs were related to MH care.\(^1\) The area to target for improvements is clear.

One hypothesis, based on our experiences in other systems, is that many more than 42.5% of these individuals and the larger group of people who present in crisis settings have significant SUD conditions and associated MH symptoms. They are at risk of being denied eligibility for RDM status if there is a choice made during the crisis assessment to state that they have a “substance-induced disorder” rather than a “Big 3” diagnosis. These high-risk individuals may thus be deemed “ineligible” for services, or referred to SUD treatment which they do not want, and then re-cycle into emergency services or into jail. As this population is a high-risk, high-cost, high-volume, and poor-outcome population, system design - especially crisis system design - needs to be prepared to welcome these individuals as a priority for service, addressing how to engage them easily in services in which they are willing to participate.

**Based on the data available to us, we hypothesize that the poor outcomes associated with the “Top 200” may be associated in part with the current design of the crisis response system.** The Dallas/NorthSTAR system, like many urban crisis systems, appears to function often in a “one-and-done” manner. There is a high degree of effort to stabilize the immediate high-risk event, often at fairly high cost, and then refer the client on for more “conventional” care. In most systems that regularly review and address their own “Top 200,” the characteristics of this group are as follows: individuals with very complex needs (MH, health, SUD, housing) who are uninterested in (and uninspired by) most conventional services (MH, SUD, housing), and who are able to manage themselves in the community for brief periods and then return to high-end crisis situations. Although many systems will say they need “more resources” to serve these people, the problem is more that the available resources are mismatched to the clients. The

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\(^1\) TriWest analysis of ValueOptions data set “Top_200_200904_201003.” Received via Personal Communication from S. Spradlin, August 10, 2010.
“solution” for many of these individuals is to connect them to relationships that are responsive to them in crisis and truly “meet them where they are,” rather than constantly trying to refer them to services they do not want. Paradoxically, when they are able to spend several months engaging in a relationship that meets them where they are, they are very often (and often only slowly) able to stabilize and engage in more conventional services with better outcomes and lower costs over time. A responsive 24/7 crisis safety net system – with an ongoing “intensive” and “flexible” crisis case management component – is a critical part of being able to provide what these individuals need.

Finding 5: Unlike many other urban systems (for example, Boston, Miami, Oakland, Tampa), including other LMHAs in Texas (for example, Tarrant County), Dallas does not have a community-based subacute / crisis stabilization unit that can function as an inpatient diversion or step-down for individuals who need a secure (locked) setting. Subacute / crisis stabilization units (S-CSUs) in many systems are designed as secure, lower-cost alternatives to psychiatric hospitalization. They are medically managed, but less intensively than a hospital, and usually operate with a “bed-day” cost of approximately $300. The figure that we obtained for the per diem for the S-CSU at JPS was $299 to $314, though we do not have a full breakdown of how much overhead allocation is included (if any) in this rate, or if this is just operating cost. In any case, this rate is somewhat higher than the per diem allocation for Terrell State Hospital (TSH) (just over $241 in SFY 2009).

In Texas, there are (we are told) five S-CSUs. We visited the one in Tarrant County at JPS, which is a 16-bed unit used exclusively for crisis diversion that is in the same “pod” as their hospital units. However, this S-CSU is only one example of possible options. Texas regulations are fairly broad about how these units can be used. They can be used for diversion or step-down from the hospital; they can be “secure” settings so that clients can less easily elope; they can have varying LOS (from a few days up to 30 days); and they can be designed to have varying amounts of programming (including recovery-oriented rehabilitation services, competency restoration, co-occurring disorder services, and so on). The recommendations for how to design and implement a S-CSU for Dallas and NorthSTAR will be described below.

Finding 7: For lack of such a community-based alternative, individuals who need continuing acute or subacute services, or individuals who need competency restoration but cannot be served in an outpatient setting, are sent to Terrell State Hospital (TSH).

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2 Determining whether to license this unit as a subacute, CSU or community inpatient unit is a function of available licensing types in Texas and was not part of our analysis. Such details will need to be worked out when implementation of the program moves forward. Our focus is on the clinical purpose and overall design of the unit.

3 Texas Department of State Health Services. (September 6, 2010). TriWest Data 09_06_10. Provided in personal communication from M. Ferrara as a Microsoft Excel file on September 7, 2010. Data analysis by TriWest Group.
Finding 8: There is potential interest at DSHS in exploring creative opportunities to partner with the NorthSTAR system to “manage” a portion of the current regional allocation for TSH (just over $35.5 million budgeted for SFY 2009-10) in order to reduce state hospital utilization and increase community-based care. Our team has explored this possibility in various ways in discussions with Mike Maples, Jack Szczepanoski, and Tony Claxton. Mike Maples clearly stated to us that this is an issue that DSHS is willing to discuss. The goal is to develop an approach to this issue that would allow all parties to “win,” including TSH. This will be described in more detail below.

Finding 9: There is currently a small detox (and unlocked) crisis residential program in Dallas County (at Homeward Bound) for individuals with co-occurring disorders. However, this program appears to be currently underutilized. Co-occurring-capable crisis residential services (with detox capacity) are another valuable (and less expensive, compared to a S-CSU) component of a crisis continuum. The current program (at Homeward Bound) seems very nicely designed, with dedicated clinicians. However, data from that program indicates that it is underutilized and that current ValueOptions utilization management activities related to SUD services seem to make it hard to get individuals connected to crisis residential services. This is suggestive of a crisis response approach that is “reactive” rather than “proactive,” and therefore becomes “pennywise and pound foolish” in its utilization of intermediate crisis services.

Recommendations

As in previous sections, the recommendations in this section are divided into phases. The first phase should begin immediately and extend over approximately 12 months. The second phase should focus on implementation activities that would go on-line no earlier than two years from now, and probably later. Note again that we are viewing the Dallas County BHLT, working in partnership with NTBHA and DSHS when appropriate, as the place where the design and implementation of the Dallas County crisis system will take place.

**Phase One (1 to 12 months): Beginning to plan and implement a welcoming, recovery-oriented, integrated crisis system**

1. **Strong recommendation: Articulate a vision for the crisis system.** Part of our recommendation is to provide you with an outline of this vision. It need not be perfectly detailed right now, as the details may change, but the “big picture” is necessary to guide future planning and implementation. We are indebted to Frank Webster for providing us with his “vision,” which has substantially informed these recommendations. The locus of formally adapting and accepting this vision should be assigned to a subgroup of the Dallas County BHLT, perhaps to the Clinical Operations Team. Other county representatives can be involved as well, as appropriate.
CRISIS SYSTEM VISION: The starting place is to envision a centralized crisis “hub” in downtown Dallas. The purposes of the hub are as follows:

a. To provide a welcoming, hopeful, inspiring place where individuals (adults and children) and families in MH and/or SUD crisis (including those who are homeless, actively using substances, picked up by the police, etc.) can walk in, be dropped off and be seen, 24/7. Note that initial contact would be provided by a combination of a master’s level clinician, case managers and peer support, with medical backup and supervision.

b. To provide a “call center” for all crisis activity in the county (and possibly the region).

c. To coordinate data on all crisis contacts and follow-ups, and to aggressively and proactively monitor follow-up information on all “at-risk” adults and families moving through the crisis continuum.

d. To provide a central point of contact and coordination for mobile crisis outreach.

e. To provide a central point of contact and coordination for crisis “tele-evaluation” activities.

f. To provide a setting for drop-in “peer support” groups and other low-threshold activities that facilitate engagement and continuity at low cost.

g. To provide linkage to satellite centers or SPN offices that may be open in other parts of the county but which provide more limited services.

h. To provide opportunities for continuing crisis intervention over a period of weeks, including daily contact and mobile outreach as needed, until the client is engaged in more routine care.

i. To provide after-hours access to psychiatric evaluation and medication when indicated.

j. To coordinate a psychiatry on-call system for the crisis hub.

k. To be geographically linked to a medical ER and PES.

l. To be geographically linked (ideally co-located) with adult OBS beds, inpatient beds, and subacute beds (S-CSU, crisis residential, sober housing), and associated programming. (This will be described in more detail below.)

m. To be programmatically linked with a similar continuum for children and adolescents.

n. To maintain linkages with other inpatient units and ERs in the county and the region, including telemedicine hookups as appropriate.
o. To provide a central point of coordination of clinical utilization management through the continuum of levels of care, in real time, while maintaining continuity of clinical responsibility until a formal handoff to an SPN can be effected successfully.

2. **Use existing improvement processes to identify early next steps for implementation.** For example, in the current work of the Clinical Operations Teams, issues related to cross-system data-sharing for crisis coordination (built on the JDIM system and other capacity at ADAPT) would be one such starting place. Other starting places will likely be identified through work on providing a continuum of services for the “Top 200” (which may also leverage some “short-term” funding from ValueOptions to move in this direction). Utilization data from this report and other sources could be used to estimate needed capacity.

3. **Starting places should emphasize lower cost “clinical processes” or “resource coordination” prior to more expensive capital investments or full-fledged program design.** Look for small steps that illustrate success in the direction of the vision. Some possible examples are listed below.
   a. **Build-out from mobile crisis.** If the strategic plan is to build a “hub,” mobile crisis currently coordinates a lot of the “hub” functions. With a relatively modest investment of resources, Mobile Crisis, in partnership perhaps with TransiCare, could begin to extend a more proactive coordination and outreach engagement function. One example would be to identify high-risk individuals who are being discharged from PES or OBS, and refer them to mobile crisis for immediate engagement, a face-to-face visit at Green Oaks (and ideally other clinical sites, as well) if need be, proactive follow-up phone contact and mobile outreach, continuity of crisis intervention, and related activities until the person is connected to ongoing care. This could be piloted as a first step.
   b. **Data coordination.** Another starting place is to broaden the existing data collection capacity so that individuals and families in crisis can be tracked in real time through multiple venues in the system, and across multiple funding streams. ADAPT showed the Clinical Operations Team at its July 2010 meeting that it currently has the technical capacity to implement this type of coordination at relatively low cost, if the details of the data sharing collaboration can be worked out, as they were with JDIM.
   c. **Resource coordination.** With the vision of the hub in mind, we begin to see how current services in the crisis map that are “disconnected” can be brought together more effectively. For example, the Association of Persons Affected by Addiction (APAA) currently has a peer outreach component, including a small crisis-response capacity and a drop-in center. Other SPNs (such as ABC and Metrocare Services) also have substantial peer support capacity. Would it be possible to begin to coordinate some of what APAA
and other peer support providers do as part of the mobile crisis hub? Another possibility is to coordinate the current after-hours clinic capacity operated by Metrocare and Southern Area Behavioral Healthcare with the resources available for mobile crisis and on-site crisis response.

d. **Utilization management coordination.** Currently, clients moving through the crisis continuum are technically coordinated by the MCO without a concomitant clinical responsibility. It might be possible to pilot some coordination of clinical case management and utilization management through mobile crisis, as follows: A person presents in any front-door setting (mobile crisis, PES) and mobile crisis is notified to begin tracking the case. Following PES, the person is referred to OBS, and then back to mobile crisis for continuity of crisis intervention. Mobile crisis determines that the CRU at Homeward Bound would provide a good transition, authorizes transfer, visits the person there as part of discharge planning and then provides two follow-up sessions while the person is connecting to SPN services, including a co-occurring group.

4. **Develop a strategic plan for locating and staffing the crisis hub (target date 2012), and then plan ways to acquire initial funding to support the vision.** This discussion, emerging from the Dallas County BHLT, would provide a clear set of recommendations for prioritizing the next allocation of crisis redesign funding for 2011. Other aspects of the funding package may be requested from county sources, the Hospital District, foundations, SAMSHA, the legislature (as happened in Bexar County), and so on. Our initial recommendation would be to develop a “start-up” funding “package” in which allocation of crisis redesign funding was “matched” by local dollars, and then use the start up to leverage more resources over time. Note that successful implementation would increase resource utilization in some areas, but would be partially offset by reductions in PES, OBS and inpatient costs, reductions in jail booking costs, and so on. Because the crisis hub represents a “big vision” that is fully consonant with the larger purpose of the state’s move toward crisis redesign, it would be smart for Dallas County and NorthSTAR to promote the vision as an example of a model crisis continuum and to seek funding within that framework.

5. **Begin the planning for the Subacute / Crisis Stabilization Unit program, Terrell State Hospital diversion and resource management, and other elements, in partnership with DSHS.** Our estimated target for implementation of the crisis stabilization unit program (see below) would be no sooner than late 2012, and more likely would occur in 2013 or 2014 given the logistics involved. There are several elements that need to be planned collaboratively, which would involve developing an identified working group that is empowered to represent the Dallas County BHLT in the process, along with NTBHA, DSHS, and TSH. Given that some of the space planning may be connected to Parkland’s capital expansion, Parkland would be a significant partner in this process. (However, we are
informed that there may be other space options available in the county; exploring this was beyond our scope.) It would be important, however, to begin the planning process now, using this report as a guidance document, so that all the issues can be worked out well ahead of implementation and can guide the details of space acquisition, staffing and programming, managed care contract parameters, performance indicators and incentives, evaluation and oversight, and so on.

Phase Two (12 to 36 months): Design and implementation of the crisis hub, the crisis stabilization unit, and the crisis residential continuum

1. Space planning and acquisition. Given that the crisis hub ultimately requires a centralized multiservice center location, early space planning, design, and acquisition will be a critical component. Given that we already have information about expected space needs for PES and OBS, and we can create some hypotheses for the crisis hub, the biggest consideration for space is the anticipated capacity for a crisis stabilization unit. Some initial design work in this area has already been initiated by emergency services medical leadership.

2. Strong recommendation: Crisis stabilization unit plan. The vision of the crisis stabilization unit is as follows: It is intended to serve as a diversion / step-down (from TSH, OBS, and inpatient), with a LOS ranging from one to 30 days for the acute psychiatry component and somewhat longer for the competency restoration component, and an average LOS of 10-14 days and 21-30 days, respectively. The unit would be secure. The goal of the S-CSU would be to initially replace a portion of the current acute capacity and competency restoration capacity at TSH (in the data analysis section, we estimated around 135 acute care cases per day with LOS under 21 days). Over time, further S-CSU expansion could potentially replace more TSH acute capacity.

For illustration purposes, if an initial target of 64 beds is set, this could be divided into two units (or four half units of 16 each in order to avoid categorization as an IMD). One unit (or pair of half units), for shorter stays, could be designed primarily for generic psychiatric and co-occurring SUD disorder programming, and the other unit (or pair of half units) could have a major focus on competency restoration, as well as psychiatric and SUD programming. All units would have mall-based programming that would allow attendance by individuals occupying S-CSU beds, as well as by individuals that have stepped down to community-based housing (see below) but are continuing in programming. The unit cost of operating this program is estimated at $300 per day, which is comparable to the unit cost at Terrell State Hospital. If we assume 83% occupancy (50/60), the daily cost would be $15,000 per day (at $300 per day), or approximately $5.5 million per year. Higher occupancy would result in costs closer to $6 million.
3. **Funding plan for the crisis hub (not PES, OBS, S-CSU).** An essential aspect of the design of the crisis hub is using a lower cost crisis team to respond to individuals and families who present in crisis. One of the national trends, as well, is increasing utilization of trained peer support specialists in the crisis evaluation and intervention process. If we hypothesize a team of one master’s level clinician ($25 per hour), one case manager ($20 per hour), and one peer support specialist ($15 per hour), with nursing (RN) ($45 per hour) and psychiatric (MD) back up ($150 per hour), and we hypothesize that each case will average two hours, then in one eight-hour shift the team could see 12 cases, for a cost of $960 (assuming two hours of MD backup and four hours RN backup for the shift), or approximately $80 per case. In addition, some crisis programs are incorporating peer support groups. One such program in California set up a twice weekly recovery group that anyone who had come to the crisis program could attend in an ongoing fashion. The group was co-led by an addiction counselor and a peer specialist. The group attracted 20-30 people per session, and unit cost was clearly quite low.

4. **Funding plan for the crisis stabilization unit.** Of course, one simple method for funding the S-CSU would be to simply allocate $6 million dollars of local funds. However, given current limited resources, that is not what we are recommending. The recommendation for funding the S-CSU is to develop a gradual process to shift part of the current TSH allocation of just over $35 million to be flexibly managed by NTBHA and its MCO (for NorthSTAR as a whole—we have estimated $26 million to be spent on Dallas County enrollees and $11.2 million spent on the 135 daily beds of acute capacity at TSH), and then to correspondingly reduce both TSH capacity and its associated funding allocation, so that all partners in this process come out ahead in terms of their clinical goals (TSH, DSHS, NorthSTAR and Dallas County). This approach is based on the fact that provision of acute-care backup for the NorthSTAR region is viewed by TSH as more of a burden than as part of its core mission. Similarly, competency restoration, while not a significant burden, is not regarded as part of their mission either. The most valuable component of what TSH has to offer is a significant strength and interest in performing long-term psychiatric rehabilitation, and TSH has both experience and interest in utilizing models such as the Fairweather Lodge for selected populations who require this kind of extended rehabilitation programming. If a plan were developed to allow TSH to completely shut down one of its two acute units and one of its two competency restoration units, and eliminate all the associated costs, including overhead, and retain 10% of that for development of rehabilitation programming (for example, $600,000), then not only would TSH come out ahead, but 90% of the funding (for example, $5.4 million) could be available to be managed in the community to support S-CSU development. ValueOptions has expressed interest in this opportunity should it become available, and clearly has expertise in this area. What is more, shifting from an IMD setting
like TSH to a community setting would allow additional federal Medicaid funds to be leveraged. If this TSH funding were combined with, for example, space or other resources provided by the Hospital District (as has occurred in Tarrant County) or other local sources, then this would be a significant contribution toward start up and development of the S-CSU. Further, TSH staff on the units that are being closed could be provided the option of being detailed or transferred to work at the S-CSU under the auspices of a community provider. Note that Green Oaks has expressed interest in partnering to operate this kind of facility, and clearly has relevant experience.

5. **Developing a crisis residential continuum.** The current Dallas County system has an excellent network of high-end crisis services, and a very capable network of SPNs and SUD service providers for providing continuing rehabilitative care. However, as we have been pointing out, there is a dearth of intermediate crisis services and rehabilitative services, including housing support, so that the “middle” of the continuum has a lot of gaps. It is possible, and recommended, to use the development of a cost-effective crisis continuum to leverage resources for expansion on a range of intermediate services that can be flexibly available to individuals passing through the crisis hub. This is also consistent with one of the key recommendations of the DSHS Continuity of Care Task Force Report, released in August 2010.

   a. **Crisis Residential Beds.** We have already mentioned the opportunity to increase utilization and ideally expand capacity of crisis residential beds (with a co-occurring SUD and MH focus).

   b. **Crisis Transitional Housing.** Another under-resourced element of the continuum is the Crisis Transitional Housing program operated by LifeNet.

   c. **Supported Sober Living.** Another step in the continuum is to leverage the development of supported sober living beds as part of the crisis continuum. It would greatly facilitate movement through higher levels of care more quickly if sober living, associated (clinically and geographically) with continuity of case management and with MH, SUD, and competency restoration programming, were readily available as part of the continuum. One method of doing this is to offer to pay sober living providers a day rate (such as $25) to make these sober living beds available to individuals in the crisis continuum for up to 30 or 60 days. (Note that the day rate cited is more than the usual daily cost of the bed, thus creating a small incentive to develop this capacity.) Following this time, the individual could remain in the sober living situation at the usual rate, or transition to live elsewhere. This process not only expands the crisis continuum, it provides incentives for willing providers who wish to partner with the system to be able to generally expand sober living capacity.
6. **Putting it all together.** One method for understanding how the crisis continuum would operate, both clinically and financially, is to look at the following scenario.

A 45-year-old man with schizoaffective disorder, alcohol dependence and cocaine dependence, who is homeless, is observed behaving strangely in the street, possibly due to being off his medication, possibly due to using drugs. A police officer picks him up. He is confused and a bit agitated, but not violent. The police officer decides not to arrest him or put him on a hold, but offers instead to take him to the welcome center. He’s heard he can get something to eat there, and that the people are nice, so he agrees to go. He is dropped off at the welcome center, and met by a peer support specialist who gets him something to eat, and engages him in a conversation. He is rambling and confused, but is able to stay calm. He is given a little bit of medication, calms down and agrees to stay in the S-CSU for a few days. By the second day, he is much clearer, and is transferred for five days to a crisis residential bed, where he is reconnected to addiction recovery, then to a sober living bed, which he is willing to give a try. His benefits are evaluated and restarted. His peer support specialist from the welcome center has maintained contact and connected him with other people from APAA who come to visit him. He is connected to the crisis hub for continuing visits for a week and then is able to get reconnected to his SPN provider, with which he had lost contact four months earlier.

*Total cost of five weeks of care: $100 for the crisis evaluation, $600 for S-CSU, $1,250 for CRU, $750 for a month of sober living, and $100 for additional crisis follow up: $2,050. NO arrest, booking, PES, or OBS. If he had PES plus OBS, plus one day of inpatient care, this would be approximately the same cost for only three days of care, with a much poorer outcome, and likely he would be back on the street “refusing” services.*
Step 7: Recovery-Oriented, Integrated System of Care for Adults with Serious Mental Illness

Background

The overall vision espoused in this section is the design of the system of care to be both recovery-oriented and integrated. Integration refers to the capacity of the system to address individuals with co-occurring MH, SUD and health issues (and other complex needs, including culture and language) in an integrated fashion within base resources across the whole system, on the assumption that “co-occurring is an expectation, not an exception.” The specifics of integrated system development will be addressed in other sections of this report. The section on the addiction system (Step 8) will address the integration of SUD and MH services; the section on the primary health system (Step 5) addressed the integration of behavioral health and primary health care.

The recommendations in this section are focused on adults. However, much of the discussion of the role of the SPNs applies equally to children’s services, which will be discussed more comprehensively in Step 11.

The recommendations in this section, as in the others, are organized according to phases of implementation, and with the assumption that the Dallas County BHLT (and representatives of the BHLT working in partnership with NTBHA, DSHS, and other counties in the NorthSTAR region) will be empowered and responsible for overseeing the implementation process. The recommendations in this section are based on a series of findings in our study, as well as some hypotheses derived from these findings, listed below.

Findings:

Finding 1: The Dallas County SPN network represents an array of committed and flexible providers who have the capacity and interest to develop a high-quality, recovery-oriented continuum of care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Metrocare, ADAPT, LifeNet, ABC, Child and Family Guidance Center, Centro de Mi Salud, and other smaller Dallas area SPNs have committed organizational, clinical, and medical leadership that is dedicated to working with very severely ill individuals and families. They are creative and flexible organizations, and increasingly have been working as partners rather than competitors within the NorthSTAR system. Each organization has developed some creative and effective programs, such as Afterhours Clinic (Metrocare), Crisis Transitional Housing (LifeNet), peer support services at Metrocare, LifeNet, ABC, and other centers, including peer training in Wellness Recovery Action Plans/WRAP, peer-led groups on co-occurring issues, and other consumer-driven approaches to illness management and recovery.
Finding 2: Currently, the SPN providers are stretched very thin, and their capacity to deliver high-quality, recovery-oriented services suffers as a result. Although many clients get excellent services and are satisfied with their service providers, there are many problems in the way the system functions to meet the needs of adults with serious psychiatric disabilities. People who present for appointments at SPNs have long wait times; case managers and other service providers have very high case loads; the SPN may not be able to provide the full array of rehabilitative services even if available; and individuals who start missing appointments can easily fall through the cracks. In our interviews with 24 adult consumers at Metrocare Services and LifeNet clinics, we asked, “In what ways would you like to see services improved?” The most frequent theme among the 10 major themes recorded in the interviews was “quicker access to services/shorter waiting times.” It was reported in other interviews that some case managers have caseloads of 200 consumers.

Finding 3: Obviously, some of these shortfalls in service can be attributed to limited resources, but we also found that some of them result from a system design in which those limited resources are not being used smartly overall. The SPNs have a range of responsibilities including next-day crisis intervention for new clients coming from PES, ongoing rehabilitative services in a variety of service packages (including ACT) for individuals with SMI, and provision of services (including psychopharmacology services) to a large number of individuals with lower levels of need in the spirit of an “open access” system. It would be hard to discharge all of these functions if well-resourced, but it is even more so when resources are limited.

Finding 4: This problem has worsened overall in recent months as a result of the change to case rate payment, and may be resulting in increasing crisis utilization in the system. Although the SPNs are benefitting from some relief of administrative burden for service authorization and increased flexibility in their own resource utilization to meet consumer needs, they generally report having less money than they did previously, without any change in their overall responsibilities within the system. Each SPN is making significant adjustments to their service model in order to survive, though there is no collective table to determine how the service delivery process should be developed as an overall system. Specifically, the case rate encourages SPNs to serve consumers at least once a month, but not necessarily to individualize and titrate care based on presenting clinical/recovery needs. It also provides an incentive to hold on to lower need cases to “balance out” higher cost care. In addition, while SPNs have had a variety of responses to the case rate approach, with some not too unhappy about it, others reported in interviews that they are considering dropping some of their services (for example, housing support services for individuals with SMI who were recently homeless) because

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4 Interviews conducted with consumers at LifeNet and Metrocare Services outpatient clinics, May 2010.
reimbursement rates had been driven so low. Further, the design of the case rate itself is focused on utilization reduction, and the incentives in the case rate are misaligned with a broader system vision of helping the SPNs to improve recovery outcomes for the most challenging individuals who need ongoing care, as described previously in the Data and Policy Analysis section. This is another example of a situation in which there was lack of system oversight capacity to negotiate appropriately with the MCO when the case rate was set, as well as a lack of a mechanism such as the BHLT for broadly leveraging system resources to address the problem (as opposed to viewing this as a “NorthSTAR only” problem that could only be addressed through NorthSTAR resources and leadership).

Recommendations

An important thrust of our recommendations is for Dallas County BHLT (and other NTBHA counties and NorthSTAR as a whole) to make a strategic commitment to reorganize the system in order to improve the capacity of the SPNs to help individuals with serious psychiatric disabilities (and co-occurring SUD and health conditions) to become more easily connected to long-term recovery support and rehabilitative services, to be less likely to disconnect from ongoing services when having a hard time, and to be more likely to be empowered to achieve happy, hopeful, and productive recovery goals (and to “graduate” from the SPN service system when appropriate).

This recommendation is directly connected to other recommendations, as follows:

1. **If Dallas County builds a welcoming, crisis safety net (as described previously in Step 6), the SPNs will have less pressure to welcome and engage new clients (as opposed to already engaged clients) right out of crisis.** There will be more time (weeks) for these individuals to be engaged in crisis support interventions within a crisis continuum of care, prior to warm handoff to the SPN continuing care service packages. (Note that some of the components of the expanded crisis continuum may be provided by SPNs, but with resources that are redirected from acute care expenditures for the “Top 200.”) This will in turn lead to the current SPN resources being less stretched in accommodating front-door crisis response.

2. **If Dallas County is able to re-direct a significant volume of lower severity clients to primary health settings (at lower cost than serving them in the SPN system, as described in Step 5), then the current SPN resources would have more capacity to provide engagement, rehabilitation and recovery to individuals with more severe disabilities (service packages 2 [to a certain extent], 3, and 4).** Currently, over two-thirds of adult clients are authorized for care in Service Package 1 (see the Data and Policy Analysis section
for more details), and the majority of them are served in the SPNs,\(^5\) so there is a lot of opportunity for progress in this area.

**Phase One (1 to 12 months): Getting started in making the shift**

1. **Articulate the vision and identify an implementation team.** This could occur through the BHLT and its Clinical Operations Teams, or through another working group reporting to the BHLT.

2. **Re-align performance indicators to become more client-driven.** By putting the stories of real people receiving services in the conversation, the implementation team can start to shift from performance indicators that are primarily keyed to volume and finance (how many people were seen for how few dollars) to indicators that emphasize the importance of identifying, engaging, and improving the lives of the most high-risk individuals. **Every person at risk is a priority to remain engaged.** In short, seeing three new low-severity cases at the expense of losing track of someone who will wind up in PES, jail, or on the streets would be misaligned with the strategic direction of this vision.

3. **Begin to work on realigning the incentives in the case rate to support the vision.**

4. **Set up mechanisms for identifying and tracking (across the whole system, including crisis outreach) every high-risk person who starts to slip, well before that person is in PES or jail.** Other aspects of tracking include prioritizing SPN access for those with more complex needs; reviewing who may be mismatched in their service package; and identifying who might need ACT (for example) who is not receiving it, as part of the Clinical Operations Team function. The goal is to shift these processes away from being performed by ValueOptions only, and into a more collaborative system delivery oversight and improvement process for adults with higher-level recovery and rehabilitation needs.

5. **Organize all potential peer support resources and start to plan how to increase access to peer counseling and other paraprofessional counseling and recovery support services (for example, Wellness Recovery Action Planning).** There is a growing array of peer support services that are available within the SPNs and from advocacy and peer-led organizations. Metrocare Services is participating in the state-level effort (through the State Mental Health Transformation Grant) to train certified peer counselors and specialists. ABC Behavioral Health also is hiring consumers, including one full-time, to lead groups and to provide other peer support services. LifeNet also has hired peers to help people navigate the clinic system and to facilitate communication between consumers and providers. Outside of the SPNs,

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there are numerous peer-led mutual support groups and illness management training opportunities, both in MH and in addictions. ValueOptions long has recognized the potential value of peer supports and locally has formally contracted with a national model peer-led organization, Association of Persons Affected by Addictions (APAA), to provide peer services to peoples with SUD. We have seen in the past few months that the peer community outside of the SPNs (but with some participation from SPN peer representatives) has come together to discuss the possibility of organizing for positive system change and for systematically supporting each other’s organizations and services. Nevertheless, although data is still incomplete, our analysis suggests that the full potential and reach of peer support in the Dallas area has not yet been realized, both in terms of numbers of consumers served and in terms of cost savings to the system.

6. All SPNs begin to share creative models for improving the delivery of recovery-based support, maintaining engagement, reducing wait times, improving responses to those who are too unstable to wait, and so on, with input from other creative minds on the operations team.

7. Increase Medicaid or Medicare penetration in the high-need adult population, with appropriate incentives, to the extent possible given Texas’s extremely restrictive financial eligibility limits. Note also that this population will have much broader Medicaid penetration by 2014, and this should be part of longer-range planning.

8. Improve the functioning of the formulary management system to reduce inefficiency in the use of physician time. This is one task that can be assigned to the Psychiatrist Leadership Group.

9. Align with other improvement areas (crisis response, criminal justice, primary health, SUD service integration, and housing/employment).

Phase Two (12 to 24 months): More detailed and longer-term implementation activities

1. Begin to articulate performance indicators that reflect incentives for closer monitoring, fewer dropouts, and measurable progress in recovery goals for individuals in higher service packages. TRAG scores, as currently designed, do not provide a sufficiently sensitive and detailed set of indicators for what Dallas would require to truly oversee this shift in system performance. Step 3 provides many ideas to promote these activities.

2. Leverage training resources (psychiatric residency, etc.) to provide more trainees in community-based settings, and to provide training in provision of therapeutic services and recovery-oriented rehabilitative services to individuals with serious psychiatric disabilities. Parkland and UTSW have significant potential to create (expand) very attractive
residency training opportunities in this regard, and there are many residents who would be interested in such placements.

3. **Clarify training and certification, scopes of practice, and reimbursement methodologies for peer support specialists and other clinical “extenders” working in SPNs as part of the clinical teams.** Nationwide, peer support specialists are increasingly functioning as recovery counselors in systems that are more cost-effective in engaging individuals with very serious psychiatric difficulties. Some systems (for example, New Mexico) have utilized trained peer support personnel to enhance the success of medication algorithm activities. This is being done to some degree already at Metrocare (and possibly other SPNs) through peer-to-peer TIMA training, but it would be worthwhile to build such peer support more systematically into the NorthSTAR system and to incentivize the MCO to support it.

4. **Collectively define and articulate recommended best practice funding models and program design models for SP2 and SP3 services.** Underfunding recovery based services for high need individuals has a price: the corresponding increased likelihood of re-entry into PES, jail, homelessness, and decreased likelihood that the client will graduate into a less specialized treatment setting. For example, a 2006 study of ACT teams in Multnomah County, OR (Portland) serving homeless adults with co-occurring SMI and SUD conditions found that ACT services cost just under $10,000 per year, but that they saved $16,299 per client per year in total utilization costs, including inpatient physical health hospitalization, emergency room visits, mental health inpatient nights, alcohol and drug inpatient nights, and incarceration days.⁶

5. **Develop a plan for formally implementing family psycho-education and illness management, and recovery Evidence Based Practice (EBP) interventions, in each SPN.**

6. **Plan to incorporate these system shifts (new definitions, best practice standards, performance indicators, case rate methodologies for SPNs, and financial incentives for the MCO) into the MCO re-contracting process for 2012.** This coincides with the timeline provided in other recommendations.

7. **Position the system to apply for SAMHSA and foundation grants that are connected to supporting recovery-oriented systems of care, peer support, and recovery services like supported employment, etc.** Note that there were resources available through the state

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⁶ Moore, T.L. (2006, May). *Estimated cost savings following enrollment in the community engagement program: Findings from a pilot study of homeless dually diagnosed adults.* Portland, OR: Central City Concern. This study is typical among many other similar studies. TriWest’s own evaluation of an Integrated Dual Disorders Treatment program in Decatur, Illinois found very similar findings over the course of a three-year demonstration program with a very similar population.
Transformation Grant that Dallas was unable to fully access. It is important to be prepared for additional resources going forward.
Step 8:  
**Recovery-Oriented, Integrated Continuum of Services for People with Substance Use and Co-occurring Disorders**

**Background**

This section addresses Step 8: developing a recovery-oriented, integrated continuum of services for adults and adolescents with SUD. There are actually two components to this section. One component relates specifically to developing a recovery-oriented continuum of services for individuals with SUD, particularly those without SMI; that is, a continuum of services for individuals who generally would not be appropriately engaged in a program for people with psychiatric disabilities. The second component relates to designing an “integrated system of care” in which individuals with co-occurring SUD and MH conditions receive appropriately matched integrated services, within base resources, in all service settings. These two components are complementary.

The recommendations in this section, as in the others, are organized according to phases of implementation, and with the assumption that the Dallas Count BHLT (and representatives of the BHLT working in partnership with NTBHA, DSHS, and other counties in the NorthSTAR region) will be empowered and responsible for overseeing the implementation process.

The recommendations in this section are based on a series of findings in our study, as well as some hypotheses derived from these findings, listed below.

**Findings**

**Finding 1: The Dallas County system currently has approximately $20 million specifically allocated to the provision of substance abuse services.** Funding for the provision of substance abuse services has been difficult to quantify given the lack of data on allocations beyond NorthSTAR. However, based on information reported to us in interviews from various sources, we estimate that this funding includes about $7.5 million of the $10.2 million overall federal substance abuse treatment block grant allocation to NorthSTAR, reportedly about $6 million of TDCJ funds in local programs, at least $1 million in estimated juvenile justice funds for community and residential services, a reported $1 million from the City of Dallas, and $3 to $4 million more reportedly through a variety of federal and state grants (for example, Homeward Bound, APAA for peer support, a state funded women’s program for Nexus, plus NIDA funds). In addition, there is a statewide Medicaid benefit for substance abuse services that will be implemented beginning in September 2010, the effect of which will have to be monitored over time.

**Finding 2: Although it is typical for county systems across the country to have a local authority specifically for managing substance abuse treatment and prevention dollars, there**
is no such locus of planning and oversight in NTBHA, ValueOptions, or Dallas County. Consequently, there is no mechanism for planning and implementing evidence-based services and system design for substance abuse services, nor for defining appropriate performance indicators and overseeing performance and outcomes with sufficient sensitivity. In particular, beyond the simple performance measure reported to DSHS on treatment continuity and aftercare, it has been difficult for us even to obtain data on how the specific substance abuse dollars allocated to NorthSTAR have been spent, and to determine the level of penetration of those dollars related to likely need, compared to other systems, and so on.

**Finding 3:** There are impressive substance abuse providers and programs in Dallas (Homeward Bound, Nexus, ADAPT, Turtle Creek, Phoenix House, etc.) that we have visited. In addition, SPN services include a substance abuse treatment component that appears to be exclusively directed at SPN clients with SMI. Also, a substantial amount of services for individuals with SUD is provided at The Bridge. However, the total volume of services and providers is small for a system this size, and even more so relative to the need of individuals with SUD who do NOT have SMI. As an example, in the NorthSTAR region approximately 2,100 adults and 300 youth were admitted to residential substance abuse treatment (excluding detox) in the past year under NorthSTAR (not including criminal justice admissions to Wilmer programs.) Estimating that 80% of this population is allocated to Dallas County, 1,680 adults and 240 youth out of a county of over three million people, would have received residential substance abuse treatment. This is much lower than the estimated levels of need of over 50,000 persons under 200% FPL with severe SUD in Dallas County.

**Finding 4:** In some arenas, ValueOptions has been a very helpful partner in supporting substance abuse services, in particular in paying for medication for individuals served at Wilmer, allocating TCOOMMI funds for the ADAPT dual diagnosis program there, and supporting the creation of the Crisis Residential Program (CRP) embedded in the Detox program at Homeward Bound. However, there is no system-wide design and implementation process, and the CRP, as noted earlier, is underutilized. Homeless individuals with severe SUD at the Bridge, particularly those without a severe and persistent mental illness (SPMI), do not have ready access to detox or residential treatment.

**Finding 5:** All SUD service providers we interviewed described frustration with the utilization management process for substance abuse services: inappropriate denials for residential care, frustration with continued stay reviews and lack of a helpful appeal process, difficulties with the recent changes in access to supportive outpatient treatment (necessitating going through prior intensive outpatient [IOP] treatment), difficulties with continuity of recovery support for individuals with complex needs, and so on. Further, the data documenting continuity of substance use services in NorthSTAR for 90 days or longer (considered the minimum recommended length of care) suggests that less than 20% of clients are in service this long.
Further, although Homeward Bound is participating in a small case rate program with ValueOptions, in general there is no current planning for creative and flexible funding models (like case rates) for substance abuse services that might encourage the development of a more recovery-oriented continuum of services. This approach would be in line with the Recovery-Oriented System of Care (ROSC) model that is being examined in Texas by DSHS (Texas Recovery Initiative) and even more extensively implemented in other states.

**Finding 6:** Dallas County has a peer support program for addiction (APAA) that is a nationally-recognized model program, which has just received an award from SAMHSA. This program is also participating with DSHS in the Texas Recovery Initiative. APAA is providing a reasonably high number of service units per client and appears to be an efficient mechanism for outreach and continuity of care. However, it is significantly under-positioned as part of the system design process in Dallas.

**Finding 7:** Availability of sober housing options is a critical element of a recovery-oriented continuum of care for individuals with addictions. There are sober housing options in Dallas, but they mostly exist independently of the organized delivery system. There is no strategic planning process to increase the total volume of sober living beds, attract resources to jump-start sober homes, and to provide appropriate supports and connections so that sober living environments are more closely embedded in the treatment continuum so that they can be helpful to individuals with more complex needs.

**Finding 8:** Individuals with co-occurring MH and SUD are an expectation in this system and are overrepresented among high utilizers of PES, jail, and homeless services. Although there are a limited number of specialized programs for these individuals, the service system itself is not leveraging all of its resources to provide better integrated services for these individuals so that they have better outcomes and lower costs over time.

**Finding 9:** There is a perception that the system is “integrated” because ValueOptions manages both MH and SA funding streams. However, our finding is that at the functional and service provision levels, integration of services is less than what it should be. For example, Parkland historically has had limited to no capacity to address substance use disorders beyond PES, though this issue is already being addressed as part of this change process. In addition, there is inconsistency among SPNs and inpatient units in regard to how well-organized they are to deliver integrated services. The Bridge has the potential to expand substance abuse service capacity beyond what is currently present, for example. Note that, in an integrated system, integration is not defined by the capacity to blend funding so much as by the capacity to organize integrated planning to meet the needs of the whole population, and to deliver integrated services within any funding stream and service setting appropriately matched to the
needs of the population. Dallas County (and NorthSTAR) does not have those development and improvement processes in place.

**Finding 10:** The NorthSTAR system has noticeably poor data on the prevalence of co-occurring MH and SUD in the population served. The reported prevalence among persons served is 24%, based on individuals accessing two types of services. This is less than half of the expected prevalence in this population. The rate is 42.5% among the “Top 200,” based on the number receiving SUD services at any level (and this, too, is likely a low estimate). Nationally, under-recognition of the population is a marker for insufficient attention to the delivery of integrated services, and is associated with poorer outcomes and higher costs.

**Finding 11:** Texas DSHS has created a program standard for all programs to be “co-occurring-disorder-capable,” and NorthSTAR is contractually required to oversee the improvement of programs’ ability to function in relation to that standard. However, no such process is in place. Nationally, many state and local systems are engaged in improvement processes within very limited resources to ensure that all programs are making measurable progress (as a performance improvement process) toward achieving co-occurring capability. A partial list of states that are involved in this includes Maine, Vermont, Michigan, Florida, South Dakota, Iowa, Montana, Alaska, and Virginia. Many other large county systems in the country are engaged in similar activities (Detroit, Miami, Oakland, Philadelphia, San Diego, Tampa, and others). ZiaPartners, Inc. provides consultation to many of these systems regarding how to implement this process within base resources using an evidence-based framework for system design called the Comprehensive Continuous Integrated System of Care (CCISC).

**Recommendations**

As in previous sections, the recommendations in this section are divided into phases. The first phase will begin immediately and extend over approximately 12 months. The second phase will focus on implementation activities that would go on line no earlier than two years from now, and probably longer. Note again that we are viewing the Dallas County BHLT, working in partnership with NTBHA and DSHS when appropriate, as the place where the design and implementation of the Dallas County crisis system will take place.

**Phase One: Beginning to plan and implement an integrated, recovery-oriented continuum of substance abuse services in Dallas County (and, potentially, in the NorthSTAR region)**

1. **Strong recommendation: Identify an empowered local (county or regional) substance abuse planning and oversight leadership team.** As with other elements of system oversight, this would be initially positioned under the Dallas County BHLT, but could evolve to have a regional presence. Part of the function of this team would be to unite substance abuse funders, providers, and advocates to create a vision and strategic plan for substance
abuse services; identify performance targets and oversight mechanisms for the MCO; coordinate data and resources; and plan for acquisition and leverage of additional resources from federal, state, and local sources.

2. **Define a consensus vision for building an integrated system with universal co-occurring capability in all Dallas County (and, potentially, NorthSTAR) programs, and identify early steps to make progress toward this vision.** This activity would initially occur under the purview of the BHLT. We would specifically recommend that the Dallas and/or NorthSTAR system of care utilize the CCISC approach to improve welcoming, engagement, and integration of services to individuals and families with co-occurring MH, SUD, and health conditions throughout the system. This approach creates a system-wide performance improvement process that can be supported in partnership by multiple funders to define step-by-step progress in improving identification, engagement, and outcomes for co-occurring clients within base resources (thus leading to improved system performance over all). This process is based on recognition that “co-occurring is an expectation” in all settings, and therefore integrated service delivery has to be universal. In Dallas, this is particularly important not only because of the high (yet under-recognized) prevalence of co-morbidity, but also because the individuals who are most likely to fall through the cracks of existing services – and wind up in more expensive crisis settings – are those who are actively using substances and also have serious MH (and often physical health) conditions, and who are not yet interested in, or capable of, maintaining sobriety, adhering to appointments, living in abstinence-expected housing settings, etc. Improving system-wide capability to use EBPs to more successfully engage individuals with mental illnesses who are actively using substances has been shown to be cost-effective in reducing crisis utilization in 6-12 months. Within a CCISC process, every program and every person delivering care makes measurable progress to become more welcoming, recovery-oriented, and co-occurring capable, within base resources. Further, MH services build integrated capacity for individuals with SMI within base MH dollars, and substance use services build integrated capacity for individuals with severe addiction who are not MH priority clients. Each system uses its resources to support capacity-building in the other set of services, so that more people with high needs can be served in a single door.

3. **Define a consensus vision for the substance abuse services delivery system, specifically for the individuals who have serious addictions and commonly have co-occurring MH conditions that are not “priority diagnoses.”** Defining this vision would initially be delegated to the substance abuse planning and oversight leadership team. Establishing a vision would then permit the development of a strategic plan to achieve the vision, and to align that planning with the major changes in the substance abuse services delivery system.
nationally that are likely to emerge in the context of health care reform and the Recovery-Oriented System of Care (ROSC) movement.

**SUBSTANCE ABUSE SYSTEM VISION:** The national trend for designing substance abuse service delivery combines a broad public health vision (which is embedded into health care reform discussions and in position statements from the US Office of Drug Control Policy) with the concept of a Recovery-Oriented System of Care approach, which shifts the design of treatment services for people with more serious SUD (for example, substance dependence or addiction)—who usually have complex co-occurring health, mental health, trauma-related, cognitive, criminal justice, parenting, housing, financial, and disability problems—away from an “acute model” of service delivery (a single treatment episode followed by time-limited aftercare with the expectation of long-term sobriety following a single episode) to a “recovery-oriented chronic disease management” approach, where front-loaded services are shifted toward continuity of care, including an emphasis on recovery coaching and peer recovery support. The components of this approach in Dallas would include the following:

a. **Building capacity for prevention, screening and brief intervention (SBIRT) for substance abuse into all possible service delivery sites and resources, particularly public health settings.** In Dallas, this would mean working with public health partners like Parkland (and primary health Medicaid) to expand SBIRT services as widely as possible as base system capacity. Notably, Parkland has already identified this activity as a strategic priority to initiate in the coming year.

b. **Facilitating engagement and entry into service at the appropriate level of care for all individuals who have more serious SUD.** This includes easy access to low-threshold substance outpatient (SOP) treatment or access to peer outreach and support, including access for those who are not yet committed to abstinence but who are interested in harm reduction. It also includes easy access to brief residential stabilization for individuals who will not succeed in lower levels of care.

c. **Facilitating development of resources to build capacity for a continuum of integrated, co-occurring capable substance abuse services at The Bridge (and at any other setting which is a major engagement site for high-need individuals).** Within the medical and MH capacity at The Bridge lies the potential to focus on the fact that SUD conditions are an expectation, and that individuals need access to medical evaluation to support outpatient detoxification, stage-matched motivational interventions for individuals and groups, various levels of active treatment, and ongoing recovery coaching and peer support.

d. **Designing a cost-effective continuum of recovery-oriented and co-occurring-capable services for high-risk individuals (that does not require that they get arrested in order**
to get served). Elements of this continuum include brief stabilization for detox and residential support, with the opportunity to have continuity of IOP, SOP and peer support available as individuals move through the continuum. A key element would be the opportunity to transition to low-cost sober living environments that are proximate to IOP and SOP services, so that individuals can have a safe place to live and ease of transportation while participating in services that include recovery coaching, at the lowest possible cost. Primary health partnerships may facilitate access to continuing medications. The goal would be to increase the percentage of individuals with severe addiction who engage in continuing services without adverse outcomes for a period of 90 days or more.

4. **Improve clinical and financial data tracking.** This activity may emerge from the Clinical Operations Team work. As noted, due to a lack of data provided to our study, it has been impossible for us to track continuity of NorthSTAR clients who attempt to enter substance use services and either do not get in or drop out, as well as track NorthSTAR substance abuse specific resources (e.g., where they are spent, who is being served with those resources). TDCJ community corrections dollars (managed by CATS) are more transparent. It would be helpful to be able to identify more specifically which clients are having poor outcomes and high costs – not just substance abuse costs, but any human service costs – and then target resources to plan how to more effectively engage those individuals.

5. **An early performance-improvement target in integrated system development is to increase the recognition of the population with SUD in the MIS system so it is closer to the expected population prevalence.** In some systems that have done this, just increasing organized identification of the population resulted in improved clinical outcomes, such as reduction of morbidity and mortality.

6. **Provide support for using limited resources for capacity-building activities in primary health and homeless settings.** The goal is NOT to pay for services, but to use funding to leverage improved service delivery through increased access to consultation, available best-practice interventions that can be incorporated into base practice, and general workforce development activities.

7. **Establish a collaborative process for improving utilization management (UM) of substance use dollars that involves providers and peer advocates.** As noted above, we were provided many specific examples of individuals that were denied access to higher-end services, with immediate and obvious poor results. Equally striking is the apparent lack of an effective appeal process. Finally, there is no clear mechanism of higher order review of the UM process itself, so that providers, funders, and the MCO decide collectively whether the UM
process and criteria need to be changed, and then collectively monitor how the change is working in a quality improvement partnership.

8. **Leverage expansion of sober living environments (SLE) and partnership with SLE providers.** The target in the first year should be to identify at least one partner and negotiate startup of one new site. There are models from other managed care systems in which MCO funds have been used to stimulate expansion of sober living environments in partnership with reputable sober living providers who are willing to work collaboratively to engage high-need individuals. One such example occurred in Massachusetts in the 1990’s with a provider called “Twelve Step of New England.” Steps include identifying SLE providers or treatment providers who are committed to quality, are potential partners, and provide clinical support (easy access to consultation, crisis backup, etc.); financial incentives to develop new sober living environments in strategic locations near provider services; and creating a shared commitment to prioritize access to those beds to individuals moving through the treatment continuum, possibly including financial incentives as described below.

9. **Pilot case rate reimbursement for high-need (but not SPMI) addicted clients, and begin to work on adjusting the case rate to make it a successful model.** The goal is to create a rate that would cover all substance use disorder services for a period of three or six months, with the provider having flexibility to offer whatever level of services make sense without additional authorizations, but remaining at risk for care should the client relapse and need higher levels of care. One way to start is to look at the typical 90-day service utilization pattern for a client authorized currently for 14 days of residential, and then use some approximation of that amount as the starting place for case rate payment. That way, the provider is incentivized to reduce residential stay and to leverage access to sober living beds instead, as well as to provide continuing engagement and peer support.

**Phase Two (12 to 36 months): Deepening the implementation of an integrated system of care and a recovery-oriented substance abuse services delivery system**

1. **Integrated system development.** By Year Two of this process, all programs should have CQI plans that demonstrate measurable progress in integrated service delivery and in integrated staff competency. In addition, performance indicators for supporting this process would be included in contract language for the MCO. Finally, as part of building an integrated system, we would recommend identifying front-line clinicians and consumers from all programs who would become “change agents” in the system, and have them begin to form an empowered, boundary spanning, and integrated team that provides tighter connections between services, as well as informing policy development from the front line level.
2. **Developing a substance abuse continuum.** By Year Two of this process, there should be an organized plan for implementing the vision, including shared data and clinical tracking across multiple funders of SUD services, development of client-centered UM criteria, and expansion of access to sober living environments that are partnered with a treatment continuum. In addition, selected performance indicators related to this type of strategic development would be incorporated into contracting with and monitoring of the MCO. Performance indicators should be connected to improving accountability of SUD specific dollars, increased volume of SUD services in primary health settings, increased engagement of and penetration of SUD services for non-SPMI clients with severe SUD, improving service continuity and reducing criminal justice outcomes for individuals who have had contact with SUD services, and expansion of the volume of clients participating in continuing peer support activities.

3. **Expansion of funding.** Individual providers in the system have been quite successful in obtaining grants. However, there is no strategic planning effort to collectively expand SUD funding. We would recommend that this be developed as part of the substance abuse leadership group. SAMHSA Targeted Capacity Expansion grants, particularly focused on primary care integration and expansion of homeless services, would be reasonable priorities. If the SUD service system were able to present itself as an organized collaborative, grant-writing activities would have a high likelihood of success in a community like Dallas.
Step 9:
Criminal Justice/Behavioral Health Service System for Adults

Background

This section addresses a powerful opportunity to create a more fully coordinated system approach between all aspects of the adult criminal justice (CJ) and behavioral health (BH) systems in Dallas County. This approach would better address every aspect of client flow, including reducing the risk of CJ involvement, and, once CJ system involvement occurs, increasing both pre-booking and post-booking diversion, reducing the frequency and length of incarceration, increasing service delivery options within the CJ system to facilitate successful re-entry and reduction of recidivism, and increasing the responsiveness of community-based services for BH clients with CJ involvement or risk.

As with almost every public BH system in the United States, Dallas County and the NorthSTAR regional service area are confronted with growing BH service needs within the CJ populations and a rapidly growing population of people who are in CJ settings as a consequence of unmet BH needs, as clearly documented in the data analysis section. Nationally, there is increasing recognition that many – probably the majority – of individuals with significant BH needs who are currently incarcerated could be more humanely, effectively, and economically served with treatment (particularly SUD treatment) in community-based settings. In fact, it is increasingly recognized that the criminalization of individuals with serious BH conditions is a national tragedy and a national disgrace.\(^1\) More and more local systems, including Dallas, are identifying resources to implement innovative programming for individuals with CJ involvement who have BH needs. In spite of these efforts, many large urban areas, including Dallas, recognize that the county jail and its related services have become the single biggest BH “program” in the county, and getting bigger all the time, as the onslaught of need outstrips the availability of resources to respond. Parkland’s jail BH services program served 19,389 people in CFY 2009, second only to the 25,535 served by Metrocare Services, and the BH population in the jail grew in the last six months of CFY 2010 at a rate more than double the average rate of that time period in the previous two years. The critical need to respond to this onslaught is reflected in NTBHA’s past (2008-10) and future (2010-12) strategic planning, and in its prioritization of relatively limited resources available for CJ diversion.

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Nonetheless, as we will illustrate below, Dallas County is, perhaps surprisingly, in a position to make remarkable progress. The unique array of services already present in the Dallas County adult CJ system can provide a foundation for an even greater capacity to “de-criminalize” behavior related to mental illness and substance use disorders in Dallas County, and produce better and more cost-effective outcomes by increasing the relative commitment of resources to treatment interventions in lieu of incarceration.

The recommendations in this section, as in the others, are organized according to phases of implementation, and with the assumption that the Dallas County BHLT (and representatives of the BHLT working in partnership with DSHS, NTBHA, and other counties in the NorthSTAR region) will be empowered and responsible for overseeing the implementation process. With regard to the adult CJ system, the BHLT can build upon, and further empower, the existing collaborations and partnerships that have been so well-developed by Ron Stretcher and others within the jail.

The recommendations in this section are based on a series of findings in our study, as well as some hypotheses derived from these findings. These findings are listed below.

**Definition:** For ease of description, we will refer to the Dallas County Adult Criminal Justice system (Dallas CJ system) as encompassing all of the following activities: BH evaluation and treatment services within the jail (Parkland and CATS); three specialty court services; MH Public Defender services; pre-booking and post-booking diversion services; Crisis Intervention Training (CIT) for law enforcement; continuing treatment programs (TDCJ and TCOOMMI) at Wilmer and other sites; continuing treatment, monitoring, and case management services provided through CATS and NorthSTAR (via SPNs and other providers) to people with CJ involvement; outpatient competency restoration services (OCR); and competency restoration services provided through TSH.

**Findings**

**Finding 1: The Dallas CJ system has an impressive array of innovative programs with demonstrated success.**

Examples include: CIT training universally provided to law enforcement; protocols for rapid law enforcement drop-off at emergency services for people who present with acute behavioral risk; rapid screening and diversion at the “front door” of the jail with quick bail and return to the community; an impressively organized and committed MH Public Defender’s program that is a model program for the nation; very well-functioning BH specialty courts (including a transitional age youth court); universal in-jail evaluation by CATS to determine treatment needs through integrated Central Intake Health Screening, assessment and diagnostic evaluation; a demonstrably cost-effective continuum of co-occurring-capable and co-occurring-enhanced
treatment services at Wilmer (largely funded with TDCJ and TCOOMMI funds); a remarkable information sharing initiative (Jail Data Instant Messaging – JDIM – initiative) that provides real-time identification and linkage for existing SPN clients presenting in the jail; a truly impressive array of within-jail behavioral health services (ranging from acute inpatient to recovery-oriented programming) administered by Dr. Waseem Ahmed under the auspices of Parkland with a range of specialized units and treatment; medication management and group programming that includes Co-occurring Psychiatric and Substance Use Disorders (COPSD), Wellness Recovery Action Plan (WRAP), Anger Management, Way to Happiness, Dialectical Behavior Therapy (DBT), Grief and Loss, Think Again, Process Group, Stress Management, Healthy Relationships and Community Resources; new projects with consumer and family advocacy to prepare individuals and families to know how to respond in the case of a crisis; a burgeoning outpatient competency restoration program; partnership with The Bridge to facilitate diversion of homeless individuals; partnerships with substance abuse treatment programs for designated high risk populations (for example, pregnant women through Nexus, street workers through Homeward Bound, and others); facilitated linkages to SPNs for eligible people at risk; and an amazingly well-functioning collaboration meeting organized by Ron Stretcher and Shay Cathey at the county. The MH Public Defender and Diversion Court programs were recognized for their success and encouraged to expand by the recently released report by the Task Force on Indigent Defense.²

Finding 2: There are considerable dollars from multiple sources that are engaged in this section of the system.

As was detailed in the Data and Policy Analysis section, the Public Adult Correctional System accounts for a significant portion of BH funding resources. Parkland’s jail-based BH services are funded (by the County via Parkland) at $7.4 million; CSCD-CATS services are an estimated $5.0 million; TCOOMMI at $1.3 million; and BH-related Dallas County Jail bed use comes in at about $6.8 million. Based on available data and estimates of data that is not available to us, we estimate that approximately 10 to 15% of public funding for adult BH services is provided within the Adult CJ System, as we have defined it above. Over one-quarter of Parkland’s BH services are provided in the jail setting. In addition, there is a high percentage of community BH services provided through NorthSTAR to individuals with CJ involvement. Although we were unable to quantify this amount precisely, TRAG 2009 outcomes data indicated that 3,422 of adult NorthSTAR adult clients out of 6,506 (52.6%) had CJ Involvement assessments. This compares

to 42.3% statewide (14,442 out of 34,128). The volume of services and the volume of need are strikingly high.

The Dallas County Jail has an ongoing census of about 6,000 individuals, of whom approximately 75-80% are determined to have BH needs (mostly SUD). Note that it is difficult to extract data that clearly demonstrates how much criminal activity is primarily attributable to unmet BH conditions, but subjectively, by report of the people we interviewed, it appears to be very high. It is estimated that at least half, potentially more, of individuals who have a serious MH or substance abuse condition have a co-occurring condition of the other type. Within the jail itself, the Parkland jail BH (BH) service treats more than 19,000 unduplicated individuals annually. This is more than 30% of the total population served by NorthSTAR regionally. If we look only at the cost of behavioral health services provided, as opposed to all CJ related costs, this averages out to $400 per person served annually, theoretically “more efficient” than NorthSTAR. In addition, the services provided are actually very good. This type of data contributes to an apparent financial disincentive to increase community-based services in order to decriminalize the CJ behavioral health population. “We can provide good care more inexpensively in jail.” More discussion of this issue will take place below.

Finding 3: Nonetheless there are major areas of concern. One of the most pressing issues is the backlog of availability of Competency Restoration Services.

The numbers and wait times for individuals stuck in jail in need of competency restoration is increasing dramatically despite increased, though still limited, state resources for OCR. There is a backlog attempting to enter TSH, lack of access to CR services for those waiting behind, and a large population who cannot take advantage of OCR services because they do not have a safe and secure living situation with appropriate support.

Finding 4: The Community Corrections and Supervision Department’s CATS services are under-resourced relative to need and relative to other parts of the state.

In the past three years, key informants report that director Theresa May-Williams at CSCD has turned around the functioning of the CATS program to facilitate flow-through and to develop a better partnership with TDCJ to attract resources to Dallas. Nonetheless, resources per felon in Dallas are reportedly about a third of the resources per felon in Harris County, and there is

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3”Copy of TRAG scores and Number Served by LMHA and NorthSTAR 1_25_10 counts” Spreadsheet received from Value Options, May 6, 2010 (personal communication, Maria Martinez). These percentages were calculated by adding the number of people receiving TRAG scores on the Criminal Justice System Involvement dimension and dividing that number by the number who received Functioning TRAG scores. The assumption is that everyone receives a Functioning score, but only those who are engaged with criminal justice system issues receive Criminal Justice System Involvement scores.
constant work needed with the Dallas legislature to ensure that those funds do not go lower. TCOOMMI funding for three comparison urban counties (Bexar, Harris, and Tarrant) is 19% to 65% higher than Dallas per capita. In addition, CATS reports that the allocation of case management services through TCOOMMI funds by NorthSTAR is only 60% (supporting three as opposed to five case managers) of what was planned and promised by NTBHA. (We could not obtain ValueOptions data to confirm or deny this report.) Overall, resources to support continuity of care for community corrections clients are lower than what they could be. *Note: Carey Welebob of the Community Corrections Division of TDCJ has accumulated excellent data demonstrating that Community Corrections services save money in the CJ arena, data strong enough to lead to increases in TDCJ community corrections funding (which include treatment and monitoring services) in the last three legislative sessions.*

**Finding 5:** Individuals with SPMI who can be attached to SPNs will be engaged in services successfully, depending on the capacity of the SPN to respond.

This capacity is variable. Unfortunately, the status of individuals with high CJ risk being attached to continuing care services is not tracked, so that many (like individuals referred to SPNs from PES or OBS) fall through the cracks.

**Finding 6:** Individuals in the CJ system who do not meet SPMI eligibility criteria have a very hard time receiving community behavioral health services, including community-based substance abuse services.

This is particularly true for individuals who do not have Medicaid, which is the majority. Although there is a fairly good system of reconnecting released individuals to benefits, many individuals are not ever benefit-eligible given Texas’s extremely low poverty threshold for eligibility, or do not have the kind of evaluation that would establish benefit eligibility, and therefore receive no organized services. There is no mechanism to prioritize individuals who are at high risk for criminal recidivism, but who do NOT clearly meet SPMI eligibility criteria for community-based continuing care services.

**Finding 7:** Certain particularly high-risk populations have unique and persistent challenges that require being diverted to community services.

The vulnerability of these individuals in jail is of particular concern because of the risk of civil rights violations. These individuals include pregnant women and individuals with combinations of developmental disabilities and behavioral health issues.

**Finding 8:** Within the group of “concerned” clinicians, judges, and public defenders in the CJ system, there is a strong sense that many more people could be attached to diversion services (MHPD, CATS, specialty court) if the whole CJ system (Sheriff’s Office, District Attorney) were more effectively organized to prioritize diversion.
One of the main contributors to underutilized capacity is concern by judges and district attorneys about criminal risk for individuals released with what is perceived to be inadequate supervision. In addition, the defendants’ bar (other than MH Public Defender’s office) is reportedly not as familiar as they could be with the long-term benefit of diversion services for their clients. Treatment recommendations made by CATS (for continuing community services and supervision) may not be followed or adequately monitored in non-specialty courts. For many individuals, these processes lead to a cycle in which resources are absorbed in less efficient ways that keep people cycling through CJ services rather than connected to more cost-effective programming that will produce better long-term outcomes. **This area is one of the biggest targets for a longer-term improvement strategy.**

**Finding 9:** There are programmatic limitations that make it harder than necessary for individuals to be successful once they are in probation-managed community services.

The number of persons in the Dallas County Jail due to probation violations has risen over 16.5% from CFY2008 to CFY2010. Felony probation violations are also rising. The figure below shows the number of felony parole violations in Dallas County between September 2008 and April 2010.

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5 The number of felony parole violations over the course of 4-month periods was calculated for five periods between September, 2008 and April, 2009, from the spreadsheet, “DEWR monthly avgs 6 2010,” which was received from Ron Stretcher, June 24, 2010. It should be noted that the number of felony parole violations dropped in May, 2010 (the last month for which we have data) to 409 from 484 in April, 2010, indicating a potential reversal in the trend.
Programmatic limitations related to this increase include under-resourced SPNs that may not be able to provide the recommended service package, or difficulties remaining in continuing recovery support services for individuals with SUD. Other limitations include a lack of models for an organized response to individuals who use substances while on probation. Similar limitations make it difficult for individuals who may not be able to easily maintain sobriety (or even want to maintain sobriety) to acquire housing. Note that many communities are learning how to work very proactively with people who may use substances while on probation, but who do not “re-offend” with the original crime. This commonly occurs through specialty courts, but does not require a specialty court. Probation officers can partner with clinicians to help a person who is using to be engaged in supportive services that try to prevent re-offense, rather than immediately surrendering the client for a probation violation.

Finding 10: Although Parkland is working on being a good partner in Behavioral Health/Criminal Justice (BH/CJ) services, Parkland’s community-based health service system (and Parkland Plus) are not currently well-organized to be responsive to the needs of many individuals in the community-based BH/CJ system.

There are multiple shifts and dislocations reported by system stakeholders, including needs for registration and re-registration, in the handoff from jail-based to community-based BH services (as at Wilmer). Parkland’s proactive commitment to this population, particularly those who are not NorthSTAR eligible, needs to formally extend into facilitating community-based continuity of care, especially health and medication services, in order not to inadvertently undo the good services provided inside the jail.

Recommendations:

General Statement: Under the guidance of a comprehensive and representative body like the BHLT, the system can more effectively organize a response to the following facts:

- **Unmet BH need should be an expectation in people entering or returning to the CJ system.**

- **Criminal justice issues are an overwhelming and common indicator of high risk and poor outcomes in people who are receiving services in the BH system.**

There is much potential for building on the strength of Dallas County’s adult CJ system and pockets of excellence across community BH providers. It has been demonstrated by community corrections data that, if these needs are proactively and systematically met in the community, the utilization of expensive CJ resources is substantially reduced, and people experience less tragic disruption in the process of recovery. This can have a very large-scale impact in Dallas if appropriately positioned.
As in previous sections, the recommendations in this section are divided into phases. The first phase should begin immediately and extend over approximately 12 months. The second phase focuses on implementation activities that would go online no earlier than two years from now, and likely longer. Note again that we are viewing the Dallas County BHLT, working in partnership with NTBHA when appropriate, as the place wherein the design and implementation of the Dallas County CJ BH system will take place.

**Phase One: Empowering the locus of oversight of CJ behavioral health, and expanding the partnership between criminal justice and non-CJ behavioral health care**

1. **Under the auspices of the BHLT, identify and commission an empowered group that is responsible for planning, implementation, and oversight of system-wide services for individuals with BH/CJ needs in Dallas County.** Note that the significance of this issue (currently 80% of the inmates of the jail) is not matched by the positioning within the county system for addressing this issue in a collaborative team with the Sheriff, the DA, the judges, and BH leadership. This is one of the reasons an empowered local BH leadership structure is so important. Further, within this BH/CJ oversight group, there should be representation from both CJ-specific services as well as community-based MH and substance abuse services in which CJ clients participate in significant numbers.

   1. **As an initial step, the group should identify the volume of resources currently utilized for BH/CJ services by each partner, the volume and characteristics of clients served, and the types of services provided.** This initial “system mapping” facilitates the development of collective ownership of the population. Note that this group is **not** a BH/CJ “clinical operations team.” That function is being ably carried out by Ron Stretcher’s current group. This is a higher-order group that has planning and oversight responsibility at the county and, eventually if appropriate, NTBHA levels.

   2. **Develop a broad, inspiring, and overarching system vision for BH/CJ services.** As with other components of the system, this vision will guide BH/CJ planning and implementation efforts. Recommended anchor points for the vision are:

      a. **Incarceration primarily due to unmet BH needs is intolerable and inhumane.** The goal is that no person with BH needs should be unnecessarily criminalized or incarcerated in Dallas County.

      b. **Prevention is the best form of diversion.** That is, if individuals in crisis are attached to services sooner, rather than only after they have been arrested, charged, booked, and/or jailed, then more people will have successful outcomes in the community.

      c. **For those for whom incarceration is unavoidable, rapid transition from incarceration to community programming is a priority.** Community programming may include a full
continuum of services (including secure residential services) that can be paid for by multiple pooled funding sources, including Medicaid (with federal match) as opposed to un-matched county resources wherever possible. Planning needs to anticipate the dramatic increase in Medicaid coverage anticipated with health care reform in 2014.

3. The vision will guide a series of initial implementation activities. Viewing unnecessary incarceration as unacceptable can start by looking at the actual stories of people that get caught in the system. These stories permit generalization within a performance-improvement framework to population trends that identify people with high-risk/poor-outcomes, and then permit quality improvement activities and monitoring with a cross-system vantage point. This activity should consider both broad and specific population analysis. Specific population analysis might include particularly vulnerable people (i.e., homeless, pregnant and parenting women, CJ involved, elderly, transitional youth, etc.). Note that part of this framework is that ValueOptions (or any MCO) needs to be responsive to the concerns raised by the local oversight authority through this process.

   - People who are under-supported in the current community-based service system (i.e., DD/MR, otherwise cognitively impaired, and transitional youth),
   - People who are not readily accepting of or engaging in the current array of services (i.e., people who are pre-contemplative about working on their addiction or individuals affected by ethnic and cultural disparities such as the extremely disproportion rate at which African Americans present in CJ settings),
   - People who have extenuating circumstances (i.e., homeless people or pregnant and parenting women),
   - People who have competency restoration issues that get stuck in the system for relatively low threshold misdemeanor crimes.

4. Using the above process, the BH/CJ Oversight Team can begin to formulate meaningful performance outcomes measures for the BH population at risk of, or having, CJ involvement. These measures can be incorporated into contract renewal activities within NorthSTAR, or in other parts of the service system. Sample indicators may include: decreasing arrest and incarceration rates for individuals with SMI; decreasing jail length of stay for individuals with competency restoration needs; decreasing re-arrest rates for SPN clients; increasing continuity of recovery support for clients with substance abuse and CJ issues; reducing revocation rates for clients who use substances; increasing the percentage of clients who receive any diversion service once booked.

5. “Criminal Justice Prevention” is connected to the development of the welcoming crisis hub, the repositioning of SPN services (so as not to be stretched too thin), the
development of the substance abuse system and housing continuum, and the community-based crisis diversion activities (including the crisis stabilization unit) that are described elsewhere in this report. This would be associated with expanding the comprehensiveness of data sharing within JDIM to include the Bridge, Parkland, and ValueOptions information, so that individuals can be quickly flagged for preventive intervention, including mobile outreach. Within these activities the BH/CJ partnership can begin to develop consultation, in-reach, and other transitional support services to facilitate successful attachment to SPN services or other continuing care. As an example, individuals in transition from jail would be highly targeted for collaborative monitoring for the first two weeks of care, with mobile outreach interventions planned if there is any indication of falling through the cracks; OR individuals who begin to miss follow up appointments are flagged through the crisis hub for mobile outreach; OR probation officers start to identify partnerships with SPNs and community providers so that they can make regular rounds on BH/CJ clients attached to particular community care sites.

6. Begin to collect data on the prevalence of CJ involvement and risk in the SPN and community addiction services populations, and in the PES/OBS populations. The purpose of this data collection is to reinforce awareness that CJ risk is an indication for higher prioritization for engagement in services prior to arrest or re-arrest. This may be factored into UM decisions as well. In addition, this permits a baseline understanding of which SPNs and other programs (Nexus, Homeward Bound, Turtle Creek) are demonstrating successes, so that more successful interventions can be replicated and expanded as part of planning efforts.

7. Initiate targeted review of diversion plans for high risk populations like pregnant women. The group should be empowered to follow through on any lack of implementation of those plans. This may lead to defining performance targets for the MCO and associated performance incentives and penalties.

8. As part of this partnership, Parkland should identify some very specific strategies to facilitate access to services for individuals who have no other source of care. A simple example would be to prioritize mobile health services at the Wilmer campus.

9. Last, but certainly not least, begin to expand the partnership. The BHLT BH/CJ oversight team needs to begin regular planning meetings with the District Attorney’s office, the Sheriff, key judges, and the police. Representatives of other NTBHA counties (like Judge Chitty) may be included as well, but only if they are supportive of the process. This high-level meeting needs to focus on helping all participants feel they are in a win/win situation that can make progress, not to leave anyone feeling challenged. The BH agenda and the public safety agenda should be positioned as mutually supportive, not mutually exclusive, as
good BH interventions with appropriate security and support for high need individuals enhance public safety within limited resources. Find the easier improvement targets to begin with, and then begin to build more complex solutions.

**Phase Two: Building on the work in phase one, start to address more challenging issues, and develop bigger system solutions**

1. Begin to collect outcome tracking data on high-risk populations, in a collaborative framework, within the BH/CJ oversight team. This will allow the emergence of collective information on the costs of success, the predictors of success, as well as the costs and predictors of poor outcomes. This data will inform subsequent activities in this phase.

2. Use this information to begin to challenge – and ultimately change – the current service prioritization “rules” that are based more on diagnosis than on CJ risk. Example: A prioritization scheme for reducing high risk and poor outcomes for targeted resource development should include CJ contact of any kind as a profound risk indicator for a BH population, meaning that the person with BH concerns who is diverted, arrested or incarcerated in a CJ setting is prioritized for community-based attention, even if he or she does not formally meet the SMI designation. (This approach was used successfully in New Mexico in the 1990s in an equally resource-poor system.) This supports the prevention and early intervention framework to minimize poor outcomes by providing more economical, effective and lower-threshold services to people with high-risk.

3. Develop mechanisms to expand Medicaid and Medicare eligibility determination for individuals with SUD conditions, given the recently enacted expansion of the Medicaid SUD benefit (September 2010), and co-occurring MH problems, whose psychiatric disability may be masked initially by their substance use and criminal behavior.

4. Continue supporting the expansion of the crisis hub, the crisis stabilization unit for Terrell State Hospital diversion, and related services (Step 6), including expansion of a continuum of sober living environments and damp housing options.

5. Plan and design a much more specific set of performance indicators and incentives to be included in the next MCO contract/RFP process for 2012 and 2013. Some of these performance targets can involve supporting the other activities listed in this set of recommendations.

6. VERY IMPORTANT: Develop a serious, over-the-top system-wide response to the need for competency restoration services. This is built upon the broad partnership that began to be developed in Phase 1. What are the components of this system-wide response?
   a. Develop competency restoration capacity and programming in all SPNs and The Bridge.
b. Design protocols for competency restoration that expedite the process of determining restoration versus being found non-restorable, particularly for misdemeanants.

c. Identify any competency restoration activities that can be included in existing jail-based BH services.

d. Develop a continuum of services that moves people more quickly into the community. One approach would be to commit resources to developing an additional 50-bed SECURE crisis stabilization unit (potentially Medicaid-reimbursable) designed for individuals coming directly from jail (as distinct from the capacity plan to shift resources from TSH). This unit could provide interventions for conditional release, as well as facilitate release to OCR services.

e. Another component would be to increase utilization of monitoring bracelets and similar supervision in OCR populations.

f. The goal is to create incremental improvements in the availability of services that unblock the jail and increase and expedite community-based (non-jail, non-TSH) competency restoration (or determination of non-restorability).

g. Expand internal court procedures to facilitate competency determinations and resolution, as with a specialty competency docket, supported by MHPDs (as has been done in Seattle).

7. In addition, an expanded S-CSU can be a vehicle for increasing jail diversion. Identify a population that could be released with comfort by the judge and District Attorney if they were going to a secure setting for a period of weeks, and then use the S-CSU as a transitional treatment facility to link the individual to community-based services, with the understanding that failure to adhere to recommendations could lead to a return to jail. Although the per-diem cost of a S-CSU is higher than jail, the LOS is likely to be shorter, and therefore the per-episode care and long-term outcomes are likely to be better.
**Step 10:**  
**System of Care and Housing Service for People who are Homeless**

**Background**

This section addresses the need for developing a continuum of services for individuals and families who are homeless and who have BH conditions.

The recommendations in this section, as in the others, are organized according to phases of implementation, with the assumption that the BHLT in Dallas (and representatives of the BHLT working in partnership with other counties in the NorthSTAR region) will partner with the Metro Dallas Homeless Alliance (MDHA) to be empowered and responsible for overseeing the implementation process.

The recommendations in this section are based on a series of findings in our study, as well as some hypotheses derived from these findings. These findings are listed below.

**Findings**

**Finding 1:** The Metro Dallas Homeless Alliance represents a model “subsystem” within the City and County of Dallas for providing integrated health, MH, substance use, employment, and, of course, housing services to individuals and families who are homeless.

The Bridge is a model for coordination of efforts from multiple funding streams and providers to create a welcoming, recovery-oriented, one-stop engagement and intervention center for homeless individuals. The success of this “welcoming continuum,” both clinically and financially, informs the vision for a broader crisis continuum for Dallas (see recommendation #4). (The Bridge provides a similar low-threshold engagement experience for homeless individuals in crisis, but would link individuals with more severe impairments to higher levels of care within the crisis hub.) In addition, MDHA is a model of how interagency partnership and collaboration can achieve a common goal. This success similarly informs the vision of the BHLT (on which MDHA is represented) to foster similarly organized collaborative efforts for all county BH services. Further, MDHA has been successful in leveraging resources from multiple sources to expand housing options. Most recent data includes $15 million to support over 1,800 housing units (including permanent supportive housing, transitional housing, and shelter plus care) and a reduction in chronic homelessness in Dallas by approximately 50% in five years.

**Finding 2:** Although it is typical for large county BH systems to have a designated “Housing Coordinator” function (specifically focused on behavioral-health-related housing issues), and although MDHA assumes a lot of this function, Dallas County (and NorthSTAR) do not have a designated locus of coordination of homeless services.
NTBHA has continually advocated for expansion of housing resources in its strategic planning, and is also advocating for expanding availability of HUD vouchers. NTBHA does not, however, currently have the resources or level of empowerment to perform a BH housing system development function, nor to leverage NorthSTAR resources accordingly.

Finding 3: Although The Bridge provides a model service “hub,” there is still room for improvement in service coordination, continuity, and integration within the county.

Clients often have challenges enrolling for health care services, enrolling separately for BH services, receiving services from different SPNs in the course of care, maintaining continuity of case management and medication, having access to substance use services, and so on. In addition, although The Bridge has an extensive capacity to track client data and outcomes, this data does not routinely cross-walk with other client data systems to facilitate continuity of client oversight and monitoring of progress.

Finding 4: Individuals who are homeless or marginally housed are notably high-risk for psychiatric emergencies and CJ involvement.

Many of these individuals are not connected with services at The Bridge. Many individuals who are connected to BH services and who need housing support (even when they have a place to stay, but are having trouble succeeding there) are not able to receive it.

Finding 5: The LifeNet Crisis Transitional Housing program appears to be a successful and cost-effective program for very high-need individuals transitioning from psychiatric inpatient facilities.

Although there seems to be good reason why programs like this should be expanded, and although NTBHA recommended the expansion of this resource in its Strategic Plan 2010-12, we could not identify the locus for implementation of that expansion, and for linking that planning to broader housing development strategies.

Finding 6: There is an extensive network of private boarding homes in Dallas County that provide housing to a significant number of low-income individuals with psychiatric disabilities. Many informants expressed to us that a high percentage of these boarding homes provided substandard care and were insufficiently regulated.

Currently, MDHA has facilitated partnerships between a few boarding homes and SPNs to create effective permanent supportive housing. There is not, however, a more highly leveraged plan to broadly address the deficiencies in boarding home services. HB 216 – effective Fall 2010 – permits increased community oversight in licensing and regulating of boarding homes, and provides an opportunity to improve the quality and capacity of these housing options.
Finding 7: Although Dallas (MDHA) has worked hard to develop a housing continuum, there is no evidence of formal planning for housing services that create a continuum that is wet, damp, and dry.

In designing a continuum of services for homeless individuals and families with BH conditions, it is important to match housing design to what people actually want and need, including in relation to using substances. Consequently, it is important to develop a continuum of housing options that are dry (“abstinence-expected” or “sober living environments”), damp (“abstinence-encouraged, but discussion of safe active use is welcomed”) and wet (“consumer choice: use substances as much as you want as long as you do not lose your housing”). Program design related to each of these options needs to be carefully developed in accordance with best practices. Although there are housing options in the continuum that are wet, damp, and dry, it is not clear how effectively consumers are matched to the right setting. Unfortunately, housing “mismatch” is a frequent reason for housing service failure and discontinuation in permanent supportive housing settings.

Recommendations

As in previous sections, the recommendations in this section are divided into phases. The first phase will begin immediately and extend over approximately 12 months. The second phase will focus on implementation activities that would go online no earlier than two years from now, and probably longer. Note again that we are viewing the Dallas County BHLT, working in partnership with MDHA, and with NTBHA and other NorthSTAR-area counties when appropriate, as the place wherein the design and implementation of the Dallas County BH homeless service system will take place.

**Phase One: Immediate planning to improve integration of services and coordination of care for individuals and families with behavioral health needs who are homeless**

1. **Formal identification of a locus of planning and implementation of services for individuals and families with BH needs who are homeless.** Our recommendation would be that this task is formally assigned to be coordinated by MDHA, with additional partners, as delegated by the Dallas County Behavioral Health Leadership Team. The purview of this group should cover homeless individuals and families with BH needs who present anywhere in the system, including primary health settings, PES, and so on.

2. **Recognize the existing models of collaboration in MDHA as a system strength that can inform planning and partnership for the larger system.** Note that the ability of MDHA to work in partnership with multiple stakeholders to leverage resources is part of the vision we are recommending for the potential of such a partnership in the larger system. Note also
that MDHA and The Bridge have leveraged an effective partnership with ValueOptions, in part because ValueOptions is only providing a relatively small percentage of their funding.

3. **Begin to collect data across multiple sources (The Bridge, CJ, ValueOptions, Parkland)** identifying homeless or marginally-housed individuals with BH needs (particularly those using high-end services of any type), and tracking whether they are engaged in services that are helping them make progress. There needs to be a systematic improvement process to increase the extent to which every client is connected to BOTH suitable supports and suitable housing.

4. **Develop a plan to track the provision of supported housing by SPNs, and expand the capacity of SPNs in this area.** This begins not with housing units but with ensuring that clinical staff have the training, skills, and program support to provide supportive housing services to clients who need that support in order to maintain their existing housing. Note that service packages include supportive housing as a covered service, but there is no current data on how much it is being provided.

5. **Develop a plan for tracking and coordinating availability and distribution of HUD vouchers for individuals with serious BH needs.** This is aligned with NTBHA’s Strategic Plan, but requires organized coordination across multiple sources of information for tracking the homeless mentally ill population.

6. **Conceptualize a plan for The Bridge (MDHA) to receive a flexible pool of sub-capitated dollars to manage a high-utilizer group of homeless individuals.** This pool of resources could come from ValueOptions, Parkland, and any other sources that might be at risk. The starting place is to identify total costs of a current high-utilizer group, and use that to hypothesize a starting place for sub-capitated or case rate funding, and then allow The Bridge to establish a pilot using those funds with full flexibility to provide or purchase needed housing, health, BH and other services and supports, and to demonstrate cost effectiveness. If the original pilot is successful, the sub-capitation can be expanded to a larger group. Note that in at least one other system (Miami), the homeless services hub (The Homeless Trust) has evolved to become one of the system’s managed care organization partners for a designated high-risk group of homeless clients.

7. **Develop a strategic plan to leverage partnerships with selected boarding homes.** The strategy followed in many other systems is to create a process for rewarding boarding homes that want to step up to provide better quality services and function as more effective partners. There are a variety of approaches, but a common one is for the MCO (or another funder) to offer to credential them (thus assuring some standard of care) as a therapeutic residential setting, providing priority access to services and supports that help out the boarding home owner, and providing a financial enhancement to support additional
service provision. This arrangement should be designed to be a win/win for all concerned. Another strategy that some systems follow is to identify funds that can be used to facilitate existing “good partner” agencies in acquiring and operating boarding homes, or even supportive apartments, themselves (for example, low-cost loans, loan guarantees, and other incentives). Ideally, the partners operate the homes in such a way that they become part of a continuum of supportive services. Finally, there needs to be a local effort to identify model regulations and licensing criteria for boarding homes that serve individuals with BH needs.

8. **Develop program models for wet, damp, and dry housing.** As noted above, it is our observation that the vast majority of housing being developed is designed as “dry” housing, which creates a significant acquisition gap for seriously impaired individuals. There are very successful evidence-based models for damp and wet housing that require specific modifications in program rules, program content, and staff treatment approaches. We recommend that these approaches be defined and then systematically expanded, implemented, and tracked within Dallas County.

9. **Advocacy for additional resources to provide housing support.** In most states, Medicaid resources can be utilized for disabled people to maintain independent living in lieu of institutionalization, as required by Olmstead and the Americans with Disabilities Act. As of October 1, 2010, under the Affordable Care Act, states have increased flexibility about how to use these Medicaid dollars to provide supports in the community for individuals with any type of disability. Many of the “support” services that would be helpful to individuals with chronic psychiatric and substance disabilities could be provided potentially with separate Medicaid dollars than would be narrowly defined as BH services within ValueOptions. We do not know how well these resources can be leveraged in Texas, but we do know that Medicaid coverage will be expanding under health care reform. We also know that housing advocates in most states are not aware of the full potential of these new regulations.

**Phase Two (12—36 months): Expanding the homeless service array**

1. **Defining and implementing system performance indicators:** The basic work described above as first-year activity will permit both data acquisition and learning about successful models that can lead to more proactive and systematic implementation. As a target, the Dallas County BHLT, with MDHA and NTBHA, should be planning to identify new performance indicators and incentives for the next ValueOptions contract and for the future RFP for the managed care system in general. These performance indicators can define how much expansion of supportive housing is required, how many “therapeutic boarding homes” or “sober living environments” are started, how many clients are sub-capitated to MDHA, and so on—more sensitive indicators than simply tracking TRAG scores.
2. **Implementing a wet, damp, dry continuum:** By Year Two, the housing plan should have some baseline targets for how much of the homeless population will need wet, damp, or dry housing options, and should be planning to organize both new and existing units to match those targets. This is activity that occurs WITHIN base resources. Current data indicates a high failure rate within current permanent supportive housing. The goal with these models is to design supportive housing that is more effectively matched to the clients, and therefore more likely to be successful. This will allow limited resources to go further.

3. **Establishing improved regulatory and programmatic oversight of boarding homes:** By Year Two, building on the introductory activities cited above, establishing more formal oversight, and leveraging expansion of boarding home services by quality “partners” would lead to improved housing supports for individuals who may benefit from a more therapeutic boarding home environment with wraparound supports.

4. **Expansion of funding:** Better partnerships are always able to leverage funding more effectively. MDHA has been very successful in obtaining a variety of HOUSING grants. However, the system should be seeking additional dollars for “HOUSING SUPPORTS”. This is funding that goes to clinical support programs that help homeless individuals or families with MH and SUD attain and maintain housing. At least two such multiyear SAMHSA grants are currently in operation in Texas, one in Bexar County. It is our view that Dallas County would be able to put together a very successful application. We would also recommend that The Bridge partner with Parkland to seek funding for a model program that incorporates a truly integrated “Health Care Home” into The Bridge setting. This would provide valuable resources to expand both BH and physical health services within a homeless continuum, and reinforce the concept of The Bridge being a sub-capitated specialty provider for identified high need clients.
Step 11:
A Youth and Family Driven System of Care for Children, Adolescents and Families with Behavioral Health Needs

Background

This section addresses developing a true system of care (SOC) for children with severe BH needs and their families. Efforts would integrate three current silos operating largely independently and separated by rigid funding eligibility rules: (1) the juvenile justice system for the highest need individuals, (2) NorthSTAR BH services for people with targeted behavioral needs, and (3) Parkland COPC resources for lower needs. Currently, each system is accessed only if funding criteria are met (that is, an arrest for juvenile justice services, NorthSTAR eligibility for specialty services, lack of NorthSTAR eligibility for Parkland COPC services). One model of integration to help guide improvements is the Dallas Independent School District’s effective partnership with NorthSTAR and Parkland to implement its Youth and Family Centers, which integrates services for students in all three systems (NorthSTAR, Parkland, and non-NorthSTAR) and reached over 4,400 students last year.

The building blocks for an effective SOC are present. The recommendations in this section, as in the others, are organized according to phases of implementation, with the assumption for the children’s SOC that the Dallas County BHLT (and representatives of the BHLT working in partnership with NTBHA, DSHS, and other counties in the NorthSTAR region) will work through its Child, Adolescent and Family Clinical Operations Team to oversee and coordinate the implementation process.

The recommendations in this section are based on a series of findings in our study, as well as additional findings related to the national SOC movement. These findings are listed below.

Findings

Finding 1: Dallas County’s juvenile justice system is state-of-the-art. Dallas County Juvenile Services has achieved remarkable across-the-board reductions in juvenile offense referral rates, with an overall 13.7% reduction from CY 1997 to CY 2009. Most of that reduction has been with younger youth, ages 10 to 15. Rates of detention have also fallen 19.5% since CY 2008 and 24.9% since CY 2005. Overall, the Dallas County Juvenile Justice system seems to have a strong array of best practices, backed up by rigorous outcomes tracking for the overall youth population and service providers.

Finding 2: Dallas County’s juvenile justice system is largely dependent on county revenue (and to a greater degree than other parts of the country that more effectively leverage Medicaid funds) and is experiencing much larger cuts in service funding (upwards of 10% per year) than the rest of the BH system. These services are largely county-funded, and the county
has endured substantial spending cuts over the past two fiscal years (CFY 2009 and CFY 2010) due to decreases in county revenue related to the economic downturn. Funding for contract non-residential community-based services, including evidence-based approaches like multisystemic therapy (MST), fell nearly 25% from CFY 2009 to CFY 2010 (though this was somewhat mitigated by an increase in county-provided services, with the county implementing functional family therapy [FFT]). Contract residential services funding also fell over 20% from CFY 2009 to CFY 2010. The vulnerability of funding for juvenile justice services is a continued concern as the economic conditions continue to be a challenge.

**Finding 3:** It is extremely concerning that nearly all intensive service availability for children is provided through the juvenile justice system (see the Data and Policy Analysis section for more specifics on this). Limiting most intensive service use to the juvenile justice system both adds the stigma of justice system involvement for youth and families seeking intensive services and also increases funding vulnerability (by limiting access to federal Medicaid reimbursement for services that could be covered).

**Finding 4:** There is very little coordination and cooperation currently between the NorthSTAR BH system and the Dallas County juvenile justice system. There is a history of conflict between NorthSTAR and the juvenile justice system in Dallas, with Dallas County successfully taking back control of some Medicaid spending from NorthSTAR early on in the process. While much coordination happens at a clinical level for providers serving both systems, some key providers do not participate in both systems (for example, Youth Villages, Inc., a major provider of services for Dallas County Juvenile Services and a nationally recognized leader in the provision of MST, mobile crisis and other intensive supports, only served three NorthSTAR members in SFY 2009). Furthermore, there is little evidence of active collaboration, data sharing, or service coordination at the system level.

**Finding 5:** There is very little coordination currently between the NorthSTAR BH system and services delivered through the child welfare system. As of this point in the study, we have yet to meet a representative of the child welfare system or access any data related to either the provision of BH services (Medicaid or otherwise funded) or coordination of services between the child welfare system and NorthSTAR. This is a major gap, as noted in the Data and Policy Analysis section. Again, the primary coordination link is through providers such as Child and Family Guidance Center (CFGC) that serve children and families involved in both systems.

**Finding 6:** There is a strong base of NorthSTAR BH services delivered in school settings to build upon through the Dallas Independent School District (DISD). When analyzing data to

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identify the top providers of services in NorthSTAR, DISD emerges the 9th highest provider of service overall within NorthSTAR in terms of persons served (1,861 members in SFY 2009; overall in the last fiscal year the program served over 4,400 students, about half of whom were involved in NorthSTAR). The Youth and Family Centers are a model of integration that can help guide improvements across the system and represents an effective partnership with DISD, Parkland and NorthSTAR to integrate BH services with primary care for students and their families across all three systems (NorthSTAR, Parkland, and non-NorthSTAR), reaching over 4,400 students last year.

**Finding 7:** Child and family-serving agencies within NorthSTAR and more broadly across Dallas County are providing many evidence-based services (Wraparound through CFGC, MST through Youth Villages) and are ready to collaborate to build a SOC. The Child, Adolescent and Family Clinical Operations Team met initially in July 2010 and has since organized itself and is scheduling, planning, and carrying out meetings independently. It represents a wide array of child and family-serving agencies and is planning to expand to include more representatives not included initially (such as DISD).

**Finding 8:** Parent and family support for the caregivers and families of children and youth with BH needs is under-developed and lacking. There currently is no dedicated parent support organization in Dallas County for the parents and families of children and youth with severe BH needs. While Grant Halliburton Foundation has established a strong mentoring program and collaborative planning process, and NAMI Dallas provides many supports, we are not aware of an empowered parent and family support organization that acts independently to advocate within the BH and broader child-serving systems.

**Finding 9:** The national SOC movement offers a path forward for organizing a youth and family driven, resiliency and strengths-focused SOC for children, youth, and families in Dallas County. Twenty-eight years ago Jane Knitzer (1982), in *Unclaimed Children: The Failure of Public Responsibility to Children in Need of Mental Health Services*, documented policy and program disconnects that denied children and youth with MH problems and their families the services they needed. In 1984 Congress authorized the National Institute of Mental Health to develop the Child and Adolescent Service System Program (CASSP) to improve services for children with

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SED and their families.\textsuperscript{9} This federal initiative was designed to create partnerships among MH, juvenile justice, physical health, education, child welfare, SUD treatment, and families. Grants were provided to all 50 states to support collaborative efforts and family organizations to alleviate the fragmentation in service delivery systems and include families in such endeavors. CASSP was the precursor to the 1992 Comprehensive Community Mental Health Services for Children and Their Families Program (or Children’s Services Program) and was designed to promote a SOC approach to service delivery.

Stroul and Friedman described the ideal SOC in their seminal 1986 publication, \textit{A System of Care for Children and Youth with Severe Emotional Disturbances},\textsuperscript{10} as “a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents.” The SOC model promotes maintenance of children in their communities, coordination of services and supports, involvement of families in the planning and delivery of services, and recognition of the importance of cultural relevance in service and support delivery. It is designed to coordinate points of entry into services for all of the organizations and service systems (for example, schools, child welfare, juvenile justice, MH, families, and primary health) that are involved in the provision of services and supports.

Stroul and Friedman articulated three core values of a SOC and 10 guiding principles.\textsuperscript{11} The core values are: (1) Child and family-centered: The needs of the child and family dictate the types and mix of services and supports provided; services are adapted to the child and family rather than expecting the child and family to conform to preexisting service and support configurations. (2) Individualized: A unique service plan is developed for each child and family which assesses their strengths and needs, prioritizes their needs in each life domain, and is responsive to the family’s cultural, racial, and ethnic identity. (3) Community-based: Services are provided within or close to the child’s home community in the least restrictive setting feasible, and are coordinated and delivered via connections between providers.

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\textsuperscript{10} Stroul, B. & Friedman, R. (1986). \textit{A System of Care for Children and Youth with Severe Emotional Disturbances.} Georgetown University Child Development Center, National Technical Assistance Center for Children’s Mental Health. Washington, D.C.

\textsuperscript{11} Stroul, B., Friedman, R. (1994). \textit{A System of Care for Seriously Emotionally Disturbed Children and Youth. (Revised Edition).} Georgetown University Child Development Center, CASSP Technical Assistance Center. Washington, D.C.
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The guiding principles of a SOC are as follows: (1) A broad array of services and supports is provided in an individualized, flexible, coordinated manner with an emphasis on treatment in the least restrictive, most appropriate setting. (2) Children who have a serious emotional disturbance should have access to a comprehensive array of services that addresses their individual physical, emotional, social, and educational needs. (3) The family’s participation in service planning and delivery is essential. Family involvement is integrated into all aspects of service planning and delivery. (4) The MH service system is driven by the needs and preferences of the child and family, using a strengths-based perspective. (5) The locus and management of services are built on multi-agency collaboration and grounded in a strong community base. Services should be integrated and coordinated between child-serving agencies. (6) Case management is fundamental to ensure service coordination, integration, and system navigation. (7) The early identification of, and intervention for, needs should be promoted in order to maximize the prospect for positive outcomes. (8) A smooth transition to the adult service system should be planned when necessary. (9) The rights of children who have a serious emotional disturbance should be protected. (10) The services offered, agencies participating, and programs generated are responsive to the cultural context and characteristics of the populations served. Children who have a serious emotional disturbance receive services irrespective of gender, ethnicity, race, income status, physical disability, and other characteristics.

“System of care” depicts a set of core values and principles rather than a prescription for specific components of care that need to be in place. Thus, SOC concepts define a model for what quality services should look like, but not what those services should be. In recent years, focus shifted from “system values” to clinical effectiveness within systems of care and the transportability of efficacious interventions and practices into MH service delivery systems. An emphasis on fidelity to implementation of systems of care at the practice level has also been stressed. Because a SOC focuses on improving access, developing a broad array of services, and ensuring coordination, it provides a context for the delivery of evidence-based practices to children and youth and their families.

**Recommendations**

As in previous sections, the recommendations in this section are divided into phases. The first phase will begin immediately and extend over approximately 12 months. The second phase will focus on implementation activities that would take on substantial activity no earlier than two years from now, and probably longer. Note again that we are viewing the Dallas County Behavioral Health Leadership Team, working in partnership with the Child, Adolescent and

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Family Clinical Operations Team and with NTBHA when appropriate, as the place wherein the design and implementation of the Dallas County SOC for children, adolescents and families with BH needs will take place.

*Phase One: Immediate planning to involve all necessary child and family-serving systems in the design, planning, and organization of a youth and family driven, resiliency and strengths focused SOC for Dallas County.*

1. **Bring all necessary partners to the table (through late 2010).** At its first meeting, the Child, Adolescent and Family Clinical Operations Team set about determining who needs to be at the table and this goal may be achieved over the next few months. Representatives of DISD, Centro de Mi Salud joined in August and September, and the child welfare system and parents of children with BH needs have been prioritized to be added as soon as possible. Youth representatives should be added, as well.

2. **Begin to plan for the SOC (late 2010 through 2011).** Given the comprehensive requirements of a SOC, SAMHSA has, since 1992, funded Children’s Mental Health Initiatives (CMHI) that provide $9 million over six years.\(^{13}\) Tarrant, Travis, El Paso and Harris Counties have all been past recipients (Harris County being the most recent in 2005).\(^{14}\) While it is not necessary to pursue such a grant in order to move a children’s SOC forward, they are helpful in supporting the planning, training, and infrastructure development of a well functioning SOC. The first year of each grant period involves a period of intense planning and system development, with service delivery to begin one year thereafter. The BHLT and the Child, Adolescent and Family Clinical Operations Team should decide soon whether or not they would want to pursue such a grant. Even if a grant were not pursued (or if it were pursued but was not successful), working through a preliminary plan regarding the following issues can help define a clearer pathway forward in developing such a system, building on past successful initiatives in Dallas County, such as the Annie E. Casey Juvenile Detention Alternatives Initiative, and extending the learning of those initiatives system-wide. For example, TriWest worked last year with Saginaw, Michigan, to develop their proposal after Saginaw spent the previous year engaged in initial planning and development with a local facilitator (Saginaw was just awarded in September 2010 one of the 16 grants awarded nationally last year). Preparation for such a grant would involve thinking through and developing an initial plan regarding the following sets of activities:

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\(^{13}\) See [http://www.samhsa.gov/grants/2009/sm_09_002.aspx](http://www.samhsa.gov/grants/2009/sm_09_002.aspx) for more information on last year’s grant and its requirements. New grant cycles typically begin in the late fall through early winter.

\(^{14}\) See [http://www.hhsc.state.tx.us/tifi/TIFI_SystemofCareCommunities.html](http://www.hhsc.state.tx.us/tifi/TIFI_SystemofCareCommunities.html) for more information on these projects.
a. **Development of a governing infrastructure:** The federal requirements for a SOC include the following elements:

- **Governance Body** – The Governance Body oversees the SOC development and implementation and ensures coordination of effort, enacting interagency agreements and tracking process and outcome data for performance improvement. Membership typically includes the leaders of key SOC partner organizations, such as BH, juvenile justice, court, child welfare, schools, and community agencies (similar in composition to the newly formed Child, Adolescent and Family Clinical Operations Team).

- **Administrative Team** – This team leads implementation and day to day operations, with accountability to the Governance Body, meeting on a weekly to biweekly basis.

- **Policy Board** – The Policy Board keeps organization members informed of SOC efforts, identifies current policies and practices that need to shift to support the SOC effort, develops strategies for shifting these policies/practices, and identifies ways to leverage resources and new opportunities. This is often a group of more senior agency leaders that supports the work of the Governance Body. It typically meets monthly initially, then bi-monthly or quarterly going forward.

- **Service Coordination/Access Group** – This group is similar in structure to the Juvenile Services Case Planning and Review Committee (CPRC) and the Community Resource Coordination Groups (CRCG). Today, these groups focus on individual cases to identify actions that can be taken at the provider level across agencies. Typically in a SOC project, actual case planning is done more frequently using Wraparound Service Coordination (based on the fidelity standards of the National Wraparound Initiative – NWI; more on this below), so these teams focus more on problem solving at an agency level than on individual case staffing. It typically meets monthly.

- **Family Advisory Board** – This group involves parents and other caregivers whose children are currently receiving services in the county and who are currently touching multiple service agencies/organizations (i.e., BH, child welfare, juvenile justice, special education). Their role is to monitor and advise SOC efforts and ensure that the SOC effort is genuinely family driven. It also often promotes family engagement and advises Peer-to-Peer group facilitators. It meets on a bi-monthly to quarterly basis, typically. Many of the current efforts of the Grant Halliburton Foundation would fall along these lines (although in a SOC project this would be entirely family-run and volunteer staffed), and other Grant
Halliburton Foundation efforts mirror activities that some of the previous groups would take on, although with more direct involvement from publicly-funded human service agencies.

- **Youth Advisory Board** – This group would be comprised of youth aged 14 to 17 typically who have been diagnosed with SED and who are currently receiving services from multiple service agencies/organizations. Its role is to advise SOC efforts, ensure the SOC effort is genuinely youth-driven, and identify strategies for promoting youth engagement. It meets on a bi-monthly to quarterly basis, typically.

**b. Systems Integration and Interagency Collaboration** – Another set of activities center on developing a strategic plan for system integration and interagency collaboration, typically formalized over a year of planning through written memoranda of understanding to engage in a collaborative interagency multisystem strategic planning process. Agreements specify each partner’s role in policy development, contributions to braided funding mechanisms, and integration of service and support provision. Policies and procedures for the integration of services and supports are developed in a manner that ensures individualized service plans are developed and implemented in a unified fashion to avoid duplication of services and agencies working at cross purposes from one another.

**c. Services Integration** – Other SOC efforts focus on planning for service integration, focusing on co-located and integrated services for MH and SUD needs, BH and primary care, and BH within juvenile justice, child welfare, and school systems and settings.

**d. Care Plan Development** – The SOC also develops a process for intensive service coordination for individual planning, usually using some variation of a cross-system Wraparound Care Coordination, preferably in full accord with National Wraparound Initiative (NWI) standards and supported through implementation of the Wraparound Fidelity Assessment System (WFAS).\(^{15}\) The Child and Family Guidance Center has received training in this approach and could serve as a lead agency in exploring the feasibility of its implementation in Dallas County. Wraparound Care Coordination involves the following:

An individualized plan of services and supports is developed by the family and their Wraparound team.

Meetings are facilitated by a Care Coordinator.

The planning process is governed by the voice and choice of family members in consultation with the team and grounded in the family’s strengths and prioritized needs as identified by family members and the team. Goals, objectives and strategies to achieve them will be prioritized by family members in consultation with the team. A review of the family’s dreams and desires serves as a foundation for guiding the team through planning and implementation of strategies.

Strategies and resources will encompass both formal services as well as natural supports. Action steps for each objective are identified and assigned to specific team members, with a timeframe for completion determined.

Safety concerns and potential crises will be addressed as a key part of developing individualized service plans. The Care Coordinator will review family members’ needs in relation to crises and safety concerns (including requirements related to court involvement), gather additional input from knowledgeable people (including the referring source), and guide a discussion with all team members on how the team will maintain safety for all family members. Family strengths in the form of supports and resources will play a key role in developing and implementing effective crisis/safety plans, in terms of both prevention and intervention strategies.

e. Workforce Development – SOCs also target knowledge gaps identified by families and professionals in the community. These typically relate to cross-system training to improve interagency and intersystem understanding and knowledge. Technical assistance and training are key activities in SOC implementation. Examples include:

• Wraparound Care Coordination training incorporating a five-dimension model centered on: (1) new techniques for training staff, (2) coaching practices that are outcome focused, (3) supervision skills that support practice change, (4) information management that documents a strength-based assessment, team approach, and an individualized plan of care and outcomes, and (5) agency culture change. Wraparound Care Coordinators and their supervisors would also need to participate in an intensive ongoing coaching process to support fidelity.

• Also needed might be cultural competency training that goes beyond the surface level training that most providers receive to confront underlying issues of racism
at both the individual and institutional levels. Training in family, youth and professional partnerships would be emphasized. A cross-system training strategy should be used whenever possible to further support an integrated, unified SOC. Given the need to adapt most empirically-supported practices when they are applied cross-culturally, training in cultural competence could also incorporate assessment of the cultural competence of each empirically-supported practice implemented, following a multi-level approach.\(^\text{16}\)

f. **Promotion of evidence-based care** – Dallas County has a wide array of EBPs in use for children, many (including MST, FFT, motivational interviewing) in place in the juvenile justice system only and others in place in the BH system. Expansion of this capacity is essential to the success of the SOC, as child and family needs must be met with effective services.

g. **Performance Standards** – Ongoing evaluation is critical to ensuring that development efforts adhere to the tenets of SOC as well as those of wraparound and the various EBPs currently in use and those that are planned. Defining performance standards for the SOC (using many of the ideas described earlier in Step 4 of the 12 Step Plan) is critical to ensure that youth and families have consistently high quality experiences across the SOC.

h. **Collaboration with other Child-Serving Systems** – Experience among agencies in collaboration is a critical foundation to the SOC. The months spent planning together, as well as times spent tackling and solving nearer term, more readily solvable needs, are critical to building a sense of teamwork and common purpose. The Child, Adolescent and Family Clinical Operations Team is off to a good start down this road.

i. **Social Marketing** – The Grant Halliburton Foundation has established a strong foundation here in the Dallas Metro area. The SOC needs a social marketing plan to address the following: (1) education regarding BH and its impact upon families and communities; (2) services and supports available; (3) education regarding EBPs that can be of benefit; (4) information on parental support organizations; (5) and how to access services and supports. In addition, the plan should address communication of the results of evaluations of SOC development activities to all stakeholders including policy makers, advocates, and funders (current and potential). Specific markets in

\(^{16}\) Stewart, D. (February 8, 2007). Adapting evidence based practices to culture and community. Presented at the 2\textsuperscript{nd} Annual Advancing Colorado’s Mental Health Care Conference, Denver, CO.
the community should have materials tailored for cultural and linguistic congruence, particularly communities of color and other groups confronted by health disparities.

**Phase Two: Implementation of a youth and family driven, resiliency and strengths focused SOC for Dallas County.**

1. **Small steps first (begin immediately and continue throughout)** – Even during the planning process, the team can begin to address issues of concern. The Child, Adolescent and Family Clinical Operations Team’s initial focus on data on the “Top 200” users across the systems to figure out where system difficulties reside is an excellent start that will identify and allow collaborative resolution of a wide array of current coordination issues.

2. **Begin to implement components of the SOC as possible (late 2011 through 2012)** – While a $9 million, six-year grant provides an excellent boost, the resources to plan and implement a SOC in a community the size of Dallas County could be found in other sources. Such planning is very important because it is not clear whether the federal government will release another round of these grants for 2011 and, even if it does, decisions will not be made until the Fall of 2011 and competition is fierce. And, while the current economic conditions are truly dire, foundations and other community organizations can come together to support a plan that truly has the buy-in of multiple agencies. Saginaw was able to generate over $1 million in local matching funds through its local government given the demonstration of the needs of their youth and the city’s resolve to address them. Collaboration and success can lead to more success.

3. **Incorporate planning to coordinate SOC development with health care reform.** Many of the priorities of health care reform to expand insurance coverage, promote health homes, and empower service recipients within the care delivery process are congruent with SOC values and priorities. However, for children, youth, and families with multi-agency needs, Medicaid, CHIP and other coverage is typically already available – the problem is getting coverage for needed intensive services. That is one reason why Dallas County has developed most of its intensive services outside of its Medicaid system, within its juvenile justice system. However, this need not be the case. Collaboration and braiding of funds can help match the right services and the right funding stream to each child and family’s individualized needs. Ensuring that the rapid and potentially far-reaching changes of health care reform follow SOC values will be essential.
Step 12: Services for Cultural and Linguistic Minorities

Background
This section addresses Step 12 in the Twelve Steps of Recovery for the Dallas County Behavioral Health System: promoting high quality services for members of cultural and linguistic minority groups.

The recommendations in this section, as in the others, are organized according to phases of implementation, with the assumption that the Dallas BHLT (working in partnership with other counties in the NorthSTAR region) will work through its clinical operations teams to oversee and coordinate the implementation process.

The recommendations in this section are based on a series of findings in our study, as well as additional findings related to health disparities. These findings are listed below.

Background Assumptions
Before offering specific findings for Dallas County, we want to summarize some assumptions that are generally well known across the BH system based on national best practices and research. While the rubric of culture can be applied to a wide variety of subsets of the Dallas County population, we have focused our review on two groups: racial/ethnic and sexual minorities. We also offer some background information about other cultural groups, such as people who are deaf or hard of hearing. Various terms are used in different studies to refer to these groups. For this report, we follow the usage and definitions below, except where a specific study we cite employs a different term, where we maintain the use of the study’s terminology where it differs from our term usage (e.g., Black versus African American). We use the terms as defined below:

- **Hispanic** – This term is inclusive of people with European (Spanish) ancestry and the four main Hispanic and Latino groupings (Mexican, Puerto Rican, Cuban, Central American). Federal Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines also mention that this group may have ancestral ties to Asia or Africa. In Dallas County, most Hispanic Americans have ties to Mexico, but the population overall is much more diverse.

- **African Americans** – This term is inclusive of all people of African and Caribbean descent.
Asian Americans and Pacific Islanders – This term is inclusive of Asian Americans, including Asian Indian, Cambodian, Chinese, Hmong, Korean, Laotian, Japanese, Philippino, Vietnamese, and others. It also includes the following Pacific Islander cultures: Native Hawaiian, Guamanian/Chamorro, Samoan, and other Pacific Islander cultures.

American Indians and Alaska Natives – This term is inclusive of all continental United States and Alaskan indigenous people.

Sexual minorities – We use this term in this report to refer primarily to persons who are lesbian, gay, bisexual, or transgendered. Current usage often expands the definition to include an even broader range of people (for example, questioning, intersex, and 2-spirit).  

The background understanding of the needs and health disparities typically experienced by these cultural groups falls into three areas.

1. Cultural Competence Standards. The most well-known national standards related to health disparities focus on services for members of ethnic minority groups. The National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS Standards) were adopted in 2001 by the U.S. Department of Health and Human Services’ (HHS) Office of Minority Health (OMH) with the goals of “equitable and effective treatment in a culturally and linguistically appropriate manner” and “as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers” in order “to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.” They include 14 standards addressing the broad themes of culturally competent care, language access, and organizational supports for cultural competence. A range of standards for specific populations is also available, but the CLAS standards are most widely recognized in the broader health field. In mental health, a set of SAMHSA standards for African American, Asian American / Pacific Islander, Hispanic / Latino, and American Indian / Alaska Native groups is also available.

19 The New York City Department of Health and Mental Hygiene has compiled a helpful listing of various sources that are readily accessible: http://www.nyc.gov/html/doh/downloads/pdf/qi/qi-ccpriority-resources.pdf.
For health care services overall, the CLAS standards set the current benchmark against which the performance of health care organizations that receive federal funds are assessed, and they are intended for wider use by a range of stakeholders, including individual providers, accrediting and credentialing agencies, policy makers, purchasers, and advocates. The CLAS definition of cultural and linguistic competence is based on the 1989 work of Cross, Bazron, Dennis, and Isaacs and is specified as follows:

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Pages 4 – 5)

The National Standards on CLAS delineate 14 standards for health care institutions to address, as follows:

• **Culturally competent care** – Guidelines addressing culturally competent care, which state that health care organizations should:
  
  1. Ensure that persons served receive, from all staff members, effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
  2. Implement strategies to recruit, retain and promote, at all levels of the organization, a diverse staff and leadership that are representative of the demographic characteristics of the service area.
  3. Ensure that staff at all levels, and across all disciplines, receive ongoing education and training in culturally and linguistically appropriate service delivery.

• **Language** – Mandates for all recipients of federal funds, which address language access and state that healthcare organizations must:

  4. Offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each person served with limited English proficiency, at all points of contact, in a timely manner during all hours of operation.
  5. Provide to persons served in their preferred language both verbal offers and written notices, informing them of their right to receive language assistance services.
  6. Assure the competence of language assistance provided to limited English proficient persons served by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the person served).
7. Make available easily understood consumer-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

- **Organizational infrastructure** – Guidelines addressing organizational support for cultural competence, which state that health care organizations should:

8. Develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

9. Conduct initial and ongoing organizational self-assessments of CLAS-related measures into their internal audits, performance improvement programs, consumer satisfaction assessments and outcome-based evaluations.

10. Ensure that data on the individual person’s race, ethnicity and spoken and written language are collected in health records, integrated into the organization’s management information systems and periodically updated.

11. Maintain a current demographic, cultural and epidemiological profile of the community, as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and consumer involvement in designing and implementing CLAS-related activities.

13. Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by persons served.

- **Public reporting** – A final recommendation regarding organizational support for cultural competence, which states that health care organizations:

14. Are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Regarding data and performance improvement, in 2004 the National Technical Assistance Center for State Mental Health Planning (NTAC) and the National Association of State Mental Health Program Directors (NASMHPD) issued a report describing best practice strategies for promoting cultural competency. The guidelines in that report focus on the importance of ongoing data collection and related quality improvement activities in the promotion of cultural

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competence. The report describes steps to institutionalize a comprehensive infrastructure at
the system level in support of improved cultural competence and reduced health disparities
over time, centering on leadership, self-assessment, performance standards, measurement of
performance related to those standards and quality improvement practices to improve
performance.

2. Health disparities across cultural groups. National data on the delivery of BH services has
found many trends in prevalence of disorders and service delivery related to culture. These are
summarized in brief, below, for those familiar with the literature. For those that are not,
additional detail is provided at the end of this section.

  • Trends related to **race and ethnicity** are summarized well in the 2001 supplement to the
    1999 Surgeon General’s Report on MH services entitled *Mental Health: Culture, Race,
    and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General* (U.S.
    DHHS, 2001a) documenting “the existence of striking disparities for [racial and ethnic] minorities in
    mental health services and the underlying knowledge base” (p. 3). The report documents
    less access to MH services, lower likelihood of receiving care, and greater likelihood that
    any care received is poorer in quality. Specific barriers include a lack of knowledge and
    awareness of cultural issues, bias, and inability to speak client languages on the part of MH
    providers, and an understandable level of fear and mistrust of treatment on the part of
    people in need of care. Disparities also relate to historical and current experiences of racism
    and discrimination, which have impacts not only on the treatment process, but also on
    mental health, economic status, and political influence. For new immigrants and refugees,
    trauma is often a factor complicating both trust in helping institutions and accurate
diagnosis when underappreciated. When persons of color do receive care, they are much
more likely to do so in non-medical human services settings.

  • Trends for **sexual minorities** include a long history of psychiatry viewing non-heterosexual
    identity as pathological which did not formally end until the mid-1990s. Today, differential
    levels of MH need for lesbian, gay, bisexual, and transgendered people are viewed in the
    literature as a function of the various stressors associated with minority status (particularly
discrimination), rather than a function of simply having a lesbian, gay, bisexual or
    transgender identity. Lesbian, gay, and bisexual people have been found to experience
    higher rates of discrimination, victimization, and violence by others than the general
    population, including particular stress during adolescence. Studies of suicide risk factors,
    including attempts, clearly document elevated risk, two to three times higher than the
    general population for lesbian, gay, and bisexual people, particularly earlier in life and
    specifically during adolescence. The information that is available suggests that risks are
    higher for stress-related needs across the group of transgender people, including SUD.
People who are **deaf or hard of hearing** are quite heterogeneous and have been increasingly recognized as cultural and linguistic minority groups. The literature suggests that people who are deaf or hard of hearing and have BH needs are often misdiagnosed or underdiagnosed, as a result of the lack of specialized providers or interpreters with MH knowledge who have the skills to appropriately communicate and knowledge of how various mental disorders may manifest themselves in this population.

3. **The role of cultural brokers.** To address the widely documented lack of diversity in the health care workforce, standards have also been developed regarding the strategy of employing cultural brokers. The potential utility of cultural brokers in MH settings has been described, and the National Center for Cultural Competence (NCCC) at the Georgetown University School of Medicine has developed a guide to promote the development of cultural broker programs. The NCCC guidelines take a broad view of culture, including factors related to sexual orientation, age, disabilities, social economic status, religion, political beliefs, and education. The guide defines a cultural broker broadly as an advocate between groups of differing cultural backgrounds; it defines the role more specifically for health care settings as a particular intervention to engage a range of individuals with diverse backgrounds to help span the boundaries between the culture of health care delivery and the cultures of the people served. These individuals range in their roles within the health care delivery system from consumers to providers to leaders. Singh and his colleagues (1999) describe the broker as acculturated in the mainstream health care delivery culture and one or more minority cultures. The NCCC guidelines note that, while cultural brokers generally achieve acculturation in a particular minority culture through their own experience as a member of that culture, membership is neither a sufficient nor a necessary requirement. The guidelines instead center on the person’s . . . history and experience with cultural groups for which they serve as a broker including the trust and respect of the community; knowledge of values, beliefs, and health practices of cultural groups; an understanding of traditional and indigenous wellness and healing networks within diverse communities; and experience navigating health care delivery and supportive systems within communities. (page 5)

The NCCC guidelines focus on the development of programs within health care organizations to expand the availability of cultural brokers for the specific communities served by those organizations. It should be noted that, while membership in a specific cultural group is not

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necessary to serve as a cultural broker, a high level of acculturation is necessary. In order for a person to bridge two cultures, a level of acculturation in both cultures is needed. A cultural broker does not have knowledge of how to work with “all cultures” or even “all members of a specific culture,” as such a standard is simply not attainable. They instead have sufficient knowledge and skill to be viewed as credible by a sufficient number of the members of the specific communities being served to function as a bridge.

Findings

With this broader set of background assumptions in mind, we offer the following findings as the basis for the recommendations that follow.

Finding 1: Culture and language currently receive too little attention in cross-system planning for BH service delivery. We were struck overall by the infrequency with which matters related to culture arose in our discussions with system leaders and planners. While many did address culture and there are experts across the system who are well-informed about the needs and strengths of Dallas County’s many cultural groups, overall there did not seem to be a sufficiently high recognition of culture or language in planning for service delivery given that persons of color (primarily African American and Hispanic) represent over 60% of Dallas County’s 2009 population and likely an even higher proportion of NorthSTAR enrollees (we were not able to access data on enrollees). One finding was that NorthSTAR does not currently track the primary language of enrollees or service recipients. Some providers reported that they track this as part of their efforts to document needs, but the lack of data at the NorthSTAR level likely relates to the fact that, despite a contract requirement that written materials be “made available in the language of any population group that comprises more than 10% of covered lives (Section 6.14.3),” written materials are reportedly only available from NorthSTAR in English and providers serving large proportions of Spanish-speaking individuals must translate materials themselves. The absence of such data also likely impedes the ability of NorthSTAR to document compliance with contract requirement 5.6.2, which states that the “Contractor shall ensure that limited English proficient individuals have equal access and participation in NorthSTAR through the provision of bilingual services.” As seen below, nearly one-fifth of Dallas County residents overall both speak Spanish at home and do not speak English “very well,” and it seems likely that this pattern would be at least as true among the more impoverished communities served by NorthSTAR.

Finding 2: There are many smaller scale initiatives and pockets of expertise within Dallas County that could serve as the basis of efforts to expand planning and responsiveness to culturally and linguistically diverse populations. These include:

- Expertise regarding African American populations among providers serving the highest proportions of African American NorthSTAR service recipients, including Dallas Metrocare
clinics (Lancaster Kiest Center, Altschuler Center, Westmoreland Clinic), as well as providers such as Southern Area Behavioral Healthcare and advocates focused on cultural issues such as NAMI Southern Sector Dallas. Many providers described initiatives to better serve African American communities. Furthermore, the Dallas County Juvenile Department has a long-standing initiative to reduce disproportionate minority involvement in the juvenile justice system, and this effort has met with some success. Support for this effort more broadly across NorthSTAR and other providers is lacking, though. One example for recent African immigrants is a support group for the Ethiopian community that has started using Mental Health American facilities for meetings.

Expertise regarding Hispanic populations among providers serving the highest proportions of Hispanic NorthSTAR service recipients, including Dallas Metrocare clinics (Westmoreland Clinic and Altschuler Center), as well as Centro de Mi Salud, all of which serve over 1,000 Hispanic NorthSTAR service recipients annually. Parkland serves a high proportion of Hispanic individuals through its community oriented primary clinics and the broader hospital system. Many of these providers described particular initiatives to reach out to Hispanic communities and many noted that they translate materials into Spanish themselves. Centro de Mi Salud has culture-specific programming. Dallas Metrocare’s Altschuler Center initiated a collaboration with faith-based organizations to expand outreach in 2008 which met with mixed success. Efforts for Spanish-speaking individuals go beyond BH settings. Parkland’s COPCs explicitly address culture and seek to recruit bilingual and bicultural staff to serve the communities in which the COPCs are located. Another example of collaboration with other physical health care services include Parkland and Children’s Medical Center, which currently have a collaborative program in the Parkland neonatal intensive care unit to support parents with feelings of anxiety, depression, and self-efficacy that particularly targets monolingual Spanish-speaking parents. Related to this, the Low Birth Weight Developmental Center (LBWDC) provides multiple services to primarily Spanish-speaking families in the Oak Cliff area, including outreach to teenage mothers, parenting classes, and linkages to Headstart programs.

Expertise regarding Asian American populations among providers serving the highest proportions of Asian American NorthSTAR service recipients, including the Dallas Metrocare clinics (Altschuler Center and the After-Hours Crisis Center at River Bend Drive), as well as the Child and Family Guidance Center and (outside of Dallas) Life Path Systems. Dallas Metrocare reported efforts to reach out to Vietnamese communities near Altschuler Centet, employing two clinical staff members who speak Vietnamese. Dallas Metrocare pays a stipend to staff who are able to provide therapy in a non-English language, but this is not supported at the system level. When these staff members are not available, the clinic (and all Metrocare clinics) have access to a limited number of interpreters, backed up by a
telephonic language line. These staff note that faith-based organizations are a key link to these communities and they have had some success with informal cultural brokers who help members of the community build trust and link with needed clinic services.

Finding 3: There are disparities in service delivery to racial and ethnic cultural groups. Data from NorthSTAR, Parkland, and Dallas County Juvenile Services show some distinct overall service trends that stakeholders we interviewed confirmed as true. These were summarized in the data analysis section and are repeated here for convenience of the reader.

- NorthSTAR serves African American members at a higher rate than their proportion of the overall Dallas population and Hispanic members at a much lower rate.
- The rate of services to African American members makes sense given the emphasis of NorthSTAR on lower income populations and the higher rates of poverty among African American communities in Dallas County.
- The rate of services to Hispanic members to some degree fits with national trends in which Hispanic populations tend to seek care in primary care settings rather than specialty BH settings, but the rates seem even more disproportionately low.
- Furthermore, the NorthSTAR data is as revealing for what it does not show as for what it shows. First of all, data on race/ethnicity was not reported for a full 23.7% of Dallas County NorthSTAR members in SFY2009. Second, it has already been observed that information on language is not collected.
- Data from Parkland shows a greater proportion of Hispanic people served overall, but available data specific to BH shows a disparity in access smaller than that through NorthSTAR, but still marked. Parkland also does not have data on primary language spoken.
- Most concerning, data from the Dallas County Juvenile Department shows African American youth involved in the juvenile justice system at twice the proportion of African Americans in the overall Dallas County population.
- Data from the Dallas County Jail BH services was not available, but data on the overall jail population shows African American adults even more over-represented than in the juvenile justice system.

Discussions with system stakeholders including providers serving racial and ethnic minority populations and consumers, families, and youth of color, reinforce these findings. Key issues identified include:

- A lack of attention to people who speak primarily Spanish. In addition to the lack of Spanish programming materials or enrollee-specific communication around denials, providers also
report a lack of Spanish public service announcements or other promotional materials for NorthSTAR involvement. This is of concern, especially in light of the low rate of Hispanic service delivery in NorthSTAR. Providers reported that they believe very few Hispanics even know that NorthSTAR exists.

- A lack of outreach at the system level to minority populations overall was noted. While specific providers have tried to locate in neighborhoods and areas of the county where specific minority communities reside, the system as a whole has not addressed such planning.

- Our conversations with African American and Hispanic parents and youth emphasized a perceived need for more community-based interventions, such as community/school education and stigma reduction, access to youth/teen peer groups, and home-based services. Providers noted that current reimbursement methods do not support home-based service delivery or outreach. Conversations with adult consumers and family members emphasized higher levels of stigma in minority communities for BH needs and particular difficulties with transportation and wait times.

- The RDM categories are seen as particularly problematic and unwieldy for minority populations whose symptom presentation does not always readily fit the “Big 3” diagnoses for adults. While there is a process for access based on other diagnostic needs, providers describe it as cumbersome and a barrier to care in itself. Providers noted particular concern when using these tools with children, and Spanish-speaking providers noted that the Spanish translation of the Ohio scales is not accurate. This was seen as particularly problematic for refugees and other immigrants with trauma-related needs, since post-traumatic stress disorder (PTSD) is not prioritized within the system and complicates accurate diagnosis in many cases (particularly with non-English speaking people). In addition, providers do not perceive that there is support for adjustment to the RDM recommended service mix when necessary to respond to culturally-related needs. The process was uniformly described as complicated, time-consuming, unclear, and, overall, a barrier to care.

- Providers report that there are no efforts to systematically assess for differential needs across minority groups. They also noted a lack of system-wide training related to cultural diversity and differential clinical approaches for diagnosis and treatment.

- Access to services in Spanish was noted as a severe problem. Providers noted in particular a lack of SUD services for Spanish-speaking populations and even more difficulty accessing psychiatrists than the system as a whole. The idea of allowing access to Spanish-speaking psychiatrists across SPNs was suggested. Pharmacy access in evenings and on weekends was also noted as lacking in predominantly Hispanic communities.
Finding 4: There are disparities in service delivery to sexual minorities. System stakeholders serving sexual minority populations reported minimal resources for the lesbian, gay, bisexual and transgender (LGBT) community. The only focus for planning, needs assessment, and targeted service delivery noted was Ryan White funding for persons affected by HIV, which, while a critical set of funding and programs, addresses only a subset of the larger LGBT population and focuses on HIV and AIDS, which also includes a broader range of individuals. Dallas County Health and Human Services oversees funding for a 12-county area through the Ryan White Planning Council of the Dallas Area, and key agencies in Dallas delivering BH supports within the broader array of Ryan White funding include Parkland, the AIDS Arms Peabody Health Center, Legacy Counseling, and the Greater Dallas Council on Drug and Alcohol Abuse. Stakeholders noted that services were generally available if a person qualified for Ryan White or other funding, and that many of the Ryan White funded providers also serve a broader range of needs for LGBT groups, but otherwise LGBT-specific resources were lacking.

Based on our review, the broader needs of sexual minorities beyond those addressed through the Ryan White planning process can be best described as invisible at the system level. While there are some community-based providers addressing the needs of LGBT people (for example, the counseling center at the Dallas Cathedral of Hope), there is no planning focus of which we are aware for the broader population beyond the HIV/AIDS-affected groups served through Ryan White funds. Data on sexual orientation is not collected within the system, and persons knowledgeable about the needs of the LGBT community are not intentionally involved in system planning efforts. This was seen as especially true for transgendered people. Also noted was a broader lack of awareness and sensitivity for LGBT persons, and even of specific issues such as AIDS/HIV treatment, in the broader system outside of specialty programs. One example of an attempt to address this was a recent collaboration between the AIDS Education Training Center and DSHS to provide staff training in state hospitals regarding HIV testing and psychiatry. We are aware of no efforts to address the broader needs of LGBT populations.

Finding 4. There are no systematic efforts to address the needs of persons who are deaf or hard of hearing. In our targeted interviews and reviews of reports, no system-level efforts to document or address the needs of persons who are deaf or hard of hearing were noted. Providers noted some access to American Sign Language interpreters, but few resources overall.

Finding 5. There is a lack of system-level attention to culture and diversity overall. While the 2009-10 NTBHA Strategic Plan set a goal to “become more responsive to the diversity of the community,” the assessment of progress in the 2011-12 NTBHA Strategic Plan was limited to a general report of NTBHA’s attention to this issue when assessing new provider applications with no specific data. A lack of data within NorthSTAR and the broader BH system seems to be a
critical limiting factor to these efforts, as noted above. By contrast, the Dallas County Juvenile Department systematically assesses its efforts to reduce disproportionate minority involvement, with many specific indicators and data tracked over time. We could discern no such systematic effort to address or even to identify health disparities within the formal BH system, as framed by the CLAS standards. It should be kept in mind that most health plans are lacking in this area,24 but the level of planning in North Texas, and for Dallas County in particular, appears to be particularly lacking in scope and priority.

Recommendations

As in previous sections, the recommendations in this section are divided into phases. The first phase would begin immediately and extend over approximately 12 months. The second phase would focus on implementation activities that would take on substantial activity no earlier than two years from now and potentially longer. Note again that we are viewing the Dallas County Behavioral Health Leadership Team, working in partnership with the two operational teams and with NTBHA when appropriate, as the forums through which the design and implementation of efforts to assess and address health disparities and promote culturally and linguistically competent care would take place.

Phase One: Begin to take systematic steps to gather data on health disparities related to culture and language and explicitly address cultural and linguistic competence of the overall Dallas County BH system in system-level planning.

3. Systematically collect data on culture and language. Systematic data collection on culture and primary language would support compliance with the NorthSTAR contract terms, as well as more effective system-level responses to the needs of its diverse community members. At a minimum this would entail:

   • Increasing the integrity of data collection for race and ethnicity so that missing data is reduced from current high levels (over 20%) to negligible levels. Data should be available for both enrollees and persons served so that levels of differential access across groups can be noted. Data collection approaches should be standardized across all system participants, including NorthSTAR and large systems such as Parkland.

   • Systematically collecting data on primary language of both enrollees and persons served, including Spanish as well as other languages. System-level resources to provide

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services in these languages should also be routinely assessed through provider credentialing and other approaches.

- Beginning to collect data relevant to other cultural groups, including data on sexual orientation and physical impairments such as deafness or hearing loss.

- Consulting on the design and implementation of all data collection efforts with system stakeholders who represent the cultures being addressed, so that variable parameters and implementation plans are maximally sensitive to cultural dynamics and effective in their implementation with diverse communities and populations.

4. **Systematically prioritize representation of diverse cultures in the BHLT, operations teams, and all system planning groups.** The representation of communities of color (African American, Hispanic/Latino, and Asian American) in these planning bodies should be explicitly prioritized and maintained over time. Outreach to the providers noted above and community organizations (including faith-based organizations) can help develop and ensure representation over time. Representation in self-help and advocacy processes should also be promoted.

5. **Provide written materials in Spanish.** It seems highly likely that more than 10% of NorthSTAR enrollees primarily speak Spanish better than English, given that 19% of the overall Dallas County population over five years old does so. Unless data is available to indicate otherwise, we recommend that NorthSTAR begin to offer all written materials in Spanish.

6. **Initiate initial performance improvement projects based on available data.** The clinical operations teams should work to establish these, and targets could focus on needs assessment to ensure at least basic compliance with other NorthSTAR contract requirements or other straightforward matters. This could include assessment of levels at which other languages are spoken by NorthSTAR enrollees and persons served, as well as bilingual capacity (including ASL capacity) across the NorthSTAR provider network (including inpatient providers). Such efforts should be coordinated with efforts to assess language needs by other system members, including Parkland and county-funded providers.

7. **Develop a plan for addressing health disparities and promoting cultural and linguistic competency more broadly.** Within the first year, system stakeholders should begin to develop a plan to address disparities and promote cultural and linguistic competence across the system. This plan should address all major cultural groups represented in the system, including racial and ethnic minorities, sexual minorities, and disabled populations. The plan should be developed with the lead of BHLT and operations team members that represent these populations, and it should build on and mutually support existing efforts by individual
providers and other systems (such as the excellent work of the Dallas County Juvenile Department).

**Phase Two: Implement a plan to reduce prioritized health disparities and increase the cultural and linguistic competence of the Dallas County BH system over time (and broader NorthSTAR, as applicable).**

4. **Make a long term commitment to reduce disparities and increase competence.** The CLAS standards imply a long-term quality improvement approach, consistent with the overall recommendations we made in Step 3 on Consumer-Oriented Performance Improvement. A long term vision, annual plan, and regular performance monitoring and refinement of the plan over time are needed.

5. **Incorporate the CLAS standards and other national standards and best practices into the plan.** While the plan should be grounded in the priorities and experiences of system stakeholders representing diverse communities, the plan should also explicitly reference the CLAS standards, as well as national best practices related to cultural brokers and specific EBPs that have been validated with specific minority communities.

6. **Collect, assess, and use data to drive system improvements.** Possible strategies could include the following:
   - Use data reporting to document existing disparities and measure change over time.
   - Improve access to specialists for each of the minority populations prioritized.
   - Build the skills of the broader workforce to provide culturally competent care.
   - Provide more access to specialty provider agencies.
   - Incorporate consultation with minority specialists into the practice of providers more generally.
   - Employ non-professionals and community members as cultural brokers.
   - Provide access to population-specific EBPs.
   - Include approaches that integrate MH and SUD services, and provide BH in primary care settings, particularly for those groups with comorbid physical health needs (such as persons living with or affected by HIV) or who tend to prefer to receive BH are in primary care settings.

7. **Incorporate the needs of smaller subgroups as well as larger groups.** While the priority should be placed on the largest groups and the biggest needs, the plan needs to include provisions to improve performance for all persons served, addressing the specific concerns
of additional populations, including recent immigrants and other emerging population groups, diverse sexual minorities, the deaf community and people with other disabilities, and bicultural individuals and families.

8. **Incorporate specific performance indicators and incentives tied to defined progress in cultural competence into BH purchasing contracts.** These could involve any of the variables discussed in this section, including data collection, Spanish materials availability, access to services, access to interpreters, implementation of cultural brokers, or other factors.

9. **Workforce Development.** Step 11 on promotion of a SOC for children and families emphasized the need for cultural competency training that goes beyond the surface level training that most providers receive to confront underlying issues of racism at both the individual and institutional levels. This should be part of a broader effort to build the workforce and its competencies, both by recruiting and increasing the number of individual and agency provider specialists, and by increasing the sensitivity and competence of the system as a whole. This should be nested within the broader effort to make the system more recovery-oriented, welcoming and capable.

**Additional Background on Health Disparities Across Cultural Groups**

National data on the delivery of BH services has found many trends in prevalence of disorders and service delivery related to culture.

**Trends related to race and ethnicity include:**

- In 2001, the U.S. Department of Health and Human Services released a supplement to the 1999 Surgeon General’s Report on MH services entitled *Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General* (U.S. DHHS, 2001a) documenting “the existence of striking disparities for [racial and ethnic] minorities in mental health services and the underlying knowledge base” (p. 3). The report documents less access to MH services, lower likelihood of receiving care, and greater likelihood that any care received is poorer in quality. These and other factors lead to the conclusion that members of racial and ethnic minority groups bear a disproportionately greater burden from unmet MH needs and suffer greater losses in overall health and productivity. The report built upon and amplified the observation from the preface to the original 1999 Surgeon General’s Report on MH that “Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services” (U.S. Surgeon General, 1999, p. vi).

- The supplemental report (U.S. DHHS, 2001a) also documents a host of barriers, culled from a systematic review of the research base and input from national experts and task forces. These include overall barriers related to the cost of care, the stigma associated with mental
disorders, and a fragmented service system. Specific barriers include a lack of knowledge and awareness of cultural issues, bias, and inability to speak client languages on the part of MH providers, and an understandable level of fear and mistrust of treatment on the part of people in need of care. Disparities also relate to historical and current experiences of racism and discrimination, which have impacts not only on the treatment process, but also on mental health, economic status, and political influence. For new immigrants and refugees, trauma is often a factor complicating both trust in helping institutions and accurate diagnosis when underappreciated. While the experience of these disparities among the diverse members of different racial and ethnic groups is itself heterogeneous, the conclusion is clear that significant barriers to care confront these minority groups.

- Compared to White populations, national studies find that persons of color receive far fewer MH services, with African Americans overall only 50% as likely to receive care and Hispanic populations only 60% as likely. Further complicating this disparity, African Americans are 90% more likely and Hispanics 50% more likely to receive MH care in government human service settings.\(^\text{25}\)

- There is evidence that, across the lifetime, African American and Hispanic populations overall suffer from somewhat lower rates of anxiety, mood and (for African Americans only) SUD than White populations, but these findings likely reflect some level of underreporting and also still represent levels of need that exceed available treatment resources.\(^\text{26}\) That being said, a link between the experience of racism, bias, and discrimination and increased risk for mental disorders has been noted across studies for many years (U.S. DHHS, 2001a) and was clearly documented in a nationally representative survey (Kessler, Mickelson, & Williams, 1999). The magnitude of the association between the combination of major and day-to-day discrimination and poorer mental health was comparable to more commonly studied stressful life events such as the death of a loved one, divorce, or loss of a job. Kessler and colleagues focused primarily on differences between African American and White groups, but other studies have made similar links between perceived discrimination and risk for depression among Asian Americans and Hispanic Americans (U.S. DHHS, 2001a). Other factors related to increased risk for mental disorders that disproportionately affect


many members of minority racial and ethnic groups include poverty, living in neighborhoods with higher levels of violence and crime, and lower education levels (U.S. DHHS, 2001a). Mental disorders are highly prevalent across all populations, regardless of race or ethnicity, but cultural and social factors contribute to the causation of mental illness in complex interactions that vary by disorder. (Surgeon general report).

Trends for sexual minorities:

• For sexual minorities, the stance of MH providers has also changed dramatically over the last four decades. Psychiatry has a long history of viewing non-heterosexual identity as pathological. While homosexuality was removed from the lists of psychiatric disorders by the American Psychiatric Association in 1973, pathologizing categories such as “ego-dystonic homosexuality” and “sexual orientation disturbance” persisted even until the most recent edition of psychiatry’s diagnostic manual (DSM-IV) in 1994 (Harris & Licata, 2000). More recent studies have generally concluded that differential levels of MH need described below for lesbian, gay, bisexual, and transgender people are a function of the various stressors associated with minority status (particularly discrimination), rather than a function of simply having a lesbian, gay, bisexual or transgender identity.

• Lesbian, gay, and bisexual people have been found to experience higher rates of discrimination, victimization, and violence by others than the general population (Mays and Cochran, 2001; Cochran, 2001), including particular stress during adolescence (Ryan & Futterman, 1998). The HIV/AIDS epidemic has also been a major source of grief, loss, and stress within gay, lesbian, and bisexual communities since it was first identified in 1981 (Cochran, 2001). Many studies have theorized that higher rates of MH need among lesbian, gay, and bisexual people are related to the experience of discrimination, largely based on the fact that the types of MH disorders showing higher rates were those known to be affected by stress and negative life events (Paul et al., 2002; Gilman, Cochran, Mays, Hughes, Ostrow, & Kessler, 2001). Mays and Cochran (2001) examined this issue specifically through a large, nationally representative study that employed a behavioral definition of sexual orientation. They found a clear empirical link between higher rates of perceived discrimination and MH needs among lesbian, gay, and bisexual men and women. The primary conclusion across nationally representative studies is that lesbian, gay, and bisexual people seem to be at elevated risk for MH disorders influenced by social stigma, including depression, other mood disorders, post-traumatic stress disorder, other anxiety disorders, and SUD (Cochran, Sullivan, & Mays, 2003; Mays & Cochran, 2001; Cochran, 2001; Gilman, et al., 2001; Ryan & Futterman, 1998). While it is important to view these findings as somewhat tentative given methodological limitations to these studies, the pattern of findings across multiple studies seems clear. Cochran and her colleagues (2003) were able
to analyze a large national data set that looked explicitly at sexual orientation. They found that gay and bisexual men were more than twice as likely as heterosexual men to meet criteria for anxiety, mood, and SUD. Differences between lesbian and bisexual women versus heterosexual women were less strong, but the same pattern of higher prevalence was observed (Cochran et al., 2003).

- Studies of suicide risk factors, including attempts, clearly document elevated risk for lesbian, gay, and bisexual people, particularly earlier in life and specifically during adolescence (Cochran, 2001; U.S. DHHS, 2001b; Goldman & Beardslee, 1999). Increased prevalence of suicide attempts reported in eight large-scale surveys conducted between 1998 and 2001 ranged from two to three times higher for lesbian, gay, and bisexual people, with higher rates generally being associated with samples that included adolescents (Cochran, 2001). The increased risk tends to occur earlier in life, with 75% of suicide attempts happening before age 25.

- The needs of people who are transgendered have come into focus as a specific population of interest in studies of MH needs and services in the last decade. Most of the psychiatric literature had previously focused primarily on the needs of transsexuals (people seeking to change their sexual orientation), generally viewing their “gender dysphoria” as pathological. But since the late 1990s, with the first publications on transgender youth and their social needs appearing in the professional literature, the needs of transgender people have begun to be viewed more broadly. The information that is available suggests that risks are higher for stress-related needs across the group of transgender people, including SUD.27

- The literature seems to clearly establish that lesbian, gay, and bisexual adults access treatment in higher numbers than do heterosexual people. Adjusting for demographic differences and current insurance status, Cochran et al. (2003) found gay, lesbian, and bisexual men and women were more likely to seek help for MH needs than their heterosexual counterparts, a finding that had been suggested in the literature for some time (Cochran, 2001). It is not clear that these findings apply to youth. Rates of service use among adolescents is complicated by lower rates of insurance and service use overall, and gay, lesbian, and bisexual youth seem particularly vulnerable to bias and stigma exhibited by health professionals (Ryan & Futterman, 1998). There is also evidence of particular disparities in access to care for transgendered individuals.28

Trends for persons who are deaf or hard of hearing:

28 Clements-Nolle et al., 2001; Gamache, P. and Lazear, K. J. (Summer 2009).
People who are deaf or hard of hearing are quite heterogeneous and have been increasingly recognized as cultural and linguistic minority groups (Dolnick, 1993). While the two groups are typically defined together, their BH needs and the strategies to address those needs may be different. The literature suggests that people who are deaf or hard of hearing and have BH needs are often misdiagnosed or underdiagnosed, as a result of the lack of specialized providers or interpreters with MH knowledge who have the skills to appropriately communicate and knowledge of how various mental disorders may manifest themselves in this population (Hindley & Kitson, 2000).

While psychiatric disorders in earlier studies were found to be at least twice as common in children who are deaf or hard of hearing as they are in the general population (Hindley, Hill, McGuigan, & Kitson, 1994), these prevalence rates appear to be decreasing as a function of improvements in educational practices and parenting skills (Hindley & Kitson, 2000). For example, in one study that found equivalent prevalence rates, the author also found that in 1994, 100% of hearing mothers and 94% of hearing fathers of children who are deaf or hard of hearing had sign language skills, whereas in 1978, only 23% of hearing mothers and 9% of hearing fathers had sign language skills (Sinkkonen, 1994, as cited in Hindley, 2000). Deaf and hard of hearing children have been found to be at increased risk of physical abuse (Sullivan & Knutson, 1998). Addressing these impediments to social support and sometimes traumatic stressors seems to have in part reduced differences in MH needs between this group and the general population.

Provider specialization is particularly important for serving people who are deaf and hard of hearing. This need is multi-faceted. For example, a provider serving deaf and hard of hearing people has to understand and accommodate a broad range of linguistic needs with sign fluency (American Sign Language and other sign systems), as well as understand the specific cultural needs within subpopulations (such as the unique needs of people who have acquired deafness versus people who are born deaf, or deaf children who attend schools with hearing children, as opposed to those who attend schools for the deaf). Similarly, providers also need to be aware of how psychological assessment tools and best practice interventions may have to be modified for people who are deaf or hard of hearing. Finally, if specialist providers are not available for direct services, it is essential for non-specialist providers to at least have access to regular specialized consultation.

Even those providers who are more accessible may still convey an attitude of inaccessibility by what they do or say. This can relate to a range of factors, including a lack of understanding about disability cultures (including terminology), about how the person culturally identifies with their disability and the disability community, or about how a disability may or may not relate to BH needs. For example, many providers make eye
contact with the interpreter who is speaking verbally rather than with their deaf client, who is signing. Similarly, differences within disability groups need to be understood and acknowledged, such as how a person who is congenitally deaf may culturally identify with the deaf community in a different way than a person who became deaf during their lifetime. This observation applies to other disability groups, as well (for example, people who are blind).