

# An Assessment of the



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## FINAL REPORT AND RECOMMENDATIONS

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March 23, 2017



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THE MEADOWS MENTAL HEALTH  
POLICY INSTITUTE FOR TEXAS

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Developed with a grant from



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## Executive Summary

In the spring of 2016, the Paso del Norte Health Foundation (the Foundation) requested that the Meadows Mental Health Policy Institute (MMHPI) conduct an assessment of the current functioning of the El Paso Behavioral Health Consortium (BHC) in order to identify opportunities for strengthening its role in promoting system enhancements. For the purpose of developing more informed recommendations, MMHPI also examined accomplishments and changes brought about in the behavioral health system since 2014, and updated basic prevalence/needs and needs met data.

MMHPI used a variety of approaches in its assessment of the El Paso BHC's functioning to identify best practices and to develop recommendations for enhancing the BHC. Methodologies included: interviewing key informants, reviewing BHC documents and meeting notes, participant observation at BHC meetings, updating prevalence and needs met figures in focal areas for children and adults, benchmarking behavioral health consortium best practices from other communities, reviewing national metric dashboard exemplars, and identifying policy opportunities.

The El Paso BHC was found to have succeeded in establishing a viable organizational structure and significant participant involvement and collaboration from important county agencies in a relatively short time. Involvement has expanded since 2014 to include behavioral health providers and authorities as well as representatives from universities, the broader health care community, county and state agencies, and other key nonprofit organizations. In addition, the BHC's leadership councils allow for growth in the breadth and depth of partnerships within each of the BHC's three key areas of focus (Family, Justice, and Integration). In addition, the BHC developed conceptual frameworks to guide its development of systems perspectives, especially in the family/child-serving system and for justice-involved persons with behavioral health conditions. It also took on significant collaborative projects aimed at enhancing systems of care.

MMHPI's multi-method approach led to numerous other key findings and the development of more than 30 recommendations for the BHC's Executive Committee and leadership councils. An abbreviated version of these recommendations is provided in Table 1 on the following page. The full set of recommendations, including more detailed guidance on implementation steps, can be found in the body of the report.

**Table 1. Overview of Recommendations for the El Paso Behavioral Health Consortium**

Recommendations for the BHC Executive Committee
<b>Involvement, Participation, and Collaboration</b>
<i>Recommendation 1</i> – The Consortium Executive Committee (CEC) should consider adding members from independent school districts, the primary health care provider community (e.g., federally qualified health center leaders), and the Veterans Administration.
<i>Recommendation 2</i> – The CEC should identify specific ways in which it will develop over time to achieve an even higher level of collaborative functioning comparable to high-performing collaboratives in Texas and nationally, as identified in MMHPI’s “benchmarking” investigation with other BHCs.
<i>Corollary Recommendations</i> – Establish a team of local leaders who would work collaboratively to increase grant funding for specific system development initiatives in the region; set two-year goals for the collaborative development of grant applications, building on strengths and identified region-wide concerns (e.g., stigma, workforce, intensive services for high-needs persons). Particular attention should be put on initiatives aligned with funding that may come out of the 85 <sup>th</sup> Legislature, including capacity development regarding intensive mental health services for children in foster care and jail / forensic state hospital diversion.
<b>Executive Committee Leadership and Oversight</b>
<i>Recommendation 3</i> – Given the imminent retirement of current Executive Committee Chair, Sharon Butterworth, the CEC should establish a sub-committee whose purpose will be to draft a succession plan to be reviewed, modified, and approved by the committee as a whole. Please refer to the full body of the report for more detail.
<i>Recommendation 4</i> – The Foundation should bolster its “backbone” support for the BHC in key ways.
<ul style="list-style-type: none"> <li>• Hire or deploy an individual with at least half-time (0.5 FTE), preferably full time (1.0 FTE) dedication to working with the CEC and the leadership councils (LCs), who would report to the Foundation’s lead (Enrique Mata) to provide logistical, coordinating support.</li> <li>• Focus the Foundation’s lead staff member role on higher level leadership, including support of BHCs’ strategic planning, engaging leaders to support their ongoing participation in and commitment to the BHCs, and working with a backbone agency to provide advanced support, such as creation of a system performance “dashboard.”</li> </ul>
<i>Recommendation 5a</i> – It could be helpful to propose the following ongoing operational strategies and expectations to the LCs and obtain their agreement or suggestions for revision.
<ul style="list-style-type: none"> <li>• <i>Recommendation 5a.1</i> – The CEC could recommend that quarterly reports from the LCs follow a common format (for each of the primary projects on which the LC currently is working.</li> <li>• <i>Recommendation 5a.2</i> – In receiving quarterly reports from the LCs, the CEC could provide regular feedback that helps each LC identify ways in which its activities overlap with those of other LCs as well as provide specific recommendations as to how LC activities can be mutually supportive.</li> </ul>
<i>Recommendation 5b</i> – Request that each LC propose one or more metric(s) for which it will develop the methodology necessary to calculate it and track changes in it over time, beginning in 2017.

<b>Recommendations for the BHC Executive Committee</b>
<b>Goals and Objectives</b>
<p><i>Recommendation 6</i> – Update the BHC goals and objectives by incorporating the highest-priority recommendations described in this report (as determined by the CEC), including the highest-priority recommendations identified by each LC.</p>
<p><i>Recommendation 7</i> – Continue to work with LCs in tracking system of care “gap filling” across child-serving and adult-serving systems. However, it could more intentionally help LCs identify overlapping concerns. For example, members of the Integrated LC could work with members of the Family LC to identify integrated care best practices for children and youth with routine vs. complex conditions, and also make plans for the collaborative development of integrated care programs for children and youth.</p>
<b>Use of Metrics and a Dashboard</b>
<p><i>Recommendation 8</i> – The CEC should work closely with the Foundation (including Mr. Mata, but also with staff leaders overseeing the Paso del Norte Information Exchange) to: a) examine the Arizona dashboard and others identified by MMHPI’s national scan of dashboards to identify a model that would work best in El Paso; and b) to develop a plan for implementing such a dashboard that would include Foundation and BHC collaborating partners, as well as address costs and potential sources of pooled funding for the endeavor. A framework to guide the selection and organization of system metrics is the “Quadruple Aim,” which indicates the importance of examining 1) access to care, 2) quality of care, 3) the consumer’s experience of care, and 4) the health of the workforce. The framework should also incorporate sensitivity to priorities of key funders, including programs expanded or developed under the 85<sup>th</sup> Legislature (e.g., waitlists, inpatient capacity, capacity development regarding intensive mental health services for children in foster care and jail / forensic state hospital diversion).</p>
<b>Policy Priorities</b>
<p><i>Recommendation 9</i> – The CEC’s primary role at this juncture should be to work collaboratively with the LCs to address the policy issues we have identified in our recommendations for each LC. However, the CEC should, on at least an annual basis, revisit the list of state policy priorities and consider whether to add to the list any additional policy concerns that have arisen over the 12-month period preceding the review.</p>

<b>Recommendations for the Family Leadership Council</b>
<b>Involvement, Participation, and Collaboration</b>
<p><i>Recommendation 1</i> – The community has seen (and anticipates) changes in the key leadership of its child-serving agencies. As agency leaders change, it is important for Family Leadership Council (FLC) representatives to reach out and engage new leadership in the work of the FLC. It is recommended that FLC chairs or selected representatives meet with new leaders to inform them of the FLC’s goals, objectives, and accomplishments, and the expected level of agency commitment. Past efforts, similar to those of the FLC, have lost momentum or dissolved when membership has changed.</p>

**Recommendations for the Family Leadership Council**

*Recommendation 2* – Specifically recruit involvement of independent school district (ISD) staff with influence over or engagement with school-based mental health services for children and youth with severe emotional disturbances (SED), and/or who have authority over school discipline policies. There may be legislative action to establish supports for school-based mental health liaisons, and this should be pursued if available post-session.

*Recommendation 3a* – One opportunity for building stronger collaboration is through the development of collaborative grant applications that could be developed in response to federal, state, or foundation requests for proposal (RFPs). Many entities who issue RFPs wish to see multi-agency collaborations; communities that present a comprehensive response to RFPs can be very successful. The FLC should review grant opportunities that they are considering and decide as a group where partnerships may strengthen applications. The FLC also should track special and grant-funded projects to safeguard an approach to sustainability.

*Recommendation 3b* – In order to continue to work to transform El Paso County into a model community for child and family behavioral health services and supports, the FLC needs to even more definitively take the lead in connecting, informing, and supporting all children’s system of care planning efforts, or give the lead to another entity. A single lead entity should serve as the umbrella entity for all other child and family behavioral health planning groups – establishing partnerships, setting system priorities, identifying opportunities for collaboration, allocating available resources, and measuring system change.

- There are currently other groups with similar goals competing for the time and attention of FLC members. The El Paso Consortium for Children, convened by Dr. Handal, is one such example. Since many of the same members attend this meeting, it is important for one entity to take the lead so that the other can align their priorities and so that participants do not have to choose to attend one meeting over the other.
- The FLC should determine whether the Texas System of Care’s (TSOC) priorities align with those of the FLC, and whether involvement with the TSOC will entail making commitments that will detract from the FLC’s current focus. Involvement with TSOC should only be pursued to the extent that it furthers local priorities.

**System of Care Priorities**

*Recommendation 4* – The FLC should continue its focus on high-needs foster care children and youth and prioritize the success and high level of functioning of intensive mental health services, such as the Multisystemic Therapy (MST) team. It should build on these efforts, and work toward serving a higher proportion of the MMHPI estimate of unmet need for intensive community and family-centered programs (see **Appendix 5**). This effort should be aligned with any foster care development resources that come from the 85<sup>th</sup> Legislature. In addition, the FLC should prioritize and set objectives toward one or more of the following goals:

**Recommendations for the Family Leadership Council**

- Develop a common method across child-serving agencies for identifying, counting, and tracking all children and youth with SED who are most at risk for out-of-home placement and/or juvenile justice system involvement;
- Prioritize the capacity of child-serving agencies to provide intensive, family-centered, and community-based programming that coordinates all service planning and service delivery processes across all agencies;
- Engage ISD decision-makers in examining school discipline policies and procedures associated with positive and negative outcomes for children and youth with SED, and formally compare them to best practices;
- Regularly track the gap between need and intensive community-based service capacity; and
- Develop creative funding and other mechanisms to expand intensive community-based service capacity.

*Recommendation 5a* – Building on its work to develop closer working relationships with managed care organizations (MCOs) over the past couple of years, the FLC (through the MCO Committee) should consider an initiative to determine the necessary resources to build capacity in the county, both inside and with additional providers beyond the local mental health authority (LMHA), to deliver rehabilitation skills training and wraparound services. These services were approved through Senate Bill 58 in 2013 as part of the Medicaid benefit, and no providers in El Paso, other than EHN, have yet been credentialed to provide them. There is a substantial need for these services for children and youth with intensive needs in this community, particularly for children involved in the foster care system.

*Recommendation 5b* – Identify one or two evidence-based prevention programs that are known to reduce the incidence and prevalence of disorders that are known to be a significant cost to MCOs.

- *Recommendation 5b.1* – Including an ISD in the discussions over time may also be of value, because many evidence-based prevention programs are conducted with the cooperation of schools.

*Recommendation 5c* – Another way to expand the service continuum to include prevention would be to add an early intervention/preventive intervention for children/youth who are at risk of later needing an intensive level of care.

**Goal, Objectives, and the Use of Metrics**

*Recommendation 6* – The FLC should continue to address gaps in services for children/youth with intensive needs and agree on metrics that will enable it to track capacity expansion and impacts. The group is encouraged to track restrictive setting use (e.g., detention use, residential care, and inpatient care).

**Policy Priorities**

*Recommendation 7* – The FLC should work with its legislative allies to promote policies that give child-serving agencies (mental health, child welfare, juvenile justice, and schools) incentives to collaborate in the service of ensuring that sufficient intensive family- and community-based services are available to the most vulnerable children and youth who are at risk for out-of-home placements, school failure, and repeated juvenile justice system involvement.

Recommendations for the Integration Leadership Council
<b>Involvement, Participation, and Collaboration</b>
<p><i>Recommendation 1</i> – The Foundation should continue to play a facilitative role for the Integration Leadership Council (ILC) and should continue to encourage wider participation, especially from primary care providers such as federally qualified health centers (FQHCs). The ILC could establish a regular schedule of more frequent meetings (e.g., meeting monthly or bi-monthly).</p>
<p><i>Recommendation 2</i> – The ILC should identify small number (one to three) of projects that could demonstrate the viability and effectiveness of integrated care programming in both primary care and specialty behavioral health settings. Given its recent inclusion as a reimbursable service under Medicare, as well as its strong evidence base, promotion of the Collaborative Care model should be considered for prioritization. The ILC could also explicitly track the number, type, and inclusivity of collaborative projects that would ensure a more dynamic ILC.</p>
<b>System of Care Priorities</b>
<p><i>Recommendation 3</i> – The ILC should use the recent MMHPI/St. David’s Foundation publication on the core components of integrated care to inform the identification of specific integrated care practices that it could recommend for adoption by all settings in El Paso.</p>
<p><i>Recommendation 4</i> – The ILC should update its goals, objectives, and strategies based on its review of the full set of recommendations provided in this final report. We recommend special attention be paid to the following:</p> <ul style="list-style-type: none"> <li>• Selecting integrated care training models recommended for implementation in primary care and behavioral health professional training programs (with particular emphasis on the Collaborative Care model);</li> <li>• Plans associated with the implementation of integrated care programs in primary care and specialty behavioral health settings; and</li> <li>• The selection of progress metrics to track, such as the number of graduate training programs that include integrated care, the number and percentage of primary care clinics that have an embedded behavioral health specialist, and the level of integration achieved by integrated care programs using the MMHPI/St. David’s IBH checklist as a guide. (See also the metrics section below.)</li> </ul>
<p><i>Recommendation 5a</i> – Continue to track trends regarding the number of behavioral health professionals trained and retained in the region.</p>
<p><i>Recommendation 5b</i> – Identify best practices in integrated care training and make plans to broaden adoption of them in the region. Review best practices in Texas, including the University of Texas-Rio Grande Valley (UT-RGV) training program for family medicine residents and the integrated care programs at Bluebonnet Trails LMHA and CommuniCare in San Antonio.</p>
<p><i>Recommendation 6a</i> – The ILC should explicate the clinical populations in need of integrated care across primary care and specialty behavioral health settings, as well as the models of integrated care that are appropriate for clinical populations in those settings. The identification of such models can set the stage for specific collaborative plans to implement integrated care in both types of settings.</p>

<p><b>Recommendations for the Integration Leadership Council</b></p>
<p><i>Recommendation 6b</i> – Eventually, the ILC could take this “population health management” activity to a more sophisticated level, in which member agencies (1) estimate the number of people needing each type and level of integrated care across the region and (2) identify implications for the number and types of integrated care programs, teams, and staff needed to meet those needs.</p>
<p><i>Recommendation 7</i> – The ILC should encourage council members and their associated agencies to collaborate in the service of implementing at least two primary care-based programs and at least two specialty behavioral health-based programs.</p>
<ul style="list-style-type: none"> <li>• <i>Recommendation 7a</i> – Collaborating providers should incorporate the input of the ILC’s training programs in order to plan for the inclusion of behavioral health and primary care trainees in these programs.</li> <li>• <i>Recommendation 7b</i> – Encourage either the participation of (1) major employers and (2) leading insurance plans in the planning processes, or deploy members to work closely with those key partners, both to ensure adequate financing for integrated care is in place and to collaboratively track the cost-effectiveness of integrated care programs.</li> <li>• <i>Recommendation 7c</i> – Use fidelity/readiness assessment tools (links to which can be found in the recent MMHPI/St. David’s Foundation publication cited above) and outcome measures.</li> </ul>
<p><b>Use of Metrics</b></p>
<p><i>Recommendation 8a</i> – The ILC should adopt at least one or two metrics related to its goal to address the dramatic lack of community capacity for both adult and child behavioral health service providers.</p>
<p><i>Recommendation 8b</i> – In order to tackle the challenge of adopting and tracking metrics, the ILC may need to appoint (or recruit) a metrics work group lead who can engage existing or new members with expertise in evaluation, data management, and the like to spearhead an effort in this area.</p>
<p><b>Policy Priorities</b></p>
<p><i>Recommendation 9</i> – Work with local legislators and their staff to ensure that state-level policy promotes the financing and regulatory environment in which integrated care can flourish. Encourage legislative allies to support policy changes to encourage annual mental health screenings for youth ages 12-18 years, as well as those that would further the recommendations of the state-level Behavioral Health Integration Advisory Committee, such as requiring MCOs to offer integrated provider sites one contract for physical and behavioral health services, even when the MCO subcontracts with a BHO.</p>
<p><i>Recommendation 10</i> – Serve as a forum for sharing models of successful organizational collaboration that promotes integrated care, including, for example, the most current and effective approaches to developing business associate agreements and data portals between agencies that allow them to collaborate in serving specific individuals and in developing population health management approaches.</p>

Recommendations for the Justice Leadership Council
Involvement, Participation, and Collaboration
<p><i>Recommendation 1</i> – The Foundation should continue to play a facilitative role for the Justice Leadership Council (JLC) and should continue to promote opportunities for system enhancement efforts to be recognized and celebrated. Facilitate ongoing efforts to link all system enhancement efforts together in a common framework, as is being done with the Sequential Intercept Mapping process. Facilitate the documentation – both qualitative and quantitative – of the effects of all system change efforts.</p>
<p><i>Recommendation 2</i> – Consider creating sub-groups of members focused on specific intercept points that do not currently have a committee overseeing its detailed work (similar to the Jail Diversion Committee that addresses Intercept 1), with an emphasis on Intercepts 0, 2, and 5. The ultimate goal would be to fulfill a function of describing, tracking, and promoting improvements across all system enhancement and gap-filling efforts so that JLC members can see the “big picture” and continually identify ways of bolstering enhancement efforts at each intercept point. The JLC should also identify opportunities that would mutually benefit the efforts of the Jail Diversion Committee and each of the other ongoing county-level committees and work groups that have pre-dated the existence of the JLC.</p>
<ul style="list-style-type: none"> <li>• <i>Recommendation 2a</i> – The intercept-specific sub-groups could provide regular updates to the JLC on plans for enhancing programming and collaborative efforts at each intercept point, along with any known timelines associated with planned efforts.</li> <li>• <i>Recommendation 2b</i> – The JLC leadership and its appointed intercept-based sub-groups could use ongoing tracking and updates to identify “points of contact” between county-level efforts across intercepts.</li> <li>• <i>Recommendation 2c</i> – The JLC, with input from sub-groups, should look for opportunities to publicize accomplishments (e.g., in the newspaper or on local news stations).</li> </ul>
System of Care Priorities
<p><i>Recommendation 3</i> – Document and describe the operational statuses of the pretrial office program and the in-jail behavioral health services provided by Emergence Health Network (EHN), noting the extent to which best practices are included in the programming, along with gaps in the planned provision of best practices.</p>
<p><i>Recommendation 4a</i> – Consider adopting the Multidisciplinary Response Team model, which is an emerging model of law enforcement/mental health system collaboration at Intercept 1.</p>
<p><i>Recommendation 4b</i> – Consider embedding a behavioral health specialist with dispatch to support efforts at Intercept 1.</p>
<p><i>Recommendation 5</i> – Serve as a forum that supports creative approaches to identifying various means of enhancing the availability of ACT, forensic ACT, and other intensive services in El Paso County to support Intercept 5. Below are specific steps that the JLC could take:</p>

**Recommendations for the Justice Leadership Council**

- *Recommendation 5a* – Further specify an ideal program model for high-utilizing adults with mental illnesses who need intensive community-based treatment and supervision. For high utilizers of the criminal justice system, a forensic model is emerging nationally which combines assertive or intensive community treatment teams with mental health-community supervision collaboration, organized within a Risk-Need-Responsivity (RNR) framework. The basic idea is that people with serious mental illness (SMI) who are high utilizers of the jails have both mental health needs as well as criminogenic risks that need to be carefully assessed and then treated and ameliorated in a way that is responsive to the assessed needs.
- *Recommendation 5b* – Once the Intercept 5 model for successfully serving and monitoring the highest utilizers with significant criminogenic needs has been developed, the JLC’s criminal justice system and mental health members should identify ways of prioritizing the funding of the ideal model in order to serve those most in need of a combined Forensic ACT/RNR model.

*Recommendation 6a* – Work with EHN to help ensure the inclusion in its First Episode Psychosis (FEP) Care program of people with a first episode of psychosis who are detected through contact with the law enforcement or criminal justice systems. FEP Care should be added to the ideal adult system of care.

*Recommendation 6b* – The “lessons learned” from EHN’s implementation – in terms of what is working best for which sub-sets of clients as well as capacity limitations of the program – should be useful in planning for implementation of a second team in approximately 2018.

**Goal, Objectives, and the Use of Metrics**

*Recommendation 7* – Collaborate to develop an evaluation process that will serve both to help the JLC remain oriented to its stated objectives and to provide continual feedback that can help it celebrate successes and identify opportunities for system enhancement.

**Policy Priorities**

*Recommendation 8* – Work with local legislatures to promote policy priorities that support the locally-driven objectives and strategies being pursued by the JLC and its constituent members. For example, Senate Bill 292 (Huffman, Nelson, Schwertner) would potentially increase state-funding for Intercept 1 diversion activities. In doing so, the JLC can draw on the Texas Judicial Council’s recent set of recommendations that, if fully reinforced by state policies and legislations as well as local implementation, could help the JLC meet its goals.

- *Recommendation 8a* – Examine and incorporate the Texas Judicial Council’s recommendations concerning state- and local-level support for compliance with state-required screening protocols (Intercept 2).
- *Recommendation 8b* – Examine the Texas Judicial Council’s recommendations concerning the appropriate use of competency restoration and decide which recommendations should be implemented in El Paso and which should be promoted at the state level with legislators and state agencies.
- *Recommendation 8c* – Review opportunities for participation in the SB 292 jail diversion expansion.

### Recommendations for the Justice Leadership Council

- *Recommendation 8d* – Recognizing the possibility that the state will partner with communities that are able to collaborate across agencies locally to eliminate forensic waitlists under SB 292, we recommend that the JLC develop a formal plan for reducing (and eventually eliminating) such waitlists that is endorsed by the county, the local mental health authority (EHN), and the hospital district (UMC of El Paso). This will strengthen El Paso’s hand in promoting state-level policies and priorities to support the goals of the JLC.

## Introduction

The El Paso Behavioral Health Consortium (BHC) was first convened in 2012 with the purpose of examining the El Paso community behavioral health system and providing input into its enhancement. In 2013, the BHC and Paso del Norte Health Foundation (the Foundation) asked TriWest Group, LLC (TriWest) to conduct an assessment of the behavioral health system in El Paso County.

Based in part on that assessment, the BHC further strengthened its leadership structure and began to encourage its members to fill gaps in the system of care that had been identified by the TriWest report. The BHC also worked to further strengthen collaborative relationships between providers, payers, and other community partners. Furthermore, following the TriWest report, the BHC established clear vision and mission statements, and its three leadership councils articulated clear objectives and strategies for achieving them.

*Vision: The El Paso Community Behavioral Health Consortium envisions an accessible, person-centered behavioral health system of care in the El Paso region.*

*Mission: The Mission of the El Paso Community Behavioral Health Consortium is to collaborate through information and knowledge exchange to drive maximization of resources and expansion of accessibility and services.*

The BHC consists of an Executive Committee and three leadership councils. The Family Leadership Council carries out strategies to meet objectives associated with enhancing the child/youth/family behavioral health-serving system, the Integration Leadership Council carries out strategies aimed at increasing access to integrated physical health and behavioral health care, and the Justice Council implements strategies to address the needs of justice system-involved persons with behavioral health conditions. The Foundation provides ongoing facilitation and support to the BHC, its Executive Committee, and all three leadership councils.

Earlier this year, the Foundation requested that the Meadows Mental Health Policy Institute (MMHPI) conduct an assessment of the current functioning of the BHC to identify opportunities for strengthening its role in promoting system enhancements.

## Overview and Purpose of the Assessment

Specifically, the Foundation contracted with MMHPI to provide the following services:

- Revise BHC and leadership council objectives and update related metrics that MMHPI subcontractor TriWest Group helped the BHC develop in early 2015.
- Provide council leadership, functioning, and strategic quality improvement recommendations.

- Develop a method for leadership councils to self-monitor through a set of metrics.
- Provide technical assistance to revise at least three (3) organizational policies.
- Provide advocacy technical assistance for at least three (3) state level policies.
- Track and analyze related behavioral health system data and report findings to develop recommendations to the Foundation's and the BHC's partners and to inform ongoing BHC development and performance.

Below, we describe our assessment methodology, followed by a detailed description of our assessment findings and recommendations that is divided into four parts – one for the Executive Committee and one each for the three leadership councils.

## Methodology

In advance of producing a comprehensive interim report in June 2016, we conducted an intensive early stage of assessment with the goal of obtaining a baseline understanding of the Behavioral Health Consortium's (BHC) functioning. (Please see **Appendix One** for a copy of the full interim report that was submitted at the end of May 2016.) This early stage of assessment involved a review of BHC documents, key informant interviews, and site visits during which we observed leadership council meetings. In this early stage, we employed three methods to facilitate our initial understanding of BHC functioning:

- We **reviewed BHC documents**, including the recorded history of meetings.
- We **observed one meeting each of the three leadership councils** (Family, Justice, and Integration).
- We conducted our first set of **key informant interviews** with eleven different people.

Subsequently, besides participating in additional leadership council meetings, we utilized the following additional methods to help assess the BHC and to identify best practices that might inform our recommendations:

- A "benchmarking" study of other Texas BHCs and one from another state to place the El Paso BHC's functioning in context and to identify best practices. (Please see **Appendix Two** for a full report.)
- A national scan of behavioral health dashboards with system performance metrics. (See **Appendix Three**.)
- An updated examination of core behavioral health need and capacity data in El Paso, for both children/youth and adults, which included 2015 estimates of the population in need, along with 2015 data on number served, including those served in selected intensive levels of community care. (See **Appendix Five**.)
- Identification of core policy opportunities that were relevant to one or more leadership councils, as well as participation in a policy event in September 2016 that was sponsored by the Foundation and the BHC.

- Development and brief presentation of preliminary findings and recommendations to the Foundation and the BHC Executive Committee.

### Review of BH Consortium Documents

MMHPI consultants reviewed all meeting agenda and notes from the Executive Committee, the Integration Leadership Council, the Justice Leadership Council, and the Family Leadership Council to determine the consistency of meetings, the number of agencies participating, participant attendance, activities of the councils, and progress.

Attachment A in **Appendix One** summarizes the number of meetings held by each leadership council as of the time of the interim report, and it lists participating agencies and organizations.

### Leadership Council Meeting Observations

In March 2016, MMHPI attended meetings for the Family Leadership Council, Justice Leadership Council, and Integration Leadership Council. We observed the level of participation and activities that were discussed during the meetings.

### Key Informant Interviews

Key informant interviews were held with representatives from the Family Leadership Council, the Justice Leadership Council, and the Integration Leadership Council.

The following table lists the key informants who were interviewed.

**Table 2. Key Informant Interviewees**

Behavioral Health Consortium	Participant
Executive Committee	Sharon Butterworth (Chair), Advocate
Family Leadership Council	Sharon Butterworth, Advocate (interviewed once, but participates in all leadership councils)
	Veronica Lowenberg, Center for Children, Therapeutic Homes Program Director
	Sandy Rioux, Center for Children CEO
	Ivonne Tapia, Aliviane CEO and FLC Chair
Justice Leadership Council	Maggie Morales-Aina, Director of Adult Probation,
	Chrystal L. Davis, EHN, Chief Operating Officer of Diversion Services
	Sheriff Wiles and Lt. Hebeker, El Paso County Sheriff Office

Behavioral Health Consortium	Participant
Integration Leadership Council	Maria Carrillo, Clinica de Salud La Fe, Social Services Administrator
	Kristi Daugherty, Emergence Health Network
	Bill Schlesinger, Project Vida
	John Wiebe, UTEP

## Findings and Recommendations

### Overview

Overall, the BHC has been very successful in establishing an organizational structure and in engaging behavioral health leaders and other decision-makers in the process of analyzing community and system needs. For example, it has developed a sequential intercept model for justice-involved adults with mental illnesses, based on expert input on needs at various intercept points, and it has identified integrated care workforce needs through the Integration Leadership Council. In a relatively short time, the BHC and its leadership councils (LCs) have formed; they have established leadership roles and filled them; they have taken on projects that involve collaborative effort on the part of BHC member agencies and their representatives; and in some cases, they have promoted the establishment or strengthening of formal relationships among county offices and non-profits (such as the Sheriff's Office, the County Commissioners Office, and Emergence Health Network). Since 2014, involvement has expanded, and the BHC has succeeded in increasing the capacity for collaboration and system enhancement in El Paso County.

In addition, the BHC addressed meaningful, system-wide challenges in the community, including, for example, placement of foster children outside of the community, integrated care workforce needs, and the problem of too many people with mental illnesses becoming involved with law enforcement and ending up in jail.

At the same time, there are areas in need of development. First, the BHC and its LCs have not identified system performance metrics that should be used to track progress in filling gaps in systems of care and otherwise improving behavioral health services systems. Second, in our key informant interviews and observations of meetings, we found that many BHC participants were at times uncertain as to the purpose of meetings and the priorities for system development and enhancement. There is a need to build on the good work already done and to develop even clearer priorities for program and policy change, as well as detailed plans for addressing them and measuring progress toward program and policy change goals. Again, much of the groundwork has been laid here (e.g., the Sequential Intercept Mapping process initiated by the Justice Council).

Periods of uncertainty and limited progress are not uncommon in the history of BHC development. In the case of the El Paso BHC, there have been significant transitions occurring in key agencies, not the least of which is the Paso del Norte Health Foundation, which has undergone a relatively lengthy process of replacing a Chief Executive Officer who led the Foundation for almost ten years. In times of transition, opportunities to promote and facilitate the further development and maturation of a very complex undertaking, such as a behavioral health consortium, become much more limited.

In the following pages, we identify key findings and associated recommendations for each of the four primary entities that constitute the BHC – the Executive Committee and each of the three leadership councils. Where indicated, we have also provided corollary recommendations and more detailed steps to help inform processes for implementing our primary recommendations.

Our recommendations are aimed at helping the BHC plan for taking their work “to the next level” of involvement, collaboration, and effectiveness in addressing challenges associated with meeting the behavioral health needs of people in El Paso County. We have organized them within each of the four structural entities: Executive Committee, Family Leadership Council, Integration Leadership Council, and Justice Leadership Council.

## **Recommendations for the Executive Committee**

### **Levels of Involvement, Participation, and Collaboration**

*Finding 1* – The Consortium Executive Committee (CEC) has been gathering since 2012. It has grown in size and increased in meeting frequency over the subsequent four (4) years.

*Recommendation 1* – The CEC should continue to meet at its current frequency. It should consider adding members from independent school districts, the primary health care provider community (e.g., FQHC leaders), and a behavioral health leader from the Veterans Administration.

*Finding 2* – The CEC has developed a solid base of collaboration, which includes engagement with decision-makers in the process of overseeing the BHC. In addition, the BHC has developed formal collaborative arrangements with other entities, including the LMHA (EHN) and the Sheriff’s Department, for example. The CEC has been focused on achieving the BHC’s identified goals and objectives, and they are working to leverage the capacity of existing resources within the community. Involvement requires at least a moderate time commitment.

*Recommendation 2* – The CEC should consider identifying specific ways in which it will attempt to move closer to the level of collaborative functioning of high-level performers in Texas and nationally, as identified in MMHPI’s “benchmarking” investigation with other BHCs (see **Appendix Two**). In particular, the Mental Health Connections (MHC) of Tarrant County program (which some representatives from El Paso have visited) should be examined as a source of input as the BHC designs specific steps toward establishing even stronger collaborative relationships for sharing organizational resources in the service of mutual goals. Recommended steps are identified below. We focus on collaborative efforts to seek grants or other funding around common, community-wide concerns. (By collaborative efforts, we mean the BHC working together to identify many different county agencies, providers, and other partners [e.g., universities, foundations] who, by virtue of working together and submitting applications and proposals jointly or through a formal BHC entity, become more competitive in obtaining funding.) According to our benchmarking analysis, success in this area appears to be associated with BHCs developing reputations for being community planning and organizing entities in which all agencies must participate if they are to remain relevant and connected to the community’s behavioral health network.

*Recommendation 2a* – The BHC could establish a team of local leaders who would periodically travel to Washington, D.C. to meet with governmental and other national funding sources, a strategy that MHC of Tarrant County has used to obtain millions of dollars in grant funding.

*Recommendation 2b* – The BHC and the team suggested above should also set two-year goals for the collaborative development of grant applications that could garner resources to address community-level problems and concerns. Goals could identify the number of grants to be submitted, as well as the amount of funding the BHC would like to successfully obtain.

*Recommendation 2c* – In the service of 2a and 2b above, the BHC could draw on its capacity to identify and assertively address region-wide needs. Recent examples include reducing the stigma of mental illness; reducing unnecessary involvement in restrictive settings for children, youth, and adults; and increasing the integrated physical health/behavioral health care workforce. In the current context, particular attention should be put on initiatives aligned with funding that may come out of the 85<sup>th</sup> Legislature, including capacity development regarding intensive mental health services for children in foster care and jail / forensic state hospital diversion.

### **Executive Committee Leadership and Oversight Role**

*Finding 3* – The Chair of the CEC, Sharon Butterworth, an important leader and strong, longstanding advocate for behavioral health, soon will retire from her role with the committee.

*Recommendation 3* – The CEC should establish a sub-committee whose purpose will be to draft a succession plan to be reviewed, modified, and approved by the committee as a whole. The sub-committee should be charged with drafting the following:

- The requisite qualifications of the new chair (in terms of levels and types of experience, knowledge of mental health systems, community reputation, and demonstrable organizational leadership skills, for example);
- The kinds of organizational affiliations that the person could have and should not have;
- A search/recruitment and interview plan; and
- A statement that the new Executive Committee Chair should be widely seen as able to be a neutral facilitator of the CEC, who would not be biased in favor of any particular county entity, behavioral health/health providers, university, or other entity.<sup>1</sup>

*Finding 4* – As described above, the CEC has been successful in establishing a BHC and its leadership councils. More work could perhaps be done to strengthen the CEC’s role, and the resources available to it, in order to encourage more consistent and productive work from the LCs.

*Recommendation 4* – The Foundation could bolster its “backbone” support for the BHC in the following ways:

- Hire or deploy an individual with at least half-time (0.5 FTE), preferably full-time (1.0 FTE) dedication to working with the CEC and the LCs, who would report to the Foundation’s lead (Enrique Mata) to provide logistical, coordinating support.<sup>2</sup> Structure this person’s role as one that would provide logistical and organizational support to the CEC and all LCs. This position would schedule meetings; track all timelines; assess LC and work group resource needs, and work collaboratively with Mr. Mata and the CEC to meet them; support all communication across the BHC; and otherwise be Mr. Mata’s “right-hand person.”
- Restructure Mr. Mata’s role to focus more on strategic planning of BHCs than he currently does (and less on the provision of logistical support); engaging leaders in Foundation 4 regions to support their ongoing participation in and commitment to the BHCs; developing Foundation capacities to provide advanced support, such as creation

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<sup>1</sup> Because of its reputation as a strong, neutral facilitator in the county, it would make sense for a person affiliated with the Paso del Norte Health Foundation to be selected as the new CEC Chair. The person should, however, have the requisite characteristics delineated in the above bulleted points.

<sup>2</sup> A full-time position could also provide Mr. Mata with significant support in establishing a BHC in the New Mexico counties that are included in the Foundation’s region. Another full-time person could be hired to play that role in Juarez, which is anticipated to need more intensive support. The exact FTEs proposed here are not as important as the overall structure of having Mr. Mata’s position oversee the Foundation’s overall work with the BHCs, with additional staff providing the requisite logistical and day-to-day details of providing institutional “backbone” support to the BHCs.

of a system performance and successes “dashboard” on the Foundation website (or on a newly-created BHC website); and supervising the BHC logistical and organizational support position(s) described in the above recommendations.

*Finding 5* – The CEC has worked to define the roles of the LCs and has guided the structure of their work. Most recently it drafted a useful “Role of Leadership Councils” document, for example. However, the councils sometimes have not achieved certain expectations established by the committee.

*Recommendation 5a* – While the CEC would not want to stifle the LCs with measures that might appear to be punitive, it could be helpful to propose the following ongoing operational strategies and expectations to the LCs and obtain their agreement or suggestions for revision (supplemental to the “Role of Leadership Councils” document cited above). The imminent change in leadership (Sharon Butterworth stepping down as chair) could perhaps be cited as the impetus for revisiting the working relationships between the CEC and the LCs.

- *Recommendation 5a.1* – The CEC could recommend that quarterly reports from the LCs follow a common format (for each of the primary projects on which the LC currently is working), including: accomplishments to date; barriers and challenges faced (including organization and state level policies) and measures taken to overcome them; resources procured in the service of meeting LC goals; identified steps for making further advances in meeting project goals; and help desired from the CEC, including, for example help garnering additional resources or other assistance.
- *Recommendation 5a.2* – In receiving quarterly reports from the LCs, the CEC could provide regular feedback that helps each LC identify ways in which its activities overlap with those of other LCs, and it should provide specific recommendations as to how LC activities can be mutually supportive. For example, the Integration LC may have data from its workforce survey that would speak to workforce issues uncovered by the Family LC as it explores gaps in the lower levels of the system of care pyramid.<sup>3</sup> The CEC can help LCs periodically examine overlapping concerns as well as opportunities for cross-LC collaboration. CEC members can direct Foundation staff in conducting the bulk of the work required to complete these tasks.

*Recommendation 5b* – Request that each LC propose one or more metric(s), for which it will develop the necessary quantitative methodologies, and track changes in them over time, beginning in 2017.

- Offer Foundation and CEC resources to assist each LC in developing the capacity to carry out this work.

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<sup>3</sup> According to personal communication with Mr. Enrique Mata, December 30, 2016, the FLC is now using the FLC Protractor model based on the Institute of Medicine’s 1994 Mental Healthcare Continuum.

- Work collaboratively with each LC to consider the best ways to present longitudinal findings on the metric(s) on a dashboard, to be maintained on the Foundation’s website or a new BHC website.<sup>4</sup> (See more detail under *Recommendation 8* below concerning the development of a metrics dashboard.)

## Articulation of Goals and Objectives

*Finding 6* – The CEC has established clearly-stated goals and objectives. It could do more to help LCs pursue them, however, and to integrate their cross-cutting concerns.

*Recommendation 6* – Update the BHC goals and objectives to incorporate the highest-priority recommendations described in this report (as determined by the CEC), including the highest-priority recommendations identified by each LC.

## System of Care Priorities

*Finding 7* – The CEC has encouraged LCs to address important gaps in the system of care, and some of its members have worked collaboratively to address behavioral health needs. It has encouraged LCs to use the TriWest Group 2014 report as a baseline and has periodically shown the extent to which gaps are being filled. This has been an approach that appears to have enlivened the work of the LCs and helped begin to unite the BHC and its LCs.

*Recommendation 7* – The CEC should continue to work with LCs in tracking system of care “gap filling” across child-serving and adult-serving systems. However, it could more intentionally help LCs identify overlapping concerns. For example, members of the Integrated LC could work with members of the Family LC to identify integrated care best practices for children and youth with complex conditions and make plans for the collaborative development of integrated care programs for children and youth.<sup>5</sup>

We do want to note an important system of care issue associated with the availability of inpatient services in El Paso County. On December 6, 2016, the BHC’s Psychiatric Inpatient Care Work Group issued a report entitled, *El Paso County Psychiatric Bed System Redesign Options*. The report followed a visit from Foundation representatives and several BHC members to John Peter Smith Hospital in Tarrant County, and it compared the option of developing a plan based on maintaining state control of the El Paso Psychiatric Center versus the option of developing

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<sup>4</sup> Because of the resource and time commitment entailed, and given that many other more pressing issues need to be addressed, we do not necessarily recommend that the BHC develop its own website at this time. However, other BHC-like entities have developed their own websites and a website can create a stronger, more solid sense of identity for a BHC.

<sup>5</sup> Models are emerging nationally, including one in Dallas for foster children/youth, under the direction of a pediatrician, Dr. Anu Partap.

local control. It is good that the BHC is thoroughly investigating these options, but we do not have a specific recommendation as to which option would be more favorable for El Paso at this juncture.

### **Use of Metrics and a Dashboard**

*Finding 8* – As was mentioned above, the BHC and LCs have used the TriWest Group system of care as a means to track efforts to fill service gaps that had been identified in TriWest’s 2014 report. This is a worthy activity. However, the *effects* of the system’s work (including its enhanced work) also need to be examined over time so that the El Paso community maintains a clear focus on the well-being of some of its most vulnerable citizens as well as on the system’s efforts to increase its efficiency and cost-effectiveness in the face of finite resources.

*Recommendation 8* – The CEC should work closely with the Foundation (including Mr. Mata, but also with the program lead in charge of the Foundation’s investment in the Health Information Exchange and others) to: a) examine the Arizona dashboard and others identified by MMHPI’s national scan of dashboards to identify a model that would work best in El Paso (see **Appendix Three**); and b) to develop a plan for implementing such a dashboard that would include metrics from Paso del Norte Health Foundation and BHC collaborating partners, including costs and potential sources of pooled funding for the endeavor. Of course, the meaningful use of a dashboard would also be contingent upon the BHC, the Foundation, and the LCs committing to tracking performance metrics over time. We believe the Arizona four-part framework provides a useful heuristic to guide the ongoing selection of metrics that should start with only a few (one or two per LC) and then build to a more comprehensive yet still relatively succinct set of metrics over time. Another framework that could guide the selection and organization of system metrics is the “Quadruple Aim,” which indicates the importance of examining 1) access to care, 2) quality of care, 3) the consumer’s experience of care, and 4) the health of the workforce. The framework should also incorporate sensitivity to priorities of key funders, including programs expanded or developed under the 85<sup>th</sup> Legislature (e.g., waitlists, inpatient capacity, capacity development regarding intensive mental health services for children in foster care and jail / forensic state hospital diversion).

### **Policy Priorities**

*Finding 9* – The CEC has identified a number of policy-related issues, both locally and at the state level. It could establish an annual process for setting clear priorities for working with its legislative and other connections, and to assertively facilitate appropriate action.

*Recommendation 9* – The CEC’s primary role at this juncture should be to work collaboratively with the LCs to address the policy issues we have identified in our recommendations for each LC. However, the CEC should, on an annual basis, revisit the list of state policy priorities and

consider whether to add to the list any additional policy concerns that have arisen over the 12-month period preceding the review.

## Recommendations for the Family Leadership Council

### Levels of Involvement, Participation, and Collaboration

*Finding 1* – The Family Leadership Council (FLC) was found to have active, consistent participation from the leadership of a majority of child-serving systems, including behavioral health, child welfare, and juvenile justice. The FLC’s participating members are key agency leaders who have the ability to commit agency resources, seek collaborative funding opportunities, and address prohibitive or outdated policies that impact system improvement. This level of involvement by key leaders provides the FLC with the ability to address cross-system challenges that affect the provision of services to youth and families. However, current and future changes in leadership necessitate forward thinking about how to maintain this ongoing level of commitment.

*Recommendation 1* – The community has seen (and anticipates) changes in the key leadership of its child-serving agencies. As agency leaders change, it is important for FLC representatives to reach out and engage new leadership in the work of the FLC. It is recommended that FLC chairs or selected representatives meet with new leaders to inform them of the FLC’s goals, objectives, and accomplishments as well as the expected level of agency commitment. For example, FLC members are expected to participate in appropriate work groups and the larger meeting. Past efforts, similar to those of the FLC, have lost momentum or dissolved when membership has changed.

*Finding 2* – While its involvement levels are generally high among child-serving agencies, the FLC could benefit from more robust participation from the school system. School district participation has fluctuated. There has been representation from Socorro Independent School District (ISD) and Ysleta ISD at different points in time, but participation from the largest district (El Paso ISD) is lacking. The Educational Service District, Region 19, is also not a regular attendee.

*Discussion* – According to a July 2014 report by the Robert Wood Johnson Foundation,<sup>6</sup> providing mental health services to students in schools is an effective strategy for addressing the mental health needs of children and adolescents. In addition, schools are the most natural setting for prevention and early intervention, as well as for identifying and assisting youth at risk of experiencing more serious behavioral health concerns. On the negative side,

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<sup>6</sup> Murphey, D., Stratford, B., Gooze, R., Bringewatt, E., Cooper, P.M., Carney, R., & Rojas, A. (2014, July). *Are the children well? A model and recommendations for promoting the mental wellness of the nation’s young people* (pp. 6-7). Princeton, NJ: Robert Wood Johnson Foundation.

exclusionary school discipline is the primary risk factor for future involvement in the juvenile justice system. When combined with zero-tolerance policies, a teacher's decision to refer a student for discipline can start a "school-to-prison pipeline" that pushes the student out of the classroom and quickly puts them at risk for entry into the juvenile justice system.<sup>7</sup>

*Recommendation 2* – Specifically recruit involvement of ISD staff who have influence over or engagement with school-based mental health services for children and youth with severe emotional disturbances (SED) and/or who have authority over school discipline policies. There may be legislative action to establish supports for school-based mental health liaisons, and this should be pursued, if available, post 85<sup>th</sup> legislative session. (Please see **Appendix Nine** for concepts and recourses related to school-based programming.)

*Finding 3* – The Family Leadership Council has developed a solid base of collaboration. The FLC has been focused on relationship building and on learning about community services and resources. These activities have built trust and have resulted in the group coming together to address issues that are important to its members. The FLC has created two work groups, one to address reimbursement from MCOs and another focused on youth in foster care. The majority of FLC members are committed to participating in the work groups in addition to the FLC meetings. The agency leaders and key decision makers have committed a significant amount of time to the functions of the FLC.

*Recommendation 3a* – While it is important for the FLC to focus on relationship building and learning about services and resources in the community, the group is encouraged to actively move towards even stronger collaboration. One opportunity for building stronger collaboration, also describe above in the Executive Committee section, is through collaborative grant applications. The group should review grant opportunities that they are considering and decide as a group where partnerships may strengthen applications. Since many grant-funded projects do not continue when grant funding ends, the FLC should track special projects and grant-funded projects to safeguard an approach to sustainability. This should be done early in the life of grants to ensure that the group has time to consider sustainability options that are collaborative.

*Recommendation 3b* – The FLC strives to transform El Paso County into a model community for child and family behavioral health services and supports. In order to accomplish this, the group needs to take an even stronger, more definitive lead than it already has taken in connecting, informing, and supporting all children's system of care planning efforts. As the leader, the FLC would serve as the umbrella entity for all other child and family behavioral health planning

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<sup>7</sup> See Appendix Nine for resources on interrupting the school to prison pipeline and on developing effective school-based programs.

groups, establishing partnerships, setting system priorities, identifying opportunities for collaboration, allocating available resources, and measuring system change.

There are currently other groups with similar goals competing for the time and attention of FLC members. The El Paso Consortium for Children, convened by Dr. Handal, is one such example. Since many of the same members attend this meeting, it is important for the FLC to take the lead both so that other groups can align their priorities and so that members do not have to choose to attend one meeting over the other. The work of the El Paso Consortium for Children should fall under the umbrella of the FLC and the group should decide how best to engage Dr. Handal. The FLC should consider using the strengths it has in the leaders at the table, their resources, and the opportunity to strengthen Dr. Handal's efforts. This should be done in a way that supports that group, possibly with Foundation leadership support. The FLC key members and Foundation leadership might start by meeting with Dr. Handal to identify overlapping goals, discuss the advantages to aligning priorities, and decide how best to combine these groups, possibly as a workgroup.

Another group with similar goals is the Texas System of Care (TSOC). The FLC should determine whether their priorities align and whether involvement will entail making commitments that will detract from the FLC's current focus. Involvement with the TSOC should only be pursued to the extent that it furthers local priorities.

Mental Health Connections (MHC) of Tarrant County is an example of a behavioral health leadership team (BHLT) that has aligned and strengthened the work of its community partners. MHC works with its members to identify system needs, determine priorities, and develop a strategic plan that considers the collaborative interests of children, their families, and community service providers. Committees are established annually to address identified goals. Examples of MHC's committees include: a grants committee that identifies funding opportunities to support improvements in their behavioral health system, a trauma committee to implement strategies to create a trauma-informed community, and a workforce committee to build a high-quality workforce. In enhancing its efforts to lead child-serving systems in El Paso, we recommend that the FLC draw on the most attractive aspects of the MHC model, while also building on the FLC's own strengths and accomplishments.

### **System of Care Priorities**

*Finding 4* – Child-serving agencies have made important strides recently in the area of intensive services for children and youth who are most at risk. However, the availability of intensive community and family-centered programs to meet the estimated needs of children and youth with severe emotional disturbances (SEDs) at risk for out-of-home placements and juvenile justice system involvement remains insufficient.

*Recommendation 4* – The FLC should continue its focus on high-needs foster care children and youth and prioritize the success and high level of functioning of the Multisystemic Therapy (MST) team. It also should build on these efforts, and on the MMHPI estimate of unmet need for intensive Wraparound cited above, to support initiatives for increasing the availability of intensive community and family-centered programs.<sup>8</sup> The FLC should adopt as one of its purposes a role that facilitates child-serving agencies in accomplishing the following:

- Developing a common method across agencies for identifying, counting, and tracking all children and youth with SED who are most at risk for out-of-home placement and/or juvenile justice system involvement, either because of assessed challenges in their own functioning, their family/caregiver possess capacities that are known to put children/youth at risk, and/or because they already have experienced out-of-home placement or juvenile justice system involvement;
- Prioritizing the capacity of child-serving agencies to provide intensive, family-centered, and community-based programming that coordinates all service planning and delivery processes across all agencies with which the child/youth has contact;
- Engaging ISD decision makers in examining school discipline policies and procedures associated with positive and negative outcomes for children and youth with SED, and formally comparing them to best practices;
- Tracking more precisely, and on a quarterly basis, the gap between need and intensive community-based service capacity; and
- Developing braided or pooled funding and other mechanisms to expand intensive community-based service capacity.

*Finding 5* – The FLC has developed a useful service continuum framework that includes preventive services in hopes of bolstering the system of care. This is a useful framework and goal. However, because of the relative lack of funding for prevention, achieving this goal will require persistent commitment.

*Recommendation 5a* – Building on its good work in developing closer working relationships with MCOs over the past couple of years, the FLC (through the MCO committee) could consider an initiative to determine the necessary resources to build capacity outside of the LMHA for delivering rehabilitation skills training and wraparound services.<sup>9</sup> These services were approved through Senate Bill 58 in 2013 as part of the Medicaid benefit and no providers other than the LMHA (EHN) have been credentialed to provide them. There is a need for these services for children and youth with intensive needs in this community. The required and necessary resources to be credentialed by the MCOs could be identified. If the resources needed to meet

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<sup>8</sup> This effort should be aligned with any foster care development resources that come from the 85<sup>th</sup> Legislature.

<sup>9</sup> As EHN's CEO has noted, EHN is a vital provider within both adult and child/family systems of care, but it should not be expected to meet all needs. Multiple providers need to be available to help ensure a complete and effective system of care.

the requirements do not exist in one agency, perhaps agencies could come together to develop the resources. The Foundation should consider whether it could provide support in this capacity building.

*Recommendation 5b* – Identify one or two evidence-based prevention programs that are known to reduce the incidence and prevalence of disorders that are known to be a significant cost to MCOs if they develop (or worsen).<sup>10</sup> The programs most likely to be chosen will be in the “selected” or “indicated” domains of prevention programs. These prevention programs identify young people with known risk factors or who already are evidencing signs/symptoms of a disorder, and help them to resolve their problems in order to avoid a more distressing and costly condition. For example, we know that anxiety disorders have an early average age of onset (in the primary school years) and that they put children/youth at risk for later developing depression, which has a later average age of onset. Identifying children/youth with symptoms of anxiety and then providing some evidence-based interventions to prevent depression could be effective.

- *Recommendation 5b.1* – While it might complicate the effort, including an ISD in the discussions is important, because many evidence-based prevention programs are conducted with the cooperation of schools. A collaboration between the FLC (and its child-serving agencies), one or more MCOs, and an ISD could be quite effective.
- *Recommendation 5b.2* – In selecting prevention interventions, the FLC should also consider the current skills/competencies of the staff who make up the member child-serving agencies in El Paso.

*Recommendation 5c* – Another way to expand the service continuum to include prevention would be to add an early intervention/preventive intervention for children/youth who are at risk of later needing an intensive level of care. This would require identifying a reliable set of clinical predictors that could be used to identify those children/youth who are at risk.

### **Articulation of Goals and Objective and Use of Metrics to Track Progress**

*Finding 6* – The Family Leadership Council has developed a set of goals and objectives that guide their activities. One of these goals is to develop and implement an El Paso County model for a child and family continuum of care. To accomplish this, the team is completing a continuum of care diagram based on the 1994 IOM Continuum of Care Protractor model. This will allow the FLC to identify gaps in the current system and determine areas where there have been improvements since the initial community assessment. Notably, several enhancements to the continuum of care have been reported and documented by the FLC. Besides the development of a Multisystemic Therapy (MST) team at EHN, the Youth Empowerment Services

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<sup>10</sup> For a succinct overview of evidence-based approaches to prevention, see **Appendix Six** for MMHPI’s recent paper on the subject.

(YES) Waiver program is now available to youth served through the Department of Family and Protective Services (DFPS). The think.change initiative has also added advocacy and education programs such as National Alliance on Mental Illness (NAMI) courses, Youth and Adult Mental Health First Aid, and De Mujer a Mujer groups.

*Recommendation 6* – As mentioned above, the group is strongly encouraged to continue to review and address the needs of youth with intensive needs. The FLC should continue to address gaps in services for this population and agree on metrics to be able to track impacts. The FLC should report this information quarterly to the Executive Committee. As it looks at expanding intensive family and community-based services, the group is encouraged to track restrictive setting use. Examples of this include tracking:

- Number of children/youth with SED admitted to inpatient facilities in a 12-month period,
- Number of children/youth with SED in out-of-home placement/foster care, and
- Number of youth with SED in juvenile detention or residential placement.<sup>11</sup>

EHN and DFPS continue to meet to track children/youth who are at risk of hospitalization or out-of-home and -community placement, targeting youth with intensive needs in particular to ensure that they are connected to services to prevent hospitalizations or have a plan in place upon discharge. This data could be used to inform progress.

Youth with intensive needs who are involved in multiple systems should continue to be a priority since inappropriate approaches to meeting their needs can be costly to a community; a lack of home- and community-based services often leads them to be more involved in multiple systems as well as more expensive residential placements. The FLC should review how to improve access to Wraparound, YES Waiver, and other intensive home and community-based services to youth. The group should explore how to develop a workforce focused on providing intensive home- and community-based services and Wraparound. These providers do not need to be licensed clinicians but do require specialized training. The group could explore how to support specialized training so that it benefits more than one agency. This may be an area where the FLC can collaborate with the Integrated Leadership Council (ILC), as the ILC is looking at workforce issues in the community.

## Policy Priorities

*Finding 7* – MMHPI has presented to the El Paso BHC a guide to state-level policy that the BHC and FLC could promote, namely, to “help vulnerable children stay in school and live at home, beginning with children in foster care.”

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<sup>11</sup> Please see **Appendix Four** for a longer list of potential metrics.

*Recommendation 7* – The FLC should work with its legislative allies to promote policies that give child-serving agencies (mental health, child welfare, juvenile justice, and schools) incentives to collaborate in the service of ensuring that sufficient intensive family- and community-based services are available to the most vulnerable children and youth who are at risk for out-of-home placements, school failure, and repeated juvenile justice system involvement.

## **Recommendations for the Integration Leadership Council**

### **Levels of Involvement, Participation, and Collaboration**

*Finding 1* – Over the past two years, it was found that the Integration Leadership Council (ILC) has had representation from a significant number of community agencies and has met fairly regularly. However, meetings do not always occur on a regular schedule (e.g., every other month, as the BHC’s Executive Committee had originally hoped).

*Recommendation 1* – The Foundation should continue to play a facilitative role for the ILC and should continue to encourage wider participation, especially from primary care providers such as federally qualified health centers (FQHCs). The new chair and vice chair should examine the participation and involvement record and set clear goals for enhancing participation in the ILC, including setting a regular bi-monthly schedule for meetings that is shared well in advance so that participants can secure plans to attend.

*Finding 2* – The ILC has developed a solid base of collaborative engagement, but could take its efforts “to the next level.”

*Recommendation 2* – The ILC should consider identifying a small number of collaborative projects that could demonstrate, among other things, the viability and effectiveness of integrated care programming in both primary care and specialty behavioral health settings. Given its recent inclusion as reimbursable under Medicare, as well as its strong evidence base, promotion of the Collaborative Care model should be considered for prioritization. (See below for more on the implementation of integrated care models.) As a means of ensuring widespread collaboration and inclusion of all members, the ILC could identify a matrix of projects and participating collaborators. ILC members, or other entities from the community who should be members of the ILC but are not yet involved in one or more collaborative efforts, could be invited to collaborate on projects. The point here is that the ILC could explicitly track the number, type, and inclusivity of collaborative projects that would ensure a more dynamic ILC, which would either meet more frequently or develop more work groups that would meet more frequently and report to the ILC when it meets.

### **Articulation of Goals, Objectives and Associated Strategies**

*Finding 3* – To our knowledge, few integrated care programs currently are operating in El Paso.

*Recommendation 3* – The ILC should use the recent MMHPI/St. David’s publication on the core components of integrated care<sup>12</sup> to identify specific integrated care practices that it could recommend for adoption by all specialty behavioral health and primary care settings in El Paso. These could include, for example:

- The inclusion of behavioral health “vital signs” in all primary care settings. Initially, this could include guidance to all primary care practices on the use of the PHQ-9 as a screening tool, along with recommendations for how practices can refer people in need for further appropriate assessment and treatment.
- The inclusion of basic health screening in all specialty behavioral health settings, along with guidance on how to refer people with positive screens for further assessment and treatment.

*Finding 4* – The ILC has laid out clear goals and objectives, as well as strategies to achieve them, but at times it seems that addressing access, behavioral health integration into primary care, and furthering recovery-oriented systems of care is a lot to tackle all at once. This may make it difficult for the group to sufficiently focus its efforts, especially until a stronger structure for tackling multiple issues – and a sufficient number of contributing members to do so – has been established.

*Recommendation 4* – The ILC should update the above goals, objectives, and strategies based on its review of the full set of recommendations provided in this final report from MMHPI. It would benefit the group to revisit its priorities and focus on no more than three key areas at once. (In particular, the health information sharing between behavioral health providers – which, by itself, is not an integrated care agenda item – could be tabled until other more pressing integrated care tasks have been sufficiently addressed.) Considering the group’s focus on integration, we recommend special attention be paid to the following:

- Selecting integrated care training models recommended for implementation in primary care and behavioral health professional training programs (with particular emphasis on the Collaborative Care model),
- Making plans associated with the collaborative implementation of integrated care programs in primary care and specialty behavioral health settings, and
- Selecting metrics for tracking progress across the county and region (see more on this below, in the section on metrics).

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<sup>12</sup> The paper can be found in **Appendix Seven**.

## System of Care Priorities

*Finding 5a* – The ILC has made workforce tracking and development a high priority. They have recognized at least two fundamental needs in this area: 1) that El Paso area institutions train more behavioral health professionals, and 2) that behavioral health and primary care training programs specifically train professionals to work within the new, integrated care paradigm.

*Recommendation 5a* – The ILC should continue to track and promote increases in the number of behavioral health professionals trained and retained in the region. (See more on this topic in the metrics section below.)

*Recommendation 5b* – At the same time, the ILC should identify best practices in integrated care training and make plans to adopt them in the region. For example, ILC members involved in training health and behavioral health professionals could either visit the training program in integrated care for family medicine residents that is offered through the University of Texas-Rio Grande Valley (UT-RGV) led by Dr. Deepu George, or invite Dr. George to El Paso to present and consult on the UT-RGV model. On the other side of the integrated care training agenda, ILC members could consult with in-state behavioral health experts who have many years of experience in implementing integrated care in primary care settings, such as Dr. Martha Medrano at CommuniCare FQHC in San Antonio and Katie Kanzler, PhD, at the University of Texas Medicine Primary Care Center in Austin. Again, either visiting their programs or inviting them to El Paso could go a long way toward developing training models that are a good fit for El Paso.

*Finding 6* – Members of the ILC have begun to identify specific integrated care models (in particular, the Cherokee model) that could guide the ILC's efforts to plan for and promote the implementation of integrated care best practices in El Paso.

*Recommendation 6a* – The ILC should explicate the clinical populations in need of integrated care across primary care and specialty behavioral health settings, as well as the models of integrated care that are appropriate for clinical populations in those settings. The identification of such models can set the stage for specific collaborative plans to implement integrated care in both types of settings.

In our recent publication of a report on integrated care (with St. David's Foundation), MMHPI used a modified four quadrant model to illustrate the potential allocation of integrated care models across settings and clinical sub-populations.<sup>13</sup> This model, depicted below, provides a

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<sup>13</sup> Meadows Mental Health Policy Institute (2016, August). *Best practices in integrated behavioral health: Identifying and implementing core components*. Austin, TX: St. David's Foundation. The full paper can be found in **Appendix Seven**.

basic structure within which more detailed analyses could be conducted. However, the fundamental notion is that for integrated care programs to be cost-effective and sustainable, planners and providers need to identify the clinical sub-populations for which they will be most appropriate. The Collaborative Care Model and the Person Centered Healthcare Home (sometimes more generically referred to as the Behavioral Health Home) are more intensive, team-based approaches that also are more expensive. They need to be devoted to serving people with the most severe and potentially expensive-to-treat co-occurring conditions.

**Figure 1. Use of a Modified Four Quadrant Model for Integrated Behavioral Health Planning**

Care Setting	Levels/Severity of Behavioral Health and Primary Health Conditions	
Primary Care Setting	<b>Quadrant I</b> (BH: Low, PH: Low to High)	<b>Quadrant III</b> (BH: Medium, PH: Low to High)
	<i>Essential Integrated Care –</i> Primary Care Behavioral Health Model	<i>Intensive Integrated Care –</i> Collaborative Care Models
Specialty Behavioral Health Setting	<b>Quadrant II</b> (BH: High, PH: Low/Medium)	<b>Quadrant IV</b> (BH: High, PH: High)
	<i>Essential Integrated Care –</i> Behavioral Health Primary Care Model	<i>Intensive Integrated Care –</i> Person Centered Healthcare Home

*Recommendation 6b* – Eventually, the ILC could take this “population health management” activity to a sophisticated level in which member agencies (1) estimate the number of people needing each type and level of integrated care across the region, and (2) identify implications for the number of integrated care programs, teams, and staff needed to meet those needs. The estimates could be broken out further across specific provider settings (e.g., specialty behavioral health settings, federally qualified health centers and other primary care centers, and – eventually, as they develop – centers that represent the Cherokee model) that provide all levels and types of integrated care to all clinical sub-groups.

*Recommendation 7* – The ILC should encourage council members and their associated agencies to collaborate in the service of implementing at least two integrated care programs in primary care settings and at least two integrated care programs in a specialty behavioral health settings by early 2018. For example, a FQHC could co-locate a mid-level primary care provider and a nurse or medical assistant in a mental health agency that is prepared for such a collaboration, and the two agencies could plan for the development of a person-centered healthcare home for those adult consumers who have serious mental illnesses and expensive chronic health conditions, as well as routine care coordination (by the nurse) for those consumers whose physical health conditions are not as chronic or expensive to treat and manage.

As another example, a behavioral health specialist from the Child Guidance Center (or another child/youth provider) could be co-located at a FQHC and could work with pediatricians and other primary care providers to establish integrated clinical pathways to treat such conditions as attention deficit hyperactivity disorder (ADHD) and other externalizing behavioral health conditions, as well as internalizing conditions such as anxiety and depression. In each case, whether implementation is in a primary care setting or a specialty behavioral health setting, an evidence-based or best practice model should be chosen, providers should be trained in it, and fidelity assessment and outcome evaluation protocols should be utilized to guide the implementation, perhaps in collaboration with university-based researchers or other evaluators.

- *Recommendation 7a* – From the outset, collaborating providers should incorporate the input of the ILC’s workforce training programs in order to plan for the inclusion of behavioral health and primary care trainees in these programs.
- *Recommendation 7b* – The ILC should encourage either the participation of (1) major employers and (2) leading insurance plans in the planning for integrated care implementation, or deploy members to work closely with those key partners to ensure adequate financing for integrated care is in place and to collaboratively track the cost-effectiveness of integrated care programs.
- *Recommendation 7c* – Evaluation/research of integrated care programs should include the use of fidelity/readiness assessment tools (links to which can be found in the recent MMHPI/St. David’s publication cited above) and outcome measures, including health indicators used in the Substance Abuse and Mental Health Services Administration (SAMHSA) Primary and Behavioral Health Care Integration (PBHCI) national implementation, as well as mental health indicators measured by the PHQ-9, for example.

### **Use of Metrics to Track Progress (at a Systems Level)**

*Finding 8* – The ILC has not yet chosen metrics for use in the ongoing assessment of the system’s progress in implementing integrated care.

*Recommendation 8a* – The ILC could further establish its leadership role in helping the El Paso region develop and expand access to integrated care by adopting, tracking, and making available various metrics associated with the objectives, strategies, and opportunities for change it has adopted.

The ILC should adopt at least one or two of the following metrics related to Opportunity for Change #1 (address the dramatic lack of community capacity for both adult and child behavioral health service providers).

Objective 1: Map the current system provider base to identify the 10-year projected need for healthcare providers trained in interdisciplinary or mental health service delivery.

Common Metrics for Objective 1 – The ILC will measure progress over time by periodically assessing the adequacy of provider coverage across professional disciplines (including peers and recovery leaders) and across specialty and primary care settings, relative to state and national benchmarks. Potential metrics include the following:

- Metric 1.1 – Number/percentage of geographic areas, facilities, and other entities in the El Paso region that are designated as Health Provider Shortage Areas (HPSAs) by the federal Health Resources and Services Administration.
- Metric 1.2 – Number/percentage of advanced behavioral health trainees (MSW, PhD, etc.) who stay to practice in the region after graduation. This could be tracked by discipline (e.g., psychologist, social worker, BSN-level nurse, APN-level nurse,<sup>14</sup> MA-level mental health counselor, substance abuse counselors).
- Metric 1.3 – Number of practicing psychiatrists available in the El Paso region, per 100,000 population.<sup>15</sup> This metric could be expanded to include all psychiatric prescribers, including advance psychiatric nurse practitioners. In later years, when the group becomes more sophisticated in its tracking, it could also track the number of primary care providers who routinely prescribe an appropriate range of psychiatric medications for children and adults (separately).
- Metric 1.4a – Number/percentage of primary care residency (family practice, internal medicine, ob-gyn, pediatric) and behavioral health graduate training programs in the El Paso region that include specialized training and practicum experience in integrated physical health/behavioral health care in their curricula.
- Metric 1.4b – Number/percentage of primary care residents (family practice, internal medicine, ob-gyn, pediatric) in the El Paso region who receive specialized training in integrated physical health/behavioral health care.
- Metric 1.5 – Number of primary care clinics/providers that have a co-located behavioral health specialist.
- Metric 1.6 – Number/percentage of services in the routine/outpatient/intensive sections of the service continuum for which clients do not have to wait more than seven (7) days (routine/outpatient), 72 hours (urgent), and one hour (emergent) for services.

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<sup>14</sup> Please see Appendix Eight for a review of advanced practice nursing programs in Texas, which MMHPI conducted as part of this BHC assessment.

<sup>15</sup> This is tracked nationally, with an estimated 26 psychiatrists needed per 100,000 people in the population. Unfortunately, we are not yet aware of good estimates of the number of other providers needed per population. However, the number of practicing professionals in each discipline should be tracked and compared to benchmark communities.

- Metric 1.7 – Penetration rate in outpatient services for adults with serious mental illness living at/below 200% of the federal poverty level (FPL); penetration rate in outpatient services for children/youth with severe emotional disturbances living at/below 200% of the FPL.
- Additional recommended metric to be used for each implementation of integrated care at the program level and across all types of settings: levels of fidelity to the chosen evidence-based model. (Please see the St. David’s/MMHPI IBH report, cited above, for a list of current fidelity measurement approaches.)

*Recommendation 8b* – The ILC does not currently have a large number of members who regularly engage in its work. However, the quality of the membership is very high. In order to tackle the challenge of adopting and tracking metrics, the ILC may need to appoint (or recruit) a metrics work group lead who can, in turn, recruit new members with expertise in evaluation, data management, and the like to spearhead an effort in this area. (In fact, the idea of identifying work group leads or “champions” and encouraging them to recruit work group contributors could serve both to expand the ILC’s human capital and reach its highest-priority goals.)

### **State and Organization Level Policy Priorities**

*Finding 9* – MMHPI has presented to the El Paso BHC a guide to state-level policy that the BHC and ILC could promote, namely, to “bring about changes to promote integrated depression care and, more generally, ensure proper reimbursements for integrated behavioral health in primary care.”

*Recommendation 9* – The ILC, BHC, and the Foundation should work with local legislators to ensure that state-level policy promotes the financing and regulatory environment in which integrated care can flourish. For example, they should encourage legislative allies to support legislation to encourage annual mental health screenings for youth ages 12-18 years, as well as those that would further the recommendations of the state-level Behavioral Health Integration Advisory Committee,<sup>16</sup> such as requiring MCOs to offer integrated provider sites one contract for physical and behavioral health services, even when the MCO subcontracts with a BHO.

*Finding 10* – The ILC has identified various organization-level issues that need to be addressed for integrated care to be most effective, including policies and practices associated with sharing data.

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<sup>16</sup> Senate Bill 58 Behavioral Health Integration Advisory Committee (2015, July). *Second report to the Health and Human Services Commission*.

*Recommendation 10* – The ILC should serve as a forum for sharing models of successful organizational collaboration that promote integrated care, including, for example, the most current and effective approaches to developing business associate agreements and data portals between agencies that allow them to collaborate in serving specific individuals and in developing population health management approaches.

## **Recommendations for the Justice Leadership Council**

### **Levels of Involvement, Participation, and Collaboration**

*Finding 1* – The Justice Leadership Council (JLC) was found to have good representation from high-level leaders in the criminal justice system and mental health communities. However, the group could meet more often, which could increase the extent to which members see the JLC as being a forum where significant plans are made for system enhancement.

*Recommendation 1* – The Foundation should continue to play a facilitative role for the JLC and should continue to promote opportunities for system enhancement efforts to be recognized and celebrated. Figuring out how to help people with mental illnesses avoid criminal justice system involvement is very difficult and all incremental steps towards achieving the JLC’s vision should indeed be recognized and celebrated. In addition, with logistical and coordination support from the Foundation, the JLC should facilitate ongoing efforts to link all system enhancement efforts together in a common framework, as is being done with the Sequential Intercept Mapping process. Finally, it should facilitate the documentation – both qualitative and quantitative – of the effects of all system change efforts. (Recommendations 7 and 7.a. below will further explicate this last part of Recommendation 1.)

*Finding 2* – The JLC has developed a strong base for collaboration, which to date has included a significant amount of coordination across agencies and systems.

*Recommendation 2* – To support its efforts in developing Sequential Intercept Mapping components and filling the gaps in the model, the JLC, with facilitative/organizational help from the Foundation, could consider creating sub-groups of members (similar to the Jail Diversion Committee that addresses intercept 1), with an emphasis on intercepts 0 (zero), 2 and 5. Each would provide updates to the JLC on specific developments within their respective intercepts.<sup>17</sup> Again, the focus would be on both recognizing and documenting accomplishments, as well as tracking progress over time. The ultimate goal would be to fulfill a function of describing and tracking, in an integrative way, all system enhancement and gap-filling efforts so that all participants can see the “big picture” and continually identify ways of bolstering enhancement

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<sup>17</sup> In January 2017, the JLC recently voted to add an “intercept zero” point to the map. To a significant degree, structural elements already are in place. For example, there is a Jail Diversion Committee that addresses issues at some of the early intercept points.

efforts at each intercept point. The JLC should also identify opportunities that would mutually benefit the efforts of the Jail Diversion Committee and each of the other ongoing county-level committees and work groups that have pre-dated the existence of the JLC.

*Recommendation 2a* – The intercept-specific sub-groups could provide regular updates to the JLC on plans for enhancing programming and collaborative efforts at each intercept point, along with any known timelines associated with planned efforts. This would not be in the service of holding the JLC accountable for these efforts, but, rather, simply to aid the JLC in its role of recognizing and documenting how all of the efforts tie together.

*Recommendation 2b* – The JLC leadership and its appointed intercept-based sub-groups could use ongoing tracking and updates to identify “points of contact” between county-level efforts across intercepts. These points of contact could alert various county-level entities of opportunities that would benefit each other’s work, including identifying ways they could collaborate in bringing additional resources into the county and advocating for various state-level policies that would be mutually beneficial.

*Recommendation 2c* – The JLC, with prompting from sub-groups, should look for opportunities to publicize (e.g., in the newspaper or on local news stations) the development of new or enhanced programming at various intercept points. For example, if behavioral health specialists were co-located with dispatchers, the JLC could work with local news outlets to broadcast or publish a story about that achievement.

### **System of Care Priorities**

*Finding 3* – While the JLC’s primary role is not to instigate collaborative system change and enhancement processes, it nevertheless has supported some progress toward its original multi-year plan.

*Recommendation 3* – In keeping with its self-identified role, the JLC can simply document and describe the operational statuses of the pretrial office program and the in-jail behavioral health services provided by EHN, noting the extent to which best practices are included in the programming, along with gaps in the planned provision of best practices. With respect to Intercept 4, for example, the JLC could describe the number of people in the jail who have mental health (MH) and substance use disorder (SUD) treatment needs and who receive such services from EHN, as well as the number who have co-occurring MH/SUD who receive integrated MH/SUD treatment.

Recommendation 3 essentially promotes the development of another, slightly more rigorous tracking of best practice implementation at key intercept points. It builds on Recommendation 2, but suggests a “deeper dive” into describing system enhancement progress with respect to

the current and ongoing intercept enhancement efforts. While Recommendation 2 would lead to the development of specific sub-groups who would continue to describe county efforts at the Sequential Intercept Mapping level, Recommendation 3 would suggest “break-out” maps that would provide more detail on any intercept points that have current, ongoing intercept enhancement efforts.

The next three findings and associated recommendations suggest a role for the JLC in facilitating both the clarification of desired program models as well as a more orchestrated approach to identifying funding or financing approaches to support the implementation of desired models. One of the findings is associated with Intercept 1, the other is associated with Intercept 5, and the final finding of the trio is associated with what could be considered “Intercept 0 (zero).”<sup>18</sup>

*Finding 4* – The JLC’s 2015-2016 sequential intercept map identifies a gap at Intercept 1, associated with Dispatch 911: There is a need to address historical data and to co-deploy Crisis Intervention Training (CIT) with law enforcement. These are indeed important gaps to fill. Also, there are two additional complementary approaches that the JLC could consider investigating further that would be helpful for El Paso County.

*Recommendation 4a* – First, it would be helpful to adopt the Multidisciplinary Response Team (MRT) model, which is an emerging model of law enforcement/mental health system collaboration at Intercept 1.

*Recommendation 4b* – Another potentially helpful approach at Intercept 1 would be to embed a behavioral health specialist with dispatch.

*Finding 5* – The availability of intensive community and team-based programs to meet the needs of adults with serious mental illnesses and very high utilization of the criminal justice, crisis, and hospital systems is insufficient to meet the estimated need.

*Recommendation 5* – The JLC could serve as a forum that supports creative approaches to identifying various means of enhancing the availability of ACT services in El Paso County. If the JLC adopted Recommendation 4, it would serve to expand its role in facilitating the identification of system opportunities and potential options for funding or financing such opportunities. (Again, the point would not be to hold agencies “accountable” to a particular set of assumed requirements, but, rather, to capitalize on the system-level purview of the JLC to

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<sup>18</sup> If and when another county-level effort already is devoted to the implementation of a desired new (or enhanced) program model, the JLC could simply provide ongoing support for that effort.

promote the interests of all participating agencies/members.) There are specific steps that the JLC could take:

*Recommendation 5a* – First, the JLC could further specify an ideal program model for high-utilizing adults with mental illnesses who need intensive community-based treatment and supervision. For high utilizers of the criminal justice system who have high criminogenic needs (are at high risk for re-offending), a model is emerging nationally which combines assertive or intensive community treatment teams with mental health-community supervision collaboration, organized within a Risk-Need-Responsivity (RNR) framework.<sup>19</sup> The basic idea is that people with serious mental illness (SMI) who are high utilizers of the jails have both mental health needs as well as criminogenic risks that need to be carefully assessed and then treated and ameliorated in a way that is responsive to the assessed needs.

The JLC could explicate an ideal model which includes the following: a) the criteria by which someone would be deemed eligible for a Forensic Assertive Community Treatment (FACT) team or other intensive model that incorporates RNR principles and the assessments to be used (including, for example, the current, state-required ORAS; other useful tools exist for ongoing community-based assessment of risk and needs); b) the establishment of one or more FACT (or equivalent) teams, and the types of mental health and community supervision professionals needed to make up the team; c) the specific criminogenic risk reductions strategies (including incentives and disincentives to individuals) that would be used, as well as the specific evidence-based treatments for SMI that would be incorporated into the intensive team; 4) the step-down criteria that would be used to graduate individuals to lower levels of care; and 5) the lower levels of care to which people could successfully be graduated, along with the basic levels and types of training in criminogenic risk assessment and treatment that the lower level of care teams would need in order to help individuals successfully avoid recidivism.

- *Note: A JLC contingent could examine in more detail the emerging models in Dallas, which are endeavoring to accomplish what is described just above.*

*Recommendation 5b* – Once the Intercept 5 model for successfully serving and monitoring the highest utilizers with significant criminogenic needs has been developed, the JLC’s criminal justice system and mental health members should identify ways of prioritizing the funding of the ideal model in order to serve those most in need of a combined Forensic ACT/RNR model. Various possibilities, such as seeking support from foundations that are interested in the

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<sup>19</sup> For more detail on the RNR and related approaches, see, for example: Skeem, J. et al. (2015). Applicability of the risk-need-responsivity model to persons with mental illness involved in the criminal justice system. *Psychiatric Services*, 66(9), 916-922. Manchak, S.M., Skeem, J., et al. (2014). High-fidelity specialty mental health probation improves officer practices, treatment access and rule compliance. *Law and Human Behavior*, 38(5), 450-461. Cusack, K.J., et al. (2010). Criminal justice involvement and costs of Forensic Assertive Community Treatment: A randomized trial. *Community Mental Health Journal*, 46(4), 356-363.

problem of jail diversion, or pooling available funds across collaborating agencies to create an inter-disciplinary criminal justice/mental health intensive team, could be pursued.

*Finding 6* – People with serious mental illnesses do not get appropriate treatment until, on average, five years after a first episode of illness.<sup>20</sup> Many of them end up in the criminal justice system because their illnesses were not detected early enough and because they did not receive the treatment necessary to help them successfully and safely remain in the community.<sup>21</sup> Through funding from the state mental health authority to Emergence Health Network, a new First Episode Psychosis (FEP) Care program will soon be available in El Paso. This is an exciting new development for the county. However, TriWest estimates there are approximately 172 people who experience a first episode of psychosis in El Paso County each year and the new program probably will not have enough capacity to meet the entire need, especially given that the typical length of stay in the program will be at least two years.<sup>22</sup> Greater capacity is needed to ensure early intervention and the prevention of unnecessary criminal justice system involvement. We also recommend the BHC add FEP Care to the ideal system of care that TriWest Group communicated to PdNHF and the BHC in its 2014 system assessment report.

*Recommendation 6a* – The JLC should work with EHN to help ensure the inclusion of people with a first episode of psychosis whose episode is detected through contact with the law enforcement or criminal justice systems. This would require assessment – at various intercept points – of persons with psychosis to determine whether they are experiencing a first episode of their illness.

*Recommendation 6b* – Because EHN is an active participant in the Behavioral Health Consortium (BHC) and is actively partnering with the Sheriff’s Office to deliver behavioral health services within the county jail, it should not be difficult for the JLC to receive updates on EHN’s progress in implementing an FEP Care program. The “lessons learned” from EHN’s implementation – in terms of what is working best for which sub-sets of clients as well as capacity limitations of the program – should be useful in planning for implementation of a second team (perhaps by EHN, but perhaps by one of the local universities or through a partnership between agencies) in approximately 2018.

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<sup>20</sup> Wang P S, Berglund P A, Olfson M, Kessler R C. (2004). Delays in initial treatment contact after first onset of a mental disorder. *Health Services Research*, 39(2), 393–415.

<sup>21</sup> A recent study of First Episode Psychosis Care found that people who receive it within 17 months of the onset of their first episode had much better outcomes than those who did not receive the treatment within the first 17 months. Kane, J.M., et al. (2015). Comprehensive versus usual community care for first episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, *ajp in Advance*, 1-11. [RAISE refers to the Recovery After First Episode Psychosis program, funded by the National Institute of Mental Health.]

<sup>22</sup> MMHPI (2016). *Best Practices in First Episode Psychosis Care*. Unpublished Manuscript, available upon request.

## Articulation of Goals and Objectives and Use of Metrics to Track Progress

*Finding 7* – The JLC has identified very important objectives and strategies for achieving them. However, a rigorous, ongoing means of tracking progress towards implementing the strategies and meeting the objectives has not yet been developed.

*Recommendation 7* – The Foundation, the BHC, and the JLC should collaborate to develop an evaluation process that will serve both to help the JLC remain oriented to its stated objectives and to provide continual feedback that can serve to help it celebrate successes and identify opportunities for system enhancement.

The evaluation could be conducted by an outside entity, perhaps funded jointly by the Foundation and participating JLC members; an internal evaluation conducted by a team of staff from participating member agencies could also work well. Whichever approach is adopted, an identified entity or group that has responsibility for evaluating the JLC’s progress toward meeting its objectives, and that uses evaluation data within a continuous quality framework, needs to be selected.

Below, we identify specific metrics associated with each of the JLC’s objectives that we recommend the evaluation group consider tracking continuously and reporting on periodically.<sup>23</sup> (These metrics also were informed by the national Stepping Up campaign.)

Objective 1: By December 31, 2017, reduce the number of individuals with a diagnosable mental illness who are incarcerated for reasons other than public safety factors related to criminal behavior. Associated strategies include the following:

- Justice Leadership Council Strategy 1: Revise the pretrial process to maximize diversion<sup>24</sup> options for individuals afflicted with a mental illness who can be safely served in community treatment settings.
- Justice Leadership Council Strategy 2: Convert to 24-hour magistrate availability to maximize opportunity for diversion when individuals with a mental illness are in crisis.
- Justice Leadership Council Strategy 3: Transform law enforcement officer training to model training on pre-arrest or assisted diversion, crisis intervention, and referral assistance for individuals with mental illness.

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<sup>23</sup> At its January 2017 meeting, the JLC voted to develop a work group that would examine possibilities for collecting data on key indicators that could be reported in a dashboard format.

<sup>24</sup> While MMHPI generally does not consider activities that occur after arrest and booking to constitute “diversion,” we understand the thrust of this objective, which is to enable more people who have been arrested and booked to avoid excessive time spent at the jail.

*Recommendation 7a: Metrics for Objective 1* – The JLC should measure and track progress on indicators of the frequency of screening and assessment for mental illnesses as well as diversion and referral to appropriate services. Potential metrics for consideration include the following:

- Metric 1.1 – Percentage of people booked at the jail who are screened and assessed for behavioral health conditions and criminogenic risk.
- Metric 1.2 – Number and percentage of people with behavioral health conditions who are safely diverted from arrest into treatment.
- Metric 1.3 – Percentage of people with behavioral health conditions who are (1) arrested or (2) booked again at the jail within twelve months of diversion from arrest.

Objective 2: By December 31, 2017, increase the number of individuals with a diagnosable mental illness who receive appropriate treatment while incarcerated.

- Justice Leadership Council Strategy for Objective 2: Strengthen the financial and programmatic collaboration between the county jail and behavioral health treatment providers in order to bolster the availability of assessment, medication, counseling, pre-release planning, and coordination of jail-based services for people with behavioral health conditions.

*Recommendation 7b: Metrics for Objective 2* – The Justice Leadership Council will measure and track progress on indicators that detained people with behavioral health disorders receive appropriate treatment while incarcerated and post release. Potential metrics for consideration include the following:

- Metric 2.1 – Percentage of people with behavioral health disorders detained in the El Paso County jail who receive individual assessment and behavioral health services based on that assessment, both while incarcerated and post release.
- Metric 2.2 – For those detained in the county jail, the percentage of people with behavioral health conditions who are (1) arrested or (2) booked again at the jail within twelve months of release from jail.

Objective 3: By December 31, 2017, increase the number of individuals with a diagnosable mental illness who receive appropriate follow-up care and support post incarceration.

- Justice Leadership Council Strategy for Objective 3: Support re-entry for people leaving correctional settings (county jail, juvenile detention, TJJ facilities, and Texas Department of Criminal Justice facilities) to connect them to person-centered, recovery-oriented care in the community.

## State Level Policy Priorities

*Finding 8* – The guiding state-level policy direction that the BHC and JLC should promote can be stated simply: *Partner with local governments to keep non-violent people with the severe mental illnesses out of our jails and get those who end up in jails out, and into treatment, as fast as possible.*<sup>25</sup>

*Recommendation 8* – The JLC, BHC, and the Foundation should work with local legislatures to promote policy priorities that support the locally-driven objectives and strategies being pursued by the JLC and its constituent members. For example, Senate Bill 292 (Huffman, Nelson, Schwertner) would potentially increase state funding for Intercept 1 diversion activities. In doing so, the JLC can cite the Texas Judicial Council’s recent set of recommendations that, if fully reinforced by state policies and legislations as well as local implementation, could help meet the goals of the JLC.

- *Recommendation 8a* – Examine the Texas Judicial Council’s recommendations concerning state- and local-level support for compliance with state-required *screening protocols* and decide which recommendations to implement and which recommendations to promote at the state level.
- *Recommendation 8b* – Examine the Texas Judicial Council’s recommendations concerning the *appropriate use of competency restoration* and decide which recommendations should be implemented in El Paso and which should be promoted at the state level with legislators and state agencies.
  - The JLC should consider working with local legislators to promote the legislature’s clarification of *existing laws concerning the licensing of competency restoration programs* and provide local communities with the authority to implement competency restoration in any safe and clinically appropriate setting that meets state standards. The JLC could also work with local legislatures to promote legislative efforts to broaden local discretion in choosing the best use of local competency restoration options, across appropriate settings, to help reduce backlogs in county jails.
  - The JLC could examine if *TCOOMMI’s funding option for new generation medications needed by 46B inmates* who are transferred to the county jail is fully available in El Paso. If not, the JLC could join the efforts of MMHPI and other entities that are interested in the legislature ensuring in statute that the process of obtaining such funding is simple and easy to follow.
- *Recommendation 8c* – Review opportunities for participation in the SB 292 jail diversion expansion.

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<sup>25</sup> This policy priority, articulated by the Meadows Mental Health Policy Institute, recently was endorsed by the Texas Judicial Council. See Texas Judicial Council. (2016, October). *Mental Health Committee Report and Recommendations*. Austin TX: Author. Please see **Appendix 10** for the full report.

- *Recommendation 8d* – Recognizing the possibility that the state will partner with communities that are able to collaborate across agencies locally to eliminate forensic waitlists under SB 292, we recommend that the JLC develop a formal plan for eliminating such waitlists that is endorsed by the county, the local mental health authority (EHN), and the hospital district (UMC of El Paso). This will strengthen El Paso’s hand in promoting state-level policies and priorities to support the goals of the JLC.

## Next Steps

The BHC Executive Committee should review the recommendations in this report and decide on which to identify as priorities for helping guide the BHC’s work in 2017 and 2018. It should also request that the leadership councils review their recommendations and report on which ones they wish to establish as priority areas for concentration in 2017 and 2018.

Once priorities are set, the Executive Committee should work with the leadership councils to identify technical assistance resources that would be helpful to procure in pursuing the recommendations that have been identified as priorities for 2017-2018. Technical assistance, training, and consultation could be obtained from a single entity that is capable of providing the full complement of assistance desired, or from a variety of agencies who collectively offer the expertise needed. It would be wise to select an entity that has broad expertise in system development and behavioral health policy, is familiar with the Paso del Norte Health Foundation region, and can help the BHC capitalize on state and national developments. However, we would also recommend that the Foundation should have the selected technical assistance/consulting provider work closely with BHC-identified universities and other entities within the county to bolster the region’s own expertise in policy, program planning, and evaluation/performance assessment.

## Appendix One: Behavioral Health Consortium Assessment Interim Report (Originally submitted May 31, 2016)

### Overview and Purpose of the Assessment

The Paso del Norte Health Foundation (PdNHF) contracted with MMHPI to:

- Revise Consortium and Leadership Council objectives and update related metrics that MMHPI subcontractor TriWest Group helped the Consortium develop in early 2015;
- Provide Council leadership, functioning, and strategy quality improvement recommendations;
- Develop a method for Leadership Councils to self-monitor through a set of metrics;
- Provide technical assistance to revise at least three (3) organizational policies;
- Provide advocacy technical assistance for at least three (3) state level policies; and
- Track and analyze related behavioral health system data and report findings to develop recommendations to PdNHF and Consortium partners to inform ongoing Consortium development and performance.

### Methodology

Our primary goal in the very early weeks of the evaluation was to obtain a baseline understanding of the Behavioral Health Consortium's (BHC) functioning. Much of this report is oriented toward describing the BHC's operations over the past few years.

In this early stage, we employed three methods in beginning to understand the BHC's functioning:

- 1) We **reviewed BHC documents**, including the recorded history of meetings;
- 2) We **observed one meeting each of the three Leadership Councils** (Family, Justice, and Integration); and
- 3) We conducted our first set of **key informant interviews** with eleven different people. Because our meeting observations and key informant interviews represented only partial samples of meetings and key persons involved, this report is, indeed, an "interim" one, and its conclusions and recommendations should not be seen as definitive, but rather as providing an early "outside perspective" that could inject the BHC and its Leadership Council with new and potentially illuminating insights and ideas.

### Review of BH Consortium Documents

MMHPI consultants reviewed all meeting agenda and notes from the Executive Committee, Integration Leadership Council, Justice Leadership Council, and Family Leadership Council to determine the consistency of meetings, the number of agencies participating, participant attendance, activities of the Councils, and progress.

Please see Attachment A for a summary of the number of meetings held by each Council as well as lists of the agencies that have participated.

### Leadership Council Meeting Observations

MMHPI attended the Family Leadership Council and Justice Leadership Council meetings held in March 2016, and the Integration Leadership Council meeting held in April. We observed the level of participation and activities being discussed during the meetings.

### Key Informant Interviews

Key informant interviews were held with representatives from the Family Leadership Council, the Justice Leadership Council, and the Integration Leadership Council.

The following key informant interviews were conducted:

Behavioral Health Consortium	Participant
<b>Executive Committee</b>	Sharon Butterworth (Chair), Advocate
<b>Family Leadership Council</b>	Sharon Butterworth, Advocate (interviewed once, but has two group memberships)
	Veronica Lowenberg, Center for Children, Therapeutic Homes Program Director
	Sandy Rioux, Center for Children CEO
	Ivonne Tapia, Aliviane CEO and FLC Chair
<b>Justice Leadership Council</b>	Maggie Morales-Aina, Director of Adult Probation,
	Chrystal L. Davis, EHN, Chief Operating Officer of Diversion Services
	Sheriff Wiles and Lt. Hebeker, El Paso County Sheriff Office Veronica Escobar, El Paso County Judge Vince Perez, El Paso County Commissioner Precinct 3
<b>Integration Leadership Council</b>	Maria Carrillo, Clinica de Salud La Fe, Social Services Administrator
	Kristi Daugherty, Emergence Health Network
	Bill Schlesinger, Project Vida
	John Wiebe, UTEP

## Findings

### Consortium and Leadership Council Functioning

#### Overview

The BHC and its Leadership Councils (LCs) have successfully formed, established leadership roles and filled them, taken on various projects that involve collaborative effort on the part of BHC member agencies and their representatives, and, in some cases, promoted the establishment of formal relationships between entities (such as the Sheriff's Office and Emergence Health Network).

At the same time, there are areas in need of development. First, the BHC and its LCs have not identified system performance metrics that should be used to track progress in filling gaps in systems of care and otherwise improving behavioral health services systems. Second, in our key informant interviews and observations of meetings we found that many BHC participants were uncertain as to the purpose of meetings and the priorities for system development and enhancement. There is a need to develop clear priorities for program and policy change, as well as detailed plans for addressing them and measuring progress toward program and policy change goals.

Periods of uncertainty and limited progress are not uncommon in the history of BHC development. In the case of the El Paso BHC, there have been significant transitions occurring in key agencies, not the least of involves the Paso del Norte Health Foundation, which has undergone a relatively lengthy process of replacing an Executive Director who had led the Foundation for many years. In times of transition, opportunities to promote and facilitate the further development and maturation of a very complex undertaking, such as a behavioral health consortium, become much more limited.

The timing of this evaluation is just right for taking stock of the progress made by the El Paso BHC, the areas in need of further development and maturation, and the opportunities for clarifying its goals and measuring its progress.

### Levels of Involvement and Participation

#### Executive Committee

The Executive Committee began gathering in 2012 and it both grew in size and increased in meeting frequency over the next three years. With representation from seven (7) agencies, the Executive Committee met three times in 2012. There was an average of eleven (11) participants at meetings that year and five (5) agencies participated in at least half of the meetings. As can be seen in **Table 1** below, **by 2015, the Executive Committee had grown to 14 agencies and had met five times in the year, with ten agencies being represented at meetings at least half of the time.** (At the time of analysis, there were no meeting notes available for 2016.)

**Table 1: Participation in Executive Committee Meetings**

Year	Number of meetings	Number of Agencies	Average Number of Participants at Meetings	Agencies Participated in Half or More of Meetings
2012	3	7	11	5
2013	6	10	12	7
2014	6	14	11	11
2015	5	14	Missing	10

While meetings originally were to take place on a quarterly basis, the Executive Committee has met an average of five (5) times per year since it first formed in 2012.

Members have been asked to complete tasks for the committee outside of meetings. Each Executive Committee member also sits on one of the leadership councils.

#### **Family Leadership Council (FLC)**

The Family Leadership Council began meeting in 2015 and had eight (8) meetings. The Family Leadership Council has strong representation and participation from child serving agencies. In the LC's first year, 27 agencies participated (including special meetings with HHSC representatives and the Foster Care and MCO work group meetings) with 12 agencies having representation at half or more of the meetings. There was an average of 17 participants at meetings.

Twelve agencies have participated in Family Leadership Council meetings in 2016 with 14 attendees at the January 2016 meeting. Meeting notes for the March 2016 meeting were not available at the time of this review.

Since 2015, 12 of all 27 participating agencies were represented at half or more of the meetings.

**Table 2: Participation in the Family Leadership Council, since 2015**

Year	Number of meetings <sup>26</sup>	Number of Agencies	Average Number of Participants at Meetings	Agencies Participated in Half or More of Meetings
2015	8	27	17	12
2016	2	12	14	Insufficient data

There has been a focus on engaging members to participate in the Consortium in order to help move the group forward. Even though the FLC has met regularly, they recently agreed to add 30 minutes to the meeting time to ensure sufficient time for a healthy dialogue on each work group and other items.

### **Justice Leadership Council (JLC)**

The Justice Leadership Council met four (4) times in 2015 (including a special meeting to complete a sequential intercept map) and provided a progress update in October 2015. The JLC's Jail Diversion Committee (JDC) met twice in early 2015. To date, between the JLC and JDC meetings, 19 different agencies have participated in meetings, with nine (9) agencies having representation at meetings more than half of the time. The average number of participants at meetings was about 20.

The Justice Leadership Council has held one meeting in 2016. This was the first meeting of the Council since their August 2015 meeting. Meeting notes were not available at the time of this report.

The Jail Diversion Committee has had three meetings in 2016 with representation from eleven (11) agencies. The average attendance at the 2016 meetings was 26 participants.

Eight (8) of 19 organizations or entities with member representation attended meetings over half the time (based on available meeting minutes). Based on information and observational data available to date, it appears there has been limited communication outside of the meetings and intermittent attendance by the City, the District Attorney's Office, and the El Paso Police Department.

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<sup>26</sup> Includes work group meetings in 2015.

**Table 3: Participation in the Justice Leadership Council, since 2015**

Year	Number of meetings <sup>27</sup>	Number of Agencies	Average Number of Participants at Meetings	Agencies Participated in Half or More of Meetings
2015	6	19	20	9
2016	1			

**Integration Leadership Council (ILC)**

The Integration Leadership Council met five (5) times in 2015 and had representation from 16 agencies. Twelve agencies had representation at over half of the meetings. The average number of participants at meetings was 13.

The Integration Leadership Council met in February and March 2016 but meeting notes were not available at the time of this review.

Twelve of the 16 agencies involved had representation at over half of the meetings of the Council. There is indication that members worked together outside of meetings to further the goals and objectives of the Council (e.g., Ms. Hernandez of Emergence Health Network and Dr. Wiebe of University of Texas at El Paso developed the workforce key stakeholder survey for the group to review and revise together).

**Table 4: Participation in the Integration Leadership Council, since 2015**

Year	Number of meetings <sup>28</sup>	Number of Agencies	Average Number of Participants at Meetings	Agencies Participated in Half or More of Meetings
2015	5	16	13	12
2016	1	No data	No data	No data

Based on meeting minutes alone, the relationships appear to be formal. The group has been largely focused on workforce issues; members have asserted that without addressing workforce issues, integrated health/behavioral health care cannot be delivered. Members have referenced salaries as a barrier to hiring professionals. The military and the VA pay more than the non-profits are able to pay.

<sup>27</sup> Includes work group meetings in 2015.

<sup>28</sup> Includes work group meetings in 2015.

## Preliminary Assessment of Collaboration Levels

In this next section of the report, we provide an early assessment of the degree to which four primary bodies of the BHC have moved across stages of development toward full collaboration. We are using a four-stage model of collaboration that has been adopted by the Paso del Norte Health Foundation (PdNHF). The model envisions an entity that might begin by merely exchanging information for mutual benefit (Stage 1 – Networking), but then builds on that initial success by altering its activities and those of its constituent members to achieve a *common* purpose (Stage 2- Coordinating). A big leap forward occurs in Stage 3 – Cooperating, when the BHC and its participating agencies also *share resources* to achieve that common purpose. Finally, to achieve full collaboration, PdNHF envisions the BHC operating in such a way that its members would also *enhance each other’s capacities* to achieve their common purpose(s).

**Table 5: Stages of Collaboration**

Stage 1	Stage 2	Stage 3	Stage 4
<p><b>Networking</b> Exchanging information for mutual benefit.</p>	<p><b>Coordinating</b> Exchanging information for mutual benefit and altering activities to achieve a common purpose.</p>	<p><b>Cooperating</b> Exchanging information for mutual benefit, altering activities and sharing resources to achieve a common purpose.</p>	<p><b>Cooperating</b> Exchanging information for mutual benefit, altering activities and sharing resources to achieve a common purpose.</p>

The model identifies three dimensions of functioning that can be used to assess an entity’s progress toward full collaboration and to help the stage at which it is functioning:

**1) Relationship**

- Relationships move from being informal to formal in nature.

**2) Characteristics**

- *Time commitment* – from minimal in Stage 1 to extensive in Stage 4.
- *Level of trust* – from limited in Stage 1 to high in Stage 4.
- *Sharing of turf* – from seeing no need to share “turf” in Stage 1 to “a sense of common turf” in Stage 4.
- *Primary focus of the group* – moves progressively from information exchange in the Networking stage to making access to services/resources more user-friendly in the Coordination stage, to sharing resources in order to achieve a common purpose in the Cooperation stage, to enhancing each other’s capacity to achieve a common purpose in the Collaboration stage.

### 3) Resources

- From no mutual sharing of resources to full sharing of resources, risks, responsibilities, and rewards.

#### Behavioral Health Consortium – Executive Committee

It is important to note that we have not yet conducted a thorough analysis of the Executive Committee’s (EC) functioning. However, based on the available documents, the EC appears to be functioning somewhere between Stage 2-Coordinating and Stage 3-Cooperating. They have been focused on achieving the BHC’s identified goals and objectives, and they are working to leverage the capacity of existing resources within the community. Involvement requires at least a moderate time commitment. Shared access to each other’s turf is not quite known, but we preliminarily assume there is little sharing of turf. Trust has not been well assessed.

Each Leadership Council is allotted time to provide updates on progress toward their goals at each Executive Committee meeting. Since the Leadership Councils/Task Forces were initiated by the Consortium to help achieve Consortium goals and objectives, the characteristics of both the Executive Committee and the Leadership Councils are difficult to separate from each other. Executive Committee members do exhibit at least a moderate time commitment and bring a wealth of knowledge and experience to share at the table.

**Table 6: Preliminary Assessment of Executive Committee Collaboration**

Stage	Relationship	Characteristics			Resources
		Time	Trust	Turf	
2 to 3 Coordinating to Cooperating	Not yet fully assessed	Moderate	(Not assessed)	Not yet shared?	Minimal sharing?

The primary focus to date appears to be somewhere in between “making access to resources/services more user-friendly” and “sharing resources to achieve a common purpose.”

#### *Progress towards multi-year plans*

The Executive Committee sees BHC activity as being led by the Comprehensive Continuous Integrated Systems of Care (CCISC) model that was developed by Minkoff and Cline. The CCISC is used as a basis for guiding structural changes to the El Paso County behavioral health system of care. (The specific ways in which the BHC uses the CCISC will be assessed in more detail in the coming months.)

During meetings in August and September 2014, the Consortium developed vision and mission statements and confirmed that three initial task forces (now leadership councils) should be initiated. The vision and mission statements developed were:

- **Vision:** The El Paso Community Behavioral Health Consortium envisions an accessible, person-centered behavioral health system of care in the El Paso region.
- **Mission:** The Mission of the El Paso Community Behavioral Health Consortium is to collaborate through information and knowledge exchange to drive maximization of resources and expansion of accessibility and services.

The Executive Committee created the following guidelines and objectives for the Task Forces (Leadership Councils):

- Engage existing groups working in complement with the Consortium's mission
- Begin with meetings scheduled for every other month
- Develop no more than three collaboration principles or guidelines for each Task Force
- Develop an inventory of services in electronic form – real time, reliable and open for caregivers to access
- Create a scorecard of mission related metrics
- Maintain a top down, bottom up communications and education plan– work will be in complement with existing community organization plans

The EC has made positive progress because of the Foundation's efforts to change the regional paradigm and reduce the negative bias associated with mental illness. Several special meetings in June and August 2015 with leadership from the Health and Human Services Commission (HHSC) were helpful in creating plans to resolve communication issues with managed care organizations. The group has also developed a media component plan.

Congressman O'Rourke committed his office to be a resource for Consortium members. The EC also recognized the need to include in the consortium more members of the community, specifically mental health advocates. For example, they voted unanimously to add the NAMI-El Paso Director as a mental health advocate for consumers.

### **Family Leadership Council**

The Family Leadership Council currently appears to be focusing on relationship building and addressing the immediate financial challenges that members are facing. Especially at the leadership level, if not throughout the FLC, there is a long-term goal of developing a full continuum of care that includes robust prevention and early intervention services. In fact, they have developed a model for a child and family continuum of care for El Paso County in the form of a pyramid with a foundation of support/prevention/early intervention services, then increasing in intensity and specialization of care as the need becomes more serious or complex.

However, to date, the FLC has not yet been able to take on the task of identifying specific gaps in the continuum of services and has not yet gained much traction in filling in those gaps in a programmatic and strategic way.

The FLC has met regularly and involved a large number of agencies. To date, identification of resources has been an important focus, and the group has served as a venue through which child/family-serving agencies have been able to approach managed care organizations (in the hopes of obtaining reimbursement for a wider range of services) in a more proactive way. However, to our knowledge, at this early stage of assessment the FLC's participating agencies are not yet sharing resources more formally outside of the meetings and in mutually beneficial, capacity-building ways.

There also seem to be different groups competing for members' time and attention. Many of the Council members are also participating in the El Paso Consortium for Children organized by Dr. Handel.

Because many FLC members have come together in the past for other initiatives for which lasting partnerships were not attained, the FLC's early focus this time on relationship building and identifying pressing issues that are of concern to many participants is understandable. (In the past, relationship building seems to start again each time groups re-engage and it has not seemed that system partners have been able to ensure an ongoing, collaborative system improvement effort.)

Thus far, our preliminary assessment is that the Family Leadership Council falls somewhere between Stage 2- Coordinating and Stage 3- Cooperating. However, in certain areas there appears to have been a higher level of collaboration. For example, the **time** commitment ranges from substantial to extensive, depending on the agency in question and the level of member involvement in additional work groups. At this time, a rating of "substantial" time commitment for the FLC as a whole appears warranted.

There has also been an intentional effort to hear from each agency involved in the group to create awareness of services available for sharing and discussion, and to reach consensus regarding decisions affecting the group. They have been sharing information about existing community resources with each other in order to achieve a common purpose. They have focused on the identified goals and objectives and are working to leverage the capacity of existing resources.

While only a preliminary assessment has been completed, our analysis at this juncture is that the FLC's members do sometimes share resources to achieve a common purpose and that there

is even some sharing of “turf,” but that these levels of collaboration have not yet been widely and routinely evident across all of the FLC’s participating agencies.

**Table 7: Preliminary Assessment of Family Leadership Council Collaboration**

Stage	Relationship	Characteristics			Resources
		Time	Trust	Turf	
2 to 3 Coordinating to Cooperating	Informal, some formal	Substantial	Moderate	Infrequently shared	Infrequently shared

The FLC met with greater frequency than that of the other leadership councils and engaged in exercises/activities between meetings related to the common purpose of the group. For instance, group members were asked to complete the Care Pyramid showing their respective levels of prevention, promotion, and intervention prior to another council meeting. This allowed everyone to be on the same page to share and learn from each other in addressing the common goals and purpose.

During at least one of its meeting, the group discussed the importance of building trust and moving forward by addressing issues positively and using factual information and data available from the community. The importance of working together was emphasized at meetings. The group strived for inclusivity in sub-groups, asking participants at each meeting to identify others who should be at the table. Thus, while some key informants indicated there were certain subjects that were difficult to bring up because of a lack of trust, the group has demonstrated strength in being able to discuss trust and how to engender it.

A major focus to date has been on developing closer working relationships with managed care organizations (MCOs), and the fact that the FLC has taken on this task suggests that trust is emerging in the group. In an environment of mistrust, child/family serving agencies and advocacy groups would not tend to participate in a *common* effort to engage MCOs.

In terms of resources, there has been some focus on developing wraparound services to help children in foster care avoid out-of-home placements, particularly residential treatment center placements out-of-state. However, the FLC has mainly focused its discussion of resources on increasing understanding of each agency’s role in the system of care, versus developing opportunities to share resources and “turf” in fleshing out a better system of care. For instance, due to group confusion about the role of Emergence Health Network (EHN), a follow-up meeting involved a presentation to clarify the scope of child and family services provided by EHN. This sparked a recommendation for future group planning to involve similar presentations from other member organizations to learn about each group’s history and services for potential

sharing of resources. Again, this does not yet rise to the level of sharing resources, but it is difficult to share resources when you do not know which resources your potential collaborators have.

#### *Multi-year plan progress*

The FLC has made some progress toward its original multi-year plan. A brief outline is provided below. More detail is provided in the next section of the report, “Articulation of Goals and Objectives, and the Use of Metrics to Track Progress.”

- The Council developed an Early Childhood Continuum of Care Framework.
- Resulting from a special meeting with Mr. Gary Jessee and the MCOs, crime victims’ funds from the State were recouped successfully.
- Two sub-groups emerged following the August 2015 meeting:
  - One to address foster care,
  - Another to connect community groups with MCOs.
- The child placing agencies are investigating inclusion of Mental Health First Aid training as part of the training for foster parents.

#### **Justice Leadership Council**

Based on available information, the level of collaboration in the JLC likely falls between networking and coordinating. The Justice LC has focused on specific projects and has not yet developed a common vision. Activities to develop a common vision and ensure everyone is “on the same page” in terms of the JLC’s overarching goals, and how to achieve and measure progress, have not yet emerged. As one key informant put it, “We just meet because we are supposed to meet, but no one knows why.”

To date, there appears to be a limited amount of information and resource sharing. In addition, while participation has been consistent from some, there needs to be more intensive involvement from some key partners, such as municipal law enforcement.

Emergence Health Network provides services in the jail under contract, but this is the only visible resource sharing taking place. JLC members indicated that there is a “good trust” to share information, but we could not find evidence of information being shared routinely across agencies. Furthermore, it is not yet clear that members have identified the information and data that would be helpful to share. There appears to be confusion among members about who can share client care information, and a sense that members are still sticking primarily to their own turf, rather than truly working together for a common purpose.

**Table 8: Preliminary Assessment of Justice Leadership Council Collaboration**

Stage	Relationship	Characteristics			Resources
		Time	Trust	Turf	
2 Coordinating	Some Formal	Moderate	Moderate	Isolated examples	Infrequently shared

*Multi-year plan progress*

The JLC has made some progress toward its original multi-year plan. A brief outline is provided below. More detail is provided in the next section of the report, “Articulation of Goals and Objectives, and the Use of Metrics to Track Progress.”

- They have completed Phases I and II of the Sequential Intercept Mapping (SIM) effort.
- Following the SIM, the County established a pre-trial office. Services were developed but to our knowledge, no policies have yet emerged to govern how to implement or use this resource.
- They have developed a process flow chart that explains the steps for processing of requests for personal health information within 24-48 hours (with valid authorization, per federal regulations).
- Now that an interlocal agreement for jail services is established and a pre-trial office is present, the goals need to be updated. There is no plan for what or how to move forward, and no discussion or immediate concern over a lack of a plan.

**Integration Leadership Council (ILC)**

The Integration Leadership Council has achieved at least a Coordinating level of functioning, but it also has shown signs of Cooperating and even hints at Collaborating. They have been sharing access to resources to achieve a common purpose. For example, the ILC brought the Trilogy group to El Paso for a presentation on the [www.tarrantcares.org](http://www.tarrantcares.org) web resource and referral tool.

The ILC has been focused on the identified goals and objectives, and they are now working to leverage the capacity of existing resources. It is difficult to ascertain the time commitment of the Council outside of actual meetings and to what extent they are sharing access to each other’s turf.

There seem to be moderate investments of time and sharing of resources and responsibilities among the group, and the potential rewards will be shared by the represented agencies and beyond. The level of trust among members could not yet be ascertained.

**Table 9: Preliminary Assessment of Integration Leadership Council Collaboration**

Stage	Relationship	Characteristics			Resources
		Time	Trust	Turf	
2 to 3 Coordinating to Cooperating	Informal	Moderate	Not assessed	Limited sharing	Some sharing

## Articulation of Goals and Objectives, and the Use of Metrics to Track Progress

In this section of the interim report, we summarize the original goals and objectives established by the Executive Committee and by each of the three Leadership Councils. We then summarize the metrics each is using to track its progress, and finally, the accomplishments that have been observed to date.

### Executive Committee

#### Executive Committee Original Goals and Objectives

The Executive Committee has identified the following goal and associated objectives:

*Overarching Goal:* Develop the El Paso County behavioral health system into the finest in the country.

#### *Consortium Objectives:*

- Increase coordination and collaboration among El Paso County treatment providers by December 2017.
- Develop a behavioral health system of care improvement action plan based on the 2014 El Paso County Behavioral Health System Assessment and Consortium partner input by November 2014.
- Develop a media and public relations plan for launch of the Consortium and develop task force communication tools by December 2015.
- Implement a series of educational sessions for Consortium partners and community stakeholders on the CCISC model and national system of care best practices by December 2016.
- Evaluate the initiative in a cost-effective and feasible manner, yielding usable results.

#### Executive Committee Metrics

We are not yet aware of specific metrics that have been chosen by the Executive Committee.

**Executive Committee Accomplishments**

The importance of the Consortium and Leadership Councils making data-informed decisions at every step in this collaborative process was reinforced by the Executive Committee.

The Executive Committee has developed a vision and mission statement and ensured development of the Leadership Councils. They created guidelines and objectives for each Council. The group has worked on reducing mental health stigma in the community and in bringing partners such as NAMI and Congressman O’Rourke’s office to the table.

They have met objectives associated with developing an action plan and with developing a media and public relations plan. The Executive Committee held a Consortium Leadership Councils launch event in May 2015, which involved a discussion of the Councils, plans for collaboration, networking, and a keynote presentation by Linda Rosenberg on “The Future of Behavioral Health – What is Person-Centered Care?” A press release was developed and disseminated for this event.

**Justice Leadership Council**

**Original Justice LC Goals and Objectives**

In identifying an overarching goal and one associated “system opportunity for change,” the JLC has been very focused thus far in its work:

- *Overarching Goal:* Collaborate with El Paso County Justice System leaders and stakeholders to transform the current system approaches to addressing mental health issues in a system supportive of person-centered, recovery-oriented care.
- *Justice System Opportunity for Change:* A recent Sequential Intercept Model mapping identified gaps in the law enforcement and correctional system processes to respond to behavioral health crises.

As can be seen in the table below, the JLC identified three objectives and four strategies that have been tied to the overarching goal and the system change opportunity.

**Table 10: Justice LC Objectives, Strategies, Progress, and Outcomes**

Process			Outcomes
Strategy #	Strategy	Progress	
<i>Objective 1:</i> Reduce the number of individuals with a diagnosable mental illness who are incarcerated for reasons other than committing a crime by December 31, 2017.			

Process			Outcomes
Strategy #	Strategy	Progress	
1	Revise the pre-trial process to maximize jail diversion options for individuals afflicted with a mental illness who have not committed a crime.	Based on needs identified by a Sequential Intercept Model map completed with the Justice Center, a pre-trial office has been established.	No specific metrics yet selected
2	Convert to <b>24-hour magistrate</b> availability to maximize opportunity for jail diversion when individuals with a mental illness are in crisis.	We are not aware that this has been accomplished.	No specific metrics yet selected
<b>Objective 2:</b> Increase the number of individuals with a diagnosable mental illness who receive appropriate treatment while incarcerated by December 31, 2017.			
3	Transform law enforcement and corrections officer training to model training on crisis intervention and referral assistance for individuals with mental illness.	We are not aware that this has been accomplished. Coordination is being done more on a case-by-case basis.	No specific metrics yet selected
<b>Objective 3:</b> Increase the number of individuals with a diagnosable mental illness who receive appropriate follow up care and support post incarceration by December 31, 2017.			
4	Support re-entry for people leaving correctional settings (adult detention, juvenile detention, TJJD facilities, and Texas Department of Criminal Justice facilities) to connect them to person-centered recovery-oriented care.	Coordination is being done more on a case-by-case basis and not as systematically, as this group has potential to operate together.	No specific metrics yet selected

### Justice LC Implementation Accomplishments

In addressing the system opportunity identified above, the JLC selected the following as priority focus items for the Justice Leadership Council:

- Creation of the pre-trial services office,
- 24-hour Magistration,
- Expansion of mental health services at the jail.

Progress has been made in these areas. For example, a partnership, which includes an interlocal agreement, has been created between the Sheriff's Office and the LMHA, Emergence Health Network, to provide behavioral health services in the jail. From observations made by MMHPI at a recent JLC meeting, it is apparent that a process for tracking people across systems is being developed.

In addition, a pre-trial office was established, after a Sequential Intercept Mapping process was completed, with assistance from Dr. Tony Fabelo of the Justice Center in Austin. Additionally, a Memorandum of Understanding among participants provides a governing arrangement for the committee.

Thus, services have been developed in the jail and the JLC meets to discuss specific cases. There has been good leadership within the jail among correctional officers to develop a mental health unit, and county jail staff have been trained in mental health first aid. There is good leadership from the Sheriff's Office within the JLC, as well.

However, the full potential of the JLC is far from realized. Some of the best practices associated with criminogenic screening and policies associated with jointly developing treatment/services/supervision programming have not been developed.

In addition, although the JLC has produced a fact sheet to communicate its priorities for the next 24 months, our sense is there remains confusion around how all of the current goals, strategies, and plans are connected. It is unclear how the Council's current efforts are tied to an overall system change agenda.

### **Justice LC Metrics and Outcomes**

As mentioned above, some of the original strategies have been implemented. However, we are not yet aware of specific metrics that have been chosen by the JLC to continually track the extent to which the objectives are being achieved. The group is at the stage of being able to work together to identify metrics associated with the clearly articulated objectives, which lend themselves well to measurement. We provide recommendations for the JLC in the last section of this report.

## **Family Leadership Council**

### **Family LC Original Goals and Objectives**

The Family Leadership Council has identified the following goals, objectives and strategies:

- *Overarching Goal:* Work with the El Paso County child, adolescent and family health organizations, other child-serving agencies, and natural support systems to transform El Paso County into a model community for child and behavioral health services and support.
- *Family/Child System Opportunity for Change #1:* The Council will collaborate to create an El Paso County model for a child and family continuum of care. The model will reflect a hierarchy of needs (pyramid) format with a broad foundation of support (prevention and early intervention options) then increasing in intensity and specialization of care for

more severe and complex needs. Successful system of care models in other communities will be investigated to inform the transformation of El Paso’s system. The Council will work with community partners to develop a shared understanding of key terms like “continuum of care,” “wraparound,” and “crisis care.”

**Table 11: Family LC Objective, Strategies, Progress, and Outcomes Associated with System Opportunity Change #1**

Process			Outcomes
Strategy #	Strategy	Progress	
<b>Objective for Change #1:</b> Develop and implement an El Paso County continuum model for children and families with a broad base of prevention and early intervention services by December 31, 2017.			
1.1	Engage the El Paso Child Wellness Council partners in service mapping and updating the current resource and referral process (including their internet application).	The FLC has developed the “pyramid” model of the system of care mentioned above. Information on the resources available has been developed and shared. Reports are that referrals among system partners are better informed and improving.	No specific metrics yet selected
1.2	Explore existing research and best practice models to compare and contrast against the current El Paso County system.	A wraparound model of sorts has been identified in attempts to serve children/youth in foster care better.	No specific metrics yet selected
1.3	Create a campaign for early access to behavioral health assessments, care, and skillful support in the settings in which children naturally seek help (e.g., family, schools, faith communities, and the family doctor).	We are not aware of specific progress made in this area.	No specific metrics yet selected

- *Family/Child System Opportunity for Change #2:* Crisis services were identified as a critical gap in the children’s system. The service array has significant gaps so children and their families are often referred to and placed within the levels and types of care that are available as opposed to the most appropriate level of care.

**Table 12: Family Leadership Council Objective, Strategies, Progress, and Outcomes Associated with System Opportunity Change #2**

Process			Outcomes
Strategy #	Strategy	Progress	
<b>Objective for Change #2:</b> Replicate model child and family crisis service system components centered on a dedicated, on-call, non-forensic mobile crisis team and supported by a continuum of community-based and residential components by December 31, 2017.			
2.1	Explore existing research and models for child and family crisis services to compare and contrast against the current El Paso County service array.	We are not aware of specific progress made in this area.	No specific metrics yet selected
2.2	Engage providers to coordinate and provide crisis services across the continuum for children and families as part of the broader crisis system.	We are not aware of specific progress made in this area.	No specific metrics yet selected
2.3	Create a targeted campaign for child and family crisis integration into the broader crisis system.	We are not aware of specific progress made in this area.	No specific metrics yet selected

### Family LC Implementation Accomplishments

The work of the Family LC has focused on improving services to children and youth in need, particularly children and youth in foster care. In addition, it has worked with managed care organizations (MCOs) to clarify their requirements for billable services, so that providers can be more competitive in their efforts to obtain reimbursement for services that are needed in the continuum of care. Some progress has been made in both of these areas, but in the case of services to children and youth in foster care, not all Family LC participants agree that the progress has been substantial.

Although not identified as an original goal of the group, members of the Council met with representatives from HHSC and the MCOs to address barriers to billable services. Actions accomplished during this meeting included HHSC sharing Medicaid managed care contract standards for credentialing timelines and expectations, and submitting a request for each MCO's credentialing process and contractual language. The MCO workgroup continues to meet with the MCOs individually to build relationships and to continue addressing solutions to this issue.

Additional accomplishments have included the following: A Family Leadership Council fact sheet was developed as a tool to communicate the Council's priorities for 24 months, and its

up-to-date information on available services is intended to improve the timely referral to appropriate services. The Council has also explored the possibility of developing an iPod/Android application for resources and referrals. United Way El Paso was mentioned as a resource for the inventory of services.

To date, the Family LC’s efforts have focused more on specific items of current interest to providers than on comprehensively or continuously pursuing its overall goals and objectives.

**Family LC Metrics and Outcomes**

Originally, “progress indicators” were identified. However, the group has not yet identified specific metrics for tracking, nor begun to obtain baseline data on them. Although we reviewed a document with metrics listed under each progress indicator, it is unclear whether these were agreed upon. There does not seem to be collection of data in those areas or a use of specific metrics in the Family Leadership Council.

**Integration Leadership Council**

**Integration LC Original Goals and Objectives**

The Integration LC originally established the following goals, system opportunities, objectives, and strategies:

- Overarching Goals: 1) Increase behavioral health integration into primary care settings; and 2) Strengthen infrastructure for a Recovery Oriented System of Care.
- *Integration Opportunity for Change #1*: Address the dramatic lack of community capacity for both adult and child behavioral health service provider bases.

**Table 13: Integration Leadership Objective, Strategies, Progress, and Outcomes Associated with *Integration Opportunity for Change #1***

Process			Outcomes
Strategy #	Strategy	Progress	
<b><i>Objective for Change #1</i></b> : Map the current system provider base to identify the 10-year projected need for healthcare providers trained in interdisciplinary or mental health service delivery.			
1	Inventory current reimbursable behavioral health service options.	We do not yet have information related to this strategy.	No specific metrics yet selected

Process			Outcomes
Strategy #	Strategy	Progress	
2	Inventory available education and training programs and the type of services individuals who graduate from these programs can provide.	<ul style="list-style-type: none"> <li>In order to identify workforce enhancement priorities, the ILC implemented a survey of 44 key leaders within the BHC and the ILC</li> <li>In addition, they have identified the current BH workforce's training needs as well as other issues (e.g., pay) affecting the workforce.</li> </ul>	No specific metrics yet selected
3	Increase the number of recovery-oriented providers in both behavioral health and primary care settings by expanding training programs and retaining more graduates.	We do not yet have information related to this strategy.	

- *Integration Opportunity for Change #2:* Improve data sharing and referral capacity among providers to help reduce system fragmentation.

**Table 14: Integration Leadership Objective, Strategies, Progress, and Outcomes Associated with *Integration Opportunity for Change #2***

Process			Outcomes
Strategy #	Strategy	Progress	
<b><i>Objective for Change #2:</i></b> The Consortium will transform cross-agency behavioral health communications into an organized, person-centered, data-driven resource and referral network by December 31, 2017.			
3	Increase the number of behavioral health providers with capacity to share data in a private electronic format.	The ILC researched tools, including one used in Tarrant County, that could facilitate the implementation of this strategy.	No specific metrics yet selected
4	Pilot a targeted campaign for behavioral health providers to use existing health information exchange systems for cross-agency private health information sharing.	We have not obtained information that indicates this strategy has been implemented.	No specific metrics yet selected

### **Integration LC Implementation Accomplishments**

In May 2015, the Integration Leadership Council developed an Integration Leadership Council fact sheet as a tool to communicate the Council's priorities for 24 months.

In order to begin mapping the current system provider base, and in order to begin estimating the 10-year need for healthcare providers trained in interdisciplinary or mental health service delivery, the ILC developed a workforce survey. The survey was administered to 44 key leaders within the Consortium and Leadership Council, of whom 13 (30%) appeared to have completed the survey. The goal of the survey was to obtain insight into which behavioral health professions the Leadership Council should prioritize in developing long-term behavioral health workforce enhancement plans. General findings were that salary was a constant challenge in recruiting and retaining staff and that psychiatrists were the most difficult to recruit among crucial staff needed by agencies.

In order to meet the objective of transforming cross-agency behavioral health communications into an organized, person-centered, data-driven resource and referral network, the ILC has identified, researched and discussed various information exchange tools. They have researched websites and resource referral tools. Members have reviewed the Tarrant County model, Tarrant Cares. A meeting was held on December 10, 2015 where Trilogy provided a presentation on their web tools alongside the current [www.healthypasodelnorte.org](http://www.healthypasodelnorte.org) vendor (HCI). A follow-up meeting with the Foundation, the Paso del Norte Health Information Exchange, and Emergence Health Network was held in February 2016 to discuss options concerning health information exchange platforms.

The concern for having a central inventory website or similar tool has been highlighted by both the ILC and the entire BHC and it has become clear that successful implementation of such a tool will require a community wide effort with ongoing support from many organizations.

### **Integration LC Metrics and Outcomes**

Specific metrics were identified by TriWest Group in their consultation from last year, but it is unclear whether the group has chosen any of them or begun collecting data.

## **Emerging Policy-Related Concerns**

### **Executive Committee**

The Executive Committee has identified local and organizational level barriers. They have identified fragmentation and a lack of substantive programmatic collaboration. They have found that there is too little system-level attention in the child and family services area in particular. There is substantially less system-level planning effort focused on the needs of children and families. Crisis services for children and families are also lacking and require

development of a focused sub-system within the broader crisis response system focused on their distinct needs.

The stigma of mental illness, which impedes access and compounds the consequences of mental health and substance use disorders in the lives of people suffering from them, was identified as a major barrier to care.

There is a need for behavioral health integration. Access to behavioral health care in routine settings in which child health concerns are generally present – pediatric practices, primary care clinics, and schools – is dramatically lacking.

There are issues with veterans' access to health care services and collaborative care. Recent findings from the Office of Inspector General show that one-third of veterans who sought care at the Veterans Administration's health service were not able to get in to see providers. It was reported that the El Paso Veterans Administration (VA) is the worst in the nation for access to mental health care for established patients and fourth worst for access to mental health care for new patients. There is funding for services, but coordination is lacking. Consortium members have shared experiences and discussed ideas to address issues, including VA participation on the Consortium Executive Committee, a possible development of a central point triage center for veterans.

They have also discussed bringing Beaumont to the table. Approximately 20% of Beaumont's budget comes from serving veterans. The reality is that recreating infrastructure is not realistic. It is unclear whether the new Beaumont facility is planned to include services to veterans. Having a sense of the true needs not filled by Beaumont will help all of the community health care providers to collaborate with Beaumont in a noncompetitive way.

The group has discussed development of a program that is completely separate from the VA as a pilot, which might allow veterans more choices in seeking out services in the community. In August, \$16 billion was appropriated for health services and a "Choice Card" was developed with conditions that individuals must live 40 miles or more away from a VA, or if the wait time for services is more than 30 days, even if individuals live inside the 40-mile perimeter. Anecdotally, veterans who have their card report they are not able to use it.

Another idea is the importance of selecting a supportive new local director, a plan, and support groups. The importance of communication with VISN 18 was reinforced as being just as important as working with the El Paso Office and Washington.

Due to a lack of capacity in both adult and child behavioral health services, the EC has identified workforce shortages as an important area to be addressed by the BHC. There is also a lack of training and readiness for law enforcement to respond to behavioral health crises.

### **Family Leadership Council**

The Family Leadership Council has discussed the need for a Wraparound model with up-to-date resource, referral, and follow-up processes in place.

There are barriers to accessing services, including mental health targeted case management and mental health rehabilitative (MH Rehab and TCM) services for children and youth served by the STAR Health program. The resources available from EHN have restrictions. The state contract has strict and narrowly defined requirements. For organizations to contract with the state, they must be able to provide the services under all four (4) levels of care. This stipulation has been difficult for local organizations to meet. Sonja Gaines discussed the possibility of funding a pilot project for services for foster children.

Schools face challenges serving undocumented children who have experienced trauma and abuse, and struggle with the recent state policy change in truancy laws. The truancy law will hold parents accountable when children do not improve their truant behavior. This is causing districts to revisit their procedures. Districts need information on community resources to be able to complete their implementation policy for these new truancy law. School districts are making advances to include a behavioral plan. As a way to address this barrier, the group discussed potentially reaching out to UTEP Social Work Department to identify an intern program to help the school districts.

Foster care needs that were identified include support and education for foster parents. A one-day training called “A World for Health” is available, but more training is required. There are also challenges in matching youth with foster families.

Providers have also identified issues with managed care organizations’ (MCOs) credentialing process. Specifically, there are concerns related to the length of time MCOs take to respond to credentialing requests and to process credentialing applications. This is a direct barrier to service delivery in the community. The credentialing process differs between MCOs and TMHP. Further, MCOs are beholden to both Texas Department of Insurance (TDI) requirements and HHSC requirements. Currently, there is not a “single, streamlined process” for credentialing providers that would be applicable across payers, programs, and MCOs. The current credentialing process should be transparent, efficient, and have appropriate communication.

MCO denials for prior authorization of services is also an issue. MCOs have discussed the methods they employ to determine medical necessity (for example, Molina expressed they use

InterQual® software). Denials also occur based on lack of clinical documentation by Qualified Mental Health Professionals (QMHPs), which are a qualified provider type to deliver MH Rehab and TCM. However, some of this documentation is beyond the scope of practice of QMHPs. The MCO networks still are not sufficient and their requirement for separate forms may delay treatment for days. The time lapse caused by the pre-authorization process leads to risk for missing crucial milestones. When a timeline for care is missed, providers have to start over with the process, causing crucial delays of treatment. Gary Jessee recommended that managed care organizations have a presence on the Council.

The group has also identified issues with behavioral health workforce training, recruitment and development (i.e., increasing the number of child/adolescent social workers trained in trauma informed care), and the complexity of workforce development. The group is trying to determine whether the issue is really a lack of workforce or a lack of reimbursement, since the workforce may be available but not fully utilized because there is no way to pay them.

State level barriers that were identified included the DSHS practice of investing money for children's services primarily through Juvenile Justice and Department of Family and Protective Services, as well as the structure of systems being strongly oriented toward sanctions.

### **Justice Leadership Council**

In July 2015, Justice Leadership Council representatives met with SAMHSA's GAINS Center to develop Sequential Intercept Mapping. The group was able to identify barriers and opportunities through this process. See Attachment B for a brief summary of the findings.

The group has also identified workforce development issues, including an understaffed police department and difficulty filling special population positions because many job seekers are not interested in and/or qualified for these types of positions.

The Council identified the priority for transforming law enforcement and corrections officer training to model training on crisis intervention and referral assistance for individuals with mental illness.

### **Integration Leadership Council**

The Integration Leadership Council (ILC) identified prevailing challenges with ensuring that behavioral health and primary care services were person-centered and available when and where people need it.

The ILC has identified numerous challenges associated with communication and coordination between providers in the system. For example, there is a need for secured communication of

clinical information as well as for the development of more effective referral and follow-up mechanisms. Currently, many providers operate in “silos” and there is insufficient continuity of care for individuals and families who need both health and behavioral health services.

The group has also identified problems associated with billing processes and obtaining sufficient reimbursement for behavioral health services in primary care settings, including medication coverage and processing. The members have suggested further examination of reimbursement systems at state and national levels.

The group has also identified challenges with primary care access and knowledge of available services. They have suggested a need to bring behavioral health providers on staff in primary care.

The group unanimously agreed that workforce development is one of the priorities they will address. There is an insufficient number of providers available to serve the population of people with co-occurring behavioral health and health care needs. The group continues to discuss current and potential mechanisms to address this issue, including UTEP’s efforts to create programs to address behavioral health provider shortages as well as using continuing education and staff development to increase integrated care expertise within agencies.

## Preliminary Recommendations

### Primary Recommendations

We have two primary recommendations at this early juncture:

1. *Primary Recommendation #1:* MMHPI is offering to structure the Executive Committee’s re-review of TriWest Group’s system enhancement recommendations from its behavioral health system assessment report in 2013, and of TriWest’s recommended metrics from their consult last year.
  - We propose to create an online survey that EC and LC members can use to weigh in confidentially on their top priorities for system enhancement and for the selection of associated metrics.
  - We would present the results of the survey at a meeting with the EC in June or early July, at which time the EC would commit to system enhancement priorities and to metrics for tracking progress.
2. *Primary Recommendation #2:* By the Executive Committee’s August 2016 meeting, we will recommend processes for enhanced facilitation and coordination of the BHC that will enable it to achieve its priorities and implement measurement and tracking of progress over time.
  - While the BHC has been successfully formed and now has several accomplishments under its belt, and while up to this point it makes sense to have empowered the LCs and

their work groups to pursue whatever agendas they can and are willing to pursue, a significant change is needed soon to enable the BHC to reach its potential.

- In June and July MMHPI will gather more information and data in the service of making a strong recommendation concerning the strengthening of BHC oversight and facilitation.
- In August, MMHPI will make a formal proposal to the EC concerning the strengthening of BHC oversight, facilitation, and staffing.

## Corollary Recommendations

We also are providing many corollary recommendations. These are provided separately for each of the four primary bodies of the BHC, and they are organized within the following three domains:

- Behavioral Health Consortium and Leadership Council Functioning
- Identification and use of Metrics
- Identification of Policy Initiatives

## Behavioral Health Consortium and Leadership Council Functioning

Within the broad domain of recommendations on BHC and LC functioning, our evaluation will address three sub-domains:

- 1) Enhancing Collaboration,
- 2) Aligning Activities with Goals and Objectives, and
- 3) Enhancing Governance Structures.<sup>29</sup>

### 1. Enhancing Collaboration

#### Executive Committee

In general, continued support and communication with the Leadership Councils and subsequent work groups will be necessary to ensure the overall success of the consortium.

#### *Recommendation 3*

**In receiving quarterly reports from the LCs, the Executive Committee should provide regular feedback that helps each LC identify ways in which its activities overlap with those of other LCs, and it should provide specific recommendations as to how LCs' activities can be mutually supportive.** For example, the Integration LC may have data from its workforce survey that would speak to workforce issues uncovered by the FLC as it explores gaps in the lower levels of the system of care pyramid. The EC can help LCs periodically examine overlapping concerns as well as opportunities for cross-LC collaboration.

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<sup>29</sup> In the area of governance structures, we will reserve our recommendations for later reports, when we have had the opportunity to obtain more information and data.

### Family Leadership Council

Based on meeting minutes alone, the FLC seems to be communicating regularly and functioning well in many ways, especially given that it is still in an early stage of development. The FLC recognized the need to develop specific work groups (Foster Care and MCOs) and gave space during the Council meetings to hear about progress from them. These work groups also had the explicit support from the Consortium to assist in the coordination of meetings, which increased the overall capacity of the FLC to pursue special projects.

In addition, the FLC has focused heavily on developing understanding of each child/family serving agency's services and access to those through referrals. This leads to our first FLC recommendation.

#### *Recommendation 4*

The FLC should employ key elements of the PdNHF's chosen model to pursue a stronger collaboration. Specifically, **the FLC should consider using an upcoming FLC meeting to charge its two existing work groups with the task of proposing sets of options for child/family serving agencies to share "turf" and resources.** The two work groups should consider the following possibilities:

- Share clinical program leader resources in identifying specific gaps in the system of care, especially mobile crisis (already singled out by the FLC as a need), and services that payers (such as MCOs) wish to purchase; and
- Identify ways in which agencies can share training resources or even co-locate to develop gap-filling services or to enhance services that are below capacity.

Because the sharing of turf and resources takes time to develop, the FLC should consider carefully how much time and assistance to allocate to this challenge.

### Justice Leadership Council

Overall, the JLC needs to meet more frequently, consider establishing more work groups (perhaps aligned with each intercept point) to add more formality to its deliberations, and to build in regular reporting on progress toward the completion of goals and objectives.

#### *Recommendation 5*

The JLC should **meet more frequently** – at least quarterly.

*Recommendation 6*

The JLC should **develop work groups**, which should meet monthly in the first year as they focus on pressing concerns, and then at least quarterly thereafter until their agendas are fully implemented and new work groups are needed.

*Recommendation 7*

At quarterly meetings, the JLC should **vote on actionable items**, often as proposed by workgroups, and should plan subsequent action steps and timelines for them.

**Integration Leadership Council***Recommendation 8*

The ILC could increase its collaboration through **systematically examining possibilities for co-location of behavioral health and primary physical health care providers** in both primary care and specialty behavioral health care settings.

- Models for co-location and integration of care – both national and in Texas (e.g., at the UT-Rio Grande Valley or at CommuniCare in San Antonio) – could be explored and presented to the ILC, as needed.<sup>30</sup>
- The ILC should set a goal of establishing at least five (5) new behavioral health-physical health integration partnerships, which would involve sharing of turf (co-location) and resources (e.g., primary care providers in BH settings, and BH consultants in primary care settings), in the next year.

**2. Aligning Activities with Goals and Objectives****Executive Committee***Recommendation 9*

The Executive Committee could provide enhanced structure to the Leadership Councils by **requesting quarterly reporting from them on each of the overarching goals and objectives identified by the LCs**, reporting on implementation progress associated with each strategy as well as any plans to modify the strategies identified. (See the closely related *Recommendation 1* above.)

*Recommendation 10*

When LCs provide quarterly updates to the Executive Committee, **the EC should provide feedback to each LC on how to ensure its ongoing implementation of various strategies remains logically connected to the overarching goals that occasioned the establishment of each LC.** (See the closely related *Recommendation 1* above.)

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<sup>30</sup> Models include for example the Primary Care Behavioral Health approach of Strohsal and Robinson, the Collaborative Care Model that is best represented by the work of the AIMS Center out of the University of Washington, and Barbara Mauer's Person Centered Healthcare Home for people with serious mental illnesses.

### Family Leadership Council

#### *Recommendation 11*

With the help of the Executive Committee, **the FLC should explicate its role within the larger child/family serving system and the implications for its role.** There are two specific recommendations associated with this preliminary observation:

- The FLC should explore how to align its efforts with those of other emerging community groups, (such as Dr. Handel’s group), as well as how to avoid duplication of efforts. It should make a specific proposal to the Executive Committee on how to work with the entire BHC to work with other emerging groups to clarify their relationships and determine how to align efforts.
- The FLC should formally explicate the full meaning of its status as the System of Care Collaborative Governing Council (as defined by the Texas System of Care). This was discussed briefly at the March 2016 meeting. The FLC should propose to the Executive Committee and Texas state-level authorities three recommendations:
  - The governance structure and FLC representation that will enable it to fulfill its role as the SoCCGC. (The current structure and membership might be sufficient.)
  - The specific responsibilities it agrees to undertake as the SoCCGC.
  - The products that it will deliver in order to fulfill its role. (These proposed products should dovetail with the FLC’s original goals and objectives.)

### Justice Leadership Council

In general, the JLC needs to set sound goals with a road map of issues to be addressed and desired outcomes. The goals and desired outcomes need to be derived from policies, and objectives need to be addressed, along with who is going to begin drafting the policies and how will they be reviewed by the group. All of this can build on the existing achievements of locating EHN’s behavioral services in the jail and establishing a pre-trial services department. However, the JLC needs to complete serious work in this area in order to develop a structure within which meaningful progress can continue to be made.

#### *Recommendation 12*

The JLC should **update its original goals, objectives, and strategies**, and it should identify specific metrics tied to each objective.

### Integration Leadership Council

No additional recommendations have yet been identified in this area. Please see *Recommendation 6* above concerning the development of collaborative partnerships involving co-location of services.

### 3. Identification of Policy Initiatives

#### Executive Committee

##### *Recommendation 13*

Overall, the Executive Committee and the Leadership Councils should work together more intentionally to identify policy initiatives at both the organization and state levels. Barriers that have been experienced in the process of implementing strategies provide good clues.

- In the near-term, we recommend the EC develop and provide to the LCs a timeline for identifying, prioritizing, and selecting initiatives, to be completed no later than September, when the Policy Summit is likely to be scheduled.

#### Family Leadership Council

##### *Recommendation 14*

**The Foster Care Work Group should be charged with identifying policy changes that could facilitate the more timely and widespread delivery of wraparound services** not only to foster care children, but also other children and youth in need of such intensive services to prevent residential treatment and other restrictive placements.

#### Justice Leadership Council

##### *Recommendation 15*

**The JLC should build on its recent successes by examining best policies and practices in diversion, pre-trial, and transition services in other Texas communities (such as Bexar, Dallas and Harris Counties) that could be implemented in El Paso.**

- Sub-teams of system partners should either visit other Texas programs or interview key informants from each.

#### Integration Leadership Council

##### *Recommendation 16*

**The ILC should be charged with identifying policy changes that could facilitate the more timely and widespread delivery of integrated care.**

### 4. Identification and Use of Metrics

#### Executive Committee

##### *Recommendation 17*

The Executive Committee could **provide enhanced structure to the Leadership Councils by requesting quarterly reporting** from them on progress toward operationalizing identified metrics that are associated with each established objective. Once metrics are chosen, then

presentations of outcome trends related to goals/objectives, as reflected in the metrics, should be requested. (See related recommendations above, including Recommendation 1.)<sup>31</sup>

### Family Leadership Council

Generally, the FLC should revisit the goals and objectives of the group and determine their commitment to those goals. As part of that work, they should also review the metrics that were proposed in 2015 and determine whether these are still the areas where they would like to have an impact. If the group decides to continue to track the current metrics, they should determine which agencies have access to the data to support the metrics identified and begin collecting the information as a baseline. A recommendation would be to ensure a focus on the metrics in order to track progress and keep the group moving forward to achieve the identified common purpose.

#### *Recommendation 18*

Based on recommendations from the work group on services to foster care children and youth, the FLC should **choose two to three metrics associated with its current work to improve the coordination and quality of services**. These metrics could be drawn from the set proposed by TriWest Group in its consultation last year, but they should allow for meaningful tracking of service quality and outcomes, and it should be possible to develop a clear operational definition. The FLC should weigh both the degree to which the metric represents meaningful quality or outcomes, as well as the feasibility of obtaining complete and valid data. Metrics could include, for example:

- Frequency of placement in residential treatment facilities,
- School attendance or school days missed,
- Days spent in juvenile detention centers,
- Frequency of safe reunifications with family.

### Justice Leadership Council

Sequential Intercept Mapping (SIM) provided a structured, thorough means for the Council to identify barriers and subsequently identify opportunities for change. Through this process, Emergence Health Network was identified as a resource to assist the group in addressing barriers related to continuity of care in the jails and courts. Aside from the original plan identified through the SIM process, the group is lacking in current goals, strategies, and metrics with which to track progress presently.

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<sup>31</sup> MMHPI is contractually obligated to assist the BHC and its LCs in identifying metrics. The EC can help MMHPI determine how MMHPI can best be of service in this area.

*Recommendation 19*

The JLC needs to revisit and clarify its goals and objectives, then establish metrics. Potential metrics could eventually include, for example:

- The percentage increase in the number of people with behavioral health conditions diverted to treatment at intercepts 1 and 2,
- The percentage decrease in the recidivism rate among people with behavioral health conditions.

**Integration Leadership Council***Recommendation 20*

The ILC should review its overarching goals, objectives, and strategies, then **choose at least two to three metrics associated with expanding the availability of integrated care in the region, developing a work force prepared to deliver integrated care.** These metrics could be drawn from the set proposed by TriWest Group in its consultation last year, but should not be confined to that list.

**Behavioral Health Consortium and LC Governance and Operations**

Recommendations will be made in future reports.

Attachment A

El Paso Behavioral Health Consortium Meetings

	Frequency of Meetings	Number of Attendees per Meeting	Agency Representation
			Agencies <i>(Note: Those bolded had representation at least half of the time)</i>
<b>Family Leadership Council</b> (Also included Child and Adolescent Leadership meetings)	<u>2015:</u> 7 times/year (Family Leadership Council)	<b>Average: 17.4</b>  15 in March (Child and Adolescent) 16 in April (Child and Adolescent and Family Leadership met back-to-back) 13 in June 9 in July 38 in August (*special meeting) 16 in September 15 in October <i>No meeting notes for December</i>	<b>Aliviane</b>
	2 times/year (Child and Adolescent Leadership Committee)		Amerigroup*
			Atlantis Health
			Cenpatico*
			<b>Child Crisis Center El Paso</b>
			<b>Child Protective Services</b>
			Early Childhood Intervention
			El Paso Behavioral Health
			<b>El Paso Center for Children</b>
			<b>El Paso Child Guidance Center</b>
			<b>El Paso County MHSS</b>
			El Paso First*
			El Paso Psychiatric Center
			<b>Emergency Health Network</b>
			Family Services of El Paso*
			Homeward Bound Inc.*
			<b>Individual</b>
Jewish Family and Children Services*			
Juvenile Probation Department			
Molina Healthcare*			
Paso del Norte Children’s Development Center			

	Frequency of Meetings	Number of Attendees per Meeting	Agency Representation
			Agencies <i>(Note: Those bolded had representation at least half of the time)</i>
Family Leadership Council	<u>2015</u> : continued	<b>Average: N/A</b>  14 in January <i>No meeting notes for March</i>	<b>Paso del Norte Health Foundation</b>
	<u>2016 to date</u> : Jan and Mar		Private Practice Psychologist
			<b>Region 19 Education Service Center</b>
			Socorro Independent School District/EPCC Board
			Superior Health Plan*
			Texas Health and Human Services Commission
			TriWest Group
			Ysleta Independent School District
			Aliviane
			Child Crisis Center El Paso
			Child Protective Services
			Early Childhood Intervention
			El Paso Child Guidance Center
			El Paso County Juvenile Justice Center
			El Paso Psychiatric Center
			Emergence Health Network
			Individual
			Paso del Norte Children’s Development Center
			Paso del Norte Health Foundation
			Region 19 Education Service Center

	Frequency of Meetings	Number of Attendees per Meeting	Agency Representation
			Agencies <i>(Note: Those bolded had representation at least half of the time)</i>
<b>Justice Leadership Council</b> (Also includes Jail Diversion Committee)	<u>2015:</u> 3 times/year plus 2 times/year for the Jail Diversion Committee	<b>Combined Average: 19.8</b> 15 in January (Jail Diversion Committee) 32 in February (Jail Diversion Committee) 16 in April 24 in July 12 in August <i>No record of attendees for October</i>	120 <sup>th</sup> District Court
			384 <sup>th</sup> District Court
			Aliviane
			<b>City of El Paso Police Department</b>
			CJC
			Commissioner Vince Perez’s Office
			<b>El Paso County</b>
			<b>El Paso County Attorney's Office</b>
			El Paso County MHSS
			El Paso County Police Department
			<b>El Paso County Sheriff's Office</b>
			El Paso Psychiatric Center
			<b>Emergence Health Network</b>
			Homeless Coalition
			<b>Individual</b>
			NAMI
			<b>Paso del Norte Health Foundation</b>
<b>Pre-Trial Services</b>			
SAMHSA Gains Center			
TriWest Group			
<b>West Texas Community Supervision and Corrections</b>			

	Frequency of Meetings	Number of Attendees per Meeting	Agency Representation
			Agencies <i>(Note: Those bolded had representation at least half of the time)</i>
<b>Justice Leadership Council</b> (Also includes Jail Diversion Committee)	<u>2016 to date:</u> Jan, Feb, March	<b>Combined Average: 25.5</b>  19 in January (Jail Diversion) 32 in February (Jail Diversion) <i>No record of attendees for March (Jail Diversion)</i>	CJC
			<b>El Paso County Attorney's Office</b>
			<b>El Paso County Police Department</b>
			<b>El Paso County Sheriff's Office</b>
			<b>El Paso Psychiatric Center</b>
			<b>Emergence Health Network</b>
			<b>NAMI</b>
			<b>Paso del Norte Health Foundation</b>
			<b>West Texas Community Supervision and Corrections</b>
			City of El Paso Police Department
Homeless Coalition			

	Frequency of Meetings	Number of Attendees per Meeting	Agency Representation
			Agencies <i>(Note: Those bolded had representation at least half of the time)</i>
Integration Leadership Council	<u>2015</u> : 5 times/year	Average: 12.8  13 in February 11 in April 11 in May 13 in August 16 in September	Atlantis Health
			<b>Centro de Salud Familiar La Fe</b>
			<b>Centro San Vicente</b>
			<b>Del Sol Medical Center</b>
			<b>El Paso Behavioral Health (FKA) UBH</b>
			<b>Emergence Health Network</b>
			<b>Independent</b>
			<b>Individual</b>
			Las Palmas del Sol (HCA)
			<b>Paso del Norte Health Foundation</b>
			<b>Peak Behavioral Health Services</b>
			<b>Project Vida</b>
			Texas Tech Health Sciences Center Psychiatry
			TriWest Group
<b>University Medical Center El Paso</b>			
<b>University of Texas at El Paso</b>			
Workforce Solutions Borderplex			
<u>2016 to date</u> : February	No meeting notes for February	N/A	

Executive Committee	Frequency of Meetings	Number of Attendees per Meeting	Agency Representation
			Agencies <i>(Note: Those bolded had representation at least half of the time)</i>
Executive Committee	<u>2012</u> : 3 times/year	<b>Average: 11.3</b>  9 in July 11 in August 14 in October	Del Sol Medical Center
			<b>El Paso Psychiatric Center</b>
			<b>Emergence Health Network</b>
			<b>Individual</b>
			<b>Paso del Norte Health Foundation</b>
			Texas Tech Health Sciences Center Psychiatry
			<b>University Medical Center</b>
	<u>2013</u> : 6 times/year	<b>Average: 11.6</b>  10 in January 11 in February 8 in September 15 in October 14 in November <i>No meeting notes for May</i>	El Paso County
			<b>El Paso Psychiatric Center</b>
			<b>Emergence Health Network</b>
			<b>Individual</b>
			<b>Paso del Norte Health Foundation</b>
			<b>Sierra Providence Health Network</b>
			Texas Tech Health Sciences Center Psychiatry
			TriWest Group
			<b>University Medical Center</b>
	<b>West Texas CSCD</b>		
	<u>2014</u> : 6 times/year	<b>Average: 11.2</b>  13 in February 8 in March 12 in June 10 in August 13 in September <i>No meeting notes for December</i>	<b>Aliviane</b>
			County of El Paso
			El Paso Behavioral Health (FKA) UBH
			<b>El Paso Psychiatric Center</b>
<b>Emergence Health Network</b>			
<b>Individual</b>			
Las Palmas Del Sol Healthcare			
<b>Paso del Norte Health Foundation</b>			
<b>Sierra Providence Health Network</b>			

	Frequency of Meetings	Number of Attendees per Meeting	Agency Representation	
			Agencies <i>(Note: Those bolded had representation at least half of the time)</i>	
	<u>2014:</u> continued		Texas Tech Health Sciences Center Psychiatry	
			TriWest Group	
			University Behavioral Health	
			<b>University Medical Center</b>	
			University of Texas at El Paso	
	<u>2015:</u> 5 times/year	Average: 14.2  12 in February 18 in March 15 in May 14 in September 12 in November		<b>Aliviane</b>
				Congressman Beto O'Rourke's Office
				<b>El Paso Behavioral Health (FKA) UBH</b>
				El Paso County
				<b>El Paso County Sheriff's Office</b>
				<b>El Paso Psychiatric Center</b>
				<b>Emergence Health Network</b>
				Hospitals of Providence
				<b>Individual</b>
				<b>Paso del Norte Health Foundation</b>
Sierra Providence Health Network				
<b>Texas Tech Health Sciences Center</b>				
<b>University Medical Center</b>				
<b>University of Texas at El Paso</b>				
<u>2016 to date:</u> Agenda for Feb, but no meeting notes	No meeting notes.	No meeting notes.	No meeting notes.	

## Attachment B

### Barriers and Opportunities Identified through the Sequential Intercept Mapping

#### Local Law Enforcement/Emergency Services – Intercept 1

- HIPAA is perceived as limiting access to needed consumer information in order to make diversion occur more frequently.
  - ✓ *Should dispatchers also run a Continuity of Care Query through DPS which will tell the arresting officer that an individual is or has received services through a state mental health provider?*
- Mobile crisis response through EOH is a very underutilized resource for diversion.
  - ✓ *Not the preferred response because of unit size and unequal training of all responders.*
- No violent offenses and/or felony diversion.
  - ✓ *Resolved through Pre-trial Office?*
- Lack of information sharing currently taking place for pre-booking diversion, 911.
  - ✓ *Should dispatchers also run a Continuity of Care Query through DPS which will tell the arresting officer that an individual is or has received services through a state mental health provider*
  - ✓ *Pre-trial Office?*
- Council of Judges – diversion policies.
  - ✓ *Pre-trial Office?*
- Lack of diversion facilities.
- No detox.
- Limited shelters (2) available to behavioral health consumers.
- Limited practical discretion for police department to make independent diversion decisions.
- Understaffed police department.
- No distinction between individuals with or without mental illness when calling into the DIMS phone line.
- Lack of communication across systems.
- Lack of participation/outreach from the Veteran’s Administration-Veteran’s Justice Officer other than in Veteran’s Court.

#### Initial Detention/Initial Court Hearings – Intercept 2

#### Jails/Courts – Intercept 3

- No specialized behavioral health pre-trial diversion.
- No jail in-reach services (planning or treatment).
  - ✓ *EHN present at intake to coordinate continuity of care.*

- Legislative roadblocks to establishing diversion opportunities in Intercepts 2 and 3. Changes within legislatively-driven policies and procedures will be long-term in nature.
- Individuals not in the state system are in the local criminal justice system (e.g., federal, out-of-state).
- Lack of communication between criminal justice/behavioral health systems.
  - ✓ *EHN available in jail/courts.*
- Lack of substance abuse treatment in the state system.
- Restrictions on who is eligible for services.
  - ✓ *Community Level*
- Jail Diversion Committee – need to look at who is missing from this committee (e.g., prosecutor) and how to restart its activity and leadership.
- Currently, no behavioral health services in the jail except medication management and competency restoration.
  - ✓ *EHN will increase services and potentially provide jail-based competency restoration.*
- No methadone treatment in the jail.
- Lack of women’s beds at Vernon State Hospital.
  - ✓ *Jail based competency restoration.*
- Co-morbid health conditions mean longer waits for treatment beds.
- Treatment court eligibility criteria can be overly restrictive.

#### Reentry – Intercept 4

#### Community Corrections/Community Support - Intercept 5

- No jail re-entry discharge planning.
  - ✓ *EHN onsite will allow for continuity of care for priority population.*
- Lack of access to 3 days of medications upon release.
  - ✓ *Transportation needs.*
- Lack of linkages to aftercare prior to release.
  - ✓ *EHN onsite will allow for continuity of care for priority population.*
- Many individuals are released from custody with time served and no supervision. They are under no legal obligation at that point.
  - ✓ *Jails will provide Release Informational Cards listing mental health emergency and assistance numbers.*
- Restrictions of treatment grants (special grant conditions).
- Caps on specialty program capacity to serve consumers.
- Filling special population positions is difficult. Many job seekers are not interested in and/or qualified for these types of positions.
- Lack of sex offender housing due to zoning restrictions.
- Lack of housing subsidies for those with criminal records.

- Service eligibility is typically quite restrictive.
- Culture change in probation policing – from being a police adjunct to now a service coordinator.

## Appendix Two: Behavioral Health Consortium Benchmarking Report (Originally submitted July 29, 2016)

### Overview and Background

In order to understand the development of the El Paso Behavioral Health Consortium (BHC) in the light of similar efforts in other Texas communities, Meadows Mental Health Policy Institute (MMHPI) evaluators interviewed leaders from other consortia to gather data on their developmental trajectories, accomplishments, and challenges. MMHPI's Jim Zahniser and Suki Martinez-Parham conducted the interviews in June and July of this year.<sup>32</sup>

Our interviews focused on basic information and key areas of consortia functioning:

- **Number of years that the BHC has been in operation** – This data is provided in the table on the next page. We generally hypothesized that the more years the BHC had been in operation, the more likely it would have developed a high level of collaboration and succeeded in enhancing the mental health system.
- **Scope of planning activity or authority** – We wanted to know the breadth of each BHC's purview and whether their work was focused on system-level change.
- **Estimated level of collaborative functioning** – Our rough estimates are based on the interviews conducted and, in some cases, additional information available from the BHC's website, if applicable. *Please note that the estimated levels of collaborative functioning are not definitive and do not represent ultimate judgments concerning the BHCs reviewed for this benchmarking report. The estimated ratings in the table are used to provide a general sense of how other BHCs are functioning, relative to the number of years they have been in operation.*
- **Notable qualities and successes of the BHC** – We noted various strategies, structural or organizational arrangements, fund-raising approaches, etc. that the BHCs shared with us in the interviews.
- **"Take-home messages"** – We also gleaned the most important learning from each BHC that represents useful input for the El Paso BHC and provided an integrative summary across all BHCs reviewed.

The table below highlights data/information from BHCs in other Texas communities whose leaders we interviewed. In order to gain additional perspective, we included one out-of-state entity, the Behavioral Health Support Foundation collaboration in Omaha Nebraska. We also

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<sup>32</sup> Please see Attachment 1 for the key informant interview schedule used by Martinez-Parham and Zahniser.

included Harris County, even though we do not know of any BHC-like entity in the county, to show that not all large population areas even have a behavioral health consortium.<sup>33</sup>

**Behavioral Health Consortia from Other Communities**

County	BH Consortium	Years in Operation (Founded)	Dedicated Full-Time Facilitator	Leadership/ Backbone	Estimated Function Levels
Tarrant	MH Connection of Tarrant County <a href="http://www.mentalhealthconnection.org">http://www.mentalhealthconnection.org</a>	17 (1999)	Yes	Board / (Own entity)	Level 4: Collaborating
Bexar	Medical Directors Round Table (MDRT) Bexar County Mental Health Consortium	10 (~2006) 2 (~2014)	No No	Participants/ Agencies (MDRT) MH Director/ County (BCMHC)	<i>Estimated collaborative functioning levels for other active BHC-like entities ranged from Level 2 (Coordinating) to Level 3 (Cooperating).</i>
Dallas	Behavioral Health Leadership Team	5 (2011)	No	Co-Chairs/ County & Parkland <sup>34</sup>	
Denton	Behavioral Health Leadership Team	1 (2015)	Yes	Members/ United Way	
Harris	None	N/A	N/A	N/A	
Omaha, NE	Behavioral Health Support Foundation collaboration	1 (2015)	Yes	Participants/ BHSF	

**Findings**

In this section of the report, we summarize our findings across all BHCs, using the bulleted outline above.

**Scope of Planning Activity or Authority**

While high-functioning BHCs have a broad scope and can address any and all mental health concerns that arise in the community, even the best BHCs we reviewed do not necessarily have “formal” authority to determine such matters as mental health system design or budgets. However, high-functioning BHCs, like Mental Health Connection (MHC) of Tarrant County, use informal (or, we might say, semi-formal), attained authority by creating an environment in

<sup>33</sup> Of course, not all of these entities refer to themselves as a “behavioral health consortium,” but the majority of them have similar purposes – to provide a vehicle through which the community can collaborate in the services of planning for and developing greater capacity to meet the mental health needs of its citizens.

<sup>34</sup> Sponsoring entities: Dallas County Commissioner’s Court and Parkland Health and Hospital System Board of Managers.

which all serious contributors to mental health system improvements *must* participate in order to advance their concerns. They develop a track record of effectiveness in addressing system challenges – they generate “early wins” – and they help their members gain access to grant funding. MHC in Tarrant County in particular has been exemplary in this regard.

### **Estimated Levels of Collaborative Functioning**

We deliberately chose BHCs that we thought would have varying levels of collaborative functioning – from Harris County, which to our knowledge does not have a BHC, to Tarrant County, which enjoys a 17-year long record of sustainability as a BHC. Most BHCs do not achieve the full level of collaborative functioning (Level 4 – “Collaborating”) that is described in the model chosen by PdNHF.<sup>35</sup> Level 4 involves “exchanging information for mutual benefit and altering activities, sharing resources, and enhancing the capacity of another to achieve a common purpose.” BHCs at the Collaborating level are marked by extensive time commitments, very high levels of trust, and development of extensive areas of common turf. “Enhancing each other’s areas of common purpose” is a primary objective in high-functioning BHCs.

Among the BHCs we reviewed, the MHC of Tarrant County most aptly represents the Collaborating level of functioning. It has developed very high levels of participation and trust that involve ongoing and often lengthy collaborative efforts to tackle major mental health-related concerns in the community – from trauma to cultural competence to suicide. Members have also worked together to collaboratively obtain nearly \$100 million in grant funding.

But the Collaborating level also suggests greater formality in the relationships of its members, and the “full sharing of resources, and full sharing of risks, responsibilities and rewards.” Even the MHC of Tarrant County does not appear to have fully actualized this level of “Collaborating” functioning in all instances, even though it does appear often to engage in extensive sharing of rewards.

Our review also has noted that some communities attempting to develop BHCs have struggled to achieve even a moderate level of collaborative functioning at the system level. As mentioned above, we are not aware of any BHC-like entity in Harris County. Through its Medical Directors Roundtable, Bexar County has had successful collaboration in a specific area focused on adults with risks for high utilization of emergency services and law enforcement attention, intensive substance use treatment, and homelessness services. But, to our knowledge, efforts to establish an authoritative, wider system-level BHC have not yet been realized, despite the efforts of experienced and knowledgeable leaders. (However, only recently has a county mental

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<sup>35</sup> Himmelman, A.T. (2002, January). Collaboration for a change: Definitions, decision-making models, roles, and collaboration process guide. Minneapolis, MN: Himmelman Consulting.

health department with dedicated, experienced leadership been established and Bexar County might develop a strong BHC-like entity in the future.)

### **Notable BHC Qualities and Successes**

Again, the MHC of Tarrant County stands out with its long history of creating a responsive, effective BHC that so many mental health-related agencies and partners participate in annually. They have been able to obtain major sustainable funding from a core group of “supporting members” while also garnering significant membership involvement and funding from dozens of other members.

Several BHCs have developed a solid range of project-based activities, with leadership from key agencies and persons in the community. Not unlike Tarrant County, Region 6 of Nebraska (the Omaha five-county metropolitan area) has developed nine work groups that are focused on filling identified system gaps in areas such as permanent supported housing, supported employment, a central psychiatric emergency/crisis service, and first episode psychosis care, among others. Just as in Tarrant County, each work group has a clear task or focus and strong leadership to fill identified system gaps.

The kind of focused efforts just described are fueled by the availability of a strong backbone entity or, in the case of Tarrant County, the creation of a new entity, Mental Health Connection of Tarrant County. In Denton County and in Nebraska’s Region 6, a non-profit serves as the fiscal agent and offers other backbone support. Perhaps most notably, full-time facilitators were hired to lead the efforts in the strongest BHCs, relative to their years of functioning; Tarrant, Denton, and Omaha each have a full-time facilitator who ensures ongoing, reliable orchestration of the BHC’s activities. The creation of such a position signals to the community the seriousness of the effort and it ensures that at least one person will continually tend to the BHC’s activities relative to its goals, communicate regularly with a board or other oversight entity, and otherwise keep the BHC “on track.”

The MHC of Tarrant County is notable for its development of “social capital” both inside and outside of its own geographic area. (This is not unlike one of the roles that PdNHF often has played in its region.) When the MHC identifies a significant area for mental health system enhancement, it commits fully by:

- Establishing ambitious goals;
- Committing to a long-term change process;
- Conducting thorough research on best practices, adopting those practices, and tailoring

them to local needs;<sup>36</sup>

- Bringing in expert speakers from Texas and nationally to inform the community and raise the stakes; and
- Traveling to Washington, D.C. to meet with federal and national leaders who provide guidance and assistance in obtaining grant funding, and with whom the MHC's leaders advocate for various advantageous policies.

The MHC of Tarrant County is also notable for its success in developing a web-based resource site, "Tarrant County Cares," that has obtained 50 million hits over approximately the past five years. They have also connected to a national resource network and data base, created by Trilogy, that has bolstered their efforts to establish social capital.

### **"Take-Home Messages"**

- It would be worthwhile to have a contingent of leaders in El Paso – PdNHF leadership, Executive Committee members, and other community leaders – visit one or two exemplary BHCs, such as Mental Health Connection of Tarrant County, to engage in a cross-fertilization of ideas.
- Successful BHCs tend to have a strong backbone or sponsoring entity and a full-time facilitator.
  - Either the sponsoring/backbone agency has ample financial resources to fuel the BHC, or, as in the case of Tarrant County, the BHC develops a membership dues structure that ensures ongoing financial sustainability for the BHC and funding for not only a full-time facilitator but also the inevitable ongoing project-related expenses such as travel, major educational events, and outside speakers.
- Successful BHC-related efforts often, but not always, are long-term and represent a significant commitment to a particular system change effort over time.
- Successful BHC-related efforts often focus on specific system change efforts (e.g., specific identified gaps in the system of care, the need for greater cultural competence training in the workforce) versus vague system change goals.
  - However, these specific change efforts often are driven by an overarching set of strategies or long-term goals.
- Several BHCs engage in strategic planning development and review to help guide them in prioritizing the activities on which they focus year-by-year.
- Tarrant County's effort to establish relationships at the national level – including in Washington, D.C. – is worth reviewing and learning more about since it appears to have

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<sup>36</sup> These intensive efforts on the part of MHC of Tarrant County have even sometimes led to their development of manuals and other documents that are thoroughly individualized to the Tarrant County community's needs and perspectives.

been a key component of their successful efforts to help the community obtain nearly \$100 million in grants over the years.

## Attachment 1: Key Informant Interview Questions

### El Paso Behavioral Health Consortium

#### Behavioral Health Consortia Key Informant Interview Guide

As part of our assessment of the El Paso Behavioral Health Consortium, we are gathering information on other similar entities in order to obtain estimates of how long it typically takes for them to develop a mature level of collaboration among participating agencies and organizations, as well as to make significant progress in filling gaps in the continuum of care and bringing about necessary system changes.

To accomplish this task, we have developed the following questions:

<b>Q1.</b>	Please describe your community behavioral health consortium (or similar entity, which will typically have a different name).
<b>A1.</b>	
<b>Q2.</b>	How did this group come together?
<b>A2.</b>	
<b>Q3.</b>	How long has the consortium been in operation?
<b>A3.</b>	
<b>Q4.</b>	How often does the group meet; how long are the meetings?
<b>A4.</b>	
<b>Q5.</b>	Does the consortium have subcommittees, and if so, what are the names and functions of subcommittee members?
<b>A5.</b>	
<b>Q6.</b>	Please describe the level of communication and cooperation among the overall group and subcommittees.
<b>A6.</b>	
<b>Q7.</b>	What are the levels of participation and collaboration among mental health providers and other partner agencies (criminal justice system, juvenile justice, child welfare, other health care)?
<b>A7.</b>	
<b>Q8.</b>	How long did it take to attain those levels of participation and collaboration?
<b>A8.</b>	

<b>Q9.</b>	Are there achievements or accomplishments of the consortium or subcommittees (for example, gaps in services filled, policies changed that improved service delivery and access to services, etc.) that you would like to highlight?
<b>A9.</b>	
<b>Q10.</b>	What key decisions and mobilization of resources made these achievements possible?
<b>A10.</b>	

## Attachment 2: BHC Interview Summaries

### Mental Health Connection of Tarrant County

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#### Key Informant Interview – Patsy Thomas

##### Sponsoring Entities

Mental Health Connection is its own organization, but is funded by membership dues from seven (7) sponsoring agencies that each contribute \$25,000 or more annually, as well by about 30 additional agencies or organizations that each contribute between \$150 and \$5,000 annually. Membership is open to groups of any type – provider, advocacy, universities, faith-based organizations, among others – or individuals, and a dues schedule provides guidance based on ability to pay. MHC also organizes social/fundraising events.

##### Age of BHC

Mental Health Connection was created in 1999 after the community came together at the Mayor's request to address issues and concerns raised in the aftermath of a shooting at a church which resulted in the deaths of seven youth and adults. The mental health system leaders who constituted MHC built on the prior work of the Community Management Team, which was founded in the late 1980s, but which had not yet evolved into the powerful community-wide planning entity that MHC has now become.

##### Scope of Planning Activity or Authority

MHC does not have formal authority as the mental health system planning entity for Tarrant County. Rather, it has become the de facto planning, organizing, and problem-solving entity in which everyone must participate if they want to advance mental health causes and concerns. It has a nine-person board of voting members who provide guidance for the MHC's overall vision, mission and goals. MHC's current vision is "*Healthy Minds, Healthy Communities,*" and its missions is "to lead the collaboration of public and private interests, healing professions, individuals and families to an exceptional behavioral health system emphasizing accessible, quality care."

Each year after reviewing its strategic plan and related priorities, MHC establishes committees to work on various system enhancement needs. The "Grants Committee" is the only one limited to member agencies; others (of which there are 10 this year) have anywhere from 10 to 40 volunteers. Examples of other current committees include the following: Workforce, Trauma (which has two sub-committees), Access, Cultural Connection, and Resilience, among others.

Every second Monday, MHC holds a membership meeting at which educational events are presented. They often bring in outside experts to speak on various topics related to the year's committee work. Networking, sharing of information, "putting issues on the table," all occur at this meeting, which usually is attended by 75 to 100 people. "People tell me they often get more work done at this meeting than during the entire rest of the week," Patsy Thomas said in the interview.

### **Estimated Level of Collaborative Functioning**

MHC might be one of the more high-functioning BHCs in the nation. Every year, hundreds of volunteers from member agencies and other entities tackle numerous system enhancement projects. MHC has established strong connections in Texas and even nationally. Tarrant County leaders have spent time traveling to Washington, D.C. to meet with national leaders and to pave the way for collaboratively-obtained federal grant funding in the amount of close to \$100 million since 1999. A community in Wisconsin has adopted the MHC model, and Patsy and her colleagues mentor them in the development of their BHC.

MHC tends to make multi-year commitments to major system enhancement efforts. Patsy Thomas specifically dwelt on two examples – the work of the Trauma and Cultural Connection committees.

MHC has a Tarrant Cares Committee, which updates and ensures the ongoing utility of a web-based searchable data base of health and human services information. (It is part of the Network of Care data base developed by Trilogy.) Five years ago, the county judge personally raised the money to allow MHC to connect to the Network of Care data base. MHC has had 50 million hits to the Tarrant Cares data base since its launch five years ago.

### **Take Home Messages**

- Mental Health Connection of Tarrant County represents a "best practice" in BHC development that should be studied in more depth. The MHC has become the "go-to," "must-participate-in" entity in Tarrant County for anyone interested in enhancing the mental health system.
- MHC benefits from a full-time facilitator who is completely dedicated to its flourishing.
- It also relies heavily on the direction of a nine-member board, funding from its members, and committee volunteers. The facilitator, much like Enrique Mata in El Paso, orchestrates the MHC's functioning, but does not direct it or "run it."
- The MHC develops "social capital," not only inside the county by bringing the entire community together in the service of bringing large amounts of grant money into the county, but it also actively and strategically develops strong relationships with experts and funders outside of the county.

## **Bexar County Behavioral Health Consortia-Related Efforts**

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### **Key Informant Interview – Amanda Tinsley-Mathias**

#### **Sponsoring Entities**

Bexar County has several different planning or organizing groups, none of which have evolved into a county-wide planning entity with the full scope of a behavioral health consortium. However, some, such as the Medical Directors Roundtable (MDRT), have had some longevity and have played an important role in improving services in Bexar County. The Bexar County Mental Health Consortium (MHC) is convened by the recently-created Bexar County Mental Health Department. However, our understanding is that while a large number of people attended meetings early on, the MHC has not developed into the planning authority with which all providers, advocates, universities, and other partners believe they need to be integrally involved in order to address pressing mental health-related concerns. The Southwest Texas Regional Advisory Council (STRAC) oversees programs and projects related to emergency medical services, ambulances, and homelessness, with a focus on homelessness and emergency services. An even smaller group, the Mobile Integrated Health Care Team, led by a county judge and the fire department, used a case study approach to address mental health-related and other problems in the emergency response system. However, from what we learned from our key informants and experience in conducting a system assessment in Bexar County, only the Medical Directors Roundtable has gained enough traction anywhere near the level of a BHC's functioning to warrant review. Below, we focus only on the MDRT.

#### **Age of BHC**

The Medical Directors Roundtable began around 2006. Participants include representatives from the local LMHA (CHCS), Haven for Hope, hospitals, the sheriff's department, the police department, the Restoration Center (connected to CHCS), and sometimes the fire department.

#### **Scope of Planning Activity or Authority**

The MDRT does not function at the level of a planning authority, but it engages in a lot of "ground level" discussion and problem-solving to address homelessness, mental illness, and substance use issues in San Antonio. Participants identify ways in which providers and law enforcement can work together to effectuate jail diversion and prevent unnecessary hospitalization, homelessness, and emergency room use. Data tracking on processes of care (e.g., utilization of various Restoration Center services, such as crisis stabilization and the sobering center) is regularly used.

According to key informants, the MDRT is fairly effective in making quick changes to address problems. For example, in responding to an epidemic of synthetic marijuana, the MDRT devised a plan to deliver public service announcements to educate the public about the dangers of this

drug. They also developed multi-agency plans to address the needs of specific individuals known to be affected.

In addressing imminent problems in the system, the MDRT often benefits from the participation of both executive-level leadership from participating agencies as well as from the participation of mid-level leaders (e.g., program managers) who can help determine how to implement collaborative programmatic efforts designed or developed at a high level by the executives (of course, often with input from the mid-level leaders). The MDRT has had some success because it “gets the right people in the room.”

### **Estimated Level of Collaborative Functioning**

Bexar County as a whole does not have a fully functioning BHC that carries the full scope of what a BHC should carry. However, the level of collaboration in the MDRT is strong.

### **Take Home Messages**

- It is helpful in BHC-like entities and in BHC-like activities to have significant, regular participation from both executive and mid-level leaders representing all key agencies.
- Establishing a county-wide planning entity that garners the ongoing and concerted attention and participation of all key parties is not easy. Bexar County has had some initial success, as demonstrated by the Bexar County Mental Health Consortium, but to our knowledge, after several months, the MHC has not emerged as the “go-to” entity that everyone feels they must join.
- Is it possible that a BHC could benefit from encouraging the creation of lower-level collaborative efforts like the MDRT? (And would the MDRT benefit from the existence of an effective BHC entity that helps it obtain more resources and provides guidance as to how it fits into the overall, ongoing mental health system enhancement process?) The El Paso BHC’s leadership councils appear to be functioning at a higher level (less “on the ground” than the MDRT), and appropriately so. But it is worth considering whether the emergence of MDRT-like entities that focus on very specific populations of people (like those with high utilization of emergency services and the jail), and can even operate on a case-level basis, should be promoted.

## Dallas County Behavioral Health Leadership Team

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### Key Informant Interview – Ron Stretcher

#### Sponsoring Entity

Dallas County Commissioner's Court and Parkland Health and Hospital System's Board of Managers empower the Dallas County Behavioral Health Leadership Team (BHLT) to function as a single point of accountability, planning, oversight, and funding coordination for all Dallas County behavioral health services and funding streams.

#### Age of BHLT

The BHLT has been meeting since January 2011. They convened as recommended after a mental health system assessment conducted by TriWest Group and Zia Partners.

The BHLT focused on addressing the 12 recommendations in the assessment. The group worked with outside facilitators during the first few meetings to expedite organization of the group and set the ground rules. They have developed two workgroups. One workgroup focuses on adult clinical operations and the other focuses on housing. The group came together relatively quickly when community members began to see that decisions were being made in the group.

#### Scope of Planning Activity or Authority

The BHLT is made up of 47 members that represent mental health advocacy, law enforcement, the district attorney's office, city and county agencies, residential facilities, outpatient providers, and payers and funders. The group is chaired and co-chaired by county commissioners.

#### Estimated Level of Collaborative Functioning

The BHLT in Dallas functions at a fairly high level of collaboration – at least at the cooperating level. It is well organized and participants come together to make all decisions involving county mental health and substance abuse concerns. Organized by a staff member in the County Criminal Justice office, the BHLT is focused on leveraging resources more effectively, creating a single point of accountability and interface for Dallas County behavioral health services with stakeholder groups, and forming an authority for all behavioral health services.

The group has an 1115 waiver that they manage and they also came together to obtain a SAMHSA grant.

### Take Home Messages

- Have an official that is well respected and everyone listens to that supports and lends expertise to the project. County commissioners chair and co-chair the program.
- Have someone on the ground to work with elected officials to get things done.
- Actively work together to accomplish goals.
- Be prepared to have difficult discussions but work through them and move forward.

## Denton County Behavioral Health Leadership Team

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### Key Informant Interview – Lacrica Olson

#### Sponsoring Entity

The United Way of Denton County is the fiscal agent and backbone organization for the Denton County Behavioral Health Leadership Team (BHLT).

#### Age of BHLT

Following the release of a 2013 community needs assessment, which included mental health needs, United Way of Denton County convened a Citizen’s Advisory Group through a private donation to look at mental health needs in the community. This group met for nine months to assess the needs of the community and conduct an inventory of available services. In November of 2014, the group asked MMHPI to conduct a mental health system assessment. The report, which included recommendations to convene as a collective body to address behavioral health issues in the community, was approved in April 2015, along with the hiring of a full-time facilitator.

In June 2015, the Behavioral Health Leadership team launched and began drafting bylaws and a charter. Five workgroups were initiated in July 2015 and a sixth workgroup began in September 2015. In November 2015, the bylaws, charter, mission, and vision were finalized.

#### Scope of Planning Activity or Authority

The BHLT 34-member team comprises 31 appointed members with three ex officios (a United Way board member, the group facilitator, and a judge). Members represent Denton County Commissioners Court, municipal government, health care providers, health insurance providers, educational institutions, law enforcement, non-profits, housing and other community organizations.

The group convenes as a policy-making team to improve the planning, coordination, oversight, and implementation required to create systems change for behavioral health services in Denton County. The group functions as a quasi-governmental team with a charter and bylaws and under the backbone of the United Way Collective Impact Model.

#### Estimated Level of Collaborative Functioning

Denton’s BHLT functions approximately at the level of “Cooperating.” With the help of the full-time facilitator, the BHLT has already made great progress in communicating regularly and sharing information about available services. Each work group conducted a Strengths Weaknesses Opportunities and Threats (SWOT) analysis, the information from which was used to identify areas for system improvement that did not depend on extra funding.

The BHLT secured funding for NAMI to expand peer support groups, create a website, and engage in Okay to Say. They applied for SB55 funding to support veterans and their families, and were subsequently awarded funding. And, as result of the assessment and their involvement with the BHLT, Texas Health Presbyterian-Denton will open a new behavioral health hospital in 2017. Their next focus is on a five-year strategic plan and will identify two to three recommendations for each workgroup's focus.

### Take Home Messages

- A foundation-facilitated process, with a collective impact backbone, has been successful.
- A full-time facilitator/coordinator of the effort, dedicated to the BHLT and its workgroups, has helped create engagement, buy-in, and communication. The facilitator serves as the main contact person for all BHLT activities and is seen as a neutral party.
- Organizing around work groups that can address specific system needs has kept the groups focused.

## **Omaha Nebraska’s Behavioral Health Support Foundation Collaborative** **Behavioral Health Consortia Key Informant Interview – Christine Johnson**

### **Region 6 in Nebraska (Omaha metropolitan area)**

#### **Sponsoring Entity**

The Behavioral Health Support Foundation (BHSF), a philanthropic organization based in Omaha, provides funding and a full-time project coordinator.

#### **Age of BHC**

In 2014-15, the BHSF asked TriWest Group to conduct a mental health system assessment, not unlike the one conducted for PdNHF. A group of behavioral health providers, regional mental health authority administrators, managed care organization representative, advocates, and graduate/medical training program leaders convened to guide the assessment process.

In 2015, BHSF and system leaders agreed to organize a comprehensive effort to fill the nine “gaps” in the mental health system that had been identified in the system assessment. BSHF hired a full-time project coordinator to facilitate the effort. They established nine different work groups that have generally have made substantial progress in the past 12 months.

#### **Scope of Planning Activity or Authority**

A state-connected entity called “Region 6” is the formal behavioral health planning authority for the Omaha metropolitan area, which includes five surrounding counties. The BHC in Omaha, which was created through the auspices of the BHSF, only has informal authority to identify and address system functioning issues. However, the current system enhancement effort appears to be well-supported by state mental health authority representatives.

#### **Estimated Level of Collaborative Functioning**

The BHC in Omaha is functioning at a high level – perhaps mostly at the “Cooperating” level but in some ways at the “Collaborating” level. It is well-organized and participants are working together actively, productively, and through cooperative agreements to fill gaps in the system that have been identified. For example, one of the most complicated gaps to address was the lack of a comprehensive psychiatric emergency service/system. A work group of 35 people has been developing a variety of solutions to this problem, including expanding mental health respite services, urgent care, and a forensic unit at one of the region’s leading inpatient centers. They are also establishing a Center of Excellence there. As another example, in the past two years they have begun implementation of two new first episode psychosis care programs in Omaha, one at an LMHA-like agency and the other at Creighton University Medical School.

### Take Home Messages

- A foundation-facilitated process, with resource backing, has been successful.
- A full-time facilitator/coordinator of the effort, dedicated to the BHC, has helped maintain momentum and ensured effective organization.
- Ensuring engagement from regional and state authorities has added weight to the project.
- Organizing around work groups that can address specific system needs has been helpful.

## **Appendix Three: Mental Health Data Dashboards Review (Originally submitted July 29, 2016)**

### **Methodology**

Mental health data dashboards were identified by conducting a targeted search of state mental health departments and other entities implementing dashboard efforts that focused on mental health. Dashboards recommended by peers in the field were also included in the review.

Review of the dashboards involved identifying chosen metrics by population, geographical designation, and other levels of aggregation, as well as the presence of any readily available or producible reports, charts, or data summaries.

### **Key Themes**

The types of metrics most common among the mental health dashboards were those concerning mental health utilization (e.g., inpatient, outpatient, residential, substance use disorder treatment, emergency department visits), mental health expenditures, behavioral health screening, and demographics. This type of data can be helpful in identifying the need for certain types of behavioral health services and in tracking outcomes over time.

The ultimate benefit of the mental health dashboards that were reviewed is the potential to encourage innovation among providers and stakeholders and inform decisions about the provision of behavioral health services that would influence mental health outcomes. Key features that made some dashboards stand out from the others included user-friendly functionality, access to exportable data, transparency about source data, and links to related reports or summaries of data.

### **State Mental Health Dashboards**

#### **Arizona Health Care Cost Containment System (AHCCCS) Behavioral Health System Performance Framework and Dashboard**

The AHCCCS Behavioral Health System Performance Framework and Dashboard organizes data (contained in trend charts) into four metric categories that are broken out by adults or children, statewide, or by geographic (GSA) groupings. Additionally, they provide PDF summaries of each metric category, including descriptions of the current metrics, scorecards for adults and children statewide and by GSA, downloadable Excel workbooks of the source data for calculating metrics, and a data dictionary detailing methodology for data collection and calculation for each metric in each category.

Metrics available for adults and children (reported separately) statewide or by GSA include the following:

- Outcomes – impact on quality of life; has quality of life improved for individuals served by the behavioral health system?
  - Percentage of individuals with prior drug/alcohol history, now no longer using;
  - Percentage not homeless;
  - Percentage employed;
  - Percentage attending school;
  - Percentage with no recent criminal justice system involvement;
  - Percentage participating in self-help groups.
- Access to services – do individuals and families have access to recovery- and resiliency-oriented services?
  - Percentage satisfied with access to services,
  - Percentage that receive timely services,
  - Percentage that live within 15 miles of an outpatient clinic.
- Delivery – are services provided based on the needs of individuals and families?
  - Percentage that participate in their treatment planning,
  - Percentage that have current and complete service plans,
  - Percentage that receive services identified on their service plan.
- Coordination/collaboration – do individuals and families get seamless behavioral and medical care coordination?
  - Percentage of individuals that have their care coordinated with their medical doctor,
  - Percentage that return to a psychiatric hospital,
  - Percentage that stay in a psychiatric hospital for various periods of time.

### **California Department of Health Care Services Dashboard Initiative**

The California Department of Health Care Services (DHCS) Dashboard Initiative involves six (6) current dashboards including: Dental Managed Care Plan Utilization, Dental Fee-for-Service Performance Measures, Managed Care Performance, Cal MediConnect, Mental Health Performance Outcome System Reports and Measures, and DHCS Pediatric. The effort is carried out in conjunction with a “Stakeholder Engagement Initiative” based on strategic planning and quality improvement principles.

This review focuses on the metrics found on the Mental Health Performance Outcome System Reports and Measures website. They provide three (3) separate reports annually for the Performance Outcome System, which includes statewide aggregate data, population-based county groups, and county-specific data. This reporting initiative is part of the performance outcomes system implemented by Medi-Cal Specialty Mental Health Services (SMHS) for children and youth. They have been working with groups of stakeholders since 2012 to create

the reporting structure and identify and develop the indicators and measures. Data sources include:

- Short-Doyle/Medi-Cal II (SD/MC II) claims (dates of service: FY11/12-FY14/15),
- Medi-Cal Eligibility Data System (MEDS) data from the Management Information System/Decision Support System (MIS/DSS) (FY11/12-FY14/15).

Metrics available for children and youth under 21 years of age receiving SMHS include:

- Demographics: unique count of children and youth by fiscal year.
  - Race distribution,
  - Age group distribution,
  - Gender distribution.
- Penetration rates: children and youth with at least one (1) SMHS visit.
  - Statewide by age, race and gender.
- Penetration rates: children and youth with five (5) or more SMHS visits.
  - Statewide by age, race and gender.
- Utilization: approved specialty mental health services for children and youth, mean expenditures and mean service quantity per unique beneficiary by fiscal year.
  - Total approved,
  - Intensive Home-Based Services (IHBS) minutes,
  - Intensive Care Coordination (ICC) minutes,
  - Case management minutes,
  - Mental health service minutes,
  - Therapeutic behavioral service minutes,
  - Medication support services minutes,
  - Crisis intervention minutes,
  - Crisis stabilization hours,
  - Full day treatment intensive hours,
  - Full day treatment stabilization hours,
  - Hospital inpatient days,
  - Hospital inpatient administrative days,
  - Fee-for-service inpatient days,
  - Crisis residential treatment services days,
  - Adult residential treatment services days,
  - Psychiatric health facility days.
- Snapshot Report: unique count of children and youth receiving SMHS arriving, exiting, and with service continuance by fiscal year.
- Time to Step Down Report: children and youth stepping down in SMHS services post inpatient discharge.
  - Median time between inpatient discharge and step down service in days,

- Mean time between inpatient discharge and step down service in days,
- Percentage of discharges by time between inpatient discharge and step down service:
  - Within seven (7) days,
  - Within eight (8) to thirty (30) days,
  - Thirty-one (31) days or more,
  - No step down.

### **New York State Office of Mental Health Dashboard**

This dashboard is the most sophisticated of those reviewed. It is easy to navigate, visually appealing, and full of useful data. In addition to the readily available charts of service units and expenditure rates for each type of service, the Office of Mental Health also links to related reports (e.g., Medicaid utilization and expenditures by treatment type) with exportable data.

Metrics available for New York state, by region, by county, and by fiscal year (2007-2015):

- Medicaid mental health expenditures;
- Adults (age 18+)
  - Case management,
  - Inpatient,
  - Outpatient,
  - Residential;
- Children (age 0-17)
  - Case management,
  - Inpatient,
  - Outpatient,
  - Residential;
- Mental health inpatient utilization;
- Adults (age 18+)
  - General hospital,
  - Private hospital,
  - State psychiatric center;
- Children (age 0-17)
  - General hospital,
  - Private hospital,
  - State psychiatric center,
  - Residential treatment facility (age 0-21);
- Psychiatric inpatient readmissions;
- Adults and children by provider name
  - Discharges and readmissions within 30 days;

- Assisted Outpatient Treatment;
- Individuals currently under court order;
- Individuals under court order at any time during the past 12 months;
- Demographics (percent male, average age, percent non-white; since Nov 1999);
- Assertive Community Treatment (ACT);
- Individuals receiving ACT services;
- Capacity (number and percent);
- Percentage of service recipients with Assisted Outpatient Treatment court order;
- Percentage of service recipients meeting high utilization criteria;
- Percentage of service recipients with coexisting alcohol or substance abuse disorder;
- Percentage homeless at most recent follow-up;
- Demographics (percentage male, average age, percentage non-white).

### **Oregon Addictions and Mental Health (AMH) Mental Health Dashboard of Medicaid Treatment in Oregon for Children and Adults**

This dashboard shows how many individuals are receiving mental health services funded through the Oregon Health Plan (Oregon's Medicaid Program).

Metrics available for adults and children (reported separately) include:

- Mental Health Dashboard
  - Unique count that received any mental health service, by quarter;
  - Unique count of those who received outpatient mental health services, by quarter;
  - Unique count of those who received residential treatment, by quarter;
  - Percentage in mental health treatment by top 10 mental health diagnoses.
- Substance Use Disorder (SUD) Dashboard
  - Unique count that received any SUD service,
  - Unique count that received outpatient SUD service,
  - Unique count that received residential SUD,
  - Percentage in SUD treatment by top 10 substances.

### **Dashboards Based on Results-Based Accountability™<sup>37</sup>**

The states of Connecticut and Vermont are utilizing similar performance dashboards built on the concepts of Results-Based Accountability™ and the Healthy Connecticut/Healthy Vermonters 2020 indicators. The performance dashboards display data and information for the respective Healthy 2020 indicators, focusing on population and performance measures and strategies.

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<sup>37</sup> For more information on Results-Based Accountability™, please see <http://resultsaccountability.com/about/what-is-results-based-accountability/>.

## **State of Connecticut Department of Public Health: Healthy Connecticut 2020 Dashboard**

The Mental Health, Alcohol, and Substance Abuse performance dashboard was pulled together by a work group with the goal to improve health through access to quality behavioral health services across a continuum that includes various levels and types of screening, early intervention/prevention and treatment.

Metrics available for Connecticut by year:

- Rate of mental health emergency department visits,
- Number of individual clients receiving mental health services at community health centers,
- Number of individual clients receiving group therapy on site at community health centers,
- Rate of binge-drinking by age (grades 9-12; ages 18 and older),
- Rate of under-age drinking,
- Rate of non-medical painkiller use (ages 12 and older),
- Rate of illicit drug use (ages 12 and older),
- Rate of trauma screening by primary care and behavioral health providers.

Each performance metric includes actual value, target value, current trend, and baseline percent change, as well as:

- Story Behind the Curve – data source(s);
- Potential partners – examples include the Department of Public Health, Department of Mental Health and Addiction Services, Department of Children and Families, Department of Corrections, primary care and behavioral health providers, etc.;
- What Works – a brief summary of evidence/rationale;
- Action Plan – strategies based on the data to improve outcomes.

## **Vermont Department of Health: Healthy Vermonters 2020 Performance Dashboard**

The Vermont Department of Health reports on the data and make decisions based on the available data. The mental health dashboard is one of 22 dashboards available on the Healthy Vermonters 2020 website.

In addition to the dashboard platform, there is also functionality for users to search the data via a “Data Explorer.” This allows one to search by topic (e.g., mental health, substance use, access to health services), location (counties, health district offices, or hospital service areas), and by two-year time period. This search yields exportable data.

Available metrics include:

- Rate of suicide per 100,000 Vermonters,
- Percent of adolescents in grades 9-12 with a suicide attempt that required medical attention,
- Percent of primary care provider (PCP) visits for adolescents that include depression screening,
- Percent of PCP visits for adults age 19 and older that include depression screening,
- Percent of people receiving non-emergency services within seven (7) days of emergency services,
- Percent of Community Rehabilitation and Treatment (CRT) clients receiving follow-up services within seven (7) days of psychiatric hospitalization discharge,
- Percent occupancy of Designated Agency adult crisis bed programs,
- Percentage of members with major depression who were initiated on an anti-depression drug and who received an adequate acute phase trial of medications (three months),
- Percentage of members with major depression who were initiated on an antidepressant drug and who completed a period of continuous medication treatment (six months),
- Follow up after hospitalization for mental illness (within seven days),
- Follow up after hospitalization for mental illness (within 30 days).

Like the Connecticut performance metrics, each of the Vermont metrics includes actual value, target value, current trend, and baseline percent change, as well as:

- Story Behind the Curve – data source(s);
- Potential partners – examples include the Department of Public Health, Department of Mental Health and Addiction Services, Department of Children and Families, Department of Corrections, primary care and behavioral health providers, etc.;
- What Works – a brief summary of evidence/rationale;
- Action Plan – strategies based on the data to improve outcomes.

## Other Dashboards

### Future of Nursing: Campaign for Action Dashboard

Metrics available for this dashboard include:

- Education – percentage of nurses with a Bachelor of Nursing degree or higher;
- Total number of nursing students enrolled in a doctoral degree program;
- State practice environment – full, reduced, or restricted practice designations by state;
- Inter-professional collaboration – number of clinical courses at nursing schools including other graduate health professionals;
- Leadership – percentage of hospital boards with a registered nurse;
- Workforce data – number of nursing workforce data items collected by each state.

**idashboards.com**

This company is an innovator in behavioral and mental health dashboards, providing self-service and custom software for data visualization (e.g., charts, graphs, infographics). Examples of their metrics include:

- Inpatient admissions by network
  - Trends by funding source, network, and disability designation;
  - Number of admits and consumers by fiscal quarter.
- Non-profit housing
  - Monthly housing costs,
  - Percentage of costs by expense type.

## Appendix Four: Family Leadership Council Recommended Metrics (Originally submitted July 3, 2016)

**Opportunity for Change #1: Access to behavioral health care in routine settings (i.e., pediatric practices, primary care clinics, and schools) is dramatically lacking.**

### Original Impetus

*The El Paso community's focus for children and families should be on meeting behavioral health needs early in the places where children live, learn and receive health care. Waiting until needs reach a crisis or result in contact with law enforcement harms our children and our community.*

*The Council will collaborate to create an El Paso County model for a child and family continuum of care. The model will reflect a hierarchy of needs (pyramid) format with a broad foundation of support (prevention and early intervention options), then increasing in intensity and specialization of care for more severe and complex needs.*

### Objectives, Strategies and Recommended Metrics

**Objective 1:** Develop and implement an El Paso County continuum model for children and families with a broad base of prevention and early intervention services by December 31, 2017.

- **Family Leadership Council Strategy 1.1:** Engage the El Paso Child Wellness Council partners in service mapping and updating the current resource and referral process (including the internet application).
- **Family Leadership Council Strategy 1.2:** Explore existing research and best practice models to compare and contrast against the current El Paso County system.
- **Family Leadership Council Strategy 1.3:** Create a campaign for early access to behavioral health assessments, care, and skillful support in the settings in which children naturally seek help (i.e. family, schools, faith communities, and the family doctor).

**Common Metrics for Objective 1:** The Council will measure and track progress on the goal of increasing access to prevention, early intervention and timely community-based services.

Potential metrics for consideration include the following:

- **Metric 1.1:** Number/percentage of primary care providers who routinely screen for child behavioral health disorders and either have a behavioral health specialist co-located or refer to behavioral health providers with whom they have formal partnerships.
- **Metric 1.2:** Number/percentage of schools who routinely screen for child behavioral health disorders and either have a behavioral health specialist co-located or refer to behavioral health providers with whom they have formal partnerships.

- **Metric 1.3:** Number/percentage of services in the routine/outpatient/intensive sections of the service continuum for which children/youth do not have to wait more than seven (7) days (routine/outpatient), 72 hours (urgent), and one hour (emergent).
- **Metric 1.4 (set of restrictive setting use outcomes):** Number of children/youth with a severe emotional disturbance (SED) admitted to inpatient facilities in a 12-month period; number of children/youth with SED in out-of-home placement/foster care; number of youth with SED in juvenile detention or residential placement.
- **Metric 1.5 (school outcomes):** Number of children/youth with SED (or an identified behavioral health problem/condition) who are removed / expelled from school. (Other possible metrics, depending on what can be measured, include: number/percentage of youth with identified behavioral health problem/condition with grade completion; school attendance rate among children/youth with identified behavioral health problem/condition.)
- **Metric 1.6:** Number of community partners (voluntary organizations, faith communities, businesses, etc.) that have participated in the think.change initiative.

## **Opportunity for Change #2: Crisis services were identified as a critical gap in the children's system.**

### **Original Impetus**

*The service array has significant gaps so children and their families are often referred to and placed within the levels and types of care that are available as opposed to the most appropriate level of care to meet their needs.*

*The Council will plan and implement on-call mobile teams that are separate from but supported by law enforcement to serve children, youth and their families in crisis across systems (mental health, substance abuse, schools, child welfare, and juvenile justice). One of the most notable gaps that will be addressed involves interventions for families (as opposed to individual therapies treating the individual child), including intensive home-based options like Multisystemic Therapy and Functional Family Therapy.*

**Objective 2:** Replicate model child and family crisis service system components centered on a dedicated on-call, non-forensic mobile crisis team and supported by a continuum of community-based and residential components *by December 31, 2017.*

- **Family Leadership Council Strategy 2.1:** Explore existing research and models for child and family crisis services to compare and contrast against the current El Paso County service array.

- **Family Leadership Council Strategy 2.2:** Engage providers to coordinate and provide crisis services across the continuum for children and families as part of the broader crisis system.
- **Family Leadership Council Strategy 2.3:** Create a targeted campaign for child and family crisis integration into the broader crisis system.

**Common Metrics for Objective 2:** The Council will measure and track progress on the development of a full continuum of intensive and crisis services that reduces time separated from family and community. Potential metrics for consideration include the following:

- **Metric 2.1:** Degree of fidelity of the child and family crisis service system to the chosen crisis services model. [This will require development of fidelity indicators and a scoring system for periodic analysis and tracking.]
- **Metric 2.2:** Number/percentage of services in the crisis section of the continuum for which children/youth do not have to wait more than one hour, once referred or requested.
- **Metric 2.3 (set of Continuity of Care metrics):** Percentage of children/youth who receive a face-to-face community-based service from a behavioral health provider within 72 hours of discharge from an inpatient facility; percentage of children/youth who receive a face-to-face community based service from a behavioral health provider within 72 hours of discharge from a residential facility; percentage of youth with an identified behavioral health problem or condition who receive a face-to-face community based service from a behavioral health provider within 72 hours of discharge from juvenile detention or residential placement. (This latter metric could also be separated out for children with SED.)
- **Metric 2.4:** Percentage of children/youth discharged/released from an inpatient facility (residential facility, detention/residential facility), who return within 12 months of discharge/release.

## The Role of the Family Leadership Council

### What the FLC Is and What It Is Not

#### The FLC is:

The Family Leadership Council (FLC) is committed to ongoing collaboration where all partners are welcome, empowered, and unified to achieve the ideal behavioral health service and support system. The FLC works with El Paso County child, adolescent and family health organizations, other child-serving agencies and natural support systems to transform El Paso County into a model community for child and family behavioral health services and support. This includes engaging and supporting existing groups with data, evaluation, best practice models and other collaborative activity to maximize available resources and document community-wide progress.

The FLC is an entity that provides El Paso County stakeholders tools for continuous communication and coordination. Under the El Paso Behavioral Health Consortium, the FLC has support and capacity to grow a unique governance and work group structure to address the needs of the region. For example, work groups convened or coordinated with the FLC include community leaders with expertise in child health, growth and development. Discussions and communication tools under the FLC will be unique to the arena as opposed to creating uniform tools for all Consortium Leadership Councils. This allows the flexibility to explore and develop solutions within the full breadth and depth of the child and family behavioral health system.

**The FLC is not:**

The Family Leadership Council is not a medical treatment service entity. The FLC does not provide health services of any type – mental health, substance abuse or other services. The FLC also does not lead specific actions. Where leaders in the community take charge of a project that is in complement with the El Paso Behavioral Health Consortium’s mission and that help achieve the FLC’s community level objectives, the FLC assists with collaboration and recognition of these vital health improvement efforts.

**Recognition of 2015-2016 community actions that contribute to achieving FLC objectives:**

- The Project Launch Child Wellness Council developed a smart phone and tablet application that assists families and health providers with up-to-date contact information for service and support providers and systems.
- The Foster Care Mental Health Work Group led by Child Protective Services convened service providers to document the current foster family continuum of care, adjust organizational policies and practices, and improve cross organization information sharing. This effort led to a reduction in the number of foster children requiring residential treatment and improved training and support for foster parents.

**Recommendations for FLC to Approve**

Generally, the FLC should revisit the goals and objectives of the group and determine their commitment to those goals. As part of that work, they should also review the metrics that were proposed in 2015 and determine whether these are still the areas that they would like to impact. If the group decides to continue to track the current metrics, they should determine which agencies have access to the data to support the metrics identified and begin collecting the information as a baseline. A recommendation would be to ensure a focus on the metrics in order to track progress and keep the group moving forward to achieve the identified common purpose.

*Recommendation 11*

With the help of the Executive Committee, **the FLC should explicate its role within the larger child/family serving system and the implications for its role.** There are two specific recommendations associated with this preliminary observation:

- **The FLC should explore how to align its efforts with those of other emerging community groups, (such as Dr. Handel’s group), as well as how to avoid duplication of efforts.** It should make a specific proposal to the Executive Committee on how to work with the entire BHC to work with other emerging groups to clarify their relationships and determine how to align efforts.
- **The FLC should formally explicate the full meaning of its status as the System of Care Collaborative Governing Council** (as defined by the Texas System of Care). This was discussed briefly at the March 2016 meeting. The FLC should propose to the Executive Committee and Texas state-level authorities three recommendations:
  - The governance structure and FLC representation that will enable it to fulfill its role as the SoCCGC. (The current structure and membership might be sufficient.)
  - The specific responsibilities it agrees to undertake as the SoCCGC.
  - The products that it will deliver in order to fulfill its role. (These proposed products should dovetail with the FLC’s original goals and objectives.)

*Recommendation 18*

Based on recommendations from the work group on services to foster care children and youth, the FLC should **choose two to three metrics associated with its current work to improve the coordination and quality of services.** These metrics could be drawn from the set proposed by TriWest Group in its consultation last year, but they should allow for meaningful tracking of service quality and outcomes, and it should be possible to develop a clear operational definition. The FLC should weigh both the degree to which the metric represents meaningful quality or outcome, as well as the feasibility of obtaining complete and valid data. Metrics could include, for example:

- Frequency of placement in residential treatment facilities,
- School attendance or school days missed,
- Days spent in juvenile detention centers,
- Frequency of safe reunifications with family.

*Recommendation 14*

**The Foster Care work group should be charged with identifying policy changes that could facilitate the more timely and widespread delivery of wraparound services** to foster care children as well as other children and youth in need of such intensive services to prevent residential treatment center and other restrictive placements.

### Appendix Five: Update of Basic Mental Health Need Versus Needs Met in El Paso County, 2015

**Selected Needs and Needs Met among Children and Youth Living at/below 200% FPL in El Paso County and Texas Statewide, 2015**

Region	Youth Population	SED Prevalence	All Mental Health Need	Non-Medicaid Served by LMHAs	Medicaid Served by LMHAs	Medicaid Served by All Providers	Need Intensive Wraparound <sup>38</sup>	Intensive Wraparound Capacity
El Paso County	153,172	13,812	30,842	339	1,220	13,008	1,300	82
<b>All Mental Health Need <u>Not</u> Met in El Paso Co.: 17,495 (57%)</b>								
<b>Intensive Wraparound Need <u>Not</u> Met in El Paso Co.: 1,218 (94%)</b>								
Texas	3,566,287	321,461	433,182	13,140	49,204	318,464	30,000	552
<b>All Mental Health Need <u>Not</u> Met in Texas: 101,578 (23%)</b>								
<b>Intensive Wraparound Need <u>Not</u> Met in Texas: 29,448 (98%)</b>								

<sup>38</sup> Based on its consultants’ experience in multiples states, MMHPI estimates that one in ten children/youth with SED need intensive, family-based wraparound.

**Selected Needs and Needs Met among Adults Living at/below 200% FPL in El Paso County and Texas Statewide, 2015**

Region	Adult Pop.	Major Depression Prevalence	SMI Prevalence	Non-Medicaid Served by LMHAs	Medicaid Served by All Providers	Need ACT or FACT <sup>39</sup>	ACT and FACT Capacity	First Episode Psychosis	First Episode Care Capacity <sup>40</sup>
El Paso County	276,806	27,155	19,172	4,659	5,370	1,534	59	172	~50
<b>Estimated SMI Need <u>Not</u> Met in El Paso Co.: 9,143 (48%)</b>									
<b>Estimated High Utilizer Need <u>Not</u> Met in El Paso Co.: 1,475 (96%)</b>									
<b>Estimated First Episode Psychosis Care Need <u>Not</u> Met in El Paso Co.: 122 (71%)</b>									
Texas Statewide	6,678,162	655,128	536,875	152,356	185,878	42,950	2,879	4,093	300
<b>Estimated SMI Need <u>Not</u> Met in Texas: 198,641 (37%)</b>									
<b>Estimated High Utilizer Need <u>Not</u> Met in Texas: 40,071 (93%)</b>									
<b>Estimated First Episode Psychosis Care Need <u>Not</u> Met in Texas: 3,793 (93%)</b>									

<sup>39</sup> MMHPI estimates this need based on two studies published by Gary Cuddeback and colleague in 2006 and 2008, in the journal, *Psychiatric Services*.

<sup>40</sup> Emergence Health Network has been approved for implementation of an FEP Care team, but we do not yet know its full capacity.

## Appendix Six: MMHPI's Paper on Prevention and Behavioral Health Promotion (October 28, 2016)

### What Is Prevention?

In 1994, the Institute of Medicine (IOM) Committee on Prevention of Mental Disorders described the scope of prevention as including *universal interventions*, which focus on the population at large, *selective interventions*, which target groups or individuals with an elevated risk, and *indicated interventions*, which target individuals with early symptoms of behaviors that are precursors for a behavioral health (BH) condition but are not yet diagnosable.<sup>41</sup> By 2009, the IOM suggested a framework that also defines “*true prevention*,” or interventions occurring prior to the onset of a BH condition. True prevention focuses on activities that help individuals of all ages succeed at normal developmental tasks, such as establishing healthy interpersonal relationships, succeeding in school and transitioning to the workforce or experiencing job and parenting success.<sup>42</sup> All levels and types of prevention programs are useful – universal, selected interventions and indicated interventions, as well as “true prevention.”

Which of the various types of prevention to choose may depend on an analysis of the costs of the intervention in relationship to what is known about the preventive effects. For example, one consideration is the “base rate problem.” Some conditions, such as first episode psychosis, are relatively rare, and a universal preventive intervention of unspecified effect may not be warranted; rather, a selective or (even more likely) an indicated intervention may be more effective. On the other hand, universal interventions known to reduce the risk of anxiety, depression (or both) – very prevalent conditions for which several prevention programs have been tested – may be cost-effective.

### Why Is Prevention So Important to Texas?

Both nationally and in Texas, half of all mental health conditions begin by age 14. In a 12-month period there are more than 300,000 Texas children and adolescents living in poverty with a severe emotional disturbance (SED). SED includes mental health conditions such as attention deficit disorders, conduct disorders and depression, along with impaired ability to function at school and home. Among youth with SED, approximately 30,000, or one (1) in 10 are at high risk for out-of-home placement or exclusionary discipline, and will require intensive services. For

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<sup>41</sup> National Research Council and Institute of Medicine. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Committee on Prevention of Mental Disorders. Patricia J. Mrazek and Robert J. Haggerty, Editors. , Washington, DC: The National Academies Press. P. 23-26.

<sup>42</sup> National Research Council and Institute of Medicine. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Youth Adults: Research Advances and Promising Interventions. Mary Ellen O’Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

adolescents aged 12 to 17 in Texas, the 12-month incidence of major depressive episodes was 11%.<sup>43</sup> And the onset of a first psychotic episode typically occurs in youth and young adults between the ages of 15-34.<sup>44</sup> The early onset of mental health conditions and their prevalence among Texas children indicate the profound effects they can have on the trajectory of young persons' lives, and they underscore the need for behavioral health promotion and prevention.

Prevention is also important for pregnant and post-partum mothers. While there is no definitive information on the rate of depression among mothers after delivery, some of the research indicates that depression may affect about 13% of mothers within the first year following birth of their children.<sup>45</sup> These mothers may need parenting support to help their infants and children reach developmental milestones and prevent future depression. In many cases, supportive or targeted interventions for their babies and other children may be indicated, as well.

### **Is there Evidence that Prevention Works?**

There is strong evidence with over 30 years of research that prevention works in multiple community settings: homes, schools, and pediatrician and family physician offices, federally qualified health centers, social and recreational settings such as Boys and Girls Clubs and mental health centers. And, some of these same studies indicate there are cost savings across a range of service systems that support young people and their families throughout the education, child welfare, primary medical care, behavioral health and juvenile justice systems.<sup>46</sup> Examples of improved outcomes are described below.

- Substance use, conduct disorder, antisocial behavior, aggression and child maltreatment can be reduced.
- Depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by one quarter to one third.
- Improved family functioning and positive parenting have positive outcomes and can moderate poverty-related behavioral health risks.
- School-based prevention interventions aimed at improving social and emotional outcomes can also improve academic outcomes.

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<sup>43</sup> Lipari, R.N., Hughes, A. and Williams, M. (2016). *State estimates of major depressive episode among adolescents: 2013 and 2014. The CBHSQ Report: July 7, 2016.* Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

<sup>44</sup> Meadows Mental Health Policy Institute. (2016, March 24). *Estimates of the prevalence of mental health conditions among children and adolescents in Texas* (pp. ixiv-ixv). See <http://texasstateofmind.org/resources/policy/>.

<sup>45</sup> O'Hara, M.W., & Swain, A.M. (1996). Rates and risk of postpartum depression-A meta-analysis. *International Review of Psychiatry*, 8:37-54.

<sup>46</sup> National Research Council and Institute of Medicine. (2009). Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities (2) (pp. 35-36).

- Interventions targeting families dealing with adversities such as parental depression and divorce demonstrate positive results in reducing risks for depression among children.

Below we feature many evidence-based prevention programs that make a difference, but many more could have been listed. The problem with prevention is not that we do not know whether it works or how to apply it but, rather, that both nationally and in Texas it has not received sufficient funding. By making a “turn toward prevention,” Texas could set a standard for other states to follow.

### What are Examples of Prevention and Behavioral Health Promotion Interventions?

- **The Triple P – Positive Parenting Program** gives parents simple and practical strategies to help them confidently manage their children’s behavior, prevent developmental problems, and build strong, healthy relationships. Triple P is currently used in 25 countries and has been shown to work across cultures, socio-economic groups and in many different kinds of family structures. See <http://www.triplep.net/glo-en/home/>
- **The Incredible Years®** is a series of interlocking, evidence-based programs for parents, children, and teachers, supported by over 30 years of research. The goal is to prevent and treat young children's behavior problems and promote their social, emotional, and academic competence. The programs are used worldwide in schools and mental health centers, and in pediatric settings and have been shown to work across cultures and socioeconomic groups. <http://incredibleyears.com/>
- **Healthy Steps** is an evidence-based program of primary health care for infants and young children (from birth to three years of age) initiated by the Commonwealth Fund in 1995. Healthy Steps focuses on promoting the emotional wellbeing of infants and young children and preventing mental health concerns. It integrates child development, trauma- informed care, and family support into primary care pediatrics. <http://healthysteps.org/about/>
- The **Strengthening Families Program (SFP)** is a nationally and internationally recognized parenting and family strengthening program for high-risk and general population families. SFP is an evidence-based family skills training program found to significantly improve parenting skills and family relationships; reduce problem behaviors, delinquency, and alcohol and drug abuse in children; and to improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more effective parenting skills. <http://www.strengtheningfamiliesprogram.org/>
- **Bright Futures** is a national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported by the Maternal and Child Health Bureau of the Health Resources and Services Administration. The *Bright Futures Guidelines* provide theory-based and evidence-driven guidance for all preventive care screenings and well-child visits. Bright Futures content can be incorporated into many public health programs such as

home visiting, child care, school-based health clinics, and many others. Materials developed especially for families are also available. <https://brightfutures.aap.org>

- The **Fussy Baby Network** at Erikson Institute, located in Chicago, provides training and consultation to organizations across the country that wish to adopt the Fussy Baby Network model. The Network started in 2003 as a prevention home visiting program for families who were struggling with their baby's crying, sleeping, or feeding during the first year of life. The Fussy Baby Network's unique approach to working with families is called the **FAN** (Facilitating Attuned INteractions). It includes a warm line for parents and a range of other interventions. <http://www.erikson.edu/fussybaby/services/>

### Are there Specific Strategies to Prevent Child Maltreatment?

Abuse and maltreatment lead to suffering in their own right, of course, and they are also known to put children at risk for a variety of mental health and substance abuse problems. Prevention initiatives to address child maltreatment and abuse focus on various home visiting interventions.<sup>47</sup> The Supporting Evidence for Behavioral Health Home Visiting website site lists other examples of evidence-based interventions, including several listed below.

<http://supportingebhv.org/crossite>

- **Healthy Families America (HFA)** is a multiyear, intensive, home-based program for new parents identified during pregnancy or birth who demonstrate an elevated risk for maltreatment on the basis of a standardized risk assessment administered to the parents of all children born within the program's service area. Services focus on promoting healthy parent-child interaction and attachment, increasing knowledge of child development, improving access to and use of services, and reducing social isolation. <http://www.healthyfamiliesamerica.org/>
- **Nurse Family Partnership (NFP)** is a multiyear, intensive, home-based program targeting pregnant first-time, low-income mothers who self-refer or are directed to the program by local health and social service programs or practitioners. Services focus on improving parent-infant bonding, improving maternal health behaviors and life choices, and improving cognitive skills and healthy child development. <http://www.nursefamilypartnership.org/>
- **Parents as Teachers (PAT)** is a multiyear, intensive, home- and group-based program provided to any parent who requests assistance with child development knowledge and parenting support. Services focus on increasing parental knowledge of early childhood development, improving parenting practices and skills, and providing early detection of developmental delays and health issues among children. <http://www.parentsasteachers.org>

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<sup>47</sup> Daro, D., Hart, B., Boller, K., & Bradley, M.C. (2012, December). *Replicating home visiting programs with fidelity: Baseline data and preliminary findings* (p. 3). Princeton, NJ: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. Contract No.:GS-10F-0050L/HHSP233200800065W. Available from Mathematica Policy Research. See <http://supportingebhv.org/crossite>.

- **SafeCare** is a 24-week program providing bimonthly home visits for families with children from birth to age five (5) that focuses on altering parental behavior in three core domains: (1) health, (2) safety, and (3) parent-child interaction. Home visits focus on training parents to use health reference materials and access appropriate treatment, identify and eliminate safety and health hazards, and increase positive parent-child interactions.  
<http://safecare.publichealth.gsu.edu/>
- **The Triple P**, (described above) as implemented within the context of home-based care, provides weekly home visits for 24 to 26 weeks targeting families with children up to age eight (8). Services focus on promoting the development, growth, health, and social competencies of children, and improving parental competence, resourcefulness, and self-sufficiency.

## Appendix Seven: Integrated Behavioral Health Core Components Paper

# Best Practices in Integrated Behavioral Health

IDENTIFYING AND IMPLEMENTING  
CORE COMPONENTS

AUGUST 2016

PRODUCED BY:

TEXAS of MIND  
STATE  
THE MEADOWS MENTAL HEALTH POLICY INSTITUTE

COMMISSIONED BY:

StDavid's  
FOUNDATION

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## FOREWORD

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**A**t St. David's Foundation, we believe that good health returns great benefits to the community. Through a unique partnership, St. David's Foundation reinvests proceeds from St. David's HealthCare to support health programs in a five-county area in Central Texas. Grant funding to more than 60 grant partners supports the work of safety net clinics, agencies serving older adults, health care workforce development, healthy living programs and mental health initiatives.

In 2006, St. David's Foundation began funding integrated behavioral health (IBH), out of the belief that good health requires sound mental health. Though we sensed the promise of IBH to improve mental and physical health outcomes, we knew little about what constituted an effective IBH program. The available research was encouraging but left many questions unanswered as to program design, sustainability and reasonable expectations for health improvements.

During the past decade, through work with evaluators, our grant partners, and key leaders in the field, we have developed a stronger sense of the core components essential to creating an effective IBH program. The research around IBH has correspondingly matured, bringing the field to a pivotal time. We believe the field has reached a point where it is both possible and appropriate to begin defining what factors are important to a successful IBH practice, setting standards for cost effective programs and interventions, and exploring how finance and policy decisions can be shaped to support IBH. Those in the field need practical guidance on creating and sustaining IBH that will be used (and improved upon) by the provider, funder, and policy communities.

As a respected statewide voice on mental health, The Meadows Mental Health Policy Institute is an ideal partner to create this report. We are excited to capitalize on the Institute's expertise to further our knowledge in this area as well as inform and advance the field. It is our hope that this work sparks dialogue and actions that take the promise of IBH and translate it into real health improvements for the state of Texas.



Earl Maxwell  
CEO, ST. DAVID'S FOUNDATION



**St. David's**  
**FOUNDATION**

## EXECUTIVE SUMMARY

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Integrated behavioral health (IBH) represents a paradigm shift in both primary care and specialty behavioral health settings. IBH entails more routine attention to behavioral health among primary care providers and other medically trained staff, as well as skillful attention to behavioral aspects of what are typically considered “physical” disorders, such as insomnia, diabetes, and obesity. Similarly, in specialty behavioral health (BH) settings that serve adults with serious mental illnesses, IBH has created a new understanding of the overall health of the people being served, offering the potential to extend health, wellness, and life expectancy.

Despite the promise of IBH and its vision of a holistic approach to care, a number of persistent challenges continue to create barriers to IBH implementation. Along with policymakers and payers, providers are not always certain about exactly which models or core components of IBH to adopt or implement. This report offers a guide for providers, funders, advocates, and policy makers interested in promoting IBH and working systematically toward achieving its promise. Much of the literature to date on IBH presents either broad conceptual frameworks or highly detailed descriptions of various aspects of IBH. In this report, we have drawn on a number of sources to propose seven crosscutting core components of IBH, as outlined in the table on the following page.

The purpose of this report is to identify and describe these core components by citing emerging issues and offering examples. By doing so, we hope to facilitate and expedite the adoption of effective IBH programs within Texas health care settings.

Measuring success in IBH is an important element of a successful model. Various systems for measuring performance and outcomes have been developed, including the frequently used Healthcare Effectiveness Data and Information Set (HEDIS) system. Teams implementing IBH should meet regularly (e.g., quarterly) to review outcome indicators and establish priorities for program enhancement.

Developing a financing approach that can support a successful IBH model is frequently noted as a challenge by providers. Financing integrated care requires a careful examination of the type of insurance coverage connected to the patient population in order to maximize available revenue and identify the ideal partners. When a significant portion of the patient population has Medicaid, using or partnering with a federally qualified health center (FQHC) will help to build a more sustainable revenue base. Additionally, because managed care is the platform on which Texas delivers almost all community-based Medicaid services, exploring the flexibility offered to managed care plans to set different rates or pay for non-traditional services is also an important vehicle for financial sustainability.

*This report offers a “road map” for providers, funders, advocates, and policymakers interested in promoting IBH and working systematically toward achieving its promise.*

## CORE IBH COMPONENTS

IBH COMPONENT	DEFINITIONAL OVERVIEW
<b>1. INTEGRATED ORGANIZATIONAL CULTURE</b>	<ul style="list-style-type: none"> <li>▶ IBH is highlighted in the organization’s vision and mission.</li> <li>▶ Leadership actively supports IBH by promoting it in all organizational functions.<sup>i</sup></li> <li>▶ IBH champions are identified and empowered.</li> </ul>
<b>2. POPULATION HEALTH MANAGEMENT</b>	<ul style="list-style-type: none"> <li>▶ IBH programs assess and differentiate their patients by their prevalent co-occurring conditions and utilization patterns.</li> <li>▶ Health information technologies are used to manage outcomes across populations to apply the right interventions at the right time, and to help ensure high quality care and optimal health and wellness outcomes.</li> </ul>
<b>3. STRUCTURED USE OF A TEAM APPROACH</b>	<ul style="list-style-type: none"> <li>▶ Both physical health (PH) and BH providers are to the fullest practical extent physically located in same space.</li> <li>▶ A team-based, shared workflow is present, through which continuous communication and collaboration occur to carry out mutually-reinforcing and coordinated physical health and behavioral health care.</li> </ul>
<b>4. IBH STAFF COMPETENCIES</b>	<ul style="list-style-type: none"> <li>▶ Providers who are part of an IBH team must be able to coordinate care with external specialty providers and social services, collaborate with colleagues, engage patients effectively, and conduct motivational interventions.</li> </ul>
<b>5. UNIVERSAL SCREENING FOR THE MOST PREVALENT PH AND BH CONDITIONS</b>	<ul style="list-style-type: none"> <li>▶ In primary care, regular and universally applied screening for common mental health and substance use conditions that are both prevalent and associated with the costliest co-occurring illnesses ensures that BH conditions are detected and incorporated into treatment plans.</li> <li>▶ IBH programs located in BH settings must incorporate screens for common and costly physical health conditions.<sup>ii</sup></li> </ul>
<b>6. INTEGRATED, PERSON-CENTERED TREATMENT PLANNING</b>	<ul style="list-style-type: none"> <li>▶ Each person should have a single treatment plan that incorporates all PH and BH conditions, relevant treatment/recovery goals, and intervention plans.</li> <li>▶ The plan should be person-centered/directed, incorporating pertinent values, lifestyles and social contexts of the people who are obtaining health care.<sup>iii</sup></li> </ul>
<b>7. SYSTEMATIC USE OF EVIDENCE-BASED CLINICAL MODELS</b>	<ul style="list-style-type: none"> <li>▶ Successful IBH programs use a systematic clinical approach that targets the specific conditions prioritized for care in that setting.</li> <li>▶ All providers use well-developed and shared clinical pathways for co-occurring conditions that are rooted in practice guidelines and evidence-based practice.</li> <li>▶ Evidence-based health/wellness programming is readily accessible to patients.</li> </ul>

**NOTE:** The terms **PEOPLE**, **PATIENT**, **CLIENT**, and **CONSUMER** are utilized interchangeably throughout the document. Some terms are utilized more often in certain settings. We acknowledge varying perspectives on these terms.

## INTRODUCTION

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Integrated behavioral health (IBH) represents a fundamental change in both primary care and specialty behavioral health settings. Over time, IBH implementation efforts may result in behavioral health becoming routinely and seamlessly integrated into primary care services to the point that the distinction between physical health (PH) and behavioral health (BH) is replaced by an understanding that these two areas are fundamentally interdependent, and professionals no longer use the term “integration.”<sup>1</sup> To help practice settings make progress toward that goal and promote use of current best practice, providers, payers, and health care systems considering adopting or furthering their integration efforts need information about what works for the populations they serve. This report is intended as a road map for providers, funders, and policymakers. It describes the research to date as well as emerging ideas regarding the core components necessary for an organization to deliver effective integrated behavioral health care.

Among medical staff, IBH entails more routine attention to BH and skillful attention to behavioral aspects of what are typically considered “physical” disorders, such as insomnia, diabetes, obesity, and nicotine dependence. Similarly, in specialty BH settings that serve adults with serious mental illnesses, IBH has created a new understanding of the overall health of people being served and offers the potential to extend health, wellness, and life expectancy. IBH is helping providers and funders move past outdated understandings of health needs, intervention approaches, and limitations on the range of potential settings in which IBH can be successfully implemented. However, this shift to fully embrace IBH will have substantial and complex implications for health care financing, health care services, and workforce training.

## THE COMPLEX CHALLENGES OF INTEGRATED BEHAVIORAL HEALTH (IBH) IMPLEMENTATION

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Despite the promise of IBH and its vision of a holistic approach to meeting health needs, a number of persistent challenges continue to stall IBH implementation. Along with policymakers and payers, providers are not always certain which models or core components of IBH to adopt or implement. In addition, selecting IBH models and features can be complicated by challenges with sustainable financing.

Additionally, the workforce in both BH and PH settings is rarely sufficiently prepared to deliver integrated care. For all these reasons and more, payers on the primary care

side often express uncertainty about the cost-effectiveness of the more intensive (and expensive to deliver) IBH models.<sup>2</sup> Behavioral health providers and policymakers often wish to see IBH implemented but puzzle over how to pay for it. Although

*Although successful, sustainable, real-life implementation of IBH can be found in select settings, this remains the exception rather than the rule.*

successful, sustainable, real-life implementation of IBH can be found in select settings, this remains the exception rather than the rule.

Nevertheless, strong models of IBH are available for both primary care and specialty behavioral health settings. These models can be adopted with confidence once the needs of the groups being served are understood and the organizations implementing IBH are prepared to obtain or create the necessary BH and/or PH resources and supports.

# THE CORE COMPONENTS OF IBH

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Much of the literature on IBH has focused on the most important clinical and organizational capacities necessary to provide IBH. However, too often this has been presented more in broad, conceptual frameworks than in practical terms. In this report, we have drawn on a number of sources to propose seven crosscutting core components of IBH. The purpose of this report is to identify and describe these core components by identifying critical issues related to each and offering examples. When guided by current practice and research-based wisdom on what constitutes IBH, implementation of IBH models has a better chance of improving the quality and outcomes of care and ensuring a sensible approach to spending health care dollars. In describing these seven

components, we drew on two particular authorities: The Center for Integrated Health Solutions' (CIHS) IBH Integration Continuum, and the Agency for Healthcare Research and Quality's (AHRQ) principles concerning how IBH should be provided and supported. See Appendix A for an overview of each. In addition to these primary sources, we drew on several other publications and reports, as well as content experts in the field through key informant interviews. A list of these individuals can be found in Appendix B.

In defining the seven core components, we have attempted to home in on the most important features of IBH that need to be in place in order for providers to achieve its objectives.

**Each component is explained in the following sections, and recommended indicators for identifying the presence of each component are summarized in the IBH Implementation Indicators Checklist table at the end of this section on pages 9 through 11.**

## CORE COMPONENT 1

### INTEGRATED ORGANIZATIONAL CULTURE

#### What Does This Mean?

An integrated organizational culture promotes the delivery of effective and efficient integrated care in all areas of administrative and clinical practice. Organizational leaders communicate a convincing vision of what IBH looks

*An integrated organizational culture promotes the delivery of effective and efficient integrated care in all areas of administrative and clinical practice.*

like and what it can achieve in terms of greater health and wellness for the patient population. They inspire, motivate, and equip staff to develop greater IBH expertise.

#### Why Is This Considered a Core Component?

Organizational culture is a component that is easily overlooked in discussions that tend to focus on strategy, but, as management consultant Peter Drucker famously

noted, *culture eats strategy for breakfast*. At the core of successful and sustainable IBH programs is a culture that believes IBH is critical to achieving improved patient care and facilitates its implementation. A recent study by the AHRQ found that administrative leaders in health provider agencies who were nominated by their peers as exemplary in the area of IBH implementation ensured that the IBH perspective was instilled in all organizational functions.<sup>7</sup> Leaders worked to align clinical, operational and financial activities, and they created “buy-in” with staff at each management and practice level of the organization.<sup>8,9</sup> Unless embedded in organizational culture, IBH implementation may depend only on a few individuals and risks being short-lived and minimally effective.

#### Applying Integrated Organizational Culture in Practice

Leaders in integrated organizations enhance the agency's vision and mission statements and strategic plans to reflect core IBH values. For example, they often use more inclusive language to reflect goals related to “whole health,” or ensuring access to “holistic treatment,” or care that is inclusive of patients' “physical, mental, and social health.” Successful programs identify champions for IBH development and implementation who can effectively translate the mission and vision or put them into use in

ways that change the culture. Champions may include either *individuals* or existing *work groups*, but they should be situated throughout the organization and empowered to bring about change in specific ways. In addition, IBH is most successful when the agency has a formal training and development plan that includes training specific to IBH practice, and exemplary IBH programs highlight integration in assessing pre-hire readiness, at orientation, and across ongoing staff development. Leaders should also develop plans for incorporating IBH into staff performance evaluation, service delivery design and structure, quality improvement processes, health information systems, and strategic plans for collaboration and partnership.<sup>10</sup> Finally, successful agencies incorporate IBH-related measures into their ongoing continuous quality improvement (CQI) activities. Conversely, failure to include IBH clinical and administrative metrics in program quality review activities has been found to result in failures in IBH implementation.<sup>11</sup>

Additionally, IBH programs often represent collaborations between more than one agency. For example, many IBH programs for people with serious mental illness are jointly developed by community mental health centers and federally qualified health centers (FQHCs). In these and other collaborative arrangements, a successful partnership must have a common or shared mission and vision for IBH that enables both organizations to develop the kind of culture described above.

### Implementation Challenges and Considerations

One of the most difficult challenges in developing an integrated organizational culture is creating time for staff, especially direct care staff, to participate in the process of incorporating IBH into the organization's ongoing quality improvement process, clinical guidelines development, staff development, and program development. Many providers are under considerable pressure to maintain productivity and taking time from direct care duties (for example, billable services) is costly. Nevertheless, because IBH is not yet foundational to the way care is delivered, organizations that fail to make the necessary investments to sustain efforts may risk failure.

## CORE COMPONENT 2

### POPULATION HEALTH MANAGEMENT

#### What Does This Mean?

Population health management is “a set of interventions designed to maintain and improve people’s health

across the full continuum of care, from low-risk, healthy individuals to high-risk individuals with one or more chronic conditions.”<sup>12</sup> Best practice IBH programs assess and differentiate patients by their prevalent co-occurring conditions and utilization patterns. They routinely identify individuals who have these conditions, introduce the appropriate evidence-based treatment interventions, and track vital PH and BH outcomes. Patient registries and other health information technologies are used to manage outcomes across populations in order to apply the right interventions at the right time and to help ensure high-quality care and optimal health and wellness outcomes.<sup>13</sup>

#### Why Is This Considered a Core Component?

Implementing population health management is fundamental to realizing the coveted “Triple Aim” of improving the quality and patient experience of care in a cost-effective manner, and it is also essential to the cost-effectiveness and broader efficacy of IBH. Additional information on cost savings in IBH is provided in Appendix C. The importance of population health management within a provider agency is emphasized in the AHRQ research on model examples of IBH as well as in its academic literature review of IBH best practices in primary care settings.<sup>14, 15</sup>

#### Applying Population Health Management in Practice

*Understanding the Patient Population.* Effective population health management requires knowing the physical, mental and social needs of the patient population being served in as much detail as possible. However, understanding the prevalence of PH, BH and co-occurring conditions

*Effective population health management requires knowing the physical, mental and social needs of the patient population being served in as much detail as possible.*

in the population being served is sometimes a challenge for providers because they lack accurate data on the prevalence of BH and PH conditions until they implement universal screening (described under Core Component

#5).<sup>16</sup> To get started, providers can draw on national estimates of the overlap in BH and PH conditions. For example, we know that 29% of adults with ongoing medical conditions also have mental health disorders, while 68%

of adults with mental health disorders have ongoing PH conditions that require intervention.<sup>17</sup> Collaborating with payers to examine utilization patterns can also help the provider identify patient sub-groups with high need, complex and co-occurring PH/BH conditions (such as persons who overuse emergency room or EMS services).

*Matching Patients to Appropriate IBH Models.* Strong population health management requires differentiating interventions based on the patient’s needs. The Four Quadrant Model is a useful framework with which to organize a providers’ understanding of the various combinations of high- and low-severity health and behavioral health conditions, and, ultimately, to plan for the appropriate and efficient implementation of evidence-based IBH models.<sup>18</sup> We modified the model to include high, medium and low severity levels, as noted in the table below. For example, people with serious mental illnesses (SMI) and co-occurring physical health conditions benefit from receiving IBH in the specialty behavioral health settings with which they are familiar (Q-II and Q-IV). However, only some people with SMI need an intensive team-based intervention, such as a multi-disciplinary Behavioral Health Home (Q-IV).

Patient registries are databases with comprehensive clinical information on patients with long-term or complex PH and BH conditions. Registries can be used to improve treatment engagement (e.g., appointment reminders and health indicator tracking) as well as provide a basis for outcome and quality improvement efforts.

*Data Sharing and the Development of Data Portals.* Developing the capacity to share clinical data in “real time” with other providers in the health care neighborhood—including hospital and emergency room (ER) providers—is also key. For example, being able to immediately provide (or receive) data on the specific medications a person is receiving when that individual arrives at an ER can help avoid clinical errors and improve care quality. Such data can also inform cost-effectiveness analysis across levels of care, as noted below.

*Tracking of Quality and Outcomes.* Exemplary IBH programs routinely collect and analyze quality, outcomes, and cost data.<sup>20,21</sup> Examination of data from screenings, assessments, and re-assessments of vital physical and behavioral health indicators in patients receiving IBH will enhance an agency’s understanding of risk/severity

**INDICATED IBH MODELS WITHIN A MODIFIED FOUR QUADRANT MODEL FRAMEWORK**

CARE SETTING	LEVELS / SEVERITY OF BEHAVIORIAL HEALTH AND PRIMARY HEALTH CONDITIONS	
Primary Care Setting	QUADRANT I (BH: LOW, PH: LOW TO HIGH)	QUADRANT III (BH: MEDIUM, PH: LOW TO HIGH)
	<i>Essential Integrated Care—Primary Care Behavioral Health Model</i>	<i>Intensive Integrated Care—Collaborative Care Models</i>
Specialty Behavioral Health Setting	QUADRANT II (BH: HIGH, PH: LOW/MEDIUM)	QUADRANT IV (BH: HIGH, PH: HIGH)
	<i>Essential Integrated Care—Behavioral Health Primary Care Model</i>	<i>Intensive Integrated Care—Behavioral Health Home</i>

In primary care settings, the Primary Care Behavioral Health (PCBH) model, which employs a BH consultant embedded with primary care providers, can be used with most patients who have low severity behavioral health conditions (Q-I). But for those who have moderately severe or difficult to treat BH conditions (Q-III), the Collaborative Care Model (CCM), a more intensively staffed team-based approach, may be needed.

*Patient Registries.* IBH best practice includes the use of patient registries as the hub(s) for tracking and managing the clinical care of people with long-term and/or co-occurring PH and BH conditions that require monitoring.<sup>19</sup>

levels across the patient population, enable it to examine outcomes over time,<sup>22</sup> and improve care for individuals who are high utilizers of emergency and hospital services.<sup>23</sup> Advanced IBH providers can develop a sophisticated understanding of the amount and mix of IBH services needed to achieve reasonable and clinically relevant outcomes, sometimes referred to as “treat-to-target trajectories,” for each PH or BH condition, as well as for prevalent co-occurring conditions.<sup>24</sup>

**Implementation Challenges and Considerations**

The necessary staff expertise for population health management is not always present, and implementing

population health management may require greater investment in CQI/evaluation staff. Larger agencies may be able to develop necessary staff expertise through the training of existing staff, but even training has a cost. Solutions include collaborating with payers and building data collection and analysis into existing clinical and administrative processes. Smaller agencies can band together within a region to develop capacity.

A second challenge is locating and paying for the health information technology (HIT) needed for population health management. In their oversight of the Primary Behavioral Health Care Integration national grant program,

SAMHSA found that many grantees did not have the HIT infrastructure to use population health management, so SAMHSA decided to add supplemental HIT grants in order to help providers develop capacity. Electronic health record (EHR) software tends to lag behind IBH developments, so

*Electronic health record (EHR) software tends to lag behind IBH developments, so primary care providers often find it difficult to integrate behavioral health fully in the EHR, and vice versa in behavioral health settings.*

primary care providers often find it difficult to integrate BH fully in the EHR, and vice versa in BH settings. In fact, one of the major challenges for providers to achieve true integration is to have a robust electronic health record (EHR) where all health data are accessible to a provider in real time in a single record. For population health management to be most effective, a single EHR that can be used to track all health conditions must be available.<sup>25</sup>

### CORE COMPONENT 3

#### STRUCTURED USE OF A TEAM APPROACH

##### What Does This Mean?

A structured team approach means that workflows are shared, that there is a set of working relationships through which the health care team continuously communicates and collaborates in the service of carrying out simultaneous, mutually reinforcing, and coordinated PH and BH care.

##### Why Is This Considered a Core Component?

Implementing IBH fundamentally involves taking on the complexity of co-occurring PH and BH conditions, and a single provider rarely is capable of effectively addressing it alone. Researchers have identified collaboration in the form of continuous communication and careful integration of BH and PH expertise in planning and delivering care—that is, good teamwork—as an important predictor of good health outcomes.<sup>26</sup>

##### Applying the Structured Use of a Team Approach in Practice

Two dimensions of collaboration are evident in successful IBH programs: (1) structured provider relationships to promote successful collaboration and (2) a focus on high-performing teams.

*Structuring relationships to promote collaboration and teamwork.* Successful IBH programs “embed” BH providers within primary care clinics—and PH providers within specialty BH settings—by structuring the workflow and environment to promote ongoing, real-time collaboration. This is done through establishing daily team meetings (e.g., a “morning huddle”); ensuring that the health care team can communicate their assessment findings and person-centered treatment goals through the integrated record; creating protocols for “warm handoffs”; and creating a culture that encourages frequent, informal “water cooler” and “curbside” consultation and conversations.

*The characteristics of high-functioning teams.* The potential of continuous collaboration is optimized if the characteristics of high-functioning teams are present,<sup>27</sup> including:

- 1) Sharing the same vision and sets of goals for IBH
- 2) Understanding each team member’s role
- 3) Enjoying mutual trust
- 4) Communicating and resolving conflict effectively
- 5) Regularly reviewing and discussing program outcomes and performance<sup>28</sup>

It is vital that IBH providers periodically assess the extent to which teams are developing these qualities and that management applies tools that help them enhance team functioning in these areas.<sup>29</sup>

Peer/recovery specialists also have an important role to play in IBH, particularly in specialty BH settings and in the person-centered healthcare home (PCHH) model in which they are required team members. Peer-developed and -delivered health and wellness approaches, such as

Whole Health Action Management, are now available and hold great promise for enhancing health and wellness outcomes in IBH.<sup>30</sup>

### Implementation Challenges and Considerations

Hiring or appointing the right personnel for IBH is one of the most difficult challenges to maintaining high-functioning integrated care teams.<sup>31</sup> Often, agencies find that training and developing team members who are relatively new to their profession is more effective in establishing an IBH-orientated culture and instilling collaborative care practice habits. Other methods include using targeted training and recruitment of IBH-ready clinicians from academic programs with curricula and degrees tailored to integrated care/collaborative care practice, and collaborating with local universities to develop such programs.

Another challenge is the development of a shared language for care that bridges the PH and BH worlds. In practice, this often means that BH providers in primary care settings need to adopt the language of the PH world (e.g., use of the term “patient”) and vice versa. However, successful IBH providers also explicitly develop a common IBH language that facilitates clinical interaction and collaboration.<sup>32</sup>

## CORE COMPONENT 4

### IBH STAFF COMPETENCIES

#### What Does this Mean?

Successfully implementing IBH requires “distinctive knowledge, skills, and attitudes, with specific training required for their attainment.”<sup>33</sup> These include, for example: the ability to quickly establish rapport with consumers/patients and their families; the capacity to function as a member of a multidisciplinary team and to skillfully coordinate care within the team and with external specialty and social service providers; and the knowledge and skills necessary to assess the patient’s stage of change and create interventions that correspond to the patient’s current state of readiness.

#### Why Is This Considered a Core Component?

The concept of team was emphasized in the last component. However, a team is only as good as its members and the *blend* of players who make up the team. It is important to invest in the right people and continue to support their ability to effectively carry out IBH. Kathol and colleagues warn, “low-cost but undertrained clinicians are a poor investment unless linked to ways in which they can support

application of evidence-based approaches to treatment in those with behavioral health conditions.”<sup>34</sup>

### Applying IBH Staff Competencies in Practice

SAMHSA-HRSA’s Center for Integrated Health Solutions’ *Core Competencies* document for IBH notes that the ability to quickly establish rapport with consumers/patients and their families and the capacity to function as a member of a multidisciplinary team (that includes

*Behavior change and developing the capacity for managing their illnesses are primary needs for people presenting with physical health and behavioral health conditions.*

consumers/patients and family members as well as other providers) are two “core competency categories.”<sup>35</sup> Because behavior change and developing the capacity for managing their illnesses are primary needs for people presenting with PH and BH conditions, whether or not a primary care setting is staffed with a behavioral health consultant (BHC), all staff members should also develop the basic ability to

assess the patient’s stage of change and match planned interventions to that stage. Motivational interviewing, an evidence-based intervention that incorporates an understanding and acceptance of a patient’s stage of readiness for change, is an approach that all staff should know how to use, particularly with patients who are in early stages of change (e.g., pre-contemplation, contemplation). This approach to assessing and motivating behavior change dovetails with person-centered planning because it draws on patients’ own goals to inform treatment decisions.

Additionally, because many IBH patients, particularly those in safety net settings, have multiple health conditions as well as social services needs (e.g., finding safe and affordable housing or child care), the skills and training of the IBH team should intentionally include the ability to provide coordination of needed medical and social services.

### Implementation Challenges and Considerations

It can be difficult for practitioners of all professions to unlearn the habits they have accrued from years of training in non-integrated models and from working in isolation from other providers. It can also be a challenge to change perceptions of fellow providers’ roles and beliefs about one’s own “turf.” Often, reward structures and staff

incentives are based on individual performance, not team performance, and productivity, not value and positive outcomes for consumers/patients. Reinforcing the desired IBH staff competencies may require change across many facets at the organizational level even after the right people are hired and trained.

## CORE COMPONENT 5

### UNIVERSAL SCREENING FOR PH AND BH CONDITIONS

#### What Does this Mean?

Just as vital signs such as blood pressure and body temperature help detect and monitor medical problems, behavioral health screening tools can act as “vital signs,” helping to detect and monitor behavioral health problems. Like physical health vital signs, they should be universally used. Universal application of screening for the entire population for which the tool is indicated removes the requirement that patients take the initiative to disclose and reduces the risk of providers failing to identify patients in need of behavioral health services. At a basic level, effective integrated care means regularly screening all patients for behavioral health issues in primary care settings and for physical health issues in behavioral health settings.

#### Why Is This Considered a Core Component?

Early detection and intervention is an important factor in the successful treatment of behavioral health conditions. In many IBH settings (particularly primary care), the behavioral health needs of clients are typically in the mild to moderate range, often involving depression and/or anxiety. Universal screening is a key tool in identifying these behavioral health needs, because mild to moderate conditions often go unnoticed by providers (even those who consider themselves adept at spotting these issues), and primary care patients rarely describe themselves as anxious or depressed and instead tend to present with complaints such as fatigue, headache, or backache. Because patients with mild to moderate behavioral health disorders rarely self-report, providers need to proactively identify behavioral health needs in their patients if they are to succeed in early detection and intervention to prevent conditions from becoming more severe. The use of universal screening tools for behavioral health issues helps to normalize and de-stigmatize behavioral health conditions among both patients and providers by regularly asking questions about mental health needs.

#### Applying Universal Screening in Practice

Universal screening tools identify the patients that may need further assessment and possible treatment. The selection of which tool(s) to use is driven by client age and clinical profile. Frequently used universal screening tools include the Patient Health Questionnaire 9 (PHQ-9), or the Generalized Anxiety Disorder 7 (GAD-7), or simplified versions of those tools. While universal screening tools assist with identification, they can also be used for ongoing monitoring to measure response to treatment, which is critical in the goal of *treating to target*. Once completed, if the scores exceed an established threshold (e.g., a score of 10 or greater for the PHQ-9), then further assessment is done to determine whether treatment is warranted.

IBH settings can employ universal screenings in a variety of ways. The PHQ-9 can be completed by patients in the waiting room prior to each visit. Additionally, the PHQ-9 can be used as both an identification and an ongoing tracking tool. Alternatively, some IBH settings include a shortened version of the PHQ-9, either the PHQ-2 or the PHQ-4, as part of each primary care visit, the results of which are collected and tracked like traditional vital signs are. Positive responses trigger the use of the more extensive PHQ-9 and then additional assessment as necessary.

In specialty behavioral health settings that serve people with serious mental illness and related conditions, providers need to routinely screen for prevalent PH conditions. The nationwide Primary and Behavioral Health Care Integration grant program, promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA) uses a robust screening regimen that includes screens for hypertension, hyperlipidemia, smoking (and breath CO<sub>2</sub>), obesity, substance use, and elevated blood glucose (e.g., A1c) levels, among others.

#### Implementation Challenges and Considerations

To ensure that a clinical practice embraces the use of universal screening tools, clear expectations must be set with the staff charged with administering the tool. If the tool is completed in the waiting room, the workflow of support and clinical staff needs to account for the administration, collection, and follow-up of this information. Clinic leadership plays a key role in establishing expectations and promoting the culture around this component. In considering the role of screening tools in measuring the vital signs of behavioral health, a clinic’s quality program should incorporate and track the appropriate use of BH screening tools as a key metric. Findings of sub-par performance should serve as triggers for en-

hanced provider education. For example, a clinical quality strategy would require regular chart reviews that evaluate the completeness of all recommended elements of a visit, including BH screening tools. Screening can also influence the interaction between providers and patient, as providers will need to actively communicate with patients about when, how much, and whether active treatment is the best course of action.

A positive screen does not always indicate the need to intervene. Like physical health care, a “watch and wait” stance is sometimes an appropriate response when there is low acuity/risk and when this is consistent with the patient’s desires. Additionally, positive screens are sometimes chiefly related to situational issues (e.g., domestic violence or unsafe housing). In these cases, the intervention may take the form of helping to connect the client to resources that remedy the situational issue before considering a medical intervention.

## CORE COMPONENT 6

### INTEGRATED, PERSON-CENTERED TREATMENT PLANNING

#### What Does This Mean?

Integrated, person-centered treatment planning means that patients receiving IBH have only one treatment plan that incorporates all PH and BH conditions, treatment/recovery goals, and intervention plans. The plan should incorporate the values, lifestyles, and social contexts of the person obtaining health care; it should reflect the fact that providers are “doing things *with* people, rather than *to* them.”<sup>36</sup>

*The treatment plan should reflect the fact that providers are “doing things with people, rather than to them.”*

#### Why Is This Considered a Core Component?

Shared decision-making and person-centered planning are emerging as important components of best practices in behavioral health care.<sup>37</sup> In part because difficulty talking about BH among both providers and patients (related to stigma or other barriers) tends to cause many patients to avoid seeking needed behavioral health care, engaging patients in the processes of defining their clinical needs, identifying goals for treatment, and choosing treatments becomes a vital aspect of ensuring active and ongoing participation in care.<sup>38</sup>

### Applying Integrated Person-Centered Treatment Planning in Practice

IBH best practice includes the development of fully integrated treatment plans that are housed in one electronic health record. As the AHRQ noted, best practice for patients with co-occurring conditions is to have one PH/BH treatment plan (not two or more).<sup>39</sup> A person-centered treatment planning process also offers an opportunity to empower both the patient and the provider. Engaging patients in the process of producing the precise phrasing of goals and objectives validates and elevates their roles so that they are seen as critical members of the care team. Other specific person-centered practices may include a treatment plan that includes a signature page that confirms the patient’s agreement with the plan. Some practices have found sharing the EHR screen with patients to be an effective way to enhance engagement in the treatment process and promote activation. Patients and their providers can also collaboratively review assessment and laboratory results, along with other aspects of care and treatment, in addition to the treatment plan.

#### Implementation Challenges and Considerations

Person-centered planning sometimes requires a shift in mindset, from an implicitly hierarchical understanding of the clinical relationship to a partnership model that is capable of activating the patient to pursue optimal health, wellness, and quality of life outcomes. For this reason, training on such topics as “person-centered planning,” “patient activation,” and “motivational interviewing” in a formal IBH training and staff development plan will be vital to supporting actual implementation of person-centered approaches, versus mere lip service to the notion of a more collaborative model.

## CORE COMPONENT 7

### SYSTEMATIC USE OF EVIDENCE-BASED CLINICAL MODELS

#### What Does This Mean?

Successful IBH programs use a systematic clinical approach with shared clinical protocols and guidelines that incorporate BH and PH conditions. Models vary, but the common component is that providers use well-developed and shared clinical pathways for co-occurring conditions that are rooted in practice guidelines and evidence-based practice. Evidence-based illness management interventions and health and wellness programming, which help people gain more control over their lives and make behavior changes, are readily accessible to patients.

### Why Is This Considered a Core Component?

Fundamental IBH practices, such as co-location and collaboration among staff and implementation of an integrated treatment record, pave the way for more effective care and better outcomes. However, unless IBH programs use evidence-based and best practice PH and BH interventions, and adhere to the best practice guidelines and elements of those evidence-based models, better outcomes and more cost-effective care will not be achieved.

### Applying Evidence-Based and Practice-Based Interventions in Practice

There are at least two levels of evidence-based practice in the implementation of IBH. First are the evidence-based *models* of IBH, such as the Primary Care Behavioral Health model<sup>40</sup> and Collaborative Care Model.<sup>41</sup> Second, there are specific, often overlapping, practices utilized within the models. For example, in primary care, IBH approaches such as the Primary Care Behavioral Health model incorporate brief interventions that are consistent with the culture and productivity demands of primary care. Drawing solution-focused techniques from cognitive-behavioral therapy, motivational interviewing, and illness management, BH specialists meet with patients in 20- to 30-minute sessions to help them experience rapid relief from symptoms, develop their own capacities to gain control over their illnesses, and achieve higher levels of functioning and quality of life.

IBH care in the specialty behavioral health setting overlaps with the implementation of behavior-related interventions for physical health problems. PH and BH specialists work together to help the entire organization develop a way to simultaneously implement evidence-based health and wellness interventions that promote behavior and lifestyle changes associated with greater activity and exercise, weight reduction, nutritious diets, and reduced

tobacco use. Overlapping interventions, which would also include motivational interviewing and illness management, should be available in both settings. However, in specialty behavioral health settings, providers draw on evidence-based and best practice interventions, such as Wellness Recovery Action Planning and Whole Health Action Management that were developed specifically for people with serious mental illnesses.<sup>42</sup>

### Implementation Challenges and Considerations

It is one thing to adopt evidence-based practices, but it is another thing altogether to implement them with fidelity to the core elements that are known to be clinically effective. The need for fidelity assessment was highlighted by

*It is one thing to adopt evidence-based practices, but it is another thing altogether to implement them with fidelity to the core elements that are known to be clinically effective.*

SAMHSA's evaluation of IBH in behavioral health settings. Many grantees in SAMHSA's program used smoking cessation and weight-related evidence-based practices, but they failed to show improvement compared with control groups, which suggests that they did not implement these practices consistently.<sup>43</sup> Implementation of evidence-based practices

requires a commitment to training staff and periodically assessing fidelity. The latter will cost organizations either time or money, but if not used, outcomes will be weaker. IBH programs can find creative ways to partner with trainers and evaluators (e.g., obtaining grants, engaging in practice-based research, etc.) or they can utilize inexpensive self-assessment tools such as the COMPASS PH/BH.<sup>44</sup>

## IBH IMPLEMENTATION INDICATORS CHECKLIST

### 1. INTEGRATED ORGANIZATIONAL CULTURE

- ▶ Is IBH integrated into the organization's most important documents (vision, mission and value statements; strategic plans)?
- ▶ Do program descriptions describe the quality and access to services for patients with complex needs, including co-occurring BH/PH conditions?
- ▶ Do promotional materials and signage use inclusive language and images for patients with complex physical and behavioral health needs?

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**1. INTEGRATED ORGANIZATIONAL CULTURE [ CONTINUED ]**

- ▶ Does the documentation of administrative policies and procedures reflect IBH (billing instructions for staff, confidentiality statements, communication with external partners)?

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- ▶ Has the organization established an IBH quality improvement team, which ideally includes multilevel, multidisciplinary staff and collects quality and milestone data related to IBH?

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- ▶ Do staff development, hiring practices, and performance evaluations explicitly include robust attention to IBH?

**2. POPULATION HEALTH MANAGEMENT <sup>45, 46</sup>**

- ▶ Does the IBH provider have a quantitative understanding of the patient population—its BH and PH conditions and utilization patterns and costs?

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- ▶ Does the provider match patients to appropriate interventions, including intensive, team-based interventions for those people with more severe conditions and/or high utilization of costly services?

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- ▶ Does the provider use an integrated treatment plan, housed in an electronic health record (EHR)?

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- ▶ Does the provider maintain a patient registry, ideally linked to its EHR, that allows for individual- and group-level tracking and analysis of services?<sup>47, 48</sup>

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- ▶ Does the provider use data portals and other mechanisms to share data with other providers in the health care neighborhood (emergency rooms, hospitals, specialty providers)?

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- ▶ Does the provider use ongoing analyses of carefully selected quality, outcome, and cost metrics within a continuous quality improvement (CQI) paradigm?

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- ▶ Does the provider include staff (and, ideally, consumers/patients) in the CQI process?

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- ▶ Does the provider incorporate population health management reports (produced from patient registries) into regular IBH quality improvement team meetings?

**3. STRUCTURED USE OF A TEAM APPROACH**

- ▶ Does the IBH program structure and organize provider relationships and communication to promote successful collaboration and care coordination?

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- ▶ Do PH or BH providers continuously communicate at every stage of treatment, from assessment to planning and the ongoing provision of care?

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- ▶ Are the characteristics of high-functioning teams manifested in PH and BH providers' attitudes and behaviors?

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- ▶ Do providers who serve people with more severe and complex co-occurring conditions use intensive multidisciplinary teams, including peer specialists, to meet their needs and reduce high utilization?

**4. IBH STAFF COMPETENCIES**

- ▶ Does the provider have the capability to quickly build rapport with consumers/patients?

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- ▶ Does the provider have the ability to work effectively as part of an inter-professional team and successfully coordinate care with external providers?

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- ▶ Do all clinicians have the basic ability to assess the patient's stage of change and match planned interventions to that stage?

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- ▶ Do all clinicians have basic proficiency in motivational interviewing?

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## 5. UNIVERSAL SCREENING FOR PH AND BH CONDITIONS

- ▶ Do primary care clinicians use widely accepted BH screens, such as the PHQ, with all patients?
- ▶ Do specialty behavioral health clinicians universally screen people with mental illnesses on core health indicators, such as BMI, tobacco use, blood pressure, and blood glucose?
- ▶ Does the IBH provider have policies, procedures, and training mechanisms in place that clarify universal screening methods and ensure they are used in clinically accurate and effective ways?

## 6. INTEGRATED PERSON-CENTERED TREATMENT PLANNING

- ▶ Is the provider's treatment plan completely integrated, with BH and PH conditions, goals, and planned treatments included in the same record?
- ▶ Do the provider's policies promote the use of person-centered and shared-decision making models of care and invite the person into an active treatment partnership?
- ▶ Does a representative sample of records indicate that BH and PH goals are chosen by patients and articulated in their own words? (Is "boilerplate" language used only sparingly?)

## 7. SYSTEMATIC USE OF EVIDENCE-BASED CLINICAL MODELS - INDICATORS

- ▶ Are staff trained in evidence-based practices and do they regularly implement them in response to patients' BH and PH needs?
- ▶ Do integrated treatment plans regularly reflect the use of evidence-based practices (EBPs) for the appropriate PH and BH conditions and match interventions to patients' stages of change?
- ▶ Are best practice guidelines, including medication algorithms, psychosocial EBPs, and wellness EBPs, incorporated into the EHR so that they are universally available to all staff?
- ▶ Does the provider periodically assess the fidelity of its EBP implementations?

### Assessment of IBH Outcomes

The ultimate goals of IBH include improving outcomes for people served while lowering or containing costs. The number and variety of potential outcome measures is vast. Given that programs do not have unlimited resources, they should focus on two key questions: *Which outcomes do our payers and other key constituents want to see (accountability focus)?* And, *which outcomes do we need to track in order to gauge how well we are doing and make program enhancements (quality improvement focus)?* The former question refers to the need to establish accountability and the latter to the need to inform a continuous quality improvement process.

Various systems for measuring performance and outcomes have been developed, including, for example, the frequently used Healthcare Effectiveness Data and Information Set (HEDIS) system.<sup>49</sup> Most approaches over-emphasize process measures, even though they do often include some outcome measures. Although process

measures can be useful (in particular, certain administrative metrics and measures of fidelity to the chosen IBH model), whenever possible, scarce resources should primarily focus on developing ways to measure health/wellness and cost-effectiveness outcomes.

Teams implementing person-centered health homes in specialty BH settings and person-centered medical homes in primary care should meet regularly (e.g., quarterly) to review outcome indicators and establish priorities for program enhancement. The key is that data are actually reviewed and program enhancements identified and implemented. For example, targeted changes (e.g., moving toward personal coaching for health and wellness instead of an exclusive emphasis on educational interventions) can often be instrumental in achieving better outcomes and can only be identified through regular review of program results.<sup>50</sup>

*Additional detail on measuring outcomes and assessing fidelity can be found in Appendix D.*

# FINANCING INTEGRATED PHYSICAL AND BEHAVIORAL HEALTH CARE PRACTICES

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## OVERVIEW

As practices consider restructuring to offer integrated physical and behavioral health care, it is important to understand the context of the financing environment. The rules, challenges, opportunities, and threats to financing integrated care practices often vary by payer environment and practice model.

Any discussion on financing must take into consideration the setting, whether it is based in behavioral health care or primary care, either at a federally qualified health center (FQHC) or a non-FQHC primary care practice. The type of entity billing for integrated care impacts the reimbursement strategies and options available to the provider. Integrated care practices are most commonly led by FQHCs, primary care practices, or community mental health centers (CMHCs). Despite some promising emerging models, the historical financing of these distinct entities, particularly in Medicaid, impacts the process and price for reimbursement and continues to perpetuate in most instances a fee-for-service model and traditional delivery patterns.

There are increasing opportunities for integrated practice sites to enhance the financial sustainability of the clinical model through new contractual arrangements with managed care organizations. While the shift away from fee-for-service of Texas Medicaid and Healthcare Partnership-specified services has been slow in the managed care environment, the requirements for this type of innovation are included in Texas Medicaid managed care contracts today. A concerted effort on the behalf of well-educated and well-organized providers is needed to move the system forward in a way that supports integrated care.

Many of the technical glitches around financing that existed in the early days of integrated care have been resolved through coordinated work of the state, providers, and managed care organizations (MCOs). The next level of integrated financing is likely to be more difficult to achieve and will require a clear understanding of the existing barriers and creative solutions to move to integrated, holistic payment models.

## STRATEGIES FOR FINANCING IBH IN TEXAS

In Texas, the majority of Medicaid beneficiaries are covered through the Medicaid managed care program. Although the framework for the program is based on a fee-for-service (FFS) model—in which services are unbundled and paid for separately, and payment is dependent on the *quantity* of care, not the *quality*—the program is not restricted to operating on FFS policies or rates. As we discuss the rules for the Medicaid program, it is important for payers and providers to remember the managed care program allows for great flexibility to meet the needs of its members.

Since financing options depend upon the setting in which IBH is delivered, either at a FQHC or a non-FQHC primary care practice, we discuss these issues by setting. This discussion also is framed in terms of what is typical, knowing that sometimes there are exceptions.

## HOW DOES THE PROVIDER TYPE IMPACT FINANCING OF INTEGRATED PRACTICES?

The type of entity billing for integrated care impacts the reimbursement strategies and options available to the provider. Integrated care practices are most commonly led by FQHCs, primary care practices, or CMHCs. The historical financing of these distinct entities, particularly in Medicaid, impacts the process and price for reimbursement for what is often the same service.

### Federally Qualified Health Centers

FQHCs are designated to receive Medicare and Medicaid payments through the federal Prospective Payment System (PPS), a methodology based on the average of each FQHC's reasonable costs. This model pays a PPS or flat minimum rate per person per day of service regardless of the number of services offered in the encounter. These PPS payment rates are higher (often significantly) than the Texas Medicaid and Healthcare Partnership (TMHP) fee schedule for like services provided by an entity other than an FQHC. In addition to the PPS rates, FQHCs have specific billing rules that allow for an additional BH encounter in an FQHC on the same day that a PH encounter is billed.<sup>51</sup>

When patients have Medicaid coverage, the FQHC PPS system provides a significant source of funding that is designed to cover the complete costs of care. For the uninsured, FQHCs have access to federal grants and discounted medication pricing. This makes FQHCs an ideal partner in collaborations around integration if the patient population has a large percentage of Medicaid or uninsured clients.

### Community Mental Health Centers<sup>52</sup>

For Medicaid/Children's Health Insurance Program (CHIP) patients, CMHCs bill primarily through MCOs per negotiated contracts and to a diminishing degree through TMHP per the state's fee schedule. CMHCs are considered comprehensive service providers; therefore, they have access to funding for mental health rehabilitative services and targeted case management when the patient's acuity meets certain requirements. These services can help support an office-based team through care coordination and home-based visits.

For the uninsured or under-insured, CMHCs receive state general revenue funding for behavioral health services when a person meets the state's clinical criteria. This does not provide an option for primary care funding. Some CMHCs do receive funding that includes both primary and behavioral health services for low-income uninsured individuals through the Texas 1115 Waiver. The 1115 Waiver Delivery System Reform Incentive Payment (DSRIP) program has been a primary source for expanding IBH for adults with serious mental illness.

### Community Primary Care Physicians

Primary care physicians based in the community without FQHC status or affiliated with a public hospital only have access to Medicaid funding available through negotiated MCO contracts (primarily) or the TMHP FFS schedule. This creates a financing disadvantage when attempting to establish integrated care.

## HOW DOES THE TEXAS MEDICAID PROGRAM IMPACT FINANCING OF INTEGRATED PRACTICES?

**T**exas Medicaid rules for reimbursement for covered services vary by the type of Medicaid program, whether FFS or managed care, and within managed care, where rules and rates may vary by MCO. These differences create opportunities and challenges for operating integrated practice sites. Within the Texas Medicaid program, the state operates the TMHP, a traditional fee-for-service program. This program now accounts for less

than 15% of all Medicaid beneficiaries, and that number is expected to decline. In this program, the Health and Human Services Commission (HHSC) sets the fee schedule and reimbursement rules for providers.

The majority of Medicaid beneficiaries are served by the Medicaid managed care program, where HHSC contracts with an MCO. The MCO then sets rates and rules for reimbursement directly with providers. MCOs for the most part continue to follow the TMHP fee schedule and reimbursement rules, which significantly limits the capacity to provide IBH (and to an increasing degree, care more broadly). However, MCOs have the flexibility to create their own fees and rules through negotiation with providers. Although not exhaustive, the following information outlines some financing issues providers should consider if they intend to operate an integrated care site for Medicaid beneficiaries in Texas.

If the MCO has an integrated plan (meaning one contract for both physical and behavioral health), one potential issue involves system checks to prevent duplicate billing. As long as the specialty type of provider (e.g., primary care provider versus BH provider) and diagnosis of the member differ, billing two of the same codes on the same day should not cause denials. In order to prevent denials and potential billing issues, the provider should proactively discuss the integrated site's program model with the MCO and work with the MCO to define appropriate billing criteria prior to accepting the MCO's members.

When the MCO subcontracts with a behavioral health organization (BHO), the provider must negotiate two separate contracts. This decreases the potential issues with duplicate billing for PH and BH, but requires more time on the front end to negotiate contracts and rates given that there are two contractually linked, but separate, entities managing the care. In addition, there is potential for issues in which the BHO denies a claim as medical, and the MCO denies the claim as behavioral health. As an example, reimbursement for injectable medications has been a problem with some MCOs. When this occurs, providers should request a joint meeting with both the MCO and BHO to discuss such crossover claim issues.

Additionally, HHSC has added a set of Health and Behavior Assessment and Intervention (HBAI) services to the Medicaid State Plan. HBAI services are used to identify and address the psychological, behavioral, emotional, cognitive, and social factors important to the treatment and management of physical health problems. HBAI is an established intervention designed to enable the consumer to overcome the perceived barriers to self-management of his/her chronic disease(s) and can be an integral part of an

effective IBH program. The HBAI services are a covered benefit for children who are 20 years of age and younger. This benefit was implemented by TMHP and MCOs in 2014. HBAI services are provided by a licensed therapist, who is co-located in the same office building or complex as the client's primary care provider.<sup>53</sup>

Integrated practice sites should determine the appropriate use of these services to support the practice. In addition, MCOs can choose to cover these services for adults in order to appropriately manage care. Providers

serving adults who have Medicaid coverage in an IBH program should include in their discussion and contract negotiations with MCOs a request to receive reimbursement for HBAI services.

Typical payments by TMHP and MCOs do not cover many important elements of integrated care sites such as doctor-to-doctor consultation, wellness programs, patient education, and care coordination. The concept of health homes, which has been included in the MCO contracts with HHSC, offers a model of care and financing to support these critical ancillary functions. However, to date, few (if any) integrated care sites have been successful in creating health home payment structures with Texas MCOs.

Care coordination is also a critical component in an integrated practice, but it is difficult to receive payment

*Providers serving adults who have Medicaid coverage in an IBH program should include in their discussion and contract negotiations with MCOs a request to receive reimbursement for Health and Behavior Assessment Intervention services.*

for this service in the TMHP environment. In both TMHP and MCOs, comprehensive service providers can bill targeted case management for specified individuals based on the outcome of a required assessment, but for most Medicaid enrollees, the MCOs have the flexibility (as well as the direction) from HHSC to reimburse health homes through value-based payments, which can include a care coordination fee for the integrated practice.<sup>54</sup> It is unclear the extent to which MCOs are currently using value-based payments with integrated care sites, but interviews with key informants suggest that it is highly limited and more theoretical than actual.

The Texas STARKids program becomes operational in September 2016 for children who receive supplemental security income (SSI) or are enrolled in the Medically Dependent Children Program (MDCP). In STARKids, the MCO must develop incentive programs for designated providers who meet the requirements for patient-centered medical homes.<sup>55</sup> STARKids also requires health homes be provided to all members.<sup>56</sup> These requirements have the potential to more fully support the scope of work necessary for successful integrated practice sites, compared with the existing financing models. However, MCOs and providers must work together to develop the IBH capacity and funding models to support them.

In summary, financing of integrated care requires a careful examination of the type of insurance coverage connected to the patient population in order to maximize available revenue and identify ideal partners. As noted earlier, if a significant portion of the patient population has Medicaid, then using or partnering with an FQHC will help to build a more sustainable revenue base. Additionally, because managed care is the platform on which Texas delivers almost all community-based Medicaid services, exploring the flexibility offered to managed care plans to set different rates or pay for non-traditional services is also an important vehicle for financial sustainability.

## APPENDIX A:

# AUTHORITIES INFORMING SEVEN CORE COMPONENTS OF IBH

### THE SAMHSA/HRSA CIHS INTEGRATION CONTINUUM

In 2013, SAMHSA developed the “Standard Framework for Levels of Integrated Healthcare” for the agency’s Center for Integrated Health Solutions (CIHS). The framework identifies six different levels of implementation that follow a continuum from collaboration to integration.<sup>57</sup> The following table summarizes the six key levels of implementation and “key differentiators” of the Standard Framework. Following this, the table also summarizes five cross-cutting domains of clinical and organizational functioning that should be considered in addressing integration, each of which can reflect varying degrees to which a provider has implemented or supported a collaborative, integrated model.

The framework groups the developmental levels within

three overarching categories—coordinated, co-located, and integrated care—and then further refines each category into two levels to create a six-level continuum of integration. For instance, *frequency of communication* is described as a critical distinction within levels of coordinated care. As communication frequency increases, *physical proximity* becomes the critical distinction for practices moving from coordinated care (levels 1 and 2) to co-located care (levels 3 and 4). Lastly, *practice change* (integration orientation by all systems, leadership and providers) is the hallmark of integrated care levels 5 and 6.

At this time, there is insufficient evidence to associate specific health outcomes to a particular level of integration,<sup>58</sup> which may be due to the fact that IBH is still relatively new, and it represents a broad range of interventions that are difficult to examine with rigorous methodologies.

### SAMHSA-HRSA CIHS STANDARD FRAMEWORK FOR LEVELS OF INTEGRATED HEALTH CARE

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5	LEVEL 6
Minimal Collaboration	Basic Collaboration at a Distance	Basic Collaboration Onsite	Close Collaboration Onsite with Some System Integration	Close Collaboration Approaching an Integrated Practice	Full Collaboration in a Transformed/ Merged Integrated Practice
<b>BEHAVIORAL HEALTH PRIMARY CARE AND OTHER HEALTH CARE PROVIDERS WORK</b> (System Integration, Communication Frequency, Collaboration, and Roles & Culture)					
<b>CLINICAL DELIVERY</b> (Screening, Collaborative Treatment Planning, Implementation of EBPs)					
<b>PATIENT EXPERIENCE</b> (Experience with Care Team, Attention to Whole Health Care)					
<b>PRACTICE / ORGANIZATION</b> (Leadership Support and Provider Buy-in)					
<b>BUSINESS MODEL</b> (Funding Integration, Sharing of Resources & Integrated Billing Structures)					

AHRQ IBH EXPERT CONSENSUS LEXICON

The Agency for Healthcare Research and Quality (AHRQ), a key governmental authority in identifying standards for integrated care, developed a summary of prin-

ciples concerning how integrated care should be provided and supported.<sup>59</sup> When combined with the SAMHSA-HRSA CIHS standard framework, the AHRQ model helps us begin to paint a picture of what it looks like when providers are implementing integrated behavioral health.

**IBH FEATURES THAT MAP SIMILARITIES AND DIFFERENCES AMONG IBH PROGRAMS<sup>60</sup>**

HOW CARE IS PROVIDED	CORRESPONDING PARAMETERS
Practice team tailored to the needs of each patient situation	<ul style="list-style-type: none"> <li>▶ Range of care team functions and expertise that can be mobilized to address needs of particular patients and target populations</li> <li>▶ Type of spatial arrangement employed</li> <li>▶ Type of collaboration employed</li> </ul>
Clear, shared understanding of patient population and mission	<ul style="list-style-type: none"> <li>▶ Clear definition of patient panel with total health outcomes and a method for identifying individuals</li> </ul>
Systematic clinical approach	<ul style="list-style-type: none"> <li>▶ Protocols are established for engaging patients in integrated care</li> <li>▶ Degree to which protocols for initiating integrated care are followed</li> <li>▶ Proportion of patients in target groups with shared plans</li> <li>▶ Degree that care plans are implemented and followed</li> </ul>
HOW CARE IS SUPPORTED	CORRESPONDING PARAMETERS
Community, population, or individuals expecting IBH as standard care	<ul style="list-style-type: none"> <li>▶ Level of community expectation for IBH as standard care</li> </ul>
Support by office practice, leadership alignment, and business model	<ul style="list-style-type: none"> <li>▶ Level of office practice reliability and consistency</li> <li>▶ Level of leadership/administrative alignment and priorities</li> <li>▶ Level of business model support for integrated behavioral health</li> </ul>
Continuous quality improvement (CQI) and measurement of effectiveness	<ul style="list-style-type: none"> <li>▶ Scale /extent of practice data collected and used to improve the practice</li> </ul>

**APPENDIX B:**  
**KEY INFORMANT INTERVIEWEES**

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<b>INTERVIEWEE</b>	<b>AGENCY/ORGANIZATION</b>	<b>AREA OF EXPERTISE</b>
Avery, Mark	University of Washington AIMS Center	Collaborative Care Model
Capobianco, Jeff	Center for Integrated Health Solutions; National Council for Behavioral Health	IBH implementation; administrative and outcome metrics in IBH
Jarvis, Dale	Dale Jarvis Associates; Consultant to National Council for Behavioral Health	IBH models and financing of IBH
Kessler, Rodger	University of Vermont, Department of Family Medicine	IBH implementation, policy and research
Khatri, Parinda	Cherokee Health Systems	Hybrid IBH model—the Cherokee Model
Medrano, Martha	CommuniCare Health Centers	Implementation, primary care setting
Reynolds, Kathleen	Reynolds Associates	IBH implementation, financing, and evaluation
Rowan, Melissa	Wertz & Rowan	IBH implementation and financing in Texas
Steiner, Leigh	Care Management Technologies	IBH best practices, clinical/system decision supports, and analytics
Strosahl, Kirk	Mountainview Consulting	Developer of the PCBH model of IBH

## APPENDIX C:

# COST SAVINGS FROM INTEGRATED HEALTH CARE

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It is beneficial for those funding or implementing integrated health care to have some understanding of the cost implications. Will implementing the core components outlined here save money? The answer is more complicated than we might hope, but critical to widespread implementation. In identifying the potential for cost savings from integrated care, it is important to understand how the distribution of costs varies between behavioral and physical health costs, and how the combined costs vary among individuals.

### INDIVIDUALS WITH BEHAVIORAL HEALTH ISSUES HAVE HIGHER HEALTH CARE COSTS

For individuals with a mental health or substance use disorder, health care treatment costs for behavioral and physical health conditions are two to three times higher (\$1,085 versus \$397 per member per month in one national study).<sup>61</sup> The greater proportion of additional cost is for PH, not BH, conditions. The distribution of per person costs contains many individuals with low to moderate use of medical and behavioral health services, and a much smaller number of individuals with very high costs (super-utilizers). These facts suggest two related strategies: (1) target the small number of super-utilizers of expensive emergency department and inpatient services (often served in community behavioral health settings) with interventions that allow them to address their physical health crises more effectively, and (2) prevent the much larger number of low utilizers of emergency department and inpatient services (often served in primary care settings) from becoming super-utilizers.

The literature does not yet contain a rigorous meta-analysis of cost studies targeting super-utilizers who use integrated health care. However, in one promising intervention, Missouri enrolled Medicaid clients with mental illness (and at least \$10,000 in Medicaid claims during the previous year) into health care homes, and expenditures on emergency department and inpatient hospitalizations declined in a before-and-after comparison. Because a control group was not used in evaluating this program, it is not clear how much of this reduction was due to the intervention itself.

### COST SAVINGS OF INTEGRATION OF PRIMARY CARE INTO BEHAVIORAL HEALTH CARE

For interventions not limited to super-utilizers, recent meta-analysis results<sup>62</sup> of the provision of primary care services in outpatient behavioral health settings (community mental health centers and substance use disorder clinics) found no significant changes in health care costs. Small declines in hospitalization were offset by small increases in emergency department use. These disappointing results may be driven by the more severe BH and PH conditions of the population served in community mental health settings.

The lack of cost savings from health care integration in behavioral health settings should be a cautionary note to policymakers and administrators seeking to fund integration through health care savings. Short-term costs may rise as individuals with mental illness receive better primary care screening and expensive-to-treat conditions are identified.

### COST SAVINGS OF INTEGRATION OF BEHAVIORAL HEALTH INTO PRIMARY CARE

Meta-analysis results of integration in primary care settings do yield significant results. Analysis of collaborative primary care for depression performed by the Washington State Institute for Public Policy (WSIPP) estimated that per person lifetime savings in health care costs from this type of integration is \$1,805, while the per person cost of integration is \$797. Similar results occur for anxiety conditions.<sup>63</sup>

Although improved PH care should in the long run result in reduced use of expensive emergency department and inpatient services, more evaluation work needs to be completed to find out the nature and timing of this savings. Integration in primary care settings is more likely to yield savings in health care costs, and it is feasible to plan for these savings in developing these programs.

## APPENDIX D:

# IBH FIDELITY, READINESS AND SELF-REVIEW TOOLS AND MEASUREMENT STRATEGIES

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### MEASURING OUTCOMES IN PRIMARY CARE

Measures used in a primary care-based program will typically include standard and brief BH measures such as the Patient Health Questionnaire-9 (PHQ-9) that can serve both as a screening/assessment instrument and as an indicator of IBH treatment progress.<sup>64</sup> Health indicators associated with prevalent PH conditions, including blood pressure, body mass index, cholesterol levels, and the like, can also be easily tracked, and they often are already incorporated within (or readily added to) typical electronic health records (EHRs). Cost-related outcomes of concern, especially for intensive programs serving people with high utilization, will include at a minimum emergency room visits and hospitalization days, but in some programs should also include expensive treatments associated with disease complications, such as amputations for people with diabetes.

The above-mentioned outcomes can be considered “ultimate” outcomes, but sophisticated programs also will assess intermediary outcomes that they know are precursors to the ultimate outcomes, as well as cost measures associated with their own outpatient/community-based service delivery to specific key sub-groups of patients. A prime example of an intermediary outcome is the use of the Patient Activation Measure (PAM) as a tool to track the degree to which patients are becoming actively engaged in their care and illness management,<sup>65</sup> because active patient engagement is associated with better ultimate outcomes.<sup>66</sup> Cost measures include, for example, the unit cost to help people with a specific, prevalent clinical condition such as major depressive disorder or diabetes (or co-occurring major depressive disorder and diabetes) to reach treatment targets.<sup>67</sup>

Two additional key issues need to be kept in mind: 1) the particular PH and BH outcomes used should address the highest-priority needs of people served and the concerns of payers with whom the provider needs to establish accountability; and 2) the program needs to establish methods for extracting and combining person-level baseline and follow-up data in order to examine changes over time. This can include, for example, conducting simple before-and-after statistical

tests of health measures. The follow-up data should be obtained at the point in treatment when most people tend to show change. For example, hypertension tends to respond more quickly to treatment than does body mass index (BMI).

### MEASURING OUTCOMES IN SPECIALTY BEHAVIORAL HEALTH CARE

The guidance for measuring outcomes in specialty behavioral health care is nearly identical, but for people with SMI, it should also include attention to indicators of community integration, including independent living and employment, as well as highly prevalent conditions such as tobacco addiction/dependence and substance use-related outcomes (e.g., use of detoxification and stage of recovery).

### ASSESSMENT OF IBH IMPLEMENTATION FIDELITY

Before examining outcomes, programs need to measure the extent to which they are consistently implementing core aspects of their particular IBH model. If it turns out that IBH is not being implemented as outlined by the evidence-based model that has been selected, the ability to measure outcomes such as changes in health and well being over time is diminished. In terms of timing, any time an evidence-based model is being implemented, baseline measures of fidelity to the model and key outcomes (e.g., health and well-being) should be obtained in order to establish the starting point for measuring change. For fidelity, initial measurement mid-way through year one (to allow time for implementation to progress sufficiently to measure) and then annually thereafter can help facilitate progress. Fortunately, several well-organized fidelity instruments have been developed, although often they are conceptualized as “capacity” or “readiness” assessments. While programs can use them to self-assess, it is often beneficial to have external reviewers conduct collaborative fidelity assessments to maximize learning.

Below are some specific tools and instruments that behavioral health centers may use to assess agency capacity and/or readiness.

### **Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration (OATI)<sup>68</sup>**

The OATI is currently the most comprehensive set of measures for establishing or improving integrated care services. The OATI is composed of four (4) primary OATI tools: the Partnership Checklist, the Executive Walkthrough, the Administrative Readiness Tool, and the COMPASS Primary Health-Behavioral Health Tool.

Specific tools associated with the OATI can be accessed from: <http://www.integration.samhsa.gov/operations-administration/assessment-tools#OATI>

including Partnership Checklist:

[http://www.integration.samhsa.gov/operations-administration/OATI\\_Tool1\\_Partnership\\_checklist.pdf](http://www.integration.samhsa.gov/operations-administration/OATI_Tool1_Partnership_checklist.pdf)

Executive Walkthrough:

[http://www.integration.samhsa.gov/operations-administration/OATI\\_Tool2\\_Executive\\_Walkthrough.pdf](http://www.integration.samhsa.gov/operations-administration/OATI_Tool2_Executive_Walkthrough.pdf)

Administrative Readiness Tool:

[http://www.integration.samhsa.gov/operations-administration/OATI\\_Tool3\\_ART.pdf](http://www.integration.samhsa.gov/operations-administration/OATI_Tool3_ART.pdf)

COMPASS Primary Health-Behavioral Health Tool:

[http://www.integration.samhsa.gov/operations-administration/OATI\\_Tool4\\_COMPASS.pdf](http://www.integration.samhsa.gov/operations-administration/OATI_Tool4_COMPASS.pdf)

### **Behavioral Health Integration Capacity Assessment (BHICA)<sup>69</sup>**

The BHICA is a readiness tool that emphasizes three key integrated care areas: coordinated care, co-location, and on-site primary care capability. Created as a self-assessment, a provider assembles an interdisciplinary work group to answer questions associated with the three key integrated care areas, including provider infrastructure. The burden to complete the assessment is relatively low and can be completed over the course of several meetings.

### **Behavioral Health Integration in Medical Care (BHIMC)<sup>70</sup>**

Designed for FQHCs, this is an advanced checklist style assessment tool for assessing the degree of primary care and behavioral health integration as it relates to the provider's capacity to treat dual diagnosis conditions. Primary domains include organizational characteristics, treatment characteristics, and care coordination/management characteristics.

### **Integrated Practice Assessment Tool (IPAT)<sup>71</sup>**

The IPAT is a simple tool that includes a stepped series of yes/no questions to help providers understand the level of integrated care at which they currently operate. Drawing on the SAMHSA framework described in Appendix A, the IPAT uses a decision-tree structure to reveal an overall IBH implementation rating from one to six.

## END NOTES

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See also: The Lewin Group and The Institute for Healthcare Improvement (2014). *Behavioral health integration capacity assessment (BHICA)*. Retrieved from <https://www.resourcesforintegratedcare.com/tool/bhica>.

See also: AHRQ Lexicon and the SAMHSA/HRSA Integrated care framework in Appendix A.

<sup>ii</sup> IBH experts have increasingly expressed concern about the use of universal screening, because, when screening is not indicated, it may make the initial encounter process overly burdensome. See, for example, Kathol, R.G., & Rollman, B.L. (2014). Value-based financially sustainable behavioral health components in patient-centered medical homes. *The Annals of Family Medicine*, 12(2), 172-175.

<sup>iii</sup> Health Improvement Network South London (n.d.). *What is person-centered care and why is it important?* Retrieved from [http://www.hin-southlondon.org/system/ckeditor\\_assets/attachments/41/what\\_is\\_person-centred\\_care\\_and\\_why\\_is\\_it\\_important.pdf](http://www.hin-southlondon.org/system/ckeditor_assets/attachments/41/what_is_person-centred_care_and_why_is_it_important.pdf).

<sup>1</sup> Key Informant Interview with Rodger Kessler, August 7, 2015.

<sup>2</sup> While a model may be more expensive to deliver, it may also be more cost-effective, when provided to patients for whom that model is indicated.

<sup>3</sup> Tice, J.A. et al. (2015).

See also: The Lewin Group and The Institute for Healthcare Improvement (2014).

See also: AHRQ Lexicon and the SAMHSA/HRSA Integrated care framework in Appendix A.

<sup>4</sup> McDaniel et al. (2014). The AIMS Center's Collaborative Care Implementation Guide. Retrieved from <http://aims.uw.edu/collaborative-care/implementation-guide/build-your-clinical-skills/care-team-training-all-members>.

See also: Tice, J.A. et al. (2015).

<sup>5</sup> IBH experts have increasingly expressed concern about the use of universal screening, because, when screening is not indicated, it may make the initial encounter process overly burdensome. See, for example, Kathol, R.G., & Rollman, B.L. (2014).

<sup>6</sup> Health Improvement Network South London (n.d.).

<sup>7</sup> Cohen, D.J., Davis, M.M., Hall, J.D., Gilchrist, E.C., & Miller, B.F. (2015). A Guidebook of Professional Practices for Behavioral Health and Primary Care Integration: Observations from Exemplary Sites. Rockville, MD: Agency for Healthcare Research and Quality.

<sup>8</sup> Kinman, C.R., Gilchrist, E.C., Payne-Murphy, J.C., & Miller, B.F. (2015). Provider- and practice-level competencies for integrated behavioral health in primary care: a literature review. (Prepared by Westat under Contract No. HHS 290-2009-00023I). Rockville, MD: Agency for Healthcare Research and Quality.

<sup>9</sup> Minkoff, K., & Parks, J. (2015). Primary Health-Behavioral Health Integration for the Population of Individuals with Serious Mental Illness. In O'Donohue, W., & Maragakis, A. (eds.). *Integrated Primary and Behavioral Care*. Springer International Publishing Switzerland.

<sup>10</sup> More details on integrating IBH into organizational functions can be found in: Tice, J.A. et al. (2015).

See also: The Lewin Group and The Institute for Healthcare Improvement (2014).

See also: AHRQ Lexicon and the SAMHSA/HRSA Integrated care framework in Appendix A.

<sup>11</sup> Scharf, D.M., Eberhart, N.K., Hackbarth, N.S., Horvitz-Lennon, M., Beckman, R., Han, B., Lovejoy, S.L., Pincus, H.A., & Burnam, M.A. (2014). Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program: Final Report (Task 13). Santa Monica, CA: RAND Corporation, RR-546-DHHS, 2014. Retrieved from [http://www.rand.org/pubs/research\\_reports/RR546.html](http://www.rand.org/pubs/research_reports/RR546.html).

<sup>12</sup> Felt-Lisk, S., & Higgins, T. (2011). Exploring the Promise of Population Health Management Programs to Improve Health. Mathematica Policy Research: Issue Brief. Retrieved from [http://www.mathematica-mpr.com/-/media/publications/pdfs/health/phm\\_brief.pdf](http://www.mathematica-mpr.com/-/media/publications/pdfs/health/phm_brief.pdf).

<sup>13</sup> Capobianco, J., & Surma, A. (2015). Population Health Management 101. SAMHSA-HRSA Center for Integrated Health Solutions. Retrieved from [http://www.integration.samhsa.gov/pbhci-learning-community/03.10.15-Population\\_Health\\_Management\\_101.pdf](http://www.integration.samhsa.gov/pbhci-learning-community/03.10.15-Population_Health_Management_101.pdf).

<sup>14</sup> Cohen, D.J. et al. (2015).

<sup>15</sup> Kinman, C.R. et al. (2015).

<sup>16</sup> Druss, B.G., & Walker, E.R. (2011). *Mental Disorders and Medical Comorbidity*. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation.

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<sup>18</sup> SAMHSA-HRSA Center for Integrated Health Solutions. Maurer, B.J. (2006 & 2009). Four Quadrant Clinical Integration Model. Retrieved from <http://www.integration.samhsa.gov/resource/four-quadrant-model>.

<sup>19</sup> Raney, L., & Kamp, N.J. (2015). *Evidence-based integration: A step-by-step guide to integrating behavioral health into the primary care setting*. Health Management Associates: HealthManagement.com.

<sup>20</sup> Cohen, D.J. et al. (2015).

<sup>21</sup> Kinman, C.R. et al. (2015).

<sup>22</sup> Minkoff, K., & Parks, J. (2015).

<sup>23</sup> Ibid.

<sup>24</sup> All co-occurring conditions are significant to the individual patient and provider, but as organizations begin to develop population health management capacity, it will be most fruitful to focus on prevalent co-occurring conditions (such as diabetes/depression in primary care, or serious mental illness-metabolic syndrome) with which they can gain the most traction and find the greatest return on their investment of organizational resources.

<sup>25</sup> At the inception of IBH in Texas, most EHRs did not have the functionality to collect and manage behavioral health data. Registries were developed by many providers to address this gap, but they still required providers to work in a two-record system (a registry and EHR). To date, there is a movement to have a "single record" for all health data. EHR vendors have now begun adding functionality and templates for mental health screening (depression), aggregation of health data from an individual and population perspective, and access to all health data, including behavioral health data, in real time. Again, the ultimate goal is to

work from a single EHR system, thus, moving away from a “two health record system.”

<sup>26</sup> Raney, L., & Kamp, N.J. (2015).  
See also: Scharf, D.M. et al. (2014).

<sup>27</sup> Mitchell, P. et al. (2012). *Core principles and values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washington, D.C. Retrieved from <https://www.nationalahaec.org/pdfs/VSRT-Team-Based-Care-Principles-Values.pdf>.

<sup>28</sup> See the AIMS Center’s Team Building Tool: [http://www.integration.samhsa.gov/workforce/UW\\_Integrated\\_BH\\_Care\\_Team\\_Building\\_Process.pdf](http://www.integration.samhsa.gov/workforce/UW_Integrated_BH_Care_Team_Building_Process.pdf).

<sup>29</sup> See the AIMS Center’s Team Building Tool, cited above. Also, the AIMS Center has a useful survey that teams can use, called the “Team Tune-Up” survey: Ratzliff, A. (2014). Team tune-up: Helping teams work better together. Washington, D.C.: PBHCI Grantee Meeting. Retrieved from [http://www.integration.samhsa.gov/Team\\_Tune\\_Up\\_Presentation\\_08\\_12\\_14\\_FINAL.pdf](http://www.integration.samhsa.gov/Team_Tune_Up_Presentation_08_12_14_FINAL.pdf).

<sup>30</sup> SAMHSA-HRSA Center for Integrated Health Solutions (2012). *Whole Health Action Management (WHAM) Peer Support Training Participant Guide*. Retrieved from <http://www.integration.samhsa.gov/health-wellness/wham>.

<sup>31</sup> Scharf, D.M. et al. (2014).

<sup>32</sup> Cohen, D.J. et al. (2015).

<sup>33</sup> McDaniel et al. (2014).

<sup>34</sup> Kathol, R.G., & Rollman, B.L. (2014).

<sup>35</sup> Hoge, M.A., Morris, J.A., Laraia, M., Pomerantz, A., & Farley, T. (2014). *Core Competencies for Integrated Behavioral Health and Primary Care*. Washington, D.C.: SAMHSA-HRSA Center for Integrated Health Solutions.

<sup>36</sup> Health Improvement Network South London (n.d.).

<sup>37</sup> SAMHSA (2012). *Shared decision making in mental health care*. Retrieved from <https://store.samhsa.gov/shin/content/SMA09-4371/SMA09-4371.pdf>.

An important recent example comes from positive results in early intervention with first-episode psychosis, which uses a model rooted in shared decision-making: Kane, J.M. et al. (2015). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, *ajp in advance*, 1-11.

<sup>38</sup> Corrigan, P.W. (2004). How stigma interferes with mental health care. *American Psychologist*, *59*(7), 614-625.

<sup>39</sup> Peek, C.J., & the National Integration Academy Council (2013). *Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus*. AHRQ Publication No. 13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from <http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>.

<sup>40</sup> Strosahl, K. (1998). Integrating behavioral health and primary care services: The primary mental health care model. In A. Blount (Ed.), *Integrated primary care: The future of medical and mental health collaboration* (pp. 139-166). New York, NY: Norton.  
See also: Robinson, P.J., & Reiter, J.T. (2007). *Behavioral Consultation and Primary Care: A Guide to Integrating Services*. NY: Springer. (Note updated edition is forthcoming/in press: Robinson, P.J., & Reiter, J.T. (2015). *Behavioral Consultation and Primary Care: A Guide to Integrating Services*. 2nd Ed. NY: Springer.)

<sup>41</sup> The Collaborative Care Model has been explicated by the AIMS Center at the University of Washington (<http://uwaims.org>).

See also: Huffman et al. (2013): <http://www.coloradohealthpartnerships.com/provider/integrated/Collaborative-Care-Meta-Analysis.pdf>.

<sup>42</sup> Cook, J. et al. (2011). Result of a randomized controlled trial of mental illness self-management using Wellness Recovery Action Planning. *Schizophrenia Bulletin*, *March 14*, 1-11.  
See also: SAMHSA-HRSA Center for Integrated Health Solutions (2012).

<sup>43</sup> Scharf, D.M. et al. (2014).

<sup>44</sup> COMPASS Primary Health-Behavioral Health Tool. Retrieved from [http://www.integration.samhsa.gov/operations-administration/OATL\\_Tool4\\_COMPASS.pdf](http://www.integration.samhsa.gov/operations-administration/OATL_Tool4_COMPASS.pdf).

<sup>45</sup> Capobianco, J., & Surma, A. (2015).

<sup>46</sup> Minkoff, K., Lloyd, D., Capobianco, J., & Reynolds, K. (2014). Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration. *Substance Abuse and Mental Health Services Administration - Health Resources and Services Administration: Center for Integrated Health Solutions*. Retrieved from [http://www.integration.samhsa.gov/operations-administration/OATL\\_Overview\\_FINAL.pdf](http://www.integration.samhsa.gov/operations-administration/OATL_Overview_FINAL.pdf).

<sup>47</sup> See the AHRQ registry user guides for additional details: Gliklich, R., Dreyer, N., & Leavy, M., eds. (2014). *Registries for Evaluating Patient Outcomes: A User’s Guide*. Third edition. Two volumes. (Prepared by the Outcome DEcIDE Center [Outcome Sciences, Inc., a Quintiles company] under Contract No. 290 2005 00351 TO7.) AHRQ Publication No. 13(14)-EHC111. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from <http://www.effectivehealthcare.ahrq.gov/registries-guide-3.cfm>.

<sup>48</sup> Patient registries can be maintained in an Excel or Access database, managed care portals or electronic medical records. Health information exchanges do not typically maintain patient registries.

<sup>49</sup> Health Plan Employer Data and Information Set (HEDIS®): The Healthcare Effectiveness Data and Information Set established by the National Committee for Quality Assurance (NCQA).

<sup>50</sup> Marshall, G., Bourne, K., & Zahniser, J.H. (2014). *Developing a High Functioning Team*. SAMHSA PBHCI Grantee National Meeting, Washington, D.C.

<sup>51</sup> Texas Medicaid & Healthcare Partnership (2015). *Texas Medicaid Provider Procedures Manual: Vol. 2*. Retrieved from <http://www.tmhp.com/HTMLmanuals/TMPPM/Current/toc.html>.

<sup>52</sup> It should be noted that CMHCs provide services to individuals that meet DSHS’s priority population. DSHS funding is directed to provide services that meet the needs of the priority population. The DSHS’s priority population for adult mental health services consists of adults who have severe mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental health conditions that require crisis resolution or ongoing and long-term support and treatment. In tailoring services to the priority population, the choice of and admission to services is determined jointly by the person seeking service and the provider. Factors used to make these determinations are the level of functioning of the individual, the needs of the individual and the availability of resources. Local authorities that wish to offer services to people other than those in the priority population may do so using non-department funds.

<sup>53</sup> Texas Medicaid & Healthcare Partnership (2015). *Texas Medicaid Provider Procedures Manual: Vol. 2. Children’s Services Handbook, Section 2.8 Health and Behavior Assessment and Intervention*. Retrieved from [http://www.tmhp.com/HTMLmanuals/TMPPM/Current/Vol2\\_Children’s\\_Services\\_Handbook.15.098.html](http://www.tmhp.com/HTMLmanuals/TMPPM/Current/Vol2_Children’s_Services_Handbook.15.098.html).

<sup>54</sup> Texas Health and Human Services Commission (n.d.). *Uniform Managed Care Terms & Conditions: Attachment A—Medicaid and CHIP Managed Care Services RFP: Section 8.1.26 Health Home*

Services. Retrieved from <http://www.hhsc.state.tx.us/medicaid/managed-care/UniformManagedCareContract.pdf>.

<sup>55</sup> Texas Health and Human Services Commission (n.d.). STAR Kids DRAFT RFP: Section 8.1.4.11.3 Health Home Services and Participating Providers. Retrieved from <http://www.hhsc.state.tx.us/contract/529130071/draft/docs/starkids-drafrfp-section08.pdf>.

<sup>56</sup> Texas Health and Human Services Commission (n.d.). STAR Kids DRAFT RFP: Section 8.1.4.11.2 Health Home. Retrieved from <http://www.hhsc.state.tx.us/contract/529130071/draft/docs/starkids-drafrfp-section08.pdf>.

<sup>57</sup> Heath, B., Wise Romero, P., & Reynolds, K.A. (2013). Standard Framework for Levels of Integrated Healthcare. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions.

<sup>58</sup> At this time there is insufficient evidence to associate specific health outcomes to a particular level of integration. See Tice, J.A. et al. (2015).

<sup>59</sup> Peek, C.J., & the National Integration Academy Council (2013).

<sup>60</sup> Adapted from Peek, C.J., & the National Integration Academy Council (2013).

<sup>61</sup> For national level results, see Milliman, Inc. (2014). Economic Impact of Integrated Medical-Behavioral Healthcare. For Texas-specific results, see Serious and Persistent Mental Illness in Texas Medicaid: Descriptive Analysis and Policy Options (2015). University of Texas School of Public Health.

<sup>62</sup> Washington State Institute for Public Policy (2015). Primary care in behavioral health settings. Retrieved from <http://www.wsipp.wa.gov/BenefitCost/Program/332>. See this source for all meta-analysis results.

<sup>63</sup> See the Washington State Institute for Public Policy's review at <http://www.wsipp.wa.gov/BenefitCost>.

<sup>64</sup> Kroenke, K., Spitzer, R.L., & Williams, J.B. (2001). The PHQ-9:

Validity of a brief depression severity measure, *Journal of General Internal Medicine*, 16(9), 606-613.

See also: Announcement of the National Quality Forum's inclusion of the PHQ-9 at: National Behavioral Healthcare (2011). NQF endorses mental health outcome measures. Retrieved from <http://www.behavioral.net/news-item/nqf-endorses-mental-health-outcome-measures?page=1>.

<sup>65</sup> Lubetkin, E.I., Lu, W.H., & Gold, M.R. (2010). Levels and correlates of patient activation in health care settings: Building strategies for improving health outcomes. *Journal of Health Care for the Poor and Underserved*, 21(3), 796-808.

<sup>66</sup> Greene, J. et al. (2015). When patient activation levels change, health outcomes and costs change, too. *Health Affairs*, 34(8). Retrieved from <http://content.healthaffairs.org/content/34/3/431.full?ijkey=qrT3DmyGCh4xk&keytype=ref&siteid=healthaff>.

See also: Tzeng, A. et al. (2015). The role of patient activation in achieving better outcomes and cost-effectiveness in patient care. *JBJS Reviews*, January; 3 (1). Retrieved from <http://reviews.jbjs.org/content/3/1/e4>.

<sup>67</sup> Key informant interview with Jeff Capobianco, University of Michigan, School of Social Work, Center for Integrated Health Solutions, August 2015.

<sup>68</sup> Minkoff, K. et al. (2014).

<sup>69</sup> The Lewin Group and The Institute for Healthcare Improvement (2014).

<sup>70</sup> SAMHSA (n.d.). Behavioral Health Integration in Medical Care (BHIMC); Version 3.0. Substance Abuse and Mental Health Services Administration. Retrieved from [http://www.integration.samhsa.gov/operations-administration/BHIMC-Version3\\_0\\_FINAL-2-.pdf](http://www.integration.samhsa.gov/operations-administration/BHIMC-Version3_0_FINAL-2-.pdf).

<sup>71</sup> SAMHSA (n.d.). IPAT: Integrated Practice Assessment Tool. Retrieved from [http://www.integration.samhsa.gov/operations-administration/IPAT\\_v\\_2.0\\_FINAL.pdf](http://www.integration.samhsa.gov/operations-administration/IPAT_v_2.0_FINAL.pdf).

## Appendix Eight: MMHPI Paper on Psychiatric Advanced Practice Nursing

### Meadows Mental Health Policy Institute

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#### Advanced Practice Nursing: Psychiatric Mental Health Nursing Programs in Texas – January 2017

##### Background

Psychiatric mental health nursing is a type of advanced practice nursing. The American Nurses Credentialing Center (ANCC) certifies psychiatric mental health nurses as either Psychiatric Mental Health Clinical Nurse Specialists (PMHCNS-BC) or Psychiatric Mental Health Nurse Practitioners (PMHNP-BC). Provider agencies and states may list psychiatric mental health nurses with one of these two titles. However, on a national level, little difference exists between the two, except that nurse practitioners may provide primary care and may have prescriptive authority in all states, while clinical nurse specialists may focus more on system issues or on providing psychotherapy and may have prescriptive authority in many states.<sup>1</sup>

All psychiatric mental health nurses specialize in psychiatric mental health care across the lifespan, treating young children, adolescents, adults of all ages, and individuals from all sections of society, including those with developmental issues, pregnancy concerns, and geriatric problems (e.g., issues related to dementia). Psychiatric mental health nurses practice in a variety of settings, such as private clinics, public health settings, prisons, and/or psychiatric hospitals, as an interdependent member of a health care team. They use advanced health assessment skills to perform screening histories, make mental health diagnoses based on DSM-V criteria, and determine a treatment plan which, if authorized, includes prescribing psychotropic medication. They can also provide group, individual, and family therapy; facilitate crisis intervention; perform case management; and provide psychiatric consultation with patients and other disciplines.<sup>2</sup>

##### Advanced Practice Nursing Degrees

In October 2004, the American Association of Colleges of Nursing (AACN) passed a position statement that called for moving the current level of preparation necessary for advanced practice nursing from the master's degree to the doctorate level by 2015.<sup>3</sup> Since then, the

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<sup>1</sup> American Psychiatric Nurses Association. (n.d.). *FAQs about advanced practice psychiatric nurses*. Retrieved from <http://www.apna.org/i4a/pages/index.cfm?pageID=3866>.

<sup>2</sup> Lieser, C. (n.d.). *Psychiatric Mental Health Nurse Practitioner Program at The University of Texas at Arlington* [Video file]. University of Texas at Arlington College of Nursing and Health Innovation. Retrieved from <https://www.uta.edu/conhi/academics/nursing-grad/msn/nurse-practitioner/pmhnp.php>.

<sup>3</sup> American Association of Colleges of Nursing. (2016, April). *DNP fact sheet: The doctor of nursing practice*. Retrieved from [http://www.aacn.nche.edu/media-relations/fact-sheets/dnp\\_](http://www.aacn.nche.edu/media-relations/fact-sheets/dnp_)

doctor of nursing practice (DNP) has become widely recognized as one of nursing's two terminal degrees (the other being a PhD) and the preferred pathway for those seeking preparation at the highest level of nursing practice.<sup>4</sup> Despite strong support for the advanced practice doctorate nationwide, only the official governing bodies for nurse anesthetists have established a deadline for requiring the doctoral degree before a student may take the national certification exam; by 2025, all new nurse anesthetists must complete the DNP degree. For all other advanced practice registered nurses (APRNs), including nurse midwives, nurse practitioners, and clinical nurse specialists, the current minimum educational requirement for taking the national certification exam is a master of science in nursing (MSN) degree.<sup>5</sup>

### Psychiatric Mental Health Nursing Programs in Texas

There are currently six public institutions in Texas that offer a psychiatric mental health nursing program;<sup>6</sup> each school refers to their program as a Psychiatric Mental Health Nurse Practitioner (PMHNP) program. These institutions are: The University of Texas Health Science Center at San Antonio (UTHSC-SA) School of Nursing, The University of Texas at Austin (UT-Austin) School of Nursing, Texas Tech University Health Sciences Center (TTUHSC) School of Nursing, The University of Texas Health Science Center at Houston (UTHSC-H) School of Nursing, The University of Texas at Arlington College of Nursing and Health Innovation (UT-ACNHI), and Midwestern State University (MWSU) Wilson School of Nursing.

The types of psychiatric mental health nursing degree programs offered at each school varies between an alternate-entry master of science in nursing (AE-MSN) program, a master of science in nursing (MSN) program, and/or a post-master's certificate (PMSN) program. No public institutions in Texas offer a DNP degree with a psychiatric mental health track. If a DNP degree program is available at these institutions, the focus areas are usually broad. During key informant interviews (discussed in more detail below), one informant stated that the DNP degree is geared more toward leadership roles rather than a focused area of clinical expertise; therefore, a psychiatric mental health track would be too specialized.

The following table provides an overview of the different degree programs offered at each of the six schools in Texas.

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<sup>4</sup> American Association of Colleges of Nursing. (2015, August). *The doctor of nursing practice: Current issues and clarifying recommendations*. Retrieved from <http://www.aacn.nche.edu/aacn-publications/white-papers/DNP-Implementation-TF-Report-8-15.pdf>.

<sup>5</sup> Texas Higher Education Coordinating Board. (2013, January). *White paper: The doctor of nursing practice degree*. Retrieved from <http://www.theccb.state.tx.us/reports/PDF/2963.PDF?CFID=45913150&CFTOKEN=70051214>.

<sup>6</sup> American Psychiatric Nurses Association. (n.d.). *Graduate programs: Rhode Island to Wyoming*. Retrieved from <http://www.apna.org/i4a/pages/index.cfm?pageid=3354#TX>.

**Psychiatric Mental Health Nursing Degree Programs at Public Institutions in Texas**

Degree Program	UTHSC-SA	UT-Austin	TTUHSC	UTHSC-H	UT-ACNHI	MWSU
AE-MSN	X	X				X
MSN	X	X	X	X	X	X
PMSN	X	X	X	X	X	X

**Key Informant Interviews**

We contacted the psychiatric mental health nursing program directors at each of the six public institutions in Texas to inquire about the types of degree programs they offer as well as the most recent two years of admission statistics for each degree program.<sup>7</sup> The purpose of these interviews was to determine how successful the schools were in attracting qualified applicants and filling available spots in their programs. We found that most of the schools consistently reported having more interested and qualified applicants than available spots, and that (with a few exceptions, discussed below) this was true for each type of degree program they offer. In fact, one school had to increase the number of available spots for its MSN degree program after receiving a high number of qualified applicants. Schools that did not set quotas for available spots still had a higher number of applicants relative to the number of students they admitted for each of their degree programs.

Two schools reported receiving a relatively low number of AE-MSN applicants in 2015 and 2016. One of these schools also had a low number of applicants for their PMSN program in 2015 and 2016; however, this school’s contact stated that it was still their most popular PMSN program. In terms of the AE-MSN programs, the contact at one school attributed the low numbers to losing people to other programs, specifically, registered nurse (RN) to bachelor of science in nursing (BSN) programs. According to the contact, there is pressure on RNs from Magnet hospitals to get a BSN,<sup>8</sup> so more RNs are pursuing their BSN degree for now since it requires less of a time commitment. The contact at the other school stated that their AE-MSN program is within a larger program that comprises students who are seeking a BSN as well as those who want to go on for a MSN. This school has designated a coordinator who is working to build the program, so they are seeing a small increase in applicants. This contact also noted that most students in the larger program are only interested in a BSN degree, but the program is not phasing out the AE-MSN option. Overall, despite some exceptions, it appears that these Texas

<sup>7</sup> Some schools were only able to offer the most recent year of admission statistics.

<sup>8</sup> A Magnet-designated hospital is an organization that has been recognized by the ANCC for demonstrating excellence in patient care in more than 35 areas of focus throughout the entire hospital. Lowell General Hospital. (n.d.). *What it means to be a Magnet hospital*. Retrieved from <http://www.lowellgeneral.org/about-lgh/a-magnet-hospital/what-it-means-to-be-a-magnet-hospital>.

institutions are successful in attracting qualified applicants and consistently capable of filling available spots in most of their degree programs.

### **Training Advanced Practice Nurses: MSN versus DNP**

In Texas, there are 23 institutions that offer advanced practice nursing degrees.<sup>9</sup> As of 2013, the Texas Higher Education Coordinating Board (THECB) has approved seven DNP programs at public institutions, for a total of 12 DNP programs in the state.<sup>10</sup> While new DNP programs at public institutions will likely be considered by THECB, the organization maintains that all DNP programs at public institutions in Texas should be post-master's degree programs rather than post-baccalaureate degree programs (i.e., BSN to DNP) in an effort to preserve the master's degree as a viable entry to advanced practice nursing. THECB's position of safeguarding master's degree programs was based on several factors: there is no patient outcome research that supports the requirement of doctoral degrees in nursing, there is increased cost and time required to complete the DNP degree, and, in their opinion, there is a dire need to maintain the master's level nursing programs since 75% of all undergraduate nursing faculty have master's level degrees.<sup>11</sup>

The Texas Board of Nursing (BON), the licensing body of nurses in Texas, reinforces THECB's stance on preserving the master's degree as the entry to advanced practice nursing. According to Rule 221.3, to be granted an APRN license in Texas, an individual must hold a current license as a registered nurse, complete a graduate degree at the master's degree level or higher in an accredited advanced nursing educational program, and pass a national certification exam within the individual's educational focus (i.e., family, adult/gerontological [primary or acute care], pediatrics [primary or acute care], neonatal, women's health, and psychiatric mental health).<sup>12</sup> Furthermore, the BON released the following statement regarding the DNP:

“Within the last year, there has been a great deal of discussion at the national level about the doctor of nursing practice degree. This degree is promoted by professional organizations such as the American Association of Colleges of Nursing (AACN). The Texas Board of Nursing has not discussed this issue and does not have a position on the issue at this time. Additionally, although the board would never discourage nurses from furthering their education, nothing in current rules requires that

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<sup>9</sup> Texas Higher Education Coordinating Board. (2013).

<sup>10</sup> R. Rosseter (personal communication, August 26, 2016).

<sup>11</sup> Texas Higher Education Coordinating Board. (2013). All programs at public institutions must be approved by THECB. This does not apply to private institutions. The focus in this paper is on public institutions since UTEP is a public school.

<sup>12</sup> Texas Board of Nursing. (n.d.). *Texas Administrative Code: Title 22, Part 11, Chapter 221, Rule 221.3: Education*. Retrieved from [http://www.bon.state.tx.us/rr\\_current/221-3.asp](http://www.bon.state.tx.us/rr_current/221-3.asp)

advanced practice registered nurses be educated at the doctoral level to obtain licensure in an advanced practice role and population focus.”<sup>13</sup>

### **Practice Autonomy and Prescriptive Authority**

In addition to the limits placed on DNP programs in Texas, both DNP- and MSN-level nurses are limited in terms of their scope of practice autonomy and prescriptive authority. In Texas, there is no difference in their licensed authority to practice. That is, whether educated at the DNP or MSN level, after passing the national certification exam, both types of graduates are eligible to apply for the same licensure through the BON. After APRN licensure, both have the same authority to practice.<sup>14</sup>

Similar to practice autonomy, both MSN- and DNP-level nurses<sup>15</sup> are required to have delegated authority to provide medical aspects of patient care in Texas, which includes prescribing medications.<sup>16</sup> Currently, if an APRN wishes to prescribe medications, he or she must have a collaborative agreement with a Texas licensed physician for delegation and supervision.<sup>17</sup> More information on APRNs’ prescriptive authority, including what the agreement must contain and the prescribing of controlled substances, can be found at the resources footnoted below.<sup>18,19,20</sup> Once again, the type of degree earned (MSN or DNP) does not factor into an APRN’s prescriptive authority in Texas.

### **Meeting Mental Health Workforce Needs in the El Paso Region**

Nationwide, there is a shortage of nurses at all levels and in most roles, including psychiatric mental health nurses.<sup>21</sup> However, the Bureau of Labor Statistics projects that the employment rate of nurse practitioners will grow 35.2% from 2014 to 2024, much faster than the average for

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<sup>13</sup> Texas Board of Nursing. (n.d.). *Frequently asked questions – advanced practice registered nurse: APRN education*. Retrieved from [http://www.bon.state.tx.us/faq\\_practice\\_aprn.asp#t4](http://www.bon.state.tx.us/faq_practice_aprn.asp#t4).

<sup>14</sup> C. Zolnierek (personal communication, August 24, 2016).

<sup>15</sup> Ibid.

<sup>16</sup> Texas Board of Nursing. (n.d.). *Frequently asked questions – advanced practice registered nurse: Questions related to prescriptive authority agreements*. Retrieved from [http://www.bon.state.tx.us/faq\\_practice\\_aprn.asp#t4](http://www.bon.state.tx.us/faq_practice_aprn.asp#t4).

<sup>17</sup> C. Zolnierek (personal communication, August 24, 2016).

<sup>18</sup> Texas Constitution and Statutes. (n.d.). *Occupations Code: Title 3, Subtitle B, Chapter 157: Authority of physician to delegate certain medical acts*. Retrieved from <http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.157.htm#157.0511>.

<sup>19</sup> Texas Board of Nursing. (n.d.). *Texas Administrative Code: Title 22, Part 11, Chapter 222, Rule 222.8: Authority to order and prescribe controlled substances*. Retrieved from [http://www.bon.state.tx.us/rr\\_current/222-8.asp](http://www.bon.state.tx.us/rr_current/222-8.asp).

<sup>20</sup> Texas Board of Nursing. (n.d.). *Frequently asked questions – advanced practice registered nurse: Questions related to prescriptive authority agreements*. Retrieved from [http://www.bon.state.tx.us/faq\\_practice\\_aprn.asp#t4](http://www.bon.state.tx.us/faq_practice_aprn.asp#t4).

<sup>21</sup> American Psychiatric Nurses Association. (n.d.). *Is psychiatric mental health nursing experiencing a shortage now?* Retrieved from <http://www.apna.org/i4a/pages/index.cfm?pageid=3292#4>.

all occupations.<sup>22</sup> This expected trend is driven by the large number of newly insured patients resulting from healthcare legislation, an increased emphasis on preventive care, and an anticipated increase in health care needs among the large, aging baby-boom population.<sup>23</sup> Specific to psychiatric needs, the Bureau of Health Professions projects that the demand for general psychiatry services will have increased by almost 20% between 1995 and 2020 and that the demand for child and adolescent psychiatric services is expected to increase by 100% during that same time frame.<sup>24</sup> Additionally, according to Health eCareers, psychiatric mental health nurses were the second most in-demand APRN position in the first quarter of 2015.<sup>25</sup> Considering these statistics, coupled with the ongoing shortage of psychiatrists in the state,<sup>26</sup> offering a psychiatric mental health nursing program would fill a critical workforce need.

El Paso County is underserved by every type of mental health professional to such a great extent that the U.S. Department of Health and Human Services has designated the region as a Health Professional Shortage Area (HPSA) in the domain of mental health. As the primary source for filling the professional human resource needs of the region – and the region’s only comprehensive institution of higher education – the University of Texas at El Paso (UTEP) is positioned to help address this workforce crisis.<sup>27</sup> UTEP has an accredited school of nursing that offers undergraduate and graduate degree programs in nursing. In addition, UTEP School of Nursing has psychiatric mental health nurse practitioners on faculty and has identified the development of a PMHNP program as a priority.

However, before a PMHNP program can be implemented at UTEP, there are several factors to consider and challenges to overcome. Most importantly, UTEP must decide what type of degree program should be developed. In addition, UTEP must consider funding for faculty release time to develop the program as well as sources for local preceptorship (i.e., mentoring) opportunities.<sup>28</sup>

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<sup>22</sup> United States Department of Labor, Bureau of Labor Statistics. (2016). *Table 1.3 fastest growing occupations, 2014 and projected 2024*. Retrieved from [http://www.bls.gov/emp/ep\\_table\\_103.htm](http://www.bls.gov/emp/ep_table_103.htm).

<sup>23</sup> United States Department of Labor, Bureau of Labor Statistics. (2015). *Nurse anesthetists, nurse midwives, and nurse practitioners*. Retrieved from <http://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm#tab-6>.

<sup>24</sup> Kweskin, S. (2010, September 1). Demand for psychiatrists continues to grow. *Psychiatric Times*. Retrieved from <http://www.psychiatristimes.com/news/demand-psychiatrists-continues-grow>.

<sup>25</sup> American Psychiatric Nurses Association. (n.d.). *PMH APRNs: Making a difference in mental health & wellness*. Retrieved from [http://www.apna.org/files/public/About\\_Psychiatric-Mental\\_Health\\_APRNs-For\\_Students.pdf](http://www.apna.org/files/public/About_Psychiatric-Mental_Health_APRNs-For_Students.pdf).

<sup>26</sup> Chron. (n.d.). *What is the job outlook for a psychiatric NP?* Retrieved from <http://work.chron.com/job-outlook-psychiatric-np-31057.html>.

<sup>27</sup> Wiebe, J. (n.d.). Mental health workforce development at the University of Texas at El Paso. (Unpublished report).

<sup>28</sup> Ibid.

Given the THECB and BON stances on the DNP degree, and the fact that both MSN- and DNP-level nurses in Texas have the same practice autonomy and prescriptive authority, there may be little benefit to initially creating a DNP degree program over a MSN degree program at UTEP. Taking this into account, along with the shortage of mental health professionals in the area, if UTEP is going to invest in a PMHNP program, it may be most beneficial to begin by developing and implementing a program that attracts as broad an applicant pool as possible. This could be done by offering a uniquely designed AE-MSN degree program.

Specifically, UTEP might consider designing the AE-MSN degree program for people who hold a bachelor or graduate degree(s) in disciplines other than nursing who are interested in pursuing both their RN license and MSN degree. The program could begin with an intensive, full-time series of foundation courses and then have students sit for the National Council Licensure Examination (NCLEX) RN exam to obtain their RN license. Afterwards, students could spend the rest of the program focusing on the coursework required for the MSN degree.

Some AE-MSN degree programs in Texas require applicants to already be a RN and have either an associate's degree or a diploma in nursing. These requirements can significantly decrease the number of people who are eligible to apply. This may help to explain the low number of AE-MSN applicants for the two schools discussed in the Key Informant Interviews section above, as both of their AE-MSN degree programs are structured in this way. Additionally, as gleaned from the key informant interviews (but not discussed in the above section), the school with a AE-MSN degree program designed for non-RN licensed individuals, as the one described in the preceding paragraph, had more interested and qualified applicants in 2015 and 2016 than they had available spots, which indicates a high demand for this type of AE-MSN degree program. By offering an AE-MSN degree program like the one discussed in the preceding paragraph, UTEP can attract a greater number of applicants, such as those with psychology, social work, and/or public health backgrounds, and train them to become psychiatric mental health nurses in a relatively brief amount of time. Doing so could help alleviate shortages of mental health professionals in the area and lead to a qualitative shift in access to mental health services in the El Paso region.

## Appendix Nine: Concepts and Resources for School-Based Programs

### Meadows Mental Health Policy Institute

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#### Closing the School to Prison Pipeline in Texas

February 2016

#### What is the “School to Prison Pipeline”?

This phrase describes the pattern of increased risk for future involvement with the juvenile and adult criminal justice systems as a result of educational practices implemented by school districts across the state and across the country. These practices feature so-called *zero tolerance policies* and the *use of police* in schools, but also include *school climate* as well as *everyday school responses* to normal classroom misbehavior.

The school-to-prison pipeline starts in the classroom. When combined with zero-tolerance policies, a teacher’s decision to refer students for discipline can be the start of a sequence through which they are pushed out of the classroom and are quickly at risk for entry into the criminal justice system.

*Suspension from 9th grade triples the chances of incarceration and doubles chances of dropping out.<sup>29</sup>*

Students are also far more likely to be arrested at school than they were 10 years ago. This is in part related to the increased police presence in schools over that time period. According to the US Department of Justice, the number of school resource officers increased about 40% in the past 10 years. School resources officers are sworn law enforcement officers responsible for security and crime prevention in schools. While the increase was driven by safety concerns, the vast majority of these arrests are for nonviolent offenses, such as being disruptive in the classroom.<sup>30</sup> While classroom disruptions must be addressed, so called “zero-tolerance”

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<sup>29</sup> Balfanz, R., Byrnes, V., & Fox, J. (2013). Sent Home and Put Off-Track: The Antecedents, Disproportionalities, and Consequences of Being Suspended in the Ninth Grade. Paper presented at the Closing the school discipline gap: Research to practice, Washington, DC. (as cited in Losen, D.J. & Martinez. T. (2013). Out of School & Off Track: The Overuse of Suspensions in American Middle and High Schools. Center for Civil Rights Remedies at UCLA’s Civil Rights Project. [[http://civilrightsproject.ucla.edu/resources/projects/center-for-civil-rights-remedies/school-to-prison-folder/federal-reports/out-of-school-and-off-track-the-overuse-of-suspensions-in-american-middle-and-high-schools/OutofSchool-OffTrack\\_UCLA\\_4-8.pdf](http://civilrightsproject.ucla.edu/resources/projects/center-for-civil-rights-remedies/school-to-prison-folder/federal-reports/out-of-school-and-off-track-the-overuse-of-suspensions-in-american-middle-and-high-schools/OutofSchool-OffTrack_UCLA_4-8.pdf)]

<sup>30</sup> James, N. & McCallion, G. (2013). School Resource Officers: Law Enforcement Officers in Schools. Congressional Research Service. [<https://www.fas.org/sgp/crs/misc/R43126.pdf>]

policies, which set one-size-fits-all punishments for a wide range of behaviors, underlie these trends.<sup>31</sup>

### Who is in the School to Prison Pipeline?

A 2011 study published by the Justice Center of the Council of State Governments tracked nearly 1 million students in Texas for six years. The study found that children with emotional disabilities (Severe Emotional Disturbances) were disproportionately suspended and expelled, and African Americans were disproportionately punished compared with otherwise similar white and Latino students.<sup>32</sup>

Nationally, students from two groups are over-represented in the school-to-prison pipeline:

- **Racial minorities:** African American students are 3.5 times more likely than their white classmates to be suspended or expelled for the same offense; black children constitute 18% of the school population, but account for 46% of those suspended more than once.<sup>33</sup>
- **Children with disabilities:** Students with disabilities are similarly at risk. Nearly 3 out of 4 students in special education are suspended or expelled, and “emotional disturbance” is among the most common underlying issues. While about 9% of public school children have been identified as having disabilities that affect their ability to learn, these students make up about 32% of youth in juvenile detention centers.<sup>34</sup>

Despite laws that prohibit discrimination against racial minorities and people with disabilities, these patterns have existed for many years.

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<sup>31</sup> Teske, Steven. “A Study of Zero Tolerance Policies in Schools: A Multi-Integrated Systems Approach to Improve Outcomes for Adolescents” 24 *J. of Child & Adolescent Psychiatric Nursing* 88, 93 (2011).

[<http://www.ncjfcj.org/sites/default/files/Zero%20Tolerance%20Policies%20in%20Schools%20%28%29.pdf>]

<sup>32</sup> Fabelo, t., Thompson, M., Plotkin, M., Carmichael, D., Marchbanks III, M., & Booth, M.A. (2011). *Breaking Schools' Rules: A Statewide Study of How School Discipline Relates to Students' Success and Juvenile Justice Involvement*. Council of State Governments Justice Center.

[[https://csgjusticecenter.org/wpcontent/uploads/2012/08/Breaking\\_Schools\\_Rules\\_Report\\_Final.pdf](https://csgjusticecenter.org/wpcontent/uploads/2012/08/Breaking_Schools_Rules_Report_Final.pdf)]

<sup>33</sup> U.S. Department of Education, Office for Civil Rights, Civil Rights Data Collection, 2009-2010 Statistics.

[<http://www2.ed.gov/about/offices/list/ocr/data.html?src=rt>]

<sup>34</sup> Center for School Mental Health. (2014). *The impact of school mental health: Educational, social, emotional, and behavioral outcomes*. Center for School Mental Health: Baltimore, MD.

[<http://csmh.umaryland.edu/Resources/Reports/index.html>]

Balfanz, R., Byrnes, V., & Fox, J. (2013). *Sent Home and Put Off-Track: The Antecedents, Disproportionalities, and Consequences of Being Suspended in the Ninth Grade*. Paper presented at the Closing the school discipline gap: Research to practice, Washington, DC. (as cited in Losen, D.J. & Martinez. T. (2013). *Out of School & Off Track: The Overuse of Suspensions in American Middle and High Schools*. Center for Civil Rights Remedies at UCLA's Civil Rights Project. [[http://civilrightsproject.ucla.edu/resources/projects/center-for-civil-rights-remedies/school-to-prison-folder/federal-reports/out-of-school-and-off-track-the-overuse-of-suspensions-in-american-middle-and-high-schools/OutOfSchool-OffTrack\\_UCLA\\_4-8.pdf](http://civilrightsproject.ucla.edu/resources/projects/center-for-civil-rights-remedies/school-to-prison-folder/federal-reports/out-of-school-and-off-track-the-overuse-of-suspensions-in-american-middle-and-high-schools/OutOfSchool-OffTrack_UCLA_4-8.pdf)]

## How Can We Close the Pipeline?

Reducing use of suspension and expulsion is not simple, especially with schools under pressure to meet accountability standards. Given the strong system of local control of education in Texas, individual school districts and administrators have tremendous power to make changes in school discipline. With leadership from the top, school discipline can change from a system of punishment to a system of student development. Evidence-informed alternatives to exclusionary discipline can simultaneously diminish the negative outcomes of harmful discipline policies, boost achievement, reduce misconduct, and maintain safe and healthy schools.<sup>35</sup>

Reviewing efforts from around the country, there seem to be four broad categories of action:<sup>36</sup>

- ***School-wide social and emotional support models that seek to improve the culture within an entire school.*** They rely on professional development to allow all staff to work together to implement positive behavioral interventions and instructional strategies to replace more punitive measures. The best-known of these programs are *Positive Behavioral Interventions and Support* (PBIS) and *Safe and Responsive Schools* (SRS).
- ***Programs that teach educators better skills in behavior management and student discipline.*** Examples include “*My Teaching Partner*” and “*Objective Threat Assessment*”.
- ***Approaches that change the way that schools respond to misbehavior.*** These approaches either replace suspension with another type of response or offer alternative activities to students during times of suspension. The *Restorative Justice* model is the most widely recognized of these strategies.<sup>37</sup>
- ***Schools can partner with health care systems to ensure access to health and mental health care for students who need it*** through school-based and school-linked health care delivery.

In addition to strategies implemented directly by schools, it is also useful to support actions such as *compiling data on disciplinary actions* organized by gender, race and disability. Ensuring *clear policies and limits to the role of law enforcement at school* – including arrests and the use of restraints – is also important. Finally, schools should make sure that clear and simple explanations of infractions and prescribed responses are known to all.<sup>38</sup>

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<sup>35</sup> Skiba, Ritter & Simmons. The Safe and Responsive Schools Project: A School Reform Model for Implementing Best Practices in Violence Prevention. 632-33. [ [http://www.indiana.edu/~equity/docs/A\\_School\\_Reform\\_Model.pdf](http://www.indiana.edu/~equity/docs/A_School_Reform_Model.pdf).]

<sup>36</sup> Metze, P. S. (2012). Plugging the school to prison pipeline by addressing cultural racism in public education discipline. *UC Davis Journal of Juvenile Law & Policy*, 16, 203.

Darensbourg, A., Perez, E., & Blake, J. (2010). Overrepresentation of African American males in exclusionary discipline: The role of school-based mental health professionals in dismantling the school to prison pipeline. *Journal of African American Males in Education*, 1(3), 196-211.

<sup>37</sup> DPS Restorative Justice Project. Executive Summary. 2007-2008. August 31, 2008. Prepared for Denver Public Schools by: Myriam L. Baker, Ph.D.

<sup>38</sup> Behrens, D., Lear, J.G. & Acosta Price, O. (2015) Improving Access to Children’s Mental Health Care: Lessons from a Study of Eleven States. Center for Health and Health Care in Schools]

## Meadows Mental Health Policy Institute

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### School-based Mental Health: Attributes that Make Schools Strong Candidates for Successful Implementation

#### Overview

According to a July 2014 report by the Robert Wood Johnson Foundation,<sup>39</sup> providing mental health services to students in schools is an effective strategy for addressing the mental health needs of children and adolescents. In addition, schools are the most natural setting for prevention and early intervention, as well as identifying and assisting youth at risk for experiencing more serious behavioral health concerns. Conversely, exclusionary school discipline is the primary risk factor for future involvement in the juvenile justice system. This “school-to-prison pipeline” starts in the classroom. When exclusionary discipline is combined with zero-tolerance policies, a teacher’s decision to refer a student for discipline can start a sequence that pushes the student out of the classroom and quickly puts them at risk for entry into the juvenile justice system.

#### School Attributes

Several attributes contribute to a school’s successful implementation of a school-wide mental health program.

- **Administrative Support:** Support at all levels of leadership, including the district superintendent and the school principals, is necessary to garner the buy-in from teachers, staff, students, and parents. This includes a willingness to adopt or modify policies related to exclusionary discipline (“zero-tolerance”), school climate, bullying, and general classroom management.
- **School-wide implementation of a social and emotional curriculum:** Schools must be willing to implement school-wide strategies for teaching positive behaviors and creating a positive school climate (PBIS, Good Behavior Game, etc.). School-wide implementation requires a commitment to train staff at all levels.
- **Shared space:** Schools must be willing to share space with community mental health providers.
- **Community-partnerships:** Schools must demonstrate a willingness to collaborate with community partners to include community-based mental health providers, law enforcement, health care providers, child welfare, and juvenile probation.

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<sup>39</sup> Murphey, D., Stratford, B., Gooze, R., Bringewatt, E., Cooper, P.M., Rojas, A. (2014). *Are the children well? A model and recommendations for promoting the mental wellness of the nation’s young people*. Robert Wood Johnson Foundation, 6-7.

- **Easy access to community-based services and supports:** Schools must be willing to establish formal and informal partnerships with community-based mental health providers including crisis intervention service teams to provide services in schools, community-based settings, and homes. Streamlined, simple referral protocols facilitate school staff ensuring students are able to access mental health professionals.
- **Family Partnerships:** Schools must demonstrate a willingness to partner with families. Families can provide critical feedback on the effectiveness of services and supports.
- **Communication and Data Sharing:** Schools must be willing to develop a communication and data sharing plan or MOU to address the challenges presented by FERPA and HIPAA.

**Data Collection, Analysis and Utilization:** Schools must be willing to utilize data to drive decision-making and the ability to demonstrate progress towards identified outcomes for the successful implementation and ongoing support of school-based mental health programs.

## **Appendix Ten: Texas Judicial Council Mental Health Committee Report and Recommendations**



# MENTAL HEALTH COMMITTEE REPORT & RECOMMENDATIONS

October 2016



## Texas Judicial Council

205 WEST 14<sup>TH</sup> STREET, SUITE 600 • TOM C. CLARK BUILDING  
(512) 463-1625 • FAX (512) 463-1648  
P. O. Box 12066 • AUSTIN, TEXAS 78711-2066

CHAIR:

HON. NATHAN L. HECHT  
Chief Justice, Supreme Court

VICE CHAIR:

HON. SHARON KELLER  
Presiding Judge, Court of Criminal Appeals

EXECUTIVE DIRECTOR:

DAVID SLAYTON

In June 2016, the Texas Judicial Council established the Mental Health Committee to:

- Gather stakeholder input, and examine best practices in the administration of civil and criminal justice for those suffering from or affected by mental illness;
- Identify and review systemic approaches for diversion of individuals with mental illness from entering the criminal justice system;
- Make recommendations to the Judicial Council on (1) systemic approaches for improving the administration of justice in cases involving mental health issues; (2) strategies to foster meaningful multi-disciplinary collaboration, enhance judicial leadership, develop and implement technology solutions, and explore potential funding sources; and (3) whether a permanent judicial commission on mental health should be created; and
- Recommend legislative changes that will improve the administration of justice for those suffering from or affected by mental illness and recommendations for diversion from the justice system, for consideration by the 85th Texas Legislature commencing in January 2017.

The members of the committee are:

Honorable Bill Boyce, Chair

Honorable Gary Bellair

Ms. Ashley Johnson

Representative Andrew Murr

Honorable Valencia Nash

Honorable Polly Spencer

Senator Judith Zaffirini

An advisory committee was appointed to assist the committee members in their charge. The members of the advisory committee are:

Dr. Tony Fabelo

Honorable Barbara Hervey

Adrienne Kennedy

Beth Ann Lawson

Honorable Harriet O'Neill

Dr. William B. Schnapp

## Introduction and Overview

The Texas Judicial Council’s Mental Health Committee was created to study and make recommendations regarding improvements to the administration of justice for those suffering from or affected by mental illness. The initial recommendations are explained more fully below.

A discussion of the intersection between mental illness and the Texas court system will put these recommendations in context. Of the 27 million people who live in Texas, approximately 1 million adults experience serious mental illness; roughly half of these adults have serious and persistent mental illnesses including schizophrenia, bipolar disorder, major depression, and post-traumatic stress disorder.<sup>1</sup> Approximately 500,000 children aged 17 or younger have severe emotional disturbance.<sup>2</sup> Substance use disorders frequently accompany mental illness; an estimated 1.6 million adult Texans and 181,000 children aged 12 to 17 have substance use disorders.<sup>3</sup>

These Texans and the communities in which they live frequently find themselves navigating the challenges of mental illness in jails, hospital emergency departments, adult criminal and juvenile justice agencies, schools, and child protective services. These settings often are more expensive and less effective for treating mental illness.

According to the Meadows Mental Health Policy Institute, Texas spends \$1.4 billion in emergency room costs and \$650 million in local justice system costs annually to address mental illness and substance use disorders that are not otherwise being adequately treated. Some of these amounts are directed to approximately 36,000 “super utilizers” who live in poverty, suffer from mental illness, and frequently use jails, emergency rooms, crisis services, emergency medical services, hospitals, and other resources for short-term interventions. While the Legislature has provided additional funding in prior sessions to invest in the behavioral health system,

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<sup>1</sup> Texas Statewide Behavioral Health Strategic Plan, Fiscal Years 2017-2021, at 10 (May 2016) (Tex. Health and Human Servs. Comm’n).

<sup>2</sup> *Id.*

<sup>3</sup> *Id.* at 11.

including funding to address waiting lists and increased outpatient treatment capacity, concerns remain about the capacity to adequately treat individuals with mental illnesses.

Although recognition of the need for outpatient treatment capacity has been growing, the Texas criminal justice system continues to serve as a default provider of mental health services for many individuals. Most inmates eventually return home, where the consequences of inadequate treatment capacity for mental illness play out in predictable and damaging ways for these individuals, their families, and their communities.

Approximately 20- to 24-percent of the inmate population in Texas has a mental health need; adults with untreated mental health conditions are eight times more likely to be incarcerated than the general population.<sup>4</sup> A 2010 study concluded that nearly eight adults with severe and persistent mental illness were in jail or prison in Texas for every adult in a state psychiatric hospital.<sup>5</sup> In fiscal year 2011, the Texas Department of Criminal Justice spent more than \$130 million on services for mental health and substance use disorders.<sup>6</sup> As of 2014, the Texas Correctional Office on Offenders with Mental or Medical Impairments spent \$21.9 million to support care coordination for offenders with special needs.<sup>7</sup>

These issues are felt at the local level. In Houston, approximately 2,200 inmates received psychotropic medications and mental health services at the Harris County jail in 2013 at a cost of \$26 million.<sup>8</sup> Total jail costs related to mental illness in Harris County in 2013 were estimated at more than \$49 million in 2013. These 2013 costs were more than \$47 million in Dallas County.<sup>9</sup>

These issues affect children and juveniles. Up to 70 percent of youth in contact with the juvenile justice system meet the criteria for a mental health disorder; 60 percent of this group also has a concurrent substance use disorder.<sup>10</sup>

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<sup>4</sup> Texas Behavioral Health Landscape at 3 (December 2014) (Meadows Mental Health Policy Institute).

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

<sup>8</sup> *Id.* at 4.

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

The judiciary is one stakeholder in a highly fragmented system intended to meet the needs and facilitate the recovery of those suffering from or affected by mental illness. In some localities, mental health authorities and law enforcement have collaborated effectively to reduce fragmentation and create innovative programs. Texas has realized improvements in the administration of justice on other highly complex issues through long-term, judicially-led, interdisciplinary initiatives. Examples are the Texas Access to Justice Commission and the Permanent Judicial Commission for Children, Youth and Families (“Children’s Commission”). These models may prove helpful to designing and implementing strategies that improve the administration of justice for those suffering from or affected by mental illness and co-occurring conditions. These models will be explored in future committee reports, along with additional recommendations.

The committee has focused on recommendations in anticipation of the 85th Legislature’s opening on January 10, 2017.

### Basic Assumptions

The committee’s recommendations below are being made based upon the assumption that adequate funding and resources will be made available to allow the changes to be effective. In particular, additional resources will be necessary for:

- local mental health authorities, local intellectual and developmental disability authorities, or other qualified mental health or intellectual disability providers to timely complete mental health assessments;
- appropriate community-based mental health or intellectual disability services for defendants through the Department of State Health Services, the Health and Human Services Commission, or another mental health or intellectual disability services provider;
- outpatient treatment services for competency restoration;
- outpatient education services for competency restoration;
- inpatient mental health facilities other than those operated by the Department of State Health Services for purposes of competency restoration; and

- jail-based competency restoration programs, either state-funded or county-funded or both.

Competency restoration has long been a state-funded responsibility. The committee recognizes this funding responsibility and urges the Legislature to continue funding competency restoration services. As stated previously, the following recommendations are reliant upon adequate funding for the mental health services mentioned above, and failure to provide adequate funding for these services will jeopardize the ability to implement the recommendations.

## Recommendations

### 1. Screening Protocols

The first step in identifying a need for mental health treatment often occurs as part of the intake process at local jails. Texas has had a statutory mechanism in place since 1993 requiring sheriffs to notify magistrates if there is cause to believe a defendant in custody is mentally ill.<sup>11</sup> Since 1993, Texas also has had statutory authorization for magistrates to release a nonviolent defendant with a mental illness on a personal bond and require treatment as a condition of release.<sup>12</sup> Violent offenses are excluded from this personal bond provision by statute. Local practices also affect the availability of personal bonds.

The Council should recommend the following steps:

- Improving transmission of screening information to magistrates under Code of Criminal Procedure Article 16.22.
- Evaluating the effectiveness of Article 16.22, compliance, timing requirements, the feasibility of standardized forms, the fiscal impact on smaller communities of screening requirements, and the effectiveness of statewide reporting.
- Evaluating amendments to Code of Criminal Procedure Article 17.032 to increase flexibility regarding bond availability and conditions for mentally ill, non-violent defendants. This evaluation should be

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<sup>11</sup> Art. 16.22, Code of Criminal Procedure.

<sup>12</sup> Art. 17.032, Code of Criminal Procedure.

undertaken in consideration of pretrial release recommendations being made concurrently by the Council's Criminal Justice Committee.

## **2. Competency Restoration**

The 2,400 beds available for inpatient psychiatric treatment in state mental health facilities do not meet the statewide need. This resource serves multiple purposes. One is to treat Texans with severe mental illness who are not involved in the criminal justice system. Another is competency restoration for mentally ill criminal defendants as authorized under Texas Code of Criminal Procedure Article 46B.071. Competency restoration generally includes two phases: (1) psychiatric stabilization, and (2) education about the criminal justice process to increase the defendant's ability to participate in presenting a legal defense. According to the Meadows Mental Health Policy Institute, the average length of stay at state mental health facilities has increased from 58 days in 2012 to 74 days in 2015. The waiting list for these beds has increased; 424 individuals were waiting in jail for a hospital bed as of January 2016.<sup>13</sup>

The capacity needed for ongoing intensive care outside of an inpatient hospital bed setting is lacking. This capacity must be expanded if reliance on inpatient psychiatric treatment is to be reduced for those Texans who can be treated effectively and safely in other settings.

The Council should recommend the following steps:

- Reevaluating whether persons charged with non-violent, misdemeanor offenses should be committed to a state mental health facility for competency restoration. Individuals charged with non-violent, Class B misdemeanors face a maximum sentence of 180 days in jail. Placing these individuals on a path to competency restoration at a state mental health facility delays treatment and causes them to languish in jail waiting for a bed. Placing these individuals in a state mental health facility to retain competency to stand trial often is a moot point once competency is restored because the maximum sentence has been exceeded. These individuals would be better served by being connected

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<sup>13</sup> Texas Statewide Behavioral Health Strategic Plan, Fiscal Years 2017-2021, at 26 (May 2016) (Tex. Health and Human Servs. Comm'n).

to treatment in their communities or, if necessary, receiving treatment through a civil inpatient bed. This approach would reduce inpatient bed demand and free up capacity for those individuals who need treatment at a state mental health facility. Successful implementation of this approach will require creation and expansion of local treatment options sufficient to meet demand and the needs of these individuals and their communities.

- Clarifying existing law to provide local communities with the authority to offer competency restoration and maintenance in any safe and clinically appropriate setting that meets appropriate standards. These settings could include outpatient residential, community inpatient, and jail settings. The Council also should recommend broadening judicial discretion in choosing the best use of local competency restoration options, across appropriate settings, to help reduce backlogs in county jails and state hospitals.
- Simplifying the procedure for reimbursing counties for a restored inmate’s medication and studying the resources necessary to address this population’s medication needs adequately.
  - This could be accomplished through the restoration of budget rider 68 in the Texas Department of Criminal Justice budget from the 78<sup>th</sup> Legislature.<sup>14</sup>

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<sup>14</sup> Rider 68, Texas Department of Criminal Justice (p. V-25): “Continuity of Care. Out of the funds appropriated above in Strategy B.1.1, Special Needs Projects, the Texas Council on Offenders with Mental Impairments shall coordinate with the Texas Department of Mental Health and Mental Retardation, county and municipal jails, and community mental health and mental retardation centers on establishing methods for the continuity of care for pre- and post-release activities of defendants who are returned to the county of conviction after the defendant’s competency has been restored. The Council shall coordinate in the same manner it performs continuity of care activities for offenders with special needs. ***As part of the Continuity of Care Plan and out of funds appropriated above in Strategy B.1.1, Special Needs Projects, the Texas Council on Offenders with Mental Impairments shall provide a 90-day post-release supply of medication for a defendant who, after having been committed to a state mental health and mental retardation facility for restoration of competency under Chapter 46, Code of Criminal Procedure, is being returned to the committing court for trial. The 90-day supply of medication shall be the same as prescribed in the Continuity of Care Plan prepared by the state mental health and mental retardation facility.***” (emphasis added)

- Addressing the effects of trial delays after competency restoration has occurred.
- Shifting the legal education component of competency restoration to an appropriate non-medical environment after psychiatric stabilization has been achieved.

### 3. Jail Diversion

The 83rd and 84th Legislatures created and funded a \$10 million pilot program to reduce recidivism and the frequency of arrests and incarceration among persons with mental illness in Harris County. This “SB 1185” jail diversion pilot program requires local matching funding from Harris County, local collaboration, and services coordination. Outcome measures focus on reducing recidivism, frequency of arrests, and incarceration. Authorization for the SB 1185 jail diversion pilot program expires in 2017; a report on its results will be issued by the end of 2016.

The Council should recommend the following steps:

- Continuing and expanding the SB 1185 jail diversion pilot program if it is shown to be effective based upon the upcoming evaluation. Any expansion should be tailored to local needs, resources, and conditions. As part of any expansion, the state should partner with communities that work collaboratively to eliminate forensic waitlists in their jails where all key local leaders (county, local mental health authorities, and, if present, the hospital district) agree on the plan. The goal should be to build sufficient treatment capacity for routine cases locally.

### Areas of Future Study

The committee discussed many other issues that may have merit. The committee recommends that the Council continue studying the following issues for potential action:

- Expand judicial education on best practices for addressing needs of mentally ill individuals in the court system; promote use of appropriate terminology to avoid outmoded and disrespectful labels.

- Require contracts with Department of State Health Services to promote coordination among local mental health agencies, courts, and service providers; review effects of contract provisions on options for preventive mental health treatment; review contractual waivers to address payment if treatment is refused.
- Mandate consistent data collection across all specialty courts to allow measurement of key factors including outcomes and recidivism.
- Suspend rather than terminate housing and other benefits for mentally ill offenders during incarceration to reduce risk of recidivism upon release. Provide acceptable housing options after release.
- Explore availability of services for juveniles and screening mechanisms to diminish delays in addressing first onset of psychosis between ages 15-25; consider options for increasing parental participation in counseling under Family Code §§ 54.041(a)(3), 61.002(a)(8).
- Evaluate the availability of mental health programs in rural areas.
  - Funding; flexibility in requiring local funding matches.
  - Impediments to care based on factors including distance, lack of local mental health professionals.
- Coordinate with OCA's guardianship compliance pilot program and guardianship reforms recommended by the Judicial Council's Elders Committee.
- Expand the scope of the Mental Health Committee, or any future commission studying mental health issues, to focus on individuals with an intellectual disability and examine the intersection of the justice system with these individuals to promote effective practices in the administration of justice when individuals with an intellectual disability are justice-involved.
- Establish a permanent judicial commission on mental health, similar to the Children's Commission; the Texas Access to Justice Commission; and the Texas Indigent Defense Commission.