Assessment of the Community Behavioral Health Delivery System in Dallas County: Main Report

Dallas County Behavioral Health System Redesign Task Force

October 2010
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Executive Summary

Data and Policy Analysis

Persons in Need

- **Impoverished populations are growing rapidly in Dallas County** (those with Medicaid or under 200% FPL), up 16.6% from State Fiscal Year (SFY) 2008 to SFY 2010.

- **Medicaid coverage is strikingly low for adults in poverty** in Dallas County (and Texas generally), with only 11% of adults below 200% FPL having Medicaid.

- In Dallas County in SFY 2009, **over 97,000 adults and children in poverty (under 200% FPL) had severe behavioral health needs** (just over 4% of the population), including over 44,000 adults and 28,500 children under 200% FPL with severe mental health (MH) needs, nearly 69,000 adults under 200% FPL with severe substance use disorders (SUD), and over 26,500 with co-occurring severe MH/SUD.

Persons Served

- **NorthSTAR serves about half of those with severe needs** who are impoverished, a relatively high rate compared to other systems in Texas and nationally.

- The emphasis on serving more people overall than most systems seems to be associated with insufficient services for those with the highest needs.

- **Dallas County Juvenile Services is state-of-the-art, but provides 40% of services to children and youth** with the highest needs and essentially all intensive community services.

- The **Dallas County Jail Behavioral Health Program** (operated by Parkland Hospital) **serves over one-quarter (28%) of adults** with the highest MH and SUD needs.

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

- NorthSTAR serves **only a fraction of individuals with primarily SUD needs** (9.7%).

There are also signs that needs are growing more intense:

- **NorthSTAR members served in acute care settings**\(^1\) **grew dramatically** (9.3%) from the six-month period of December 2008 through May 2009 to the same six-month period in 2009-2010; enrollees not previously registered as in treatment primarily drove the increase.

\(^1\) Acute care settings include emergency departments, 23-hour observation, and acute inpatient hospital units.
• Numbers of people in the Dallas County jail waiting for behavioral health placement grew more than four times as fast as the rest of the jail population from County Fiscal Year (CFY) 2008 to CFY 2010.

• The juvenile justice system is experiencing very large cuts in funding (upwards of 10% per year) and is much more dependent on county revenue than other parts of the country that make better use of Medicaid.

System Providers

• Dallas County has less community hospital capacity than the rest of Texas and falls below national averages (12.9 beds per 100,000, versus 26.4 in Texas and 25.2 nationally).

• In SFY 2009, NorthSTAR provided most acute care through Terrell State Hospital (64% of acute care days, $11.2 million or 41% of acute care spending).

• Acute community inpatient lengths of stay are only one-half to one-third as long as in comparison cities (2.9 to 4.6 days).

• ADAPT Mobile Crisis is effective, but its capacity is insufficient to meet the range of needs.

• There has been fixed capacity for SUD residential care for years and sharply decreased access to SUD outpatient services since November 2009.

System Funding and Expenditures

• NorthSTAR accounts for just over half (51%) of identified system funding for public behavioral health services and supports. It is very likely less than half of all public funding.

• Under Health Care Reform, rates of health care coverage through Medicaid for adults under 133% FPL and through subsidies to purchase care for adults from 133% to 400% FPL are expected to increase dramatically in 2014, with more federal funds expected.

• On a per capita basis, NorthSTAR’s General Revenue allocations are comparable to those of other urban (Bexar County, Harris County, and Tarrant County) Local Mental Health Authorities (LMHAs). In terms of per capita behavioral health expenditures (using recent data compiled by the Legislative Budget Board [LBB]), NorthSTAR leverages its allocation to deliver total expenditures for services comparable to the Bexar County service area ($34.05 versus $36.20 per capita, respectively, though Bexar County spends much more on psychiatric medication) and total expenditures for service much higher than the Harris County and Tarrant County service areas ($23.62 and $21.24 per capita, respectively). It should be noted that the LBB data is somewhat skewed by higher reporting of indigent emergency room, observation and non-state hospital inpatient expenses for NorthSTAR.

• Per capita spending for SUD services is essentially equal across these urban areas ($4.63).
• **NorthSTAR gets less** Texas Correctional Office on Offenders with Medical or Mental Impairment (TCOMMI) **funding per capita** (the other counties get 19%–65% more).

• NorthSTAR has the only full-risk managed care system nationally in which **funding for the uninsured is capped and service access and provision is unlimited**. This may contribute to a misalignment of resources in which there is **over-emphasis on increasing numbers served and under-emphasis on making sure the highest need individuals are served adequately**.

**Policy Analysis**

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

• The current structure and function of the North Texas Behavioral Health Authority (NTBHA) as the regional authority lacks empowerment by its member counties and sufficient expertise to be able to effectively oversee a complex regional managed behavioral health care system.

• For health reform, the **organization and readiness of local systems will be key to controlling complex, co-morbid behavioral health costs**, a central driver of overall costs.

• Emerging integrated delivery system models such as **accountable care organizations (ACOs)** can bring together health care providers and the broader human services delivery system to address the needs of those with the most complex conditions.

Dallas County has **five critical gaps to address**:

1. **Dedicated county-level and hospital district behavioral health leadership.**
2. Exploration of opportunities for **county-MCO** partnerships in the short and longer term.
3. Expanding **provider-MCO partnerships** to build an infrastructure for ACO-like entities.
4. **Broadening partnerships through collaboratives** (for example, to build a new crisis unit).
5. **Expanding partnerships in performance management** to use data and contractually-based performance incentive targets to improve MCO performance and provider care delivery.

**The Twelve Steps: Areas of Recommendation**

Our recommendations center on four systemic steps to **empower county-level system oversight** (Steps 1 and 2), shift the focus and dramatically enhance the effect of **performance management** (Step 3), and **better leverage data** (Step 4) to reorient current system resources toward the unmet priorities of Dallas County (and ultimately other NTBHA county).

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2 MCO = managed care organization
stakeholders. This can be done with or without increases in system funding and will better position Dallas County and NTBHA to attract and use increased system funding over time. The other eight steps describe specific applications of the initial four core systemic shifts.

Step 1: Creating and Implementing a Behavioral Health Leadership Team (BHLT) in Dallas County. The purpose of creating the Dallas County BHLT is twofold: (1) To identify and formalize a partnership process and structure for Dallas County in which all significant stakeholders can come together to organize and oversee planning, decision-making, resource sharing, and implementation strategies for behavioral health; and (2) to help Dallas County be organized to be a more effective partner within NTBHA as a whole.

Step 2: Models of System Authority, Oversight and Funding. Building on the BHLT, Dallas County should develop a county-based locus of authority and decision-making to organize and coordinate the delivery of county-funded behavioral health services within the broader array of regional behavioral health, health care and human services. Furthermore, there are multiple models for county behavioral health systems to organize and oversee contracts with managed care organizations (MCOs), summarized by two concepts:

- A range of risk arrangements, ranging from partial risk or shared risk corridors, where the risks and rewards of care delivery are shared and less potentially volatile, to no risk or administrative services organization (ASO) where the MCO functions on a fixed budget.

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

Step 3: Customer-Oriented Performance Improvement. Although the NorthSTAR system has had a positive impact on the regional behavioral health system during the past 10 years, current methods for measuring system performance are inadequate for assessing how the system is truly performing. There needs to be a more sophisticated process to develop, monitor, and incentivize performance measurement and improvement, grounded in local priorities and meaningful indicators and focusing on more than just NorthSTAR.

Step 4: Data Sharing for System Management. This was prioritized based on one of the most significant findings in the study: that both clinical and financial management information in the Dallas County and NorthSTAR systems is not well developed, nor used as successfully as it could be to oversee and manage a complex behavioral health care system. Current data elements provide an incomplete and only partially accurate picture of NorthSTAR’s performance, both in and of itself, and in comparison to other parts of Texas. Further, the depth and breadth of information shared across all system partners, service types, levels of care and funding
arrangements is not adequate to ensure the effectiveness of Dallas County (or regional) behavioral health services and supports within a total system of care.

**Step 5: Primary Health/Behavioral Health Integration** is essential given that the economics of health care reform will require enhanced capacity to serve people with behavioral health needs in primary care settings and integration of care delivery across tertiary settings (hospitals), secondary specialty care (behavioral health), and primary health. **Parkland’s Community-Oriented Primary Care (COPC) clinics and broader ambulatory health resources offer an initial primary care and broader health delivery infrastructure upon which to build.**

**Step 6: Welcoming, Recovery-Oriented, Integrated Continuum of Crisis-Intervention and Acute-Care Services.** This centers on developing a proactive crisis response system with a continuum of crisis, stabilization, and residential services. The current Dallas County system (and NorthSTAR) is designed to be highly crisis-reactive and significant resources are invested in “back-end,” more expensive crisis response and acute care. Despite a limited set of excellent mobile crisis services, Dallas does not have a welcoming, integrated, and comprehensive crisis hub that can routinely respond to crises before the need for involuntary care emerges and can provide ongoing crisis intervention for individuals unable to connect to more routine services. Further, unlike many other urban systems and other LMHAs in Texas, Dallas does not have a community-based subacute / crisis stabilization unit (S-CSU) that can function as an inpatient diversion or step-down for individuals who need a secure setting.

**Step 7: A Recovery-Oriented, Integrated System of Care for Adults with Serious Mental Illness** would be based on an overall vision of a system of care where “co-occurring is an expectation, not an exception.” We recommend a strategic commitment to reorganize the system in order to improve the capacity of the NorthSTAR Specialty Provider Network (SPN) to help individuals with the most severe conditions to become more easily connected to long-term recovery support and rehabilitative services, to be less likely to disconnect from ongoing services when having a hard time, and to be more likely to be empowered to achieve happy, hopeful, and productive recovery goals and to “graduate” from the SPN service system when appropriate.

**Step 8: Recovery-Oriented, Integrated Continuum of Services for People with Substance Use and Co-occurring Disorders** center on adults and adolescents with substance use disorders (SUD), both those with co-occurring MH and SUD needs and individuals with SUD who do not have a serious mental illness (SMI). The goal is to **plan and implement an integrated, recovery-oriented continuum of substance abuse services in Dallas County (and, potentially, in the NorthSTAR region)** by first identifying an empowered local (county or regional) substance abuse planning and oversight leadership team to begin to build an integrated system with universal co-occurring capability, and planning early steps to make progress toward this vision, under the purview of the BHLT.
Step 9: Criminal Justice/Behavioral Health Service System for Adults focuses on recommendations to reduce the risk of criminal justice involvement, and, if such involvement occurs, increase both pre-booking and post-booking diversion, reduce the frequency and length of incarceration, increase service delivery options within the criminal justice system to facilitate successful re-entry and reduction of recidivism, and increase the responsiveness of community-based services for behavioral health clients with criminal justice involvement or risk.

Step 10: System of Care and Housing Services for People who are Homeless activities should center on the Metro Dallas Homeless Alliance, a model “subsystem” within the City and County of Dallas for providing integrated health, mental health, substance use, employment, and housing services to individuals and families who are homeless. The goal is to improve integration of services and coordination of care for individuals and families with behavioral health needs who are homeless through a formal locus of planning and implementation of services for individuals and families with behavioral health needs who are homeless.

Step 11: A Youth and Family Driven System of Care for Children, Adolescents and Families with Behavioral Health Needs depends on knitting together the fragmented current continuum of services for children and families. These recommendations center on the concepts of the national system of care movement, a path for organizing a youth and family driven, resiliency and strengths-focused system of care for children, youth, and families.

Step 12: Services for Cultural and Linguistic Minorities. Systematic assessment, planning, and action are needed to better assess and respond to current health disparities related to culture and language. Current gaps and opportunities to improve performance center on the need to increase the cultural and linguistic competence of Dallas County and broader regional systems.
Main Report

Introduction

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

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

Through this process we reached a clear recognition that everyone across the behavioral health systems of Dallas County and the surrounding NTBHA region is laboring under very challenging circumstances with limited resources. And across our many conversations, we discovered that the people within these systems have tremendous heart and are searching for ways to provide the best care possible to people with tremendous challenges.

This report is organized into three sections: this Introduction, our Data and Policy Analysis, and The Twelve Steps: Areas of Recommendation.

The Data and Policy Analysis section includes detailed analysis of data on population trends, service needs, service provision, and funding, as well as an overview of national and state policy trends that inform strategic planning for the Dallas County and NorthSTAR systems, and which inform our recommendations. These analyses were shared in the form of a working draft of this
report in August 2010, and significant additional feedback and input has been received and incorporated into this report.

The Twelve Steps: Areas of Recommendation section includes findings and recommendations that mostly coincide with the 12 Steps of Recovery for the Dallas County Behavioral Health System that were presented by the TriWest/ZiaPartners Team at the July 2010 meetings of the Coalition on Mental Illness (COMI) and the Dallas County Behavioral Health System Redesign Task Force, but their direction has been modified since then based on further data analysis and stakeholder input. In addition, we have attempted to align the general thrust of our recommendations with both the NTBHA Strategic Plan for 2010-12 and with Charting the Path: A Strategic Plan for Dallas County.

The Twelve Steps or Areas of Recommendation include the following:

1. Creating and Implementing a Behavioral Health Leadership Team (BHLT) in Dallas County
2. Models for System Authority, Oversight, and Funding
3. Customer-Oriented Performance Improvement
4. Data Sharing for System Management
5. Primary Health/Behavioral Health Integration
6. Welcoming, Recovery-Oriented, Integrated Continuum of Crisis-Intervention and Acute-Care Services
7. Recovery-Oriented Integrated System of Care for Adults with Serious Mental Illness
8. Recovery-Oriented Integrated Continuum of Services for People with Substance Use and Co-occurring Disorders
9. Criminal Justice/Behavioral Health Service System for Adults
10. System of Care and Housing Services for People Who are Homeless
11. Development of a Children’s System of Care
12. Services for Cultural and Linguistic Minorities

Each of the 12 Steps is organized with a brief background section, a list of major findings, and then a series of actionable recommendations. The recommendations themselves are divided into phases, usually with the first phase defining action steps to begin immediately and continue over the next 12 months and the second phase referring to action steps or objectives for 12-36 months.

Much discussion of behavioral health in Dallas County naturally centers on the performance of NorthSTAR, even though NorthSTAR represents barely half of the total resources currently spent in Dallas County for public behavioral health. Under NorthSTAR there have been many documented areas of progress: expanded access, more providers, lower costs per person served, and comparable performance to other parts of Texas. At the same time, the overall level of public mental health funding in Texas is 48th nationally, urban areas like Dallas are
particularly challenged by low funding and Medicaid enrollment in Texas, NorthSTAR is particularly challenged by increasing numbers of uninsured enrollees without commensurate funding increases, and there is wide recognition that the system is moving toward overload. Stakeholders shared with us the impression that the Dallas County and NorthSTAR systems cannot improve performance substantially without more resources, and we gave this very specific attention and analysis. Overall, this report attempts to take the data that is most familiar to stakeholders and go deeper and wider to help readers “see” the Dallas County and broader NorthSTAR systems from a different perspective, and to help you to improve your system more effectively as a result.

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

Data and Policy Analysis

Persons in Need

**Impoverished populations are growing rapidly in Dallas County** (those with Medicaid or under 200% of the Federal Poverty Level/FPL), up 16.6% from State Fiscal Year (SFY) 2008 to SFY 2010, compared with 2.0% growth for the population as a whole. **Medicaid coverage is strikingly low for adults in poverty** in Dallas County (and Texas generally), compared to children and to other states, with only 11% of adults below 200% FPL having Medicaid. See the table that follows.
<table>
<thead>
<tr>
<th>Overall Population</th>
<th>SFY 2009 Population&lt;sup&gt;3&lt;/sup&gt;</th>
<th>Average Monthly FY 2009 Medicaid Members&lt;sup&gt;4&lt;/sup&gt;</th>
<th>SFY 2009 &lt;200% FPL&lt;sup&gt;5&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>NorthSTAR Total (all counties)</em>&lt;sup&gt;6&lt;/sup&gt;</td>
<td>3,690,653</td>
<td>378,559</td>
<td>1,114,402</td>
</tr>
<tr>
<td>Dallas County</td>
<td>2,412,431</td>
<td>305,559</td>
<td>872,972</td>
</tr>
<tr>
<td>Dallas County – 0 to 18&lt;sup&gt;7&lt;/sup&gt;</td>
<td>670,565</td>
<td>241,101</td>
<td>244,703</td>
</tr>
<tr>
<td>Dallas County – 19 and older</td>
<td>1,741,866</td>
<td>64,458</td>
<td>618,407</td>
</tr>
</tbody>
</table>

In Dallas County in SFY 2009, **over 97,000 adults and children in poverty (under 200% FPL) had severe behavioral health needs** (just over 4% of the population – see the table below). This included over 44,000 adults and 28,500 children under 200% FPL with severe mental health (MH) needs (3.0% of the population, versus 1.6% in the other NTBHA counties). Over 51,000 Dallas County adults under 200% FPL that year had severe substance use disorders (SUD). Over 26,500 of these adults had co-occurring severe MH and SUD, and nearly 25,000 more had SUD (many of whom have other co-occurring MH conditions, though not necessarily severe.

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<sup>4</sup> Texas Health and Human Services Commission (HHSC). Final Count Reports for Medicaid Enrollment, Medicaid Enrollment by County, State Fiscal Year 2009. Retrieved from: http://www.hhsc.state.tx.us/research/MedicaidEnrollment/MedicaidEnrollment.asp. Average was computed across the 12 months of enrollment.

<sup>5</sup> SFY 2009 figures for <200% FPL will not be available from DSHS until October/November 2010. Therefore, we estimated these figures by using 2008 FPL figures and modifying them based on the change in average Medicaid enrollment between 2008 and 2009. Changes were increases of 6.8% for NorthSTAR Counties, 6.5% for Dallas County, 7.1% for Dallas County youth, and 4.6% for Dallas County adults. We believe that the Medicaid increase is the best proxy, as it reflects both population growth and increases in the rate of poverty. SFY 2008 <200% FPL estimates were obtained from the Texas HHSC, Strategic Decision Support Office, Copy of Estimated Population at-Below FPL in 2008 by Zip Code, via Personal Communication from M. Ferrara, August 16, 2010.

<sup>6</sup> NorthSTAR Counties: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall. Note that the SFY 2010 Quarter 1 NorthSTAR Databook reports an average of 384,130 for SFY 2009. NorthSTAR data was not broken down by county, so we used figures direct from the HHSC website. The numbers are comparable and likely differ due to different approaches to averaging counts across the year.

<sup>7</sup> The average Medicaid eligibles include 2,201 children on average each month who are in foster care. These children are not included in NorthSTAR figures.
<table>
<thead>
<tr>
<th>Type of Condition</th>
<th>SFY 2009 Adults in Need (AIN)</th>
<th>Percent of Population</th>
<th>SFY 2009 AIN &lt; 200% FPL&lt;sup&gt;8&lt;/sup&gt;</th>
<th>Percent of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dallas County Total MH Need</td>
<td>82,913</td>
<td>4.8%</td>
<td>44,197</td>
<td>2.5%</td>
</tr>
<tr>
<td>Dallas County MH but Not SUD</td>
<td>33,165</td>
<td>1.9%</td>
<td>17,679</td>
<td>1.0%</td>
</tr>
<tr>
<td>Dallas County MH and SUD (Co-Occurring)</td>
<td>49,748</td>
<td>2.9%</td>
<td>26,518</td>
<td>1.5%</td>
</tr>
<tr>
<td>Dallas County SUD but Not MH</td>
<td>65,494</td>
<td>3.8%</td>
<td>24,674</td>
<td>1.4%</td>
</tr>
<tr>
<td>Dallas County Total MH and SUD</td>
<td>148,407</td>
<td>8.5%</td>
<td>68,871</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

**Persons Served**

NorthSTAR serves about half of those with severe needs who are impoverished, a relatively high rate compared to other systems in Texas and nationally. However, the emphasis on serving more people overall than most systems seems to be associated with insufficient services for those with the highest needs. **One core finding is that, while NorthSTAR can provide data that appears to demonstrate satisfactory overall performance, there are significant groups of individuals with very high needs that are not “seen” by the current approach to performance monitoring and not effectively served.** These are the individuals who “fall through the cracks” of the current system and are more likely to utilize a high level of resources in multiple systems:

- **Dallas County Juvenile Services is state-of-the-art, but provides 40% of services to children and youth** with the highest needs and essentially all intensive community services.
- The **Dallas County Jail Behavioral Health Program** (operated by Parkland Hospital) served over one-quarter (28%) of adults with the highest MH and SUD needs.

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<sup>8</sup> Data on severe needs by county is from Chuck Holzer, Ph.D. and Nguyen, Ph.D., who make 2007 state level estimates available on their web site: http://66.140.7.153/. 2007 county level estimates for NTBHA counties were purchased for this project. Estimates are for people who would be described as having a serious mental illness as defined by having one of a specified set of relatively severe mental health diagnoses, a high level of functional impairment, and, for adults, as having more than 120 days off work as a result of their mental illness in the last year. The 200% FPL figures used by Holzer were based on SFY 2007 census data. As noted previously, there is evidence that the proportion of the Dallas County population under 200% FPL has increased since SFY 2007. However, the Holzer proportions from SFY 2007 were maintained in order to preserve the internal integrity of the Holzer model. Accordingly, there is some chance that the SFY 2009 need levels for persons under 200% FPL are higher than those noted here.
• **African American youth are served in the juvenile justice system at twice their proportion of the population (43% versus 20); African American adults are even more over-represented in the jail (53%).**

• **Hispanic people comprise 40% of the population, but only 24% of NorthSTAR persons served; 19% of Dallas County speaks Spanish at home and English “less than very well,” but NorthSTAR does not track primary language and provides no written materials in Spanish.**

• NorthSTAR serves **only a fraction of individuals with primarily SUD needs** (9.7%).

• See the Detailed Report for a comprehensive summary of persons served by system area.

<table>
<thead>
<tr>
<th>NorthSTAR Enrollees Served</th>
<th>SFY 2009 Average Proportion of Persons Served</th>
<th>Persons in Need (PIN) &lt;200% FPL Proportions⁹</th>
<th>Proportion of &lt;200% FPL PIN Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD Primarily</td>
<td>4.9%</td>
<td>25.3%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Co-Occurring MH/SUD</td>
<td>25.5%</td>
<td>27.2%</td>
<td>46.9%</td>
</tr>
<tr>
<td>MH Primarily</td>
<td>69.0%</td>
<td>47.4%</td>
<td>72.7%</td>
</tr>
</tbody>
</table>

There are also signs that needs are growing more intense:

• NorthSTAR **members served in acute care settings**⁹⁰ grew dramatically (9.3%) from the six-month period of December 2008 through May 2009, compared to the same six-month period in 2009-2010; enrollees not previously registered as in treatment primarily drove the increase (defined as those without a current SPN and assigned level of care or LOCA – see figure on the following page).

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⁹ Holzer and Nguyen, previously cited. Figures are for Dallas.

⁹⁰ Acute care settings include emergency departments, 23-hour observation, and acute inpatient hospital units.
• **Numbers of people in the Dallas County jail waiting for behavioral health placement grew more than four times** as fast as the rest of the jail population from County Fiscal Year (CFY) 2008 to CFY 2010 (see the figure below).

• Dallas County’s state-of-the-art **juvenile justice system is experiencing very large cuts** in funding (upwards of 10% per year) and is much more dependent on county revenue than other parts of the country that make better use of Medicaid.

• NorthSTAR has identified a group of very high utilizers, termed the “Top 200,” who are using recurrent acute services. **The cost of care for the “Top 200” in calendar year (CY) 2009 was just under $3.85 million.** Also of note is that the “high utilizer” cost data for this population is based only on NorthSTAR utilization, not on a cross walk of utilization of services funded by other sources. We have reviewed other data sets of high utilizers at
Parkland, Green Oaks, and the Dallas County Jail, as well as of persons served at The Bridge, but within our data sets we are not able to determine the degree of overlap with the “Top 200” identified by NorthSTAR.

System Providers

**Dallas County has less community hospital capacity** than the rest of Texas and falls below national averages (12.9 beds per 100,000, versus 26.4 in Texas and 25.2 nationally); capacity is comparable to that of Denver, CO. In SFY 2009, **NorthSTAR provided most acute care through Terrell State Hospital** (64% of acute care days, $11.2 million or 41% of acute care spending).

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Beds</th>
<th>Total Behavioral Health</th>
<th>Psychiatric Beds</th>
<th>Alcohol / Drug Beds</th>
<th>Dual Diagnosis Beds</th>
<th>Dedicated Child / Adolescent Psychiatric Beds</th>
<th>Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodist Richardson</td>
<td>205</td>
<td>42</td>
<td>30</td>
<td>12</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Green Oaks **</td>
<td>106</td>
<td>106</td>
<td>78</td>
<td>–</td>
<td>20</td>
<td>8*</td>
<td>–</td>
</tr>
<tr>
<td>Hickory Trail **</td>
<td>86</td>
<td>86</td>
<td>28</td>
<td>14</td>
<td>–</td>
<td>30*</td>
<td>14</td>
</tr>
<tr>
<td>Timberlawn **</td>
<td>144</td>
<td>144</td>
<td>56</td>
<td>16</td>
<td>–</td>
<td>55*</td>
<td>17</td>
</tr>
<tr>
<td>Parkland</td>
<td>672</td>
<td>18</td>
<td>18</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Children’s Medical Center</td>
<td>487</td>
<td>12</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>12*</td>
<td>–</td>
</tr>
<tr>
<td>UTSW University Hospital</td>
<td>422</td>
<td>18</td>
<td>18</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>THR Presbyterian Dallas</td>
<td>895</td>
<td>50</td>
<td>50</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>–</strong></td>
<td><strong>476</strong></td>
<td><strong>278</strong></td>
<td><strong>42</strong></td>
<td><strong>20</strong></td>
<td><strong>105</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

* Pediatric and adolescent capacity

**Psychiatric Hospitals (other hospitals are general acute care with a psychiatric unit)**

NorthSTAR currently delivers most of its acute inpatient care through Terrell State Hospital and two freestanding psychiatric hospitals (Green Oaks and Timberlawn). Acute community
inpatient lengths of stay are only one-half to one-third as long as in comparison cities (2.9 to 4.6 days). In addition, three hospitals – Green Oaks Hospital, Parkland Health and Hospital System, and Timberlawn Mental Health System – provide psychiatric emergency services. A great many of these visits involve police, and numbers served in these settings are increasing.

- Green Oaks Hospital’s emergency department served 6,799 NorthSTAR members across 10,124 visits. The first six months of 2009 versus the first six months of 2010 saw an increase of over 17% in visits (4,940 to 5,797, with the sharpest rise in May and June).
- Parkland’s psychiatric emergency department served 5,824 people across 7,048 visits. Of those served, 77% of charges were for Medicaid payers (including Medicaid and Medicare/Medicaid dual eligibles). The first six months of 2009 versus the first six months of 2010 saw an increase in people seen of 9.5% (4,487 to 4,878).
- Timberlawn Mental Health System has been designated as the primary place for police to bring children and adolescents in need of emergency mental health services.

**ADAPT Mobile Crisis is effective, but its capacity is insufficient** to meet the current and growing range of needs. It responded to a total of 39,523 total phone calls in CY 2009 (88.6% involving adult NorthSTAR members and 11.4% involving children). Of these, 6,374 crisis calls (16.1%) involved face-to-face interventions. Of these crisis calls, only 906 resulted in a hospitalization (14.2%). Perhaps more importantly, only 10 cases resulted in a call to the police (0.2%). Most cases (nearly 75%) resulted in connections to treatment providers.

One major accomplishment of the NorthSTAR system has been the expansion of the provider network. In SFY 2009, NorthSTAR utilized 291 facility and individual providers to serve members from Dallas County. Those outpatient and residential facilities serving more than 1,000 persons per year are shown on the following page. The table includes the distribution of authorized Resiliency and Disease Management (RDM) levels of care (LOC) for persons in ongoing care as of December 2009 to illustrate the different population subgroups with which each provider tends to specialize. There has been **fixed capacity for SUD residential care for years and sharply decreased access to SUD outpatient services** since November 2009. Overall, NorthSTAR has a strong core of providers able to provide intensive services, but their mix of service delivery is biased toward less intensive service delivery.

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3. All data from ValueOptions December 2009 UM Report.
<table>
<thead>
<tr>
<th>Facility Providers Serving &gt;1,000 Dallas County FY09 NorthSTAR Members</th>
<th>Persons Served</th>
<th>Provider Type</th>
<th>Percent Served Adult</th>
<th>Percent Served Child</th>
<th>Adult Service Mix</th>
<th>Child / Adolescent Service Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Providers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dallas SFY09 NorthSTAR</strong></td>
<td><strong>48,643</strong></td>
<td>All Providers</td>
<td><strong>72%</strong></td>
<td><strong>28%</strong></td>
<td><strong>67%</strong></td>
<td><strong>Child Brief (% of All Child)</strong></td>
</tr>
<tr>
<td>Dallas Metrocare Services</td>
<td>25,535</td>
<td>MH Outpatient</td>
<td>80%</td>
<td>20%</td>
<td>60%</td>
<td>12%</td>
</tr>
<tr>
<td>LifeNet Behavioral Healthcare</td>
<td>2,801</td>
<td>MH Outpatient</td>
<td>96%</td>
<td>4%</td>
<td>60%</td>
<td>2%</td>
</tr>
<tr>
<td>ADAPT Of Texas, Inc.</td>
<td>2,474</td>
<td>MH Outpatient</td>
<td>89%</td>
<td>11%</td>
<td>78%</td>
<td>0%</td>
</tr>
<tr>
<td>Child And Family Guidance Center</td>
<td>2,175</td>
<td>MH Outpatient</td>
<td>32%</td>
<td>68%</td>
<td>47%</td>
<td>39%</td>
</tr>
<tr>
<td>ABC Behavioral Health, LLC</td>
<td>1,836</td>
<td>MH Outpatient</td>
<td>100%</td>
<td>0%</td>
<td>77%</td>
<td>0%</td>
</tr>
<tr>
<td>Centro De Mi Salud, LLC</td>
<td>1,109</td>
<td>MH Outpatient</td>
<td>64%</td>
<td>36%</td>
<td>81%</td>
<td>17%</td>
</tr>
<tr>
<td>University of Texas Medical Branch</td>
<td>1,009</td>
<td>MH Outpatient</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Facility Providers Serving &gt;1,000 Dallas County FY09 NorthSTAR Members</td>
<td>Persons Served</td>
<td>Provider Type</td>
<td>Percent Served Adult</td>
<td>Percent Served Child</td>
<td>Adult Service Mix</td>
<td>Child / Adolescent Service Mix</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>----------------</td>
<td>---------------</td>
<td>----------------------</td>
<td>----------------------</td>
<td>----------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>SUD Services Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeward Bound, Inc.</td>
<td>2,547</td>
<td>SUD Residential / Outpatient</td>
<td>100%</td>
<td>0%</td>
<td>Detox, Residential Recovery, Outpatient</td>
<td></td>
</tr>
<tr>
<td>Solace Counseling Associates, PLLC</td>
<td>1,887</td>
<td>SUD Detox / Outpatient</td>
<td>100%</td>
<td>0%</td>
<td>Outpatient Detox, Outpatient</td>
<td></td>
</tr>
<tr>
<td>Nexus Recovery Center, Inc.</td>
<td>1,213</td>
<td>SUD Residential / Outpatient</td>
<td>95%</td>
<td>5%</td>
<td>Residential Recovery, SFR, Outpatient – Specializing in women and children programs</td>
<td></td>
</tr>
<tr>
<td>Association of Persons Affected by Addictions</td>
<td>1,066</td>
<td>SUD Outpatient</td>
<td>100%</td>
<td>0%</td>
<td>Peer support and recovery coaching</td>
<td></td>
</tr>
<tr>
<td>Specialty OP Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dallas Independent School District</td>
<td>1,861</td>
<td>School-Based</td>
<td>0%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADAPT Community Solutions, Inc.</td>
<td>1,740</td>
<td>Mobile Crisis</td>
<td>88.6%</td>
<td>11.4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
System Funding and Expenditures

We were able to identify nearly $211 million in total expenditures for behavioral health services in Dallas County in 2009 (see the table below). **NorthSTAR accounted for just over half of current identified system funding for public behavioral health** services and supports. It is **very likely less than half** of all public funding available, if all sources could be counted. **System funding is highly fragmented**, with NorthSTAR behavioral health funding at the system level essentially uncoordinated with other funding sources.

<table>
<thead>
<tr>
<th>Care Setting 15</th>
<th>Expenditures</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Expenditures for Behavioral Health Services and Supports for Sources Reporting</td>
<td>$210,778,288 (100%)</td>
<td>Various</td>
</tr>
<tr>
<td>NorthSTAR Dallas County Expenditures (% of Total)</td>
<td>$107,395,201 (51.0%)</td>
<td>Various</td>
</tr>
<tr>
<td>Other Medicaid (FSS, PCCM, HMO, Medications)</td>
<td>$24,835,821 (11.8%)</td>
<td>Federal / State</td>
</tr>
<tr>
<td>Other Dallas County Expenditures (% of Total)</td>
<td>$75,436,622 (35.8%)</td>
<td>Various</td>
</tr>
<tr>
<td>Homeless Services Expenditures (% of Total)</td>
<td>$19,200,000 (9.1%)</td>
<td>Various</td>
</tr>
<tr>
<td>Parkland Expenditures (% of Total)</td>
<td>$29,624,111 (14.1%)</td>
<td>County / Other Payers</td>
</tr>
<tr>
<td>Dallas County Expenditures (% of Total)</td>
<td>$17,638,814 (8.4%)</td>
<td>County Primarily</td>
</tr>
<tr>
<td>Other Correctional Expenditures (% of Total)</td>
<td>$4,973,697 (2.4%)</td>
<td>State / Federal</td>
</tr>
<tr>
<td>Dallas City/School Expenditures (% of Total)</td>
<td>$4,000,000 (1.9%)</td>
<td>Local / State / Federal</td>
</tr>
</tbody>
</table>

**Under Health Care Reform**, rates of health care coverage through Medicaid for adults under 133% FPL and through subsidies to purchase care for adults from 133% to 400% FPL are expected to increase dramatically in 2014. The public sector can expect **more federal dollars to support the expansion of Medicaid access.**

**Advocacy for more state funding based on the efficiency of the system has not been successful** historically. Texas has no excess funding available for behavioral health given its low

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15 See the Detailed Report for citations for all data cited below.
national ranking in per capita funding (48th in ranking of the 50 states\textsuperscript{16}), and it is facing the potential of dramatic future cuts in state spending. This compounds the difficulty in using an efficiency-based argument to justify increased funding. While such an argument could serve as a possible rationale for expanding the NorthSTAR model to other parts of Texas (an argument that is at least logically based on efficiency and being weighed by the Legislative Budget Board [LBB]), efficiency has yet to be a sufficient argument for increased spending through NorthSTAR. Instead, the history of NorthSTAR has been dominated by repeated funding cuts over the past decade as “efficiencies” were taken out of the system.\textsuperscript{17} The cumulative impact of these cuts over time has been striking, representing nearly a one-third reduction in available funds per person served (not even accounting for inflation, which means that the reductions are an order of magnitude greater in terms of services purchasing power).

To broaden the perspective on how Dallas County and NorthSTAR funding compares to the rest of the state, our study has sought to access data on funding sources that looks at the broader population in the three comparison counties previously cited, and their related service delivery areas (SDAs): Bexar, Harris and Tarrant Counties.

On a per capita basis for General Revenue allocations, NorthSTAR receives a level of funding comparable to other urban Local Mental Health Authorities (LMHAs) (Bexar County, Harris County, and Tarrant County). On a per capita basis across all behavioral health expenditures identified by the LBB in its June 2009 draft data book, NorthSTAR expenditures for MH services (excluding medication costs) are at a level comparable to those of the Bexar County service area ($34.05 versus $36.20 per capita, respectively, though Bexar County spends much more on psychiatric medication) and are much higher than Harris and Tarrant Counties’ service areas ($23.62 and $21.24 per capita, respectively). It should be noted that this is somewhat skewed by higher reporting of indigent emergency room, observation and non-state hospital inpatient expenses for NorthSTAR.\textsuperscript{18}

\textsuperscript{18} LBB. (June 29, 2010). Draft data book for LBB comparative report: Comparative analysis of publicly funded behavioral health systems in Texas by HHSC service delivery area. Received via personal communication from L. Garza, August 31, 2010, in response to Open Records Request.
Per capita spending for SUD services is essentially equal across these areas ($4.54 to $4.95 per capita, with NorthSTAR at $4.63).

<table>
<thead>
<tr>
<th>Area</th>
<th>LMHA Allocation Per Capita</th>
<th>SFY 2009 Population</th>
<th>BH $ Per Capita</th>
<th>MH $ Per Capita</th>
<th>Non-Medication MH $ Per Capita</th>
<th>SUD $ Per Capita</th>
<th>Medicaid $ Per Capita</th>
<th>Indigent $ Per Capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>NorthSTAR</td>
<td>$11.93</td>
<td>3,690,653</td>
<td>$44.70</td>
<td>$40.06</td>
<td>$34.05</td>
<td>$4.63</td>
<td>$19.56</td>
<td>$25.14</td>
</tr>
<tr>
<td>Bexar</td>
<td>$12.30</td>
<td>2,021,692</td>
<td>$81.89</td>
<td>$76.94</td>
<td>$36.20</td>
<td>$4.95</td>
<td>$59.60</td>
<td>$22.29</td>
</tr>
<tr>
<td>Harris</td>
<td>$11.71</td>
<td>5,663,845</td>
<td>$51.37</td>
<td>$46.43</td>
<td>$23.62</td>
<td>$4.94</td>
<td>$34.53</td>
<td>$16.84</td>
</tr>
<tr>
<td>Tarrant</td>
<td>$11.95</td>
<td>2,849,024</td>
<td>$43.90</td>
<td>$39.36</td>
<td>$21.24</td>
<td>$4.54</td>
<td>$28.74</td>
<td>$15.16</td>
</tr>
</tbody>
</table>

The NorthSTAR area also receives less Texas Correctional Office on Offenders with Medical or Mental Impairment (TCOMMI) funding per capita (the other counties got 19% to 65% more in SFY 2009). Furthermore, NorthSTAR has the only full-risk managed care system nationally in which funding for the uninsured is capped and service access and provision unlimited. This may contribute to a misalignment of resources in which there is over-emphasis on expanding numbers served and under-emphasis on making sure the highest need individuals are served adequately.

Policy Analysis

Dallas County benefits from a regional behavioral health authority (NTBHA) to facilitate shared planning with surrounding counties and blended behavioral health funding streams, but it

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19 The LBB data book notes that emergency room, non-state hospital inpatient, and observation costs for indigent people, as well as other “Non-State Hospital costs for indigent persons,” are understated outside of the NorthSTAR region, so the apparent higher level of NorthSTAR indigent funding is not valid.

20 Texas DSHS. (November 23, 2009). NorthSTAR County Trends Report 11_23_09. The LMHA populations used to compute the per capita amounts are as follows: NorthSTAR counties 3,772,013, Bexar County 1,636,642, Harris County 4,096,052, and Tarrant County 1,825,548.

lacks the county-level structure (dedicated leadership, staffing, and organization) necessary to coordinate interagency efforts within Dallas County and participate effectively regionally. The Dallas County Hospital District (Parkland) is just beginning to articulate and empower its own internal behavioral health “product line,” and needs to join with other county stakeholders to build a full partnership between primary health and behavioral health service delivery. Further, the current structure and function of NTBHA as the regional authority lacks empowerment by its member counties and sufficient expertise to be able to effectively oversee a complex regional managed behavioral health care system. Both Dallas County and the NorthSTAR region need to be more effectively organized to manage the performance of ValueOptions (or any MCO). There are lessons to be learned from the partnership strategies of more successful county and regional arrangements in other states that inform our recommendations for the future development of the NorthSTAR system to be more effective in addressing high-risk populations. Dallas County’s current strategic plan, Charting the Path, A Strategic Plan for Dallas County, 2007-2017,\(^{22}\) sets the vision of Dallas as “model interagency partner” at the top of its five visions, followed by priorities on a healthy and safe community. The eight goals of NTHBA’s current strategic plan (North Texas Behavioral Health Authority Strategic Plan, SFY 2010-2012\(^{23}\)) also reinforce these observations.

Looking nationally, the opportunities and uncertainties of health care reform loom largest. For health care reform to be successful, the organization and readiness of local systems will be key to controlling complex, co-morbid behavioral health costs, a central driver of overall health costs. These


\(^{23}\) NTBHA. (2010). North Texas Behavioral Health Authority Strategic Plan, SFY 2010-2012.
findings are reviewed in depth in the Detailed Report. Whatever happens in the future with health care reform, “bending the cost curve” for overall health care will require effective strategies for addressing co-morbid behavioral health costs.

This has enormous implications for Parkland in particular in its strategic planning regarding health care reform and primary care/behavioral health integration, as well as the broader behavioral health system as it plans to support community-level health care reform. Emerging integrated delivery system models such as accountable care organizations (ACO) can bring together health care providers and the broader human services delivery system to address the needs of those with the most complex conditions. Efforts across the country are starting to move in this direction, anticipating major changes in existing funding streams (reductions in Upper Payment Limit/UPL and Disproportionate Share/DSH payments to hospitals), increased regulation due to mental health parity, and the need to plan for health authority governance in a post-reform, post-parity environment. Dallas County has five critical gaps to address:

1. Dedicated county-level and hospital district behavioral health leadership.
2. Exploration of opportunities for county-MCO partnerships in the short and longer term.
3. Expanding provider-MCO partnerships to build an infrastructure for ACO-like entities.
4. Broadening partnerships through collaboratives (for example, to build a new crisis unit).
5. Expanding partnerships in performance management to use data and contractually-based performance incentive targets to improve MCO performance and provider care delivery.

The Twelve Steps: Areas of Recommendation

Our recommendations center on four systemic steps to empower county-level system oversight (Steps 1 and 2), shift the focus and dramatically enhance the effect of performance management (Step 3), and better leverage data (Step 4) to reorient current system resources toward the unmet priorities of Dallas County (and ultimately other NTBHA county) stakeholders. While increased funding would of course be desirable, these four systemic recommendations can be accomplished with or without increases in system funding, and they will better position Dallas County and NTBHA to attract and use increased system funding over time. The other eight steps describe specific applications of the initial four core systemic shifts.
Four Core Systemic Steps

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

This initial step is critical in order to strengthen the functional decision-making capacity of the Dallas County behavioral health system by creating an empowered horizontal and vertical partnership of representatives who collectively own responsibility for the design, implementation, and oversight of a true system of care within Dallas County, as well as in relationship to the other counties participating in the NorthSTAR Region. The purpose of creating the Dallas County BHLT is twofold: (1) To identify and formalize a partnership process and structure for Dallas County in which all significant stakeholders can come together to organize and oversee planning, decision-making, resource sharing, and implementation strategies for behavioral health; and (2) to help Dallas County be organized to be a more effective partner within NTBHA as a whole.

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

The initial activity under this step – already carried out in August and September 2010 – was that the BHLT be organized and chartered by the County Commissioners, ideally in partnership with the Hospital District (Parkland). Subsequent recommended activities include: building ties across Dallas County and NTBHA, in partnership with DSHS, using the TriWest / Zia Report as a road map for future system change over the next six to 12 months, and focusing on early wins (such as data sharing and addressing the “Top 200” high utilizers).

Step 2: Models of System Authority, Oversight and Funding

This step focuses on the longer term. Building on the BHLT, Dallas County should take further steps over the next three years to develop a county-based locus of authority and decision-
making to organize and coordinate the delivery of county-funded behavioral health services within the broader array of regional behavioral health, health care and human services. Other urban behavioral health systems across the country are aggressively developing various types and levels of partnership with MCOs, providers, and diverse stakeholders. **There are multiple funding models and alternatives to the current NorthSTAR arrangement** of a single behavioral health MCO that are used and in the process of redevelopment in light of health care reform across the country by public managed behavioral health systems in designing contractual relationships and allocating risk. These include:

- **A range of risk arrangements**, ranging from **partial risk or shared risk corridors**, where the risks and rewards of care delivery are shared and less potentially volatile, to **no risk or administrative services organization (ASO)** where the MCO functions on a fixed budget.

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

There are **multiple models for county behavioral health systems to organize and oversee “managed care structures”** and contract with MCOs (which can be used individually or mixed):

- One model involves **the state Medicaid authority directly contracting with a local county (or an organized group of counties)**, which in turn directly contracts with an MCO.

- Another alternative is to **develop locally-controlled, non-profit MCOs** (usually through provider / stakeholder partnerships that can involve counties).

- More complex arrangements let **local authorities oversee and coordinate multiple MCOs, each responsible for distinct populations** (so they are not fundamentally competitive), which can be either for-profit MCOs or locally controlled non-profits.

- Another arrangement involves **the behavioral health managed care function as a carve-in by an integrated MCO** (or sub-contracted within a carved-in arrangement as a carve-out).

The lack of an organized authority structure in Dallas for coordinating funding from multiple sources (such as Dallas County funding, NorthSTAR funding, and other state funding) also leads to **missed opportunities to utilize county dollars to leverage Federal Medicaid matching dollars under the NorthSTAR waiver**, thereby missing a valuable opportunity to increase total available county behavioral health funding.
In addition, Parkland Health and Hospital System is just beginning the process of identifying its own internal locus of authority and decision-making for a behavioral health service line. At the beginning of our consultation, Parkland’s behavioral health services did not have a mechanism for routine internal coordination of behavioral health services, reported up through multiple senior managers, and had no identified single point of accountability for planning, implementation, coordination and external communication. In recent months, however, this has begun to shift substantially, with an identified Parkland lead, both internally and in the Dallas BHLT development, and representatives of all Parkland behavioral health programs beginning to meet regularly to create an internal Parkland behavioral health leadership team. To leverage the opportunities and address the challenges of health care reform, both the behavioral health and broader health care delivery systems of Dallas County must evolve.

Over the next year to 18 months, we recommend that Dallas County organize an authority to work within the existing NTBHA structure to maximize performance in collaboration with other NTBHA counties to: (1) manage Dallas County resources more effectively, (2) better represent Dallas County stakeholders, (3) support Parkland as it continues to make progress to organize and empower its own internal behavioral health services line, (4) organize county-level behavioral health services decision-making to be collaborative with the new authority, (5) begin to manage more effectively within the existing NTBHA authority structure, and (6) work with the other NTBHA counties to the extent possible, and independently to the extent necessary, to improve the effectiveness of the next NorthSTAR contract for 2011-2013.

Over the longer term (2 to 3 years), we recommend collaborative planning for the 2013 NorthSTAR procurement to further position Dallas County and other counties in North Texas for the implementation of more sophisticated authority structures and funding models, as well as for the implementation of health care reform in 2014. We visualize three levels of potential development (each of which has multiple permutations). These options are only intended as suggestions to help stakeholders envision possibilities. There are many possible variations and permutations that can emerge as the system evolves, including possibilities that are not even contemplated in these three levels. Our goal in this report is to open up ideas for future consideration and encourage other creative approaches that may emerge during the process. In that spirit, we offer the following three levels as a focus for initial discussions:

- **Level 1: Continue the development of an empowered Dallas County structure (and to the extent possible, an empowered regional authority) through both the current and the next contract cycles.** This is the most readily achievable option and the primary focus of the Step 1 recommendations.

- **Level 2: Deliberately consider the prospect of developing a locally controlled non-profit MCO that could be in place to “compete” for the 2013 re-procurement.** This arrangement
has many advantages, but it will involve much up front development to work well. It is essential not to get distracted by starting this process too soon at the expense of building the Dallas County BHLT (Step 1) and fully engaging in all the Step 2 Phase One activities over the next year. The local partnership needs to build its capacity for action, decision-making, and responsibility first. Note also that such an arrangement does not necessarily either exclude or compete with ValueOptions. In fact, ValueOptions can be positioned to be a key partner to provide ASO functions, consultation, and even shared risk within the new entity (although we recommend that this be under a clear contract that is periodically re-procured), and thereby maintain a significant future role. Note also that the locally-controlled MCO must still be accountable to a true local authority grounded in county government and distinct from the MCO. However, within such a structure it may be easier to braid resources from other Dallas County sources and facilitate community reinvestment of any “profits” (as is currently the case in Colorado, Washington, and Pennsylvania counties and regions). Finally, although the advantages of this arrangement should be fairly clear (and can in actuality be launched relatively quickly, even over the next 12 months), it is important to note that there is a lot of initial developmental work required to help such a brand new organization function effectively.

- **Level 3: A coalition of providers inclusive of the Dallas County Hospital District would be developed as an ACO that would compete for the NorthSTAR contract** to incorporate the carved-out behavioral health contract within the broader ACO. As an alternative, the ACO could instead carve-out its behavioral health line and subcontract it in turn to a locally controlled non-profit behavioral health MCO that is also working in an ASO or consultative partnership with a behavioral health managed care vendor. The advantages of this arrangement include bringing together health and behavioral health, local ownership and accountability, and direct leveraging of MCO technology to address the concerns and realize the potential clinical and economic outcomes needed under health care reform. More importantly, it is an arrangement that demonstrates a very compelling vision and capacity that would establish Dallas County as a true leader in developing innovative care systems in the era of health care reform, and correspondingly have the potential to attract both state, federal, and private foundation development funding to support and evaluate the model. However, **we are not recommending this structure at this time**, not because we do not think it is a good idea, but because nobody can predict whether all of the needed partners in Dallas County will be able to commit to and carry out the preparatory work necessary to develop and make operational such a structure within three years.
Step 3: Customer-Oriented Performance Improvement

This is the third essential element of the systemic shift. Although the NorthSTAR system has had a positive impact on the regional behavioral health system during the past 10 years, current methods for measuring system performance are inadequate for assessing how the system is truly performing to meet the needs of its “customers” – the individuals and families with mental health and substance use disorders that are in need of services. The NorthSTAR system and its constituent counties have relied primarily on state-defined performance measures. These measures do not substitute for locally-defined and locally-relevant performance measures that reflect the experiences and needs of people served in Dallas County (and NorthSTAR more broadly). There needs to be a more sophisticated process of developing, monitoring, and incentivizing an expanded approach to performance measurement and performance improvement that is grounded in local priorities and meaningful indicators. Furthermore, system performance, either for Dallas County or for the NorthSTAR region, cannot be evaluated only by looking at NorthSTAR.

The BHLT and evolving local authority must take control of the MCO and the provider network by designing and implementing a customer-oriented, performance-improvement-driven system of care, identifying potential performance indicators and outcomes for such a system, and connecting those indicators to performance incentives that are built into funding mechanisms, including managed care contracting. We recommend three phases:

- **Phase One (1 to 6 months):** Building a customer-oriented performance-improvement culture by defining a vision for performance improvement, grounding the process in stories of real people in the system, beginning with easier targets for improvement (such as improvements for the “Top 200”), developing a systematic approach, piloting suggested solutions and evaluating their outcomes, translating pilot interventions into more systematic changes and associated performance indicators, and tying reimbursement to these indicators contractually.

- **Phase Two (6 to 12 months):** Develop more sophisticated indicators for performance-improvement activities to further establish the role of the BHLT in overseeing performance by designing indicators based on what people actually need and want (25 sample indicators are provided in the full report), developing organized mechanisms for prioritizing indicators for attention, and utilizing in-depth root cause analyses for high-profile issues, critical incidents, and serious adverse outcomes. **There is no such organized function at present within Dallas County or NTBHA, and it urgently needs to be developed.**

- **Phase Three (2011 through 2012):** Incorporate performance improvement indicators, targets, and incentives into behavioral health oversight functions, including MCO
contracting based on the working knowledge of how to use performance-improvement incentive contracting for all system funding streams learned in the first two phases. By the next NorthSTAR contract cycle, Dallas County, the other NTBHA counties, and NTBHA should be prepared to negotiate – and monitor – a managed care contract with much more performance improvement leverage. In Dallas County, similar strategies can be applied to contracts utilizing other funding sources (Dallas County CSCD and Juvenile Services already incorporate outcomes monitoring into contract oversight and could serve as a base).

**Step 4: Data Sharing for System Management**

The fourth systemic step was prioritized based on one of the most significant findings in the study: that **both clinical and financial management information sets in the Dallas County and NorthSTAR systems are not well developed**, nor are they used as successfully as they could be to oversee and manage a complex behavioral health care system. **Current data elements provide an incomplete and only partially accurate picture of NorthSTAR’s performance**, both in and of itself, and in comparison to other parts of Texas. Further, **the depth and breadth of information shared across all system partners, service types, levels of care and funding arrangements is not adequate to ensure the effectiveness** of Dallas County (or regional) behavioral health services and supports within a total system of care. At the core, there is no single point of accountability for using data as a system management tool that encompasses the comprehensive purview of the total system of care. Even when data is available in Dallas County and NorthSTAR, it takes a great deal of effort to retrieve the types of system information sets that other counties routinely use to manage their behavioral health systems. While there is a range of discrete initiatives to promote data sharing and analysis for improving partnered activities (the Jail Data Instant Messaging [JDIM] initiative being the best example), the system as a whole has limited prowess for smartly using its collective data, primarily because there is no collective responsibility for using comprehensive data sets to drive decision-making that spans any individual funding or data partner’s responsibility. For example, DSHS reports that NTBHA has access to the same level of system data they do, but nearly all data used for this report came from DSHS, not NTBHA. Therefore, we recommend:

- **Phase One (late 2010 through 2011):** Initial implementation should focus on formulating a policy framework through the BHLT related to system-wide data production and sharing by and between all funded entities, including MCOs and direct-service providers. This starts with examining available information about the experiences of the people that traverse multiple systems, building on analysis of the “Top 200,” but including other additional information and data sources, as well as additional “high utilizers” beyond the NorthSTAR data set. Clinically-driven data sharing can be used to “discover” the experiences of people...
with poor outcomes and help identify systemic, data-driven improvement opportunities to be prioritized and targeted by the BHLT, building on past success like the JDIM initiative.

- **Phase Two (1 to 3 years):** More detailed implementation can occur as the information and experiences from Phase One evolve to inform the design of performance requirements for MCO re-contracting (see Step 3 above), both in terms of data content and data-sharing requirements. These data development and data-sharing objectives must be held in the framework of Continuous Quality Improvement (CQI). Overall system data performance indicators and data-sharing strategies should be designed as well to meet the needs of important external policy and funding partners, most notably DSHS and the legislature.

**Eight Specific Developmental Steps**

**Step 5: Primary Health/Behavioral Health Integration**

Development of this capacity is essential given that the economics of health care reform will require enhanced capacity to serve people with behavioral health needs in primary care settings and integration of care delivery across tertiary settings (hospitals), secondary specialty care (behavioral health), and primary health. Parkland’s Community-Oriented Primary Care (COPC) clinics and broader ambulatory health resources offer an initial primary care and broader health delivery infrastructure upon which to build, but that capacity needs to be increased substantially even to address current needs. The COPCs served over 5,700 unique individuals in CFY 2009; Parkland as a whole served over 16,000 people with behavioral health needs. Increasing integrated behavioral health capacity in the COPCs is a current priority and it is likely that this number has grown, perhaps significantly, in the past fiscal year. Behavioral health services in the COPCs reach a very diverse population (39% are Hispanic, 30% White, 29% African American and 2% Asian American / Pacific Islander). However, the system should be serving a much higher capacity of persons in primary care settings. Nationally, 54% of mild cases and 37% of severe cases of behavioral health need are treated in primary care settings. The proportion served in the COPCs represents less than 6% of the 97,379 adults and children under 200% of the Federal Poverty Level (FPL) that have severe behavioral health needs in a given year, and a much smaller percentage of the broader population of persons with mild to moderate needs under 200% of FPL.

Despite this, the Parkland COPCs have made a focused initial commitment to moving toward evidence-based models of integrated care. The Frew-funded Services Uniting Pediatrics and Psychiatry Outreaching to Texas (SUPPORT) project targeting Medicaid children with behavioral health needs and a recently completed Hogg Foundation pilot for adults both built on the IMPACT model, one of a wide variety of available evidence-based approaches. SUPPORT had
reached nearly 900 children by the end of August 2010 and has been especially successful in engaging Hispanic children and families (over 72% of persons served are Hispanic). Parkland’s resources also support the delivery of primary care in specialty behavioral health settings, much as they have in the Dallas Independent School District (DISD) Youth and Family Centers and other initiatives. Parkland has also sent staff to receive training from Intermountain Health in Utah, which is one of a handful of model integrated ACO models in the country, adding further to the expertise base at Parkland available for future development. A separate project funded under the Frew Settlement through Children’s Medical Center provides a telephone referral and consultation service for primary care pediatricians focusing on diabetes, gastrointestinal, cardiology, and psychiatric consultation. There is a website with resources and pediatricians can call a centralized number and get a telephone consultation within 30 minutes.

Expanding these models will require a substantial system-level commitment within the county and within systems such as Parkland’s. Reimbursement models for integrated behavioral health and primary care will need to go beyond direct fee for service billing to support these more integrated approaches, but the biggest challenges center on the primary care provider and behavioral health work force. Our recommendations fall into three phases:

- **Phase One (2010 through first half of 2011): Develop a planning framework to guide multi-level behavioral health and primary care integration**, beginning with planning to expand capacity to provide behavioral health care in Parkland’s COPCs, with a goal of (1) expanding access to current COPC patients and (2) developing a step-down capacity for people ready to exit NorthSTAR’s SPN. This will involve a step-wise **shift from a payer-centered level of coordination** (for example, NorthSTAR eligible individuals are served by a SPN and non-NorthSTAR diagnoses and payer types are served by COPCs) to **coordination driven by level of need** (for example, lower need people served by COPCs and higher need by SPNs). NorthSTAR should consider provision of “grant” funding (rather than fee for service funding) to Parkland to support the development of expanded behavioral health capability and capacity in primary health settings. **A strong commitment to workforce development and retooling will be essential.** Planning should begin for pilots with select SPNs, partnership with UTSW (and potentially Children’s Medical Center) to build physician leadership, flexible funding approaches, and possible restructuring of the 340B program.

- **Phase Two (second half of 2011 through 2012): Begin to implement multi-level behavioral health and primary care integration** through multiple key steps: (1) identifying physician leadership within Parkland to ground the shift in physician and other primary care provider practice as soon as possible; (2) coordinating integration efforts with the overall behavioral health product line manager at Parkland; (3) systematically converting each COPC from a traditional behavioral health delivery model to a collaborative care model, beginning in mid-
2011 in order to realize the needed efficiencies for health care reform; (4) broader piloting of integrated primary care with SPNs; and (5) planning for more sophisticated methods of tracking cost-savings from primary care/behavioral health integration in Parkland.

- **Phase Three (begin as soon as possible, but expect primary planning to occur in 2012 and later):** Incorporate behavioral health integration into planning for a potential ACO structure (or structures). The future of health care will depend on the success of multi-specialty, integrated care delivery systems, whether they organize as ACOs or otherwise. As noted in Step 2, Parkland and other partners within the BHLT may have the option to integrate management of behavioral health care within the larger development of a county or regional ACO. Eventually, NorthSTAR and each STAR/STARPlus Medicaid and CHIP MCO must address this issue, and the BHLT will need to decide how to position with each one. To the extent that leaders in Dallas County and NTBHA can prepare for and help guide that transition, it will be less likely that decisions made at the state level will disrupt ongoing care delivery. DSHS and the Health and Human Services Commission will be key partners in this planning.

**Step 6: Welcoming, Recovery-Oriented, Integrated Continuum of Crisis-Intervention and Acute-Care Services**

These recommendations center on developing a proactive crisis response system with a continuum of crisis response, stabilization, and residential services. The current Dallas County system (and NorthSTAR) is designed to be highly crisis-reactive. As a result, significant resources are invested in what we would call “back-end,” more expensive crisis response such as psychiatric emergency services (PES) and 23-hour observation (OBS), rather than lower-cost proactive crisis response that would reduce the “crisis tone” (and crisis cost) in the system over time. The current system evolved as an urgent stopgap measure to control hospital utilization, and by this measure it has been successful. However, both PES and OBS are relatively expensive, highly medicalized services, and individuals tend to access these services involuntarily.

The volume of PES and OBS, and the cost of these services, outstrip the current capacity of the Mobile Crisis services provided by ADAPT. Despite this limited set of excellent mobile crisis services, **Dallas does not have a welcoming, integrated, and comprehensive crisis hub that can routinely respond to crises before the need for involuntary care emerges and can provide ongoing crisis intervention for individuals unable to connect to more routine services.** There is also no tracking to determine if they actually got there, as well as no continuity of responsibility to assure follow-up if they “fall through the cracks.” The experience of the “Top 200” utilizers identified by ValueOptions bears this out. Over 34% of their behavioral health claims fell into
the crisis continuum (PES, OBS, inpatient), comprising nearly two-thirds (64%) of their $3.85 million in costs and suggesting strongly that their experience has much to teach us about possible improvements. Another 13.4% of costs are related to SUD services (42.5% received at least one CD service), and the remaining 23.2% of costs were related to MH care in non-acute settings. Based on data available to us, we hypothesize that poor outcomes associated with the “Top 200” may be associated in part with the current design of the crisis response system.

Further, unlike many other urban systems and other LMHAs in Texas, Dallas does not have a community-based subacute / crisis stabilization unit (S-CSU) that can function as an inpatient diversion or step-down for individuals who need a secure (locked) setting. Such programs usually operate with a bed-day cost of around $300. Without this, individuals who need continuing acute / subacute care or competency restoration that cannot be provided in an outpatient setting are sent to Terrell State Hospital (TSH). There is potential interest at DSHS and TSH in exploring creative opportunities to partner with the NorthSTAR system to “manage” a portion of the current regional allocation for TSH in order to reduce state hospital utilization and increase community-based care. Another important part of the crisis continuum is the small detox (and unlocked) crisis residential program at Homeward Bound for individuals with co-occurring disorders, a program that appears to be currently underutilized. Our recommendations include:

- **Phase One (1 to 12 months):** Begin to plan and implement a welcoming, recovery-oriented, integrated crisis system by first articulating a vision for the crisis system to provide a welcoming, hopeful, inspiring place where individuals (adults and children) and families in mental health and/or substance abuse crisis (including those who are homeless, actively using substances, picked up by the police, etc.) can walk in (or be dropped off) and be seen. A wide variety of operational details in support of this are included in the full report. Starting places emphasize lower cost clinical processes and targeted reinvestment prior to more expensive capital investments and full-fledged program design, including expansion of current mobile crisis capacity and coordination of improved data-sharing, cross-system resources, and utilization management activities within a strategic plan for how to locate and staff the crisis hub (with a target implementation date in 2012 and plan for how to acquire initial funding to support the vision) in partnership with TSH and DSHS. Given that some of the space planning may be connected to Parkland’s capital expansion, Parkland would be a significant partner in this process (though other space options may be available).

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24 TriWest analysis of ValueOptions data set “Top_200_200904_201003.” Received via Personal Communication from S. Spradlin, August 10, 2010.
• **Phase Two (12 to 36 months): Design and implement the crisis hub, the crisis stabilization unit, and the crisis residential continuum.** For illustration purposes, if an initial target of 64 beds is set (approximately half of the estimated 135 daily bed use at TSH for acute care cases), operating costs would be $5.5 to $6 million annually (coincidentally, this equates to half of the $11.2 million of state funding that we currently estimate is spent on Dallas County acute care at TSH). The full report discusses a process whereby some resources currently allocated to TSH shift to the community to be managed by NorthSTAR without creating a negative impact on TSH. The S-CSU could also be developed to increase capacity for community-based competency restoration, and would be supported by a broader system that included a crisis residential continuum, including crisis residential beds, crisis transitional housing, and supported sober living, as well as integrated peer support.

**Step 7: A Recovery-Oriented, Integrated System of Care for Adults with Serious Mental Illness**

This critical shift would be based on an overall vision of a system of care where “co-occurring is an expectation, not an exception.” The Dallas County SPN represents an array of committed and flexible providers who have the capacity and interest to develop a high quality recovery-oriented continuum of care for adults with serious mental illness and children with serious emotional disturbance. However, SPN providers are stretched very thin, and their capacity to deliver high quality, recovery-oriented services suffers as a result, with long waits, low service intensity in many cases, and frequent high case loads: a function not just of limited resources, but also of system design seemingly worsened by the incentives of the current SPN case rate.

We recommend a strategic commitment to reorganize the system in order to improve the capacity of the SPNs to help individuals with the most severe conditions to become more easily connected to long-term recovery support and rehabilitative services, to be less likely to disconnect from ongoing services when having a hard time, and to be more likely to be empowered to achieve happy, hopeful, and productive recovery goals and to “graduate” from the SPN service system when appropriate. **The ability to carry this out depends on the ability to improve the crisis safety net (Step 6) and move out lower level cases able to be seen in primary care settings (Step 5) in order to free up funds to expand SPN capacity to provide ongoing recovery services for individuals and families with higher need.** We recommend:

• **Phase One (1 to 12 months): Getting started in making the shift** by articulating the vision and identifying an implementation team that would be supported by the Step 3 activities to realign performance indicators to become more client-driven. Adjustments in the near term to the case rate based on these performance indicators should be undertaken, as should mechanisms for identifying and tracking (across the whole system, including crisis outreach) every high-risk person who starts to slip, well before that person is in an acute setting or
jail. This would also involve organizing all potential peer support resources and starting to plan how to increase access to peer counseling and other paraprofessional counseling and recovery support services. In addition, SPNs should be supported in sharing creative models for improving the delivery of recovery-based support, maintaining engagement, reducing wait times, and improving urgent responses, as well as reviewing the efficacy of the current formulary management system by the Psychiatrist Leadership Group.

- **Phase Two (12 to 24 months): More detailed and longer-term implementation activities will be grounded in the articulation of performance indicators that provide incentives for closer monitoring, fewer dropouts, and measurable progress in recovery goals for individuals in higher service packages.** Leveraging training resources (such as psychiatric residency) to provide more trainees in community-based settings will be critical, in partnership with Parkland and UTSW, as well as clarifying training and certification, scopes of practice, and reimbursement methodologies for peer support specialists and other clinical “extenders” working in SPNs and for expanded access to evidence-based programs. SAMHSA and foundation grants can play an essential role in this development.

**Step 8: Recovery-Oriented, Integrated Continuum of Services for People with Substance Use and Co-occurring Disorders**

These recommended activities center on adults and adolescents with substance use disorders (SUD), both those with co-occurring MH and SUD needs and individuals with SUD who do not have a serious mental illness (SMI).

We have estimated that the Dallas County system currently has approximately $20 million specifically allocated to the provision of substance abuse services across a variety of funding sources, including federal substance abuse treatment block grant funds, TDCJ Rider 84 funds in local programs, juvenile justice community and residential services, City of Dallas funding, and a variety of federal and state grants (for example, Homeward Bound, APAA for peer support, a state funded women’s program for Nexus). In addition, there is a statewide Medicaid benefit for substance abuse services that will be implemented beginning in September 2010, the effect of which will have to be monitored over time.

Despite this, there is no mechanism for planning and implementing evidence-based services and system design for SUD services, nor for defining appropriate performance indicators and overseeing performance and outcomes with sufficient sensitivity. While there is an impressive

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25 See Detailed Report for the specifics of this estimate.
array of service provision to build upon, SUD service delivery is heavily managed and access has been systematically reduced over time. Although Dallas County has a peer support program for addiction (APAA) that is a nationally recognized model program, sober housing options (a critical element of a recovery-oriented continuum of care for individuals with addiction) are limited and outside the formal system, and people with SUD are overrepresented in use of emergency, jail, and homeless services. While the integration of funding streams through NorthSTAR leads to the perception among some that the system is “integrated,” our finding is that at the functional and service provision levels this is not the case, and the NorthSTAR system has notably poor data on the prevalence of co-occurring mental health and substance use disorders in the population served. We recommend:

• **Phase One (1 to 12 months):** Beginning to plan and implement an integrated, recovery-oriented continuum of substance abuse services in Dallas County (and, potentially, in the NorthSTAR region) by first identifying an empowered local (county or regional) substance abuse planning and oversight leadership team, defining a consensus vision for building an integrated system with universal co-occurring capability, and planning early steps to make progress toward this vision, under the purview of the BHLT. The vision should also encompass the needs of people with serious addictions who do not have priority mental health diagnoses. Initial steps could address capacity for prevention, screening and brief intervention (SBIRT) at all levels and settings, facilitation of engagement and entry into service for those with more serious SUD, enhanced resources to build a continuum of integrated, co-occurring-capable SUD services at The Bridge (and at any other setting which is a major engagement site for high-need individuals), a cost-effective continuum of recovery-oriented and co-occurring-capable services for high-risk individuals (that does not require that they get arrested in order to get served), improved clinical and financial data tracking, performance improvement targets, capacity in primary health care settings, more collaborative utilization management, expanded sober living environments (and partnership with these providers), and piloting case rates for high-need non-SMI addicted individuals.

• **Phase Two (12 to 36 months):** Deepening the implementation of an integrated system of care and a recovery-oriented substance abuse delivery system by shifting focus to integrated system development in which all programs have CQI plans that demonstrate measurable progress in integrated service delivery and in integrated staff competency. Further development of the continuum of care and funding expansion would continue.
**Step 9: Criminal Justice/Behavioral Health Service System for Adults**

This set of recommendations offers a powerful opportunity for a more fully coordinated system approach between all aspects of the adult criminal justice and behavioral health systems in Dallas County. It is increasingly recognized that the criminalization of individuals with serious behavioral health conditions is a national tragedy and a national disgrace. More and more local systems, including Dallas, are identifying resources (though often limited) to implement innovative programming for individuals with criminal justice involvement who have behavioral health needs. In spite of these efforts, many large urban areas, including Dallas, recognize that the county jail and its related services are have become the single biggest behavioral health “program” in the county, and getting bigger all the time, as the onslaught of need outstrips the availability of resources to respond – Parkland’s jail behavioral health services program served 19,389 people in CFY 2009, second only to the 25,535 served by Metrocare Services, and the behavioral health population in the jail grew in the last six months of CFY 2010 at a rate more than double the average rate of that time period in the previous two years. The critical need to respond to this onslaught is reflected in NTBHA’s past (2008-10) and future (2010-12) strategic planning, and in its prioritization of relatively limited resources available for criminal justice diversion.

The target of our recommended approach would be to reduce the risk of criminal justice involvement, and, if such involvement occurs, increase both pre-booking and post-booking diversion, reduce the frequency and length of incarceration, increase service delivery options within the criminal justice system to facilitate successful re-entry and reduction of recidivism, and increase the responsiveness of community-based services for behavioral health clients with criminal justice involvement or risk. Dallas County is in a position to make remarkable progress to further “de-criminalize” behavior related to mental illness and substance use disorders, and produce better and more cost-effective outcomes by increasing the relative commitment of resources to treatment interventions in lieu of incarceration. The Dallas criminal justice (CJ) system’s impressive array of innovative programs has demonstrated success, with considerable funding from multiple sources.

Yet major areas of concern remain, including: the backlog of available competency restoration services, under-resourcing of the Community Supervision and Corrections Department’s services relative to other parts of the state, a lack of tracking of individuals with high CJ risk.


served by SPNs, a lack of services for people who do not meet targeting criteria for the “Big 3”
diagnoses and who lack Medicaid (that is, most adults), particular needs for services for
pregnant women and individuals with co-occurring developmental disabilities and behavioral
health issues, a consensus among key CJ stakeholders that diversion can be expanded, and
barriers to access for broader health services, even within Parkland’s community-based system.

Our recommendations center on a **shift to expect unmet behavioral health needs for all
people entering or returning from the criminal justice system and recognition of criminal
justice issues as priority risk factors within the behavioral health system**, as follows:

- **Phase One (1 to 12 months):** Empowering the locus of oversight of CJ behavioral health,
  and expanding the partnership between CJ and non-CJ behavioral health care by the BHLT
  first identifying and commissioning an empowered group that is responsible for planning,
  implementation, and oversight of system-wide services for individuals with BH/CJ needs in
  Dallas County. As an initial step, the group should identify the volume of resources currently
  utilized for BH/CJ services, the volume and characteristics of persons served, and the types
  of services provided. Based on this, the group should develop a broad, inspiring, and
  overarching system vision for BH/CJ services, predicated on the following ideas that:
  **incarceration primarily due to unmet BH needs is intolerable and inhumane, prevention is
  the best form of diversion**, and, for those for whom incarceration is unavoidable, **rapid
  transition from incarceration to community programming is a priority**.

This vision will guide a series of initial implementation activities focused on high priority
groups, such as people who are under-supported in the current community-based service
system (people with DD/MR/otherwise cognitively impaired, transitional youth), people
who are not readily accepting of or engaged in current BH services (people who are pre-
contemplative about working on their addiction or individuals who suffer from ethnic and
cultural disparities), people who have extenuating circumstances (homeless people or
pregnant / parenting women), and people who have competency restoration issues for
relatively low threshold misdemeanor crimes. The BH/CJ oversight team should then
formulate meaningful performance outcomes measures for the prioritized at-risk
populations. The performance management (Step 3), data collection (step 4), crisis system
development (step 6), “Criminal Justice Prevention” across SUD services (Step 8), homeless
services (Step 9), and services for minority groups (Step 12) will be essential tools in
addressing these concerns. Additionally, Parkland should identify very specific strategies to
facilitate access to services for individuals who have no other source of care (such as
prioritizing mobile health services at the Wilmer campus). Over time, activities can expand
to include other NTBHA counties.
• **Phase Two (1 to 2 years):** Building on the work in Phase One, start to address more challenging issues and develop bigger system solutions, prioritizing efforts by outcome tracking data on high-risk populations, in a collaborative framework, through the BH/CJ oversight team. This information can be used to begin to challenge – and ultimately change – the current service prioritization “rules” that are based more on diagnosis than on CJ risk. Key priorities over time will include mechanisms to expand Medicaid and Medicare eligibility determination, incorporation of related performance indicators and incentives in the next MCO contract / RFP process, and development of a system-wide response to the need for competency restoration services that expands community capacity, expedites the process for restoration for misdemeanants, includes existing jail-based BH services, develops a continuum of options, expands use of monitoring technology, expands specialty courts, and commits to continuous, incremental improvements over time.

**Step 10: System of Care and Housing Services for People who are Homeless**

All of the recommended activities should center on the Metro Dallas Homeless Alliance, a model “subsystem” within the City and County of Dallas for providing integrated health, mental health, substance use, employment, and housing services to individuals and families who are homeless. The Bridge is a model for coordination of efforts from multiple funding streams and providers to create a welcoming, recovery-oriented, one-stop engagement and intervention center for homeless individuals. The LifeNet Crisis Transitional Housing program also appears to be a successful and cost-effective program for very high-need individuals transitioning from psychiatric inpatient facilities.

Despite this, there are gaps. Large county behavioral health systems typically have a designated “Housing Coordinator” function (specifically focused on behavioral-health-related housing issues), and although MDHA assumes a lot of this function, Dallas County (and NorthSTAR) have not designated such a locus of coordination of services for people with BH needs who are homeless. There is also an extensive network of private boarding homes in Dallas County, many of which reportedly provide substandard care and are insufficiently regulated. There is also no evidence of formal planning for housing services that create a continuum that is wet, damp, and dry. Our recommendations focus on the following:

• **Phase One (1 to 12 months):** Immediate planning to improve integration of services and coordination of care for individuals and families with behavioral health needs who are homeless should begin with a formal identification of a locus of planning and implementation of services for individuals and families with BH needs who are homeless, which we recommend be assigned to MDHA, with additional partners, as delegated by the Dallas County BHLT. Efforts to improve offerings should recognize the existing models of
collaboration in MDHA as strengths to inform planning and partnership for the larger system. Early efforts should focus on collecting data across multiple sources to identify homeless or marginally-housed individuals with BH needs (particularly those using high-end services of any type) and tracking whether they are engaged in services that are helping them make progress. Permanent supported housing (PSH) should continue to be expanded, in partnership with SPN providers. Tracking and coordinating distribution of HUD vouchers for people with serious BH needs should also be expanded. Plans can also be developed for (1) The Bridge (through MDHA) to receive a flexible pool of funds to manage a high-utilizing group of homeless individuals, (2) strategies to partner with selected boarding homes, (3) development of program models for wet, damp, and dry housing, and (4) advocacy for additional PSH resources.

- **Phase Two (12 to 36 months): Expanding the homeless service array.** Efforts in this phase will shift more to defining and implementing system performance indicators, implementing a wet/damp/dry continuum, establishing improved regulatory and programmatic oversight of boarding homes, and expansion of funding for PSH.

**Step 11: A Youth and Family Driven System of Care for Children, Adolescents and Families with Behavioral Health Needs**

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

The building blocks for an effective system of care are present. Dallas County’s juvenile justice system is state-of-the-art, achieving across the board reductions in juvenile offense referral rates (with an overall 13.7% reduction from CY 1997 to CY 2009) and in rates of detention (down 19.5% since CY 2008 and 24.9% since CY 2005). It has accomplished this through a strong array of best practices, backed up by rigorous outcomes tracking for the overall youth population and service providers able to deliver evidence-based models such as multisystemic therapy (MST) and functional family therapy (FFT). However, this system can only be accessed
through an arrest, it disproportionately involves youth of color (particularly African American), and it is too dependent on county funding and under-leveraging of Medicaid. It is most concerning that essentially all intensive community-based capacity for youth is accessible only through this system. Complicating matters, there is very little coordination and cooperation at the system level currently between the NorthSTAR behavioral health system, the county juvenile justice system, and STARHealth services for children in foster care. Child and family-serving agencies within NorthSTAR, and more broadly across Dallas County, currently carry the collaboration burden and provide many evidence-based services. The Grant Halliburton Foundation has also established an important infrastructure for planning, parent involvement, and social marketing. But parent and family support for the caregivers and families of children and youth with BH needs is underdeveloped and lacking.

Our recommendations center on the concepts of the national system of care movement, a path for organizing a youth and family driven, resiliency and strengths focused system of care for children, youth, and families. The guiding principles of a system of care include: (1) A broad array of services and supports is provided in an individualized, flexible, coordinated manner with an emphasis on treatment in the least restrictive, most appropriate setting. (2) Children who have a serious emotional disturbance should have access to a comprehensive array of services that addresses their individual physical, emotional, social, and educational needs. (3) The family’s participation in service planning and delivery is essential. Family involvement is integrated into all aspects of service planning and delivery. (4) The mental health service system is driven by the needs and preferences of the child and family, using a strengths-based perspective. (5) The locus and management of services are built on multi-agency collaboration and grounded in a strong community base. Services should be integrated and coordinated between child-serving agencies. (6) Case management is fundamental to ensure service coordination, integration, and system navigation. (7) The early identification of, and intervention for, needs should be promoted in order to maximize the prospect for positive outcomes. (8) A smooth transition to the adult service system should be planned when necessary. (9) The rights of children who have a serious emotional disturbance should be protected. (10) The services offered, agencies participating, and programs generated are responsive to the cultural context and characteristics of the populations served. Children who have a serious emotional disturbance receive services irrespective of gender, ethnicity, race, income status, physical disability, and other characteristics. To achieve this promising vision, we recommend the following key actions:

- **Phase One (1 to 12 months):** Immediate planning to involve all necessary child and family-serving systems in the design, planning, and organization of a youth and family driven, resiliency and strengths focused system of care for Dallas County by first bringing all
necessary partners to the table through the Child, Adolescent and Family Clinical Operations Team (through late 2010) and then developing a plan for the system of care (late 2010 through mid 2011), potentially through planning to pursue a federal Children’s Mental Health Initiative (CMHI) grant. Given the comprehensive requirements of a system of care, SAMHSA has, since 1992, funded the CMHI program to provide $9 million in grant funding over six years. Tarrant, Travis, El Paso and Harris Counties have all been past recipients (Harris County being the most recent in 2005). While it is not necessary to pursue such a grant in order to move a children’s system of care forward, they are helpful in supporting the planning, training, and infrastructure development of a well functioning system of care. Even if a grant were not pursued (or if it were pursued and was not successful), working through a preliminary plan regarding the following issues can help define a clearer pathway forward in developing such a system, building on past successful initiatives in Dallas County, such as the Annie E. Casey Juvenile Detention Alternatives Initiative, and extending the learning of those initiatives system-wide. Key steps in this planning will involve: development of a governing infrastructure (including family and youth advisory boards), a strategic plan for system integration and interagency collaboration (typically formalized through written memoranda of understanding), planning for service integration, developing a process for intensive service coordination (usually using some variation of a cross-system care coordination based on National Wraparound Initiative standards), workforce development, building evidence-based care capacity, performance standard development, collaboration with other child-serving systems, and social marketing.

**Phase Two (begin immediately, but achieve full effort by late 2011 through 2012):**

**Implementation of a youth and family driven, resiliency and strengths focused system of care for Dallas County,** beginning with immediate small steps that build over time. For example, the Child, Adolescent and Family Clinical Operations Team has put an initial focus on data for the “Top 200” users across the systems to inform system improvements. Whether or not a federal CMHI grant is pursued (they are typically solicited in late fall, due in early winter, and awarded / implemented the following fall), the system of care infrastructure can be planned over the next year (as described above), with full implementation targeted from late 2011 through 2012. System of care development should also be integrated with the planning for overall system governance redesign (Step 2), performance management (Step 3), data integration (Step 4), and cultural issues (Step 12).

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27 See http://www.samhsa.gov/grants/2009/sm_09_002.aspx for more information on last year’s grant and its requirements. New grant cycles typically begin in the late fall through early winter.

28 See http://www.hhsc.state.tx.us/tifi/TIFI_SystemofCareCommunities.html for information on these projects.
Step 12: Services for Cultural and Linguistic Minorities

The population of Dallas County is tremendously diverse (Parkland’s COPCs report 48 languages spoken by the people they serve), and we have focused our review on three overall groupings: racial/ethnic minorities, sexual minorities and people who are deaf or hard of hearing. National standards related to health disparities focus on services for members of ethnic minority groups (the National Standards for Cultural and Linguistically Appropriate Services in Health Care or CLAS Standards). Their goal is to ensure “equitable and effective treatment in a culturally and linguistically appropriate manner” and “as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers” in order “to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.” They include 14 standards that address culturally competent care, language access, and organizational supports (including data tracking) for cultural competence. The existence of health disparities across all the aforementioned cultural groups is well established and described in the full report. One emerging strategy is the use of cultural brokers to supplement the lack of diversity in the health care workforce. Cultural brokers advocate between groups to help span the boundaries between the culture of health care delivery and the cultures of the people served.

Against this background, we generally found that culture and language currently receive too little attention in cross-system planning for BH service delivery. While there are many smaller scale initiatives and pockets of expertise across Dallas County that could serve as the basis of efforts to expand planning and responsiveness to culturally and linguistically diverse populations, they are generally carried out by single provider agencies. Strong providers include several Dallas Metrocare clinics (Lancaster Kiest Center, Altschuler Center, Westmoreland Clinic, After-Hours Crisis Center at River Bend Drive), Centro de Mi Salud, Southern Area Behavioral Healthcare, and Child and Family Guidance Center, as well as advocates focused on cultural issues such as NAMI Southern Sector Dallas. Across the broader health continuum, Parkland and Children’s Medical Center currently have a collaborative program in the Parkland neonatal intensive care unit to support parents with feelings of anxiety, depression, and self-efficacy that particularly targets monolingual Spanish-speaking parents.

At the system level, clear disparities in access to care for Hispanic populations in specialty BH settings (though access in primary care and integrated settings is very high) and overrepresentation of African Americans in juvenile justice and correctional settings were discussed in the data analysis section, as were systematic barriers to outreach, a lack of attention and resource for the large number of Spanish-speaking people in Dallas, and too few bicultural and bilingual providers. The RDM categories were seen as particularly problematic and unwieldy for minority populations whose symptom presentation does not always readily fit
the “Big 3” diagnoses for adults. Disparities in service delivery to sexual minorities include minimal resources beyond Ryan White funding for people affected by HIV, which, while a critical set of funding and programs, addresses only a subset of the larger population and focuses on HIV and AIDS, which also includes a broader range of individuals. Based on our review, the broader needs of sexual minorities beyond those addressed through the Ryan White planning process can be best described as invisible at the system level. And there are no systematic efforts to address the needs of people who are deaf or hard-of-hearing. To address this, our recommendations include:

• **Phase One (1 to 12 months):** Begin to take systematic steps to gather data on health disparities related to culture and language, and explicitly address cultural and linguistic competence of the overall Dallas County behavioral health system in system-level planning. The BHLT would first identify and commission an empowered group that is responsible for planning, implementation, and oversight of system-wide services for cultural minorities in Dallas County. As an initial step, the group could focus on systematically improving data collection on culture and language by increasing the integrity of data collection for race and ethnicity so that missing data is reduced from current high levels (over 20%), collecting data system-wide on primary language, and beginning to collect data relevant to other cultural groups (such as data on sexual orientation, physical impairments such as deafness / hearing loss). Beyond this, all planning groups should prioritize representation of diverse cultures, particularly for the BHLT, operations teams, and all system planning groups. Additional concrete steps include providing written materials in Spanish for all system participants (including NorthSTAR), initiating performance improvement projects based on available data (for example, projects to document which other languages are spoken by communities and persons served, as well as bilingual capacity, including ASL capacity), and developing a comprehensive plan by the end of 2011 for addressing health disparities and promoting cultural and linguistic competency broadly.

• **Phase Two (late 2011 through 2012):** Implement a plan to reduce prioritized health disparities and increase the cultural and linguistic competence of the Dallas County behavioral health system over time (and broader NorthSTAR, as applicable) based on the work of Phase One and a long term commitment to reduce disparities and increase competence, centered on a CQI approach. As part of this, the system should consider incorporating the CLAS standards and other national standards and best practices into its cultural competency plan. Possible system improvement activities are wide ranging and include (among other options): data reporting to document existing disparities and measure change over time, improving access to specialists for each of the minority populations prioritized, building the skills of the broader workforce to provide culturally competent care,
providing more access to specialty provider agencies, incorporating consultation with minority specialists into the practice of providers more generally, increasing use of cultural brokers, providing access to population-specific evidence-based practices (including approaches that integrate mental health, SUD and primary care services), and incorporating the needs of smaller subgroups (such as recent immigrant groups, diverse sexual minorities, the deaf community, people with other disabilities, and bicultural individuals and families). Specific performance indicators and incentives tied to defined progress in cultural competence can be incorporated into BH purchasing contracts, and workforce development can be aligned with the performance indicators and incentives.