Review of Harris County Mental Health Systems Performance

Final Report

May 2015

Executive Summary

Harris County engaged the Meadows Mental Health Policy Institute to review its public mental health service delivery systems, with a primary focus on the Mental Health and Mental Retardation Authority of Harris County (MHMRA).

Findings on Mental Health Needs (N) in Harris County

- **N-1: Harris County is large, growing, and diverse; with this growth, the number of people living in the county with severe mental health needs has also grown to over 140,000 adults and 90,000 children.** This report focuses on mental health needs within the context of the broader behavioral health needs of the community, including substance use disorders, co-occurring mental illness and substance use, and developmental disabilities. Within that context, MHMRA has the role of serving those with the most severe needs in the public system. This centers on 143,000 people (87,000 adults and 56,000 children) in poverty (under 200% FPL) that serves as the minimum benchmark of need to be met by the broader public mental health system (see table below). Two-thirds of the overall population – and over 80% of the population in poverty – are African American or Latino.

Adults with SMI and Children with SED Living at or below 200% of Federal Poverty Level (FPL)

County	Total Population	Adults with SMI	Adults with SMI Under 200% FPL	Children with SED	Children with SED Under 200% FPL
Harris	**4,471,427**	**142,930**	**87,283**	**91,414**	**56,044**
Bexar	1,882,834	54,055	34,913	36,974	21,780
Dallas	2,496,859	88,279	54,112	53,222	35,365
Tarrant	1,959,449	64,191	35,873	39,006	21,569
Travis	1,144,887	38,253	21,673	19,965	10,703

- **N-2: For adults, the core outpatient public mental health system in Harris County – comprised of MHMRA, Harris Health, 12 federally qualified health centers (FQHCs), and three Medicaid managed care networks – has capacity to provide some level of service to 75% (65,000) of those in poverty with severe needs, but the system has dramatically too little intensive service capacity. As a result, Harris County relies too much on correctional and emergency room settings to serve those with the most severe and complex needs.**
  - While the other system components can provide ongoing care for those who are relatively stable, persons in need of more intensive supports must rely on MHMRA and the growing array of supports being developed by the Medicaid managed care organizations (MCOs). The most severe mental illnesses generally require multiple years

of recovery-oriented, often intensive, community-based treatment as well as an array of additional supports, including housing, employment, and peer services.
  - In its role, MHMRA has focused on the 16,000 most in need, but – like all of its peer agencies across Texas – it lacks ongoing treatment capacity sufficient to maintain people with the most complex needs in care. Relying primarily on MHMRA, Harris County has an estimated one-ninth of needed intensive service capacity, one-tenth of supported housing capacity, and one-seventh of supported employment capacity, compared to the level of severe need in in the community and best practice benchmarks.
  - As a result, high need cases cycle repeatedly through jails, hospitals, and inadequate outpatient care, costing nearly $50 million in jail costs and $150 million in emergency room costs because the system is designed with too little core capacity.
- **N-3: For children and families, the core outpatient public mental health system in Harris County has capacity to provide some level of service to 56% (31,000) of those in poverty with severe needs, but the system has dramatically too little intensive service capacity. As a result, Harris County relies too much on juvenile justice, child welfare, and emergency room settings to serve those with the most severe and complex needs.**
  - MHMRA and the six child Medicaid MCO networks (five STAR and STAR Health) offer the primary resource for intensive services. MHMRA focuses on the 8,000 with the most severe needs, but – similar to adults and to all other LMHAs in Texas – it has too little capacity for those with the highest needs (less than one-fifth compared to best practice benchmarks).
  - Relatedly, Harris County spent over $18 million in local juvenile justice costs in 2013.
- **N-4: While the crisis system has been a major focus of development since 2007, and while hundreds of new private beds are being built, Harris County's public system relies too much on state-funded psychiatric inpatient capacity, lacks at least 100 inpatient beds for the uninsured, and has only one geographic location for its primary crisis programs: the NeuroPsychiatric Center (NPC) operated by MHMRA and the Ben Taub Psychiatric Emergency Department operated by Harris Health.**
- **N-5: While targeted funding for new projects by DSHS and DSRIP has increased dramatically (especially since 2012), DSHS funding for treatment capacity for the uninsured has shrunk on a per capita basis relative to inflation for adults and children, and Medicaid funding has increased.** Also, MHMRA administrative spending is lower than that for comparison LMHAs, and performance metrics tracked by DSHS show better performance in many areas for adults. Compared to the statewide average of funding for adult and child mental health services, MHMRA is funded between $6 million and $9 million lower.
- **N-6: State-level policy impedes local system development in Harris County by focusing too much on a crisis-driven service model for the uninsured, designing a largely separate system for Medicaid without a structure for coordination with state-funded services,**

failing to ensure equity in the distribution of limited state funds for the uninsured, overly restricting local control over the use of these limited funds, and tying financial incentives to compliance rather than performance improvement.

Primary County Level Findings (CF) and Recommendations (CR)

- CF-1: Harris County lacks an organized, functional and integrated behavioral health system. Major providers and funding streams operate in parallel, rather than in a coordinated manner, leading to both inefficiencies and poor outcomes.
- CF-2: Only Harris County is positioned to convene and develop a new framework for partnership and collaboration across behavioral health providers and systems. MHMRA can take a lead role, but it cannot function as the overarching convener for behavioral health (BH) leadership.
- CF-3: There is a solid foundation on which to build an effective BH system of care across MHMRA, Harris Health, FQHCs, Medicaid MCO networks, other key providers for outpatient care, and the Harris County Psychiatric Center (HCPC) and local hospitals for inpatient care.
- CF-4: Improvements in partnership and collaboration are essential to improve clinical performance.
- CF-5: There is no consistent vision of care at the county level to guide collaboration.
- *CR-1: Commit county resources to convene the leaders of the major county-funded mental health providers – MHMRA, Harris Health, and HCPC – to develop an initial partnership framework for a collaborative, strategic and ongoing planning process at the county level (6 months). Once the initial county-level partnership framework is in place for collaborative planning and management, the process should involve the dozens of additional partners that need to be engaged, with a most immediate priority of engaging the Medicaid MCOs, criminal justice agencies, Council on Recovery, local hospitals, and an array of child-serving agencies.*
- *CR-2: The leadership of the major county-funded mental health providers – MHMRA, Harris Health, and HCPC – will each need to decide if their respective entity wants to commit to engage in this process in a spirit of genuine partnership (6 months), as will each other partner that joins over time (1-2 years).*
- *CR-3: Within the new partnership framework, improved collaboration should be advanced through an initial set of initiatives, with an emphasis on: establishing a vision, engaging major funding partners, and improving information sharing, crisis system capacity, and access (6-12 months).*
- *CR-4: The broader system oversight structure should also coordinate BH system development across a set of more focused medium-term initiatives (1-2 years): crisis continuum development, funding stream coordination (e.g., Medicaid), integrated care (with physical health, substance use disorders), children's system development, justice system diversion, homelessness, public-private partnerships, and workforce development.*

- *CR-5: Harris County should use the new partnership framework to engage its state-level funders, legislative representatives, and local advocates to address state-level policy gaps.*

Major MHMRA Findings (MHF) and Recommendations (MHR)

- MHF-1: MHMRA leadership is committed to a vision of integrated, effective, and efficient person-centered care for individuals and families in need, but MHMRA's functional organizational structure, a lack of a county-level partnership framework, and state-level policy all impede implementation.
- MHF-2: Despite a number of discrete collaborative initiatives, MHMRA is widely perceived by other county-level agencies as more reactive than proactive in terms of collaboration at the agency level.
- MHF-3: MHMRA's board and leadership have indicated a priority to improve collaboration and committed to improve sharing information with the criminal justice system.
- MHF-4: The overall organization of MHMRA lacks key functional capabilities necessary for an agency of its size to operationalize its vision.
- MHF-5: The current organizational structure and processes lack the clinical administrative capacity to operationalize important improvement activities, particularly an organization-wide clinical care vision and quality improvement.
- MHF-6: MHMRA information technology (IT) has a number of significant challenges, including a lengthy, costly and, to date, unsuccessful legacy system replacement and electronic health record (EHR) development project (though a new contract, vendor and plan have been put in place). IT is also challenged by a rapid increase in business area staffing to support DSRIP projects and regulatory changes requiring system modifications.
- MHF-7. Financial oversight, including reporting, at MHMRA has been in place and functioning solidly for several years. MHMRA is operating in a positive financial position.
- *MHR-1 (6-12 months): Without reducing clinical service capacity, modify and enhance the current organizational structure and processes to implement MHMRA's vision and address the scope and responsibilities of an agency of its size with expanded and focused functionality at the executive team level (e.g., Chief Medical Officer function, Chief Operating Officer function focused on clinical operations, Chief Administrative Officer function focused on administrative operations) and other key areas (e.g., quality improvement, children's services leadership, project management).*
- *MHR-2: MHMRA needs to better incorporate front line and mid-management staff in system change and quality improvement processes (6-12 months).*
- *MHR-3: MHMRA needs to clearly define its vision, scope of services and clinical approach.*
- *MHR-4: Continue to develop the current service array and organizational culture to support that vision, focusing on: evolving beyond the current model that is centered primarily on MD / RN / medication care and integrating this base of medical care into a team-based model based more on flexible person/family-centered care; developing more welcoming and*

customer-centered access models (e.g., access at every outpatient clinic); expanding intensive treatment capacity for adults and children; improving treatment of co-occurring substance use disorders; expanding the crisis continuum; organizing delivery of children's services; and expanding peer leadership and programs (initial efforts should begin in the short term, but substantial implementation will likely take 1-2 years).

- *MHR-5: For IT, complete the planned IT risk assessment and update the Disaster Recovery Plan (6 months). Regarding the electronic health record, implement the planned legacy system upgrade to address urgent requirements for ICD-10 (6 months), and finish the full electronic health record conversion (1-2 years).*
- *MHR-6: MHMRA's facility planning should include a strong focus on identifying organizations where co-location of services can occur, with the intent to improve access to services for clients in the neighborhoods where they live (1-2 years).*