

**OPTIMIZING BEHAVIORAL
HEALTH SERVICES IN
HARRIS COUNTY**

**DRAFT
Final Report**

The Technical Assistance Collaborative, Inc.

April 16, 2007

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BACKGROUND

The Harris County Healthcare Alliance (hereafter “the Alliance”), under the leadership of its Behavioral Health Care Committee¹, engaged the Technical Assistance Collaborative, Inc. (TAC), to review behavioral health services in the county with a view toward recommendations to optimize care for County residents who experience problems with mental health and/or substance use disorders. This interim report is based upon a series of phone interviews, a three-day site visit (January 31-February 2, 2007), and reviews of relevant reports and data on service patterns in Harris County.

SYMPTOMS OF SUBOPTIMAL SERVICES

TAC’s preliminary review identified a number of indicators that behavioral health services are not currently functioning ideally. The most salient symptoms we noted are:

- Lack of central management and coordination of behavioral health resources;
- Structural and institutional barriers to integrating behavioral health access and service delivery between payer sources, service delivery organizations and target populations;
- Limited resources or incentives to implement preferred and best practice community based service interventions;
- Minimal integration of primary health and behavioral health services;
- High rates of utilization of Emergency Departments to access care;
- High rates of persons with mental and/or addictive disorders in jail;
- Rapid cycling in and out of care for those individuals identified as having the most serious conditions, especially those qualifying for Resiliency and Disease Management services from the Mental Health and Mental Retardation Authority of Harris County (MHMRA);
- Difficulties in cross-referral from the substance use disorders treatment system to the mental health system and vice versa.

¹ The Harris County Health Care Alliance was formerly known as the “Harris County Public Health System Council”; when it was reconstituted as the Alliance, the existing Behavioral Health Care Committee was authorized to continue as an operational committee of the new organization.

- High loss rates between identification of a mental health and/or substance use disorder and initial post-hospital or post-incarceration contact for follow-up care;
- A lack of services for persons with multiple co-morbid conditions: mental conditions, substance use conditions, and a host of general medical concerns; and
- Difficulties in accessing the right level of services (whatever the issue) at the right time.
- Texas' and Harris County's high rates of uninsured individuals; the uninsured rate for Texas is 25%, and for Harris County it is 30%, one the highest rankings in the state, and the largest number of uninsured.² Given that many general health insurance policies include no coverage for behavioral health (and the Texas Medicaid plan does not cover substance use disorders), the numbers of Harris County residents lacking behavioral health coverage is even higher.
- Access to Medicaid is difficult in Texas, covering only those adults at 21% of the Federal Poverty Level, and national trend in declining employer-provided healthcare coverage poses serious challenges to low income individuals.
- The diversity of Harris County's population poses special challenges in providing culturally and linguistically competent services for its safety net populations. Rates of uninsured individuals of color are two- to three-times those of the Anglo population,³
- The homeless population in Harris County is exceedingly high in comparison to national data: Harris reports an estimate of 12-14,000 homeless individuals, of whom 56% of adults self-report a mental illness⁴.
- The very low rate of funding for Harris County relative to the rest of Texas: the Harris County MHMR Center is second from the bottom in per capita general revenue funding, with \$8.59 per capita as compared to the state average of \$10.91. The highest funded Center (West Texas MHMR) receives \$22.89 per capita in general funds.
- Projected population growth in Harris County, coupled with the barriers cited above, will only exacerbate access problems and service shortages.

There seemed to be broad consensus among the participants in the interviews that current conditions in the behavioral health system in Harris County are unacceptable.

ETIOLOGY OF THE CURRENT STATUS OF THE BEHAVIORAL HEALTH SYSTEM

A number of factors have created the current state of the behavioral health system in Harris County. As a result of these factors, Harris County has developed a patchwork of services in the public and private sectors that are encapsulated within differing funding streams and eligibility criteria, and display varying degrees of organizational commitment to providing public behavioral health services. Ironically, as is often the

² Source: Texas State Data Center and the Texas Health Institute.

³ Source: Texas Health Institute

⁴ Source: deAndre (2005) Blue Ribbon Commission report.

case, a scarcity of resources leads to greater inefficiencies, as providers tend to isolate and protect their limited resources to serve their priority populations and to perceive calls for collaboration as a threat to their mission to serve specifically mandated populations. The result is a “system” that is comprised of disparate, unconnected elements, and that appears especially fragmented and unresponsive to consumers of services and their families.

Harris County is geographically large and spread out, and has a rapidly growing and very diverse population. In an environment with extremely limited resources, these factors exacerbate the difficulty of delivering and managing effective community based behavioral health services. As noted below, geographic and transportation-related barriers to service access and continuity of care are reported to be major issues in the Harris County system. These factors are compounded by the tradition of site-based service delivery models as opposed to the more consumer-responsive mobile service modalities being developed in many other jurisdictions throughout the United States.

POSITIVE SIGNS

We were encouraged by the general recognition of the dimensions of the problem, and a willingness to candidly share ideas. The leadership of the Alliance and its Behavioral Health Committee in bringing focus to the issue cannot be overstated, as only a community-wide approach to solutions has any hope for success.

The Alliance has adopted a set of guiding principles for this work that are cogent and reflect a value-set that can drive planning and implementation of the needed changes. The Alliance has also adopted consumer focused indicators of positive outcomes and good system performance that could and should be used to track and monitor improvements in the current system (See Appendix B for copies of these principles and outcome measures.)

Most significantly, we heard considerable consensus around an end-goal that could result from focusing on this issue: improved access, efficiency and effectiveness of the services system, regardless of any particular strategy or mechanism chosen to reach the ultimate goal.

DIRECTIONS FOR CHANGE

Although this report is preliminary, we see a range of activities that may at the least alleviate some of the most urgent concerns identified by the community partners whom we interviewed, and at best could result in significant improvements in both access and outcomes for service recipients, and in increased efficiencies in behavioral health expenditures of both public and private resources in Harris County.

We will begin with a global or philosophical construct that can guide next steps, and then identify some intermediate and immediate options for intervention. Each will require review and revision on the part of the Alliance and its partners, and significant refinement for implementation planning; the devil (ultimate buy-in and commitment) is certainly to be found in the details.

LONG RANGE OPTION: GLOBAL TRANSFORMATION

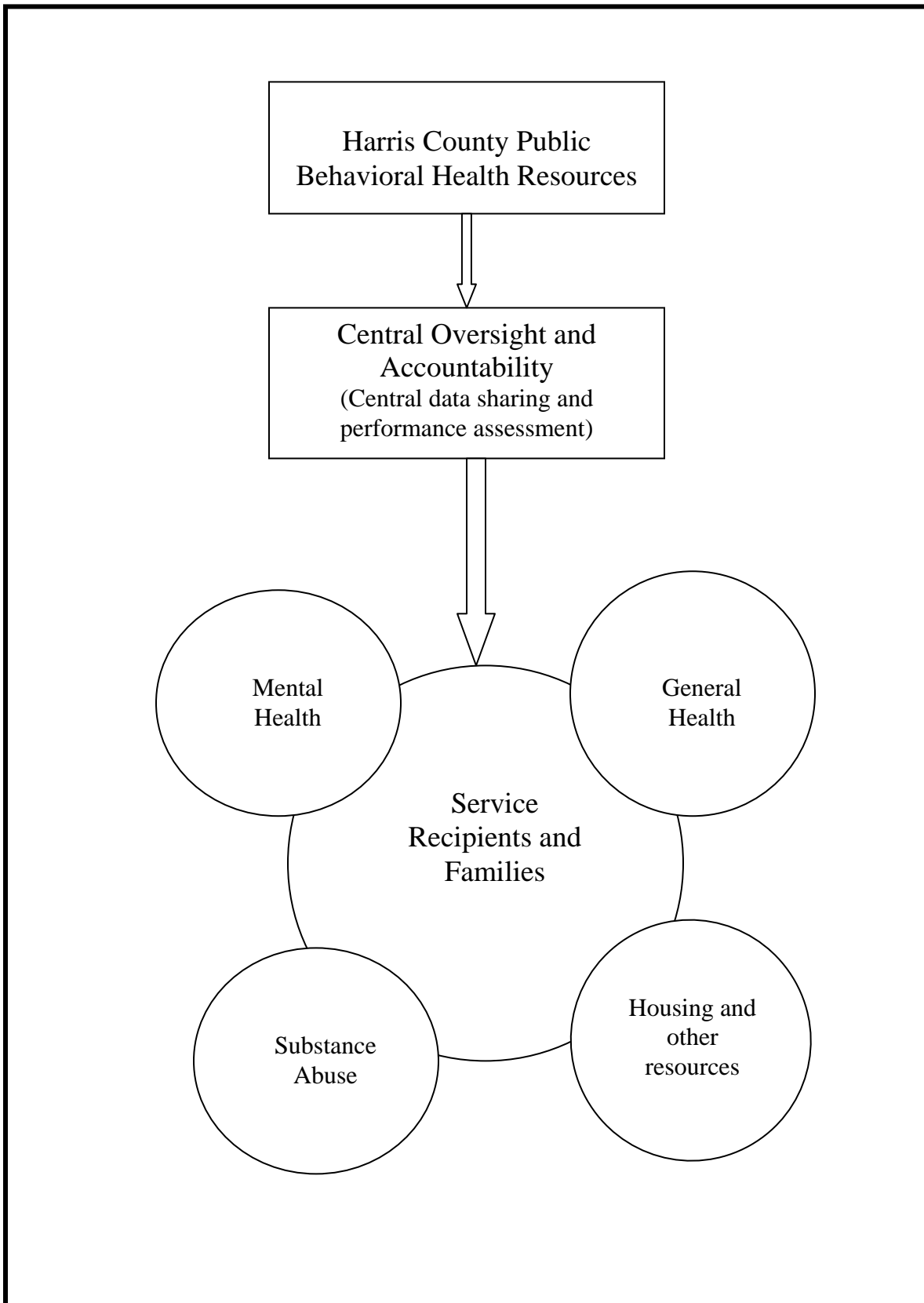
To achieve the Alliance's service system principles and outcome expectations, a broad-based transformation will be required. The desired end-state of improved access, efficiency and effectiveness cited above, might be represented graphically by **Figure 1**. This figure simplistically reflects a concentration of resources, managed systematically, in support of a consumer and/or family, with necessary services and supports wrapped around the individual or family as needed.

Very few behavioral health systems have achieved such an intentional model⁵, as most (like Harris County) must start with legacy systems and an array of funding streams that must be coordinated.

We recommend that Harris County immediately pursue short term and intermediate steps to improve coordination and access to achieve the goals of the ideal configuration. However, in the longer term structural changes may be required to achieve the desired end-state. The complexities of maintaining separate administrative and funding silos (not to mention the probable duplicative administrative costs) should not be underestimated. Harris County's leaders should be prepared to constantly evaluate progress toward their goals to assess whether or not more fundamental reforms are required to meet the County's goals. To facilitate this on-going progress measurement and performance evaluation, the Harris County Healthcare Alliance and its Behavioral Health Committee may wish to set clear benchmarks for progress. System-wide application of the performance standards and measures already identified by the Alliance (see Appendix B) would be a good first step in this process. These benchmarks will alert leaders to the need for more far-reaching changes, up to and including new organizational structures to manage resources and achieve desired consumer and family outcomes.

⁵ The New Mexico Behavioral Health Purchasing Collaborative, a multi-agency design that pools all funds to allow behavioral health services to be purchased through a single entity, may be the purest expression of this model. Other examples include the regional Behavioral Health Agencies (RBHAs) in Arizona and the County MHMR Authorities in Michigan.

Figure 1. Client-centered care model.



In Figure 1.:

- The resources in the top box may be pooled, braided or blended (see glossary in Appendix B);
- The central oversight and accountability can be structured in a wide variety of ways, and can be voluntary as opposed to mandatory;
- The consumer and family are the focus of attention and the central organizing principle for all supportive services.

While this simple model reflects a desirable end-state, it also serves as a conceptual “true north” to guide incremental changes, always seeking to come closer to an ideal service system that is truly consumer/family driven.

OPTIONS FOR IMMEDIATE AND INTERMEDIATE ACTION

There are some actions that the key partners can take now to improve the experience of care for Harris County residents who seek services. We have made no attempt here to detail all necessary action steps, but rather to give an overview of critical elements of change.

***Improved Access**

Under *Improved Access* there are several action steps that could significantly enhance movement among the elements of the service system. The three steps below interact, although each will require some distinct planning and implementation activities:

Institute a genuine “No Wrong Door” policy. There are significant barriers for most clients in moving from one part of the service system to another. The “hand-off” mechanism most frequently used appears to be referral, and for many people seeking services, just the simple expedient of transportation among service sites is a virtually insuperable barrier. We often heard that the public transportation system is inconvenient, complicated and time consuming. For individuals with thought disorders—especially compounded by poverty—there is little likelihood of follow-through on a passive referral.

This seems especially problematic at major transition points from some of the most restrictive (and hence expensive) elements of the system: the jail and the psychiatric hospital or emergency department. People who are not effectively connected (and in some cases, this means transported or escorted) to the first link in the aftercare chain will not engage, will simply drop out of sight, only to reappear at the next crisis point. This is enormously costly to the individual (in terms of a successful recovery plan) and to the system in the over-use of the highest end services.

Jurisdictions with effective “no wrong door” approaches include Milwaukee (Wrap-Around Milwaukee program for multi-system youth); San Francisco (for high risk mental health, substance abuse, co-morbid primary health, and homeless-related systems); Multnomah County (Portland, OR); and King County (Seattle, WA).

Implement a common intake form and process. Apparently there has been effort on this in the past, and we heard interest in this concept from several respondents to our inquiries. A single face-sheet that could be FAX'd, electronically transmitted (see below), or simply handed to the individual to take to the next site, would minimize burden on people seeking care. Ideally, the information on the form could be gradually expanded to serve as a true common eligibility form for all agencies, expediting review/approval for services.

States such as Massachusetts, Maine and Rhode Island have unified public benefits and service system eligibility processes that are based on a single set of intake and eligibility data collected electronically at many dispersed remote locations (wherever people present), that provides an automatic eligibility determination and gateway into a whole variety of public benefits and service systems.

Implement electronic application at all service sites. We understand that there have been efforts in this direction, and we cannot overemphasize how crucial a step this could be to begin to create a seamless access process into Harris County services. While the effort and expense of implementing such a system would be considerable, we believe that it would pay for itself in reduced paperwork and improved client (and ultimately worker) satisfaction. A client should be able to present for services anywhere he or she encounters the system, and be assessed for eligibility (and necessary application processes initiated) at the point of service electronically. A desirable addition to such a system is the use of “navigators”, staff trained to assist individuals with managing their way through the thickets of services, providers and options.⁶ As noted below, there is a general lack of consumer operated peer supports in the Harris County behavioral health system, and this navigator function could be an effective platform for increasing peer supports throughout the system.

[For electronic enrollment reference: Palm Beach County Community Health Alliance. Also, see above]

Expand and enhance mobile as opposed to site based service approaches. Harris County has some examples of mobile services (e.g., Assertive Community Treatment (ACT) services; mobile crisis response.) However, most consumers must travel to a site-based clinic, eligibility center or crisis triage center to receive services. Providing community support and other related outreach service has become the norm in some communities, and could be expanded substantially in Harris County. Out-stationing behavioral health clinicians at community health centers and schools, already discussed in this report, is

⁶ We have seen such a service being utilized in Palm Beach County, FL, and understand that it was piloted in Austin, TX.

another excellent option to improve access and overcome geographic barriers. There may be additional opportunities for establishing “circuit riding” approaches for psychiatrists and other clinicians to most appropriately reach geographically and culturally diverse priority service populations.

Jurisdictions with well developed mobile and out-stationed, co-located service components include Portland, Oregon; and Columbus, Ohio.

***Improved Provider and Consumer Information**

The existing gaps in services and access are driven in part by a lack of awareness on the part of consumers and families about what services are available and how to access them, but also on the part of providers who may know what their own agency or system provides, but who would find it nearly impossible to remain current with changing service options outside of their immediate purview.

We have been impressed by the impact on counties and local service systems of implementing the Network of Care system. Developed by Trilogy Integrated Resources, Inc., the Network of Care system develops a county-specific Internet site that can drive a number of practical applications.

This description from the Trilogy website (www.trilogyir.com) captures the core of the service:

“...the mental-health site features a fast and comprehensive Service Directory; a political advocacy tool; an enormous library; links to mental-health Web sites nationwide; important information to help link individuals to support groups and personal advocacy resources in the community, as well as a repository of best practices - successful, creative ways for communities to respond to their mental-health needs.

Trilogy's mental-health site supports the "No Wrong Door" philosophy of care, enabling families to access needed mental-health services regardless of their first point of contact with the public system. It facilitates the integration of services in the System of Care by allowing public and nonprofit agencies to work together more effectively in providing Wraparound and other collaborative services to individuals and families.”⁷

The Network of Care model was endorsed by the President’s New Freedom Commission on Mental Health, and TAC (which has no financial or business relationship with Trilogy Integrated Resources, Inc.) has seen the system operational in a number of counties across the country. Were the Harris County Health Care Alliance to sponsor one or more Network of Care sites (there are specific designs for behavioral health, developmental disabilities, children’s services, and geriatric services) several benefits would accrue: a visible, user-friendly service for the greater Harris County community; links to state and

⁷ Accessed on the Internet February 6, 2007.

national information banks; and support for grass roots advocacy around behavioral health issues.

A demonstration of the capacities of the sites are given at the TrilogyIR website noted about, or one may choose an existing “live” site, such as San Diego, CA, one of the first sites, at <http://sandiego.networkofcare.org/mh/home/index.cfm>]

****Increase the involvement of consumers, persons in recovery, and families in the design, implementation, delivery and evaluation of services***

The system as it currently operates is not consumer-centered or consumer-friendly. Several recent national reports, by the Institute of Medicine⁸, the President’s New Freedom Commission⁹, and the Annapolis Coalition on the Behavioral Health Workforce¹⁰, have all highlighted the pivotal role that consumers and their families play in the management of behavioral health disorders and recovery. The shift to truly consumer-driven care is profound, and it is difficult to achieve. All of healthcare is moving in this direction, and it is an instance where behavioral health may have a slight edge as the consumer and recovery movements have a long history in substance use disorders and increasingly so in mental health.

Practically speaking, Harris County needs to create more robust mechanisms for routinely engaging current service recipients in giving feedback on their experience of care. Tools exist (such as the SAMHSA sponsored MHSIP Survey, some use of which is required for state block grant reporting) to assist Harris County with collecting, analyzing and reporting consumer experiences of care.

As any planning process moves forward in Harris County, it will be critical to have significant consumer and family input into the design of service improvements. This is often difficult to implement unless the Alliance and its partners are willing to provide practical supports for consumer involvement (transportation, stipends, child-care), as many of the very consumers who are most current in their knowledge of the system are at a serious disadvantage because of issues related to their disabling conditions.

And finally, in this regard, we heard repeated mention of shortages of trained staff to meet the needs of consumers. Many states have implemented, with demonstrable success, formal peer support services that yield a high return on investment. The “certified peer specialist” model has been adopted in several states as a Medicaid reimbursable service, and training curricula exist for certifying consumer providers to fill this critical role. Of course, we endorse involvement of qualified self-identified consumers in all levels of clinical and administrative operations.

⁸ *Improving the Quality of Health Care for Mental and Substance-Use Conditions* (2006);

⁹ *Achieving the Promise: Transforming Mental Health Care in America* (2005)

¹⁰ *An Action Plan for Behavioral Health Workforce Development* (2007), in press.

In the case of children and adolescents (see more below), it is critical to have family and youth involvement in many of the same ways that we identify for adults above.

As noted, several states have implemented specific peer-support models (Georgia, South Carolina, Michigan). States have also created offices of consumer affairs, which have had varying degrees of success; there is now a national organization of such offices, the National Association of Consumer/Survivor Mental Health Administrators (NACSMHA).

****Increase planning for home- and school-based services for children and adolescents.***

At the time of the preliminary report, we were conscious of an emphasis on a crisis in the adult services system, and we have focused much of our reporting on that priority. Having noted this, our preliminary review suggests that a collaborative effort needs to focus on the needs of young children, families, and youth transitioning into adulthood.

Service design and delivery for young people and families are qualitatively different from those for adults, and generally these efforts require even more complex multi-agency/multi-system approaches. Schools, primary care and pediatric practices, social services and juvenile justice agencies may all have a role in assisting a single child; coupled with the complexities of family systems, this planning must receive specialized attention, in our view, and is outside of the scope of the current review. Since Harris County has a Systems of Care grant, this will provide a strong foundation for future work.

Wrap-Around Milwaukee is an exemplar here, but many System of Care grantees have made significant strides in changing children’s services.

****Rapidly increase co-location and other integration strategies with primary healthcare.***

The issue of medical and behavioral co-morbidities is a national crisis, and it has been growing worse. The following quote from Ron Manderscheid, formerly the Chief of the Survey and Analysis Branch of the Center for Mental Health Services:

“In 1986, twenty years ago, I wrote a paper on the disproportionate risk for early death when comparing people with mental illnesses with the general population. At that time, for example, males with serious mental illnesses were likely to die 10 years earlier than their age cohort in the general population. In a recent study, that gap ballooned to 25 years—a truly shocking acceleration. I probed into that data, and found that only 20% of the gap can be explained by what we might consider mental health causes, e.g. suicide. The remaining 80% are explained by the consequences of undiagnosed, untreated, or undertreated conditions like diabetes, chronic obstructive pulmonary disease, cardiovascular disease, etc. This is simply an unacceptable state of affairs.”¹¹

¹¹ *Prescriptions for Progress*, Volume 1, No. 7, November 2006, p. 10.

Failure to take into account the interactions between and among mental and other medical conditions is not sub-optimal care, it is becoming irresponsible care. And it increases costs on both sides of the artificial divide between behavioral health and primary health care.

Harris County can move forward to dramatically improve the general healthcare of its residents with behavioral health problems—and we believe coincidentally reduce costs for undiagnosed or untreated medical complications—by aggressively pursuing integration of care by the most simple expedient of co-location of primary care professionals in behavioral health settings and vice versa. The Hospital District (HCHD) and MHMRA are currently implementing such co-location on a small scale. However, to substantially increase the co-location of services it will be necessary to resolve some of the common eligibility and reimbursement issues discussed above. For example, there are opportunities for Medicaid reimbursements for behavioral health and related services provided within federally qualified health centers, but the current informal model for co-location may not be able to take full advantage of these opportunities.

Co-location, it should be noted, would ideally be only a way-station on efforts to truly integrate behavioral and general medical care, but it is an essential first step.

Cherokee Health Systems in Knoxville, TN has been a leader in true integration of behavioral and general medical care. Central City Concerns in Portland, OR is another good example if integrated health, substance abuse and mental health services coordinated with permanent supportive housing approaches.

**** Model a different accountability structure that formalizes accountability in a more robust fashion.***

A significantly complex option would be to create a mechanism for planning and accountability at the County level, while leaving both the funding and services in existing silos. This type of arrangement can usually be achieved by interlocking Memoranda of Agreement that commit the partnering agencies to particular courses of action/interaction with one another. The concept is not blended funding, but what is sometimes referred to as “braided” funding, where separate and distinct threads of funding are woven together to create a single set of supports. The agencies remain discrete entities, but to the consumer the services appear seamless. To make steps like this possible, Harris County would initially want to organize itself around one or more critical community problems/solutions, for example jail diversion, supports for homeless individuals, or an integrated community crisis response.

The required sub-agreements might include “no-refusal” agreements among service providers, co-location of staff, etc. A critical element in such arrangements would be transparency of utilization data and other programmatic information, as no individual agency will want to participate unless there is accountability for all. A logical first effort

might be erasing the operational lines between the Neuropsychiatric Center (NPC) and Ben Taub emergency room.

The outlines for just such a structure are not new for Harris County, as similar structural recommendations were made by the Public Health Delivery Group in December, 2004.¹²

Vermont has a long track record of setting system outcome goals and managing all services to achieve those targets. The Mental Health Board in Columbus Ohio is another good example of focused and vision-driven long term system development and change.

**Address workforce issues, in terms of both the quality and quantity of the members of the workforce.*

A linchpin in sustainable change is a well trained, culturally and linguistically competent workforce (which includes not only the traditionally understood workforce of psychiatrists, psychologists, nurses, social workers and counselors, but peer- and family-support specialists as well), present in sufficient numbers to meet demands for services.¹³ Almost no community in the country is prepared to meet these challenges, but increasingly communities are organizing around workforce issues.

The presence of a large medical complex and two psychiatric training programs, along with University of Houston's clinical social work and psychology programs, provides an unusual opportunity for Harris County. Public academic linkages are not easy to build and sustain, but the potential benefits for trainees, researchers and service recipients are large. There is also a huge and generally untapped resource in the workforce: consumers of services, people in recovery, and their families; they are often not even considered a real part of the workforce, and yet self-care, and peer- and family- supports are integral in building a recovery oriented system.

The State of Alaska has the most robust and integrated public/academic training model, although New Mexico is working to develop a very broad coalition. The Texas Health Institute, as part of its mental health transformation efforts, has designated workforce concerns as one of its priority focus areas.

NEXT STEPS FOR HARRIS COUNTY: BUILDING ON STRENGTHS

Private philanthropy has always played a role as either a partner or as a catalyst in the development and implementation of innovative service strategies for Harris County. The behavioral health services crisis seems to be yet another challenge best addressed by looking beyond the traditional providers of services. A partnership among advocates,

¹² Report of the Public Health Delivery Study Group to County Judge Eckels and Commissioners Lee, Garcia, Radack, and Eversole, December 17, 2004. Retrieved from the Internet 2/6/07.

¹³ Hoge, Morris, Daniels, Stuart, Huey & Adams. (2007) *A National Action Plan on Behavioral Health Workforce Development*, The Annapolis Coalition, www.annapoliscoalition.org

consumers and families, funders, providers and private philanthropy may be the only way to avoid the sort of bureaucratic inertia that could derail positive change.

We believe that the Alliance, with its broad partnership and its position of leadership in Harris County, can serve as a catalyst for system changes that may start small but which can build toward a fundamental transformation of the experience of care for residents of Harris County who have behavioral health needs. However, positive ideas and strong but informal partnerships cannot by themselves forge the fundamental system changes needed to start moving Harris County towards best practice community behavioral health services. Each of the major partners of the system will have to assume new responsibilities to collaborate, and each will have to cede some control of resources and turf, to engage in true transformation of the Harris County behavioral health system.

We believe that all of the above intermediate and short term initiatives can be implemented without legislative action. However, legislative action might provide the necessary impetus and incentives to move forward. Legislative action could also provide for an implementation structure that could overcome some of the organization barriers and funding silos now present in the Harris County behavioral health system.

- (1) Institutionalize attention to system improvement by creating a formal structure, with paid staff, housed within the Harris County Community Healthcare Alliance. A mechanism should be developed to ensure a broad-based commitment to progress by building a cross-agency budget for this effort.
- (2) Adopt as a priority project implementation of the consensus performance measurement tools already developed for Harris County.
- (3) Create a “council” or other structure to advise and support the Alliance and its dedicated staff on long range planning for improved services.
- (4) Create a multi-year strategic plan that identifies, establishes priorities, and sets public milestones for accomplishment as a way of affirming consensus on priorities and creating a mechanism for accountability among the partners.
- (5) Provide for one or more demonstrations of integrated services and integrated funding for a high priority target populations;. In each case the purpose of the demonstration(s) would be to identify a defined sub-group of a high risk, high cost service population, and then to deliver best practice multi-system service interventions to the defined priority consumer groups. The outcome and performance measures adopted by the Alliance and incorporated in the legislation should be used to evaluate the success of the demonstration(s). The legislation would provide a statutory basis for any specific actions to be taken at the state level to waive state requirements or funding limitations and to integrate Medicaid and non-Medicaid funding for these demonstrations. The legislation could also stimulate submission by the state of Harris County-specific Medicaid plan changes under recent federal Deficit Reduction Act provisions that could facilitate increased eligibility and services flexibility for priority consumers, including consumers that might be included in one or more of the proposed demonstration projects. If that strategy proves insufficient, the County may wish to consider one of several possible categories of federal Medicaid waivers.

CONCLUSION

The Technical Assistance Collaborative, Inc., is pleased to provide this preliminary report, and we thank the many individuals who gave so generously of their time, energy and wisdom to inform this document. We trust the interim report will stimulate considerable dialogue, which in turn will result in a refined set of recommendations for actions to be carried out on a priority basis within Harris County. These refined recommendations may also form the basis for a request to the Texas legislature for Legislative support for implementing some or all of the recommendations.

Stephen L. Day, MSW
Executive Director

John A. Morris, MSW
Director, Human Services Practice

APPENDIX A: INDIVIDUALS INTERVIEWED IN PERSON OR BY PHONE¹⁴

Dr. David Buck

Dr. John Burrus

Mr. Jack Callahan

Mr. Ron Cookson

Dr. Avrim Fishkind

Mr. Leonard Kincaid

Ms. Karen Love

Dr. Curtis Mooney

Dr. Lois Moore

Dr. Sylvia Muzquiz

Ms. Jackie St. Germain

Dr. William Schnapp

Dr. Steve Schnee

Ms. Clarissa Stephens

Ms. Besty Schwartz

¹⁴ Consultant John Morris also attended a meeting of the Jail Diversion Task Force, which provided useful information from a number of additional sources, and both TAC consultants met with the local planning group on .

APPENDIX B: Harris County Behavioral Health Principles and Performance Measures

APPENDIX C: GLOSSARY

TAC presents definitions for some of the terms that are used in the report, with examples to clarify each.

Pooled funding. This is a dramatic departure from traditional pipelines of funding that is often referred to as “categorical”, that is, the money is for a certain “category” of people or efforts (e.g., child welfare, juvenile justice, etc.) In this model, the funds are poured into a common “pool” and used to achieve service goals without reference to the category that an individual service recipient may have traditionally represented. Conceptually it is often expressed that the services are provided “no matter which agency touches the individual first.”

Example. The most striking example of truly pooled funding is the State of New Mexico Behavioral Health Purchasing Collaborative. New Mexico created in statute a governing body of the key agencies funding behavioral health (including corrections), and all of those dollars are combined in a common fund. Services are purchased and payments managed through an Administrative Services Organization (United Behavioral Health.)

Blending vs Braiding Funding. (This material from The Bazelon Center for Mental Health Law, www.bazelon.org accessed 3/7/07):

Blending or braiding federal funds allows decisions on services to be made with the family and by those working most closely with the family. Both strategies offer local flexibility and allow providers to focus on outcomes. However, this flexibility must be accompanied by accurate measurement of outcomes. Those interviewed stressed that systems of care must track, document and account for the funds they spend, whether using a blended or a braided funding approach. To collect the information needed to demonstrate effective outcomes for children served and accountability to taxpayers, systems of care must coordinate monitoring across agencies and strive to demonstrate total costs and benefits across systems.

Blended funding—even on a small scale – has advantages over braiding of funds because it offers significant flexibility for state and local agencies and reduces the work required for reporting and accountability measures. Blended funding can allow systems to fund activities that are not reimbursable through specific categorical programs. In so doing, blended funds can help plug funding gaps in the services continuum. This is particularly true when blended funding includes flexible dollars such as those available through a state’s general fund.

Braiding, on the other hand, allows resources to be tracked more closely for the purpose of accounting to federal program administrators. It thus recognizes the categorical nature of existing programs and avoids some of the conflicts that can arise in blended funding pools.

Examples of Blended and Braided Funding

Wraparound Milwaukee, Wisconsin is a county-based managed care program operating with a blended funding pool. Medicaid, child welfare, juvenile justice and mental health agencies all contribute resources. Medicaid pays on a capitated basis, the other agencies pay case rates. Thus each agency knows the cost of services to children it refers to the system.

Vermont has operated a braided funding system for the past 15 years, using child welfare, juvenile justice, mental health and special education funds to develop innovative community-based treatment plans for children, adolescents and their families with the most intensive and complex needs. For the past 10 years, mental health, juvenile justice and child welfare have blended funds to operate a comprehensive immediate-response system in each of the 12 regions of the state.

Michigan, in 17 counties, uses a case-rate and wraparound approach to blend funding from mental health, juvenile justice, child welfare and education to serve children with serious mental or emotional disorders. Funding is separately tracked for accounting purposes, but at the child-family level the source of appears to be a single pool.

New Jersey, in a new statewide initiative, combines blending and braiding approaches. The payment source for a specific service is unknown to providers and families, who see only a flexible pot of funds available for the child's services. The state contracts with an administrative services organization to address payment issues and to support individualized service planning at the local level. The ASO identifies the payment source for each identified service or support for the child and family. This is facilitated through the creation of a single electronic record. Funds for the initiative (Medicaid and non-Medicaid funds) are held by the state Medicaid agency and the Medicaid agency handles all reimbursement through its existing financial management system.

The Dawn Project in Indiana has braided funds from mental health, special education, child welfare and juvenile court to create a case rate paid per member per month to be used flexibly by providers in the system to finance an individualized and comprehensive plan of care for each child and family. Agencies contribute to the case rate based on established eligibility criteria. The project uses clinical-management software which can integrate clinical and fiscal data. These data are used to handle cost approval and analysis and claims adjudication.