Dallas County Behavioral Health Leadership Team
Thursday, May 14, 2015
Henry Wade Juvenile Justice Center
2600 Lone Star Drive, Dallas, TX
Room 203-A at 9:30 -11:30 a.m.

I. Welcome and Call to Order

II. Review/ Approval of Minutes from last meeting*

III. Sunset Commission*
- Legislative Status
- Indigent Services Plan

IV. Presentations
- 1115 Waiver Update- Metrocare Services, Gala Dunn
- HHSC Health Plan Management (Medicaid/ CHIP), Rudy Villarreal

V. BHLT Activity Tracking

VI. Dallas County Behavioral Health Housing Workgroup

VII. Reports from and Charges to BHLT Committees
- CSP Governance Committee
- Clinical Operations Team
- FACT
- BHSC
- Legislative Committee

VIII. NorthSTAR Update
- NTBHA Update
- ValueOptions NorthSTAR Update
- State Advisory Committees

IX. The Cottages at Hickory Crossing Update

X. Funding Opportunities
- Safety and Justice Challenge
- SAMHSA Drug Court Expansion

XI. Upcoming Events and Notifications

XII. Public Comments

XIII. Adjournment

* Indicates items requiring approval from Dallas County Behavioral Health Leadership Team

Dallas County Behavioral Health Leadership Team
Meeting Notes
Thursday, April 9, 2015

Welcome and Call to Order
The meeting was called to order by Commissioner John Wiley Price at 9:30 AM.

Review/Approval of Minutes
The minutes from the BHLT meeting held on March 12, 2015 were included in the meeting packet. BHLT committee members voted to approve the minutes without modification.

Introductions and Absent BHLT Members:
Gregory Dillon was introduced as the new Dallas County CSCD Deputy Director.

Sunset Commission:
Commissioner John Wiley Price opened the meeting for discussions on the Sunset Commission report. Jane Metzinger stated that the Texas Legislature had filed HB3990 (Rep. Rose) and SB1979 (Senator Hall) and they are currently preparing it for the House and Human Services Committee. The co-authors of HB3990 are Rep. Stuart Spitzer, Rep. Evan Davis, Rep. Raphael Anchia, and Rep. Kenneth Sheets. This Bill will give the Sunset Committee time to prepare for the 3,700 indigent clients. Collin County wants out of Northstar by September 2016.

Presentations:

1115 Waiver Update- Tamara Johnson, Executive Director HCA Physician Services & New Project Development at Green Oaks, provided an overview of their 1115 Waiver projects. Ms. Johnson reported that the Tele-Psychiatry/Integrated Clinic program was first implemented as a pilot program in 2012. The purpose of this initiative is to develop expertise in delivering behavioral health care via telemedicine to expedite care. The tele-psychiatry services brings behavioral healthcare and disposition assistance to both rural and urban area hospitals who find that psychiatry and other resources are necessary to provide the most advanced and expedited behavioral health services. As of April 1, 2015 Green Oaks has consulted with 366 patients of the 3300 needed to reach their goal (September 30, 2016). The program has made several changes; for example, they have created a SharePoint site to help share and update information on patients, doctor's profiles, and algorithms.

BHLT Activity Tracking: Mr. Stretcher stated that the information was located in the packet for everyone's review.

Behavioral Health Housing Work Group (BHHWG) Update: Mr. Stretcher explained that the information regarding BHHWG was located in the Supplemental Packet. He also indicated that a presentation would be given at next month's meeting on the CSH Conference. Mr. Stretcher also

credited Commissioner Daniel and Germaine White on finding a contact with Health and Human Services regarding contracting with Managed Care Organization (MCOs). There will be a presentation given at next month's meeting.

Reports from and Charges to BHLT Committees

Crisis Services Project (CSP) Governance Committee: Mrs. Randolph reported that the next meeting would be held on April 21, 2015 at 3:30pm at City Square and resume July first Tuesday meetings in July. The goal of CSP is to serve 350 unique consumers each month. Although CSP fell short of its December and January service goal, the project is on schedule to meet its annual metric goal required for matched funding CSP served 466 clients in February, and 553 clients in March. Mrs. Randolph also reported that as of February 28, 2015, CSP has seen a 15% reduction in criminal justice readmissions for program participants. In addition, 68% and 77% of CSP clients have been connected with a prescriber within 7- and 30-days following hospital discharge.

Clinical Operations Team (ACOT): Sherry Cusumano stated that ACOT is currently looking at Apprehension by Police Officer Without a Warrant (APOWWs), and Daniel Byrd and Jennifer Torres are going to put together a presentation on how to manage crises as an alternative to using 911. Ms. Cusumano also stated that she has contacted Dave Hogan, Manager for Dallas Police Department Crisis Intervention Unit, to get information on their APOWWs. Mr. Hogan advised that they had currently updated their computer system and that information was not available to him at that time.

FACT: Kelli Laos, co-chair of FACT reported that the committee did not meet.

BHSC: Judge Kristen Wade stated that at the last BHSC meeting the committee took a tour of the new Med-Mod in the jail. Judge Wade also commended Pat Jones on all his hard work in coordinating the tour. Mr. Jones has since offered a subsequent tour for the judges at Frank Crowley Court building. Mr. Stretcher recommended that everyone on BHLT tour the facility as well. Tamara Woods from Veteran Affairs asked when providers would be allowed access to their clients in the jail. Sharon Phillips offered to assist Ms. Woods on this issue.

Legislative Advisory Committee: Commissioner Price stated that the Legislative update had been given with the Sunset Commission status report.

NTBHA Update: Alex Smith stated the board has finally executed a county specific project with Rockwall and are currently working on a Penalty Incentive Project. In the Penalty Incentive Fund (PIF) Project, NTBHA received $400,000 last year and had plans to allocate most of the funds to transportation services; however, transportation proved to be less of a significant issue than previously thought. Therefore, NTBHA plans to allocate most of last year's PIF funds to housing, as well as most of the $400,000 they expect to receive this year. Currently, NTBHA has approximately two hundred-thousand dollars left in PIF from last year. Mr. Smith stated that there hasn't been much movement on the Sunset Community Plan; although they continue to have on-going conversations with HHSC. Mr. Smith stated that he did testify before the HHSC Senate Committee and he has asked the committee for more time to plan out the changes to NorthSTAR. Mr. Smith stated that one barrier to creating a community plan is the uncertainty of how much funds are going to be given to the NorthSTAR system. Mr. Smith reported that NTBHA also welcomed new board chair, Ron Stretcher, new member, Mr. Gordon Hikel (Commissioner Court Assistant Administrator), and bid farewell to Sandy Potter with ValueOptions of Texas.

ValueOptions Update: Sandy Potter introduced Holly Brock as the Interim CEO of ValueOptions and John Quattrin as the new Chief Operations and Financial Officer. VO is currently setting up a dashboard for individuals needing information on county specific SPN information in the NorthStar system. The dashboard will include information on Medicaid Indigent, Medicare, Chips, Pharmacy, etc. The dashboard will not include any information on crisis services, transportation, or other services billed by invoice (claims pay). Mr. Quattrin will send out a one-page document of what VO has seen over the last three years regarding the indigent funds.

State Advisory Committees: There were no updates given on the Advisory Committee.

The Cottages at Hickory Crossing Update: Ron Stretcher reported that construction on the Cottages continues.

Safety and Justice Challenge: Mr. Stretcher reported that the grant has been submitted and we are waiting on a response.

SAMHSA Drug Court Expansion: Mr. Stretcher commended Becca Crowell and her contribution to the Grant.

Upcoming Events and Notifications: Mrs. Randolph announced that the next Learning Cooperative Event will be held May 27-28, 2015. Vanita Halliburton invited the BHLT to join a special event on Wednesday, May 6, 2015, where they will launch a new website featuring a searchable database of mental health providers and resources in North Texas. Tamara Woods from Veterans Hospital announced the new Homeless Mobile Unit from which medical and social worker services will be provided to homeless veterans. The mobile unit will be located at Dallas Interfaith Street Church on Wednesdays and at City Square on Fridays. Sherri Cusumano announced that NAMI Walks will be held on May 9, 2015.

Adjournment: A motion was made, seconded, and approved to adjourn the meeting at 11:15 AM.

Metrocare Services' 1115 Waiver Projects

Metrocare
SERVICES

Dallas County Behavioral Health Leadership Team Meeting

May 14, 2015

Metrocare Services' 1115 Projects

Metrocare is north Texas' leading nonprofit dedicated to helping people with mental illness, developmental disabilities, and severe emotional problems live healthier lives. Metrocare provides a comprehensive array of individually-tailored services to help the people we serve toward meaningful and satisfying lives.

- 12 approved Delivery System Reform Incentive Payment (DSRIP) projects totaling $71.5 million
  - Seven 5-Year Projects
  - Five 3-Year Projects
  - All projects provide services to consumers with mental illness and / or developmental disabilities
  - 90% of all consumers served are Medicaid and/or Low Income-Uninsured

Altshuler Center for Education and Research

Metrocare SERVICES

The Altshuler Center for Education and Research (ACER) provides training to enhance the development of specialty behavioral health care and improve consumer choice by increasing the number of behavioral health professionals in the public sector.

- Cumulative Quantifiable Patient Impact – 5,300
- 120 ACER trainees enrolled as of May 6, 2015; DY4 - 110
- 1,160 consumers served as of May 6, 2015; DY4 – 1,600
- Category 3 - Patient Satisfaction
  - IT-6.2.a – Client Satisfaction Questionnaire 8 (CSQ-8)
- 100% milestone achievement

Metrocare at Grand Prairie

The Metrocare at Grand Prairie Clinic provides services including psychiatric evaluations, pharmacy services, counseling, rehabilitation and skills training and case management.

- Cumulative Quantifiable Patient Impact – 3,850
- 1,704 consumers enrolled as of May 6, 2015; DY4 – 1,200
  Category 3 - Behavioral Health / Substance Abuse Care
  - IT-11.26.c – Adult Needs & Strengths Assessment (ANSA)
  - IT.11.26.d – Children & Adolescent Needs & Strengths Assessment (CANS)
- 100% milestone achievement

Integrated Primary and Behavioral Health Care Services at Metrocare – Adults

Integrated Primary and Behavioral Health Care Service Clinics provide integrated models of easy, open access to primary care services for persons who are receiving behavioral health services in Metrocare's community based behavioral health clinics.

- Cumulative Quantifiable Patient Impact – 8,000
- 2,139 consumers enrolled as of May 6, 2015; DY4 – 2,500
- Category 3 – Primary Care and Chronic Disease Management
  - IT-1.7 – Controlling High Blood Pressure
- Third location scheduled to open Summer 2015
- DY3 Carry-Forward Metric: Improve No-Show Rates

Assertive Community Team for Persons with Developmental Disabilities (ACT-DD)

Metrocare SERVICES

The Assertive Community Team for Persons with Developmental Disabilities Program provides on-call services for travel to acute care facilities, jail or schools to help assess and stabilize consumers and also provides follow-up services to enrolled clients to ensure the destructive pattern that led to the need for acute services is eliminated or significantly reduced.

- Cumulative Quantifiable Patient Impact – 122
- 37 consumers enrolled as of May 6, 2015; DY4 – 41
- Category 3 – Behavioral Health / Substance Abuse Care
  - IT-1.26.b – Aberrant Behavior Checklist
- 100% milestone achievement

Family Preservation Program (FPP)

The Family Preservation Program provides short-term, intensive services that includes crisis intervention, medication management, counseling and case management to children recently released from the psychiatric hospital or those at-risk for out-of-home placement and their families.

- Cumulative Quantifiable Patient Impact – 720
- 181 consumers enrolled as of May 6, 2015; DY4 – 240
- Category 3 – Quality of Life / Functional Status
  - IT-10.1.a.v – Pediatric Quality of Life (PedsQL)
- 100% milestone achievement

Center for Children with Autism at Metrocare (CCAM)

The Center for Children with Autism at Metrocare (CCAM) is an applied behavior analysis based program for children on the autism spectrum and/or children with other developmental disabilities. The program is structured as a tiered system; offering 1:1 staff/ client ratio for Level 1, 1:2 staff/ client ratio for Level 2 and group participation for Level 3.

- Cumulative Quantifiable Patient Impact – 436 (2 Projects)
- CCAM I: 87 consumers enrolled as of May 6, 2015; DY4 – 80
- CCAM II: 27 consumers enrolled as of May 6, 2015; DY4 – 60
- Category 3 – Quality of Life / Functional Status
  - IT-10.4.a – Developmental Profile 3 (DP3)
  - IT-10.4.b – Vineland Adaptive Behavior Scales (VABS)
- CCAM III location scheduled to open Summer 2015
- 100% milestone achievement

Behavioral Treatment Center (BTC)

Metrocare SERVICES

The Behavioral Treatment Center provides short-term behavior intervention and urgent safety net services for individuals with intellectual / developmental disabilities and mental health issues.

- Cumulative Quantifiable Patient Impact – 112
- 17 consumers enrolled as of May 6, 2015; DY4 – 32
- Category 3 – Behavioral Health / Substance Abuse Care
  - IT-11.26.b – Aberrant Behavior Checklist
- 100% milestone achievement

Metrocare at Midway

The Metrocare at Midway Clinic expanded behavioral health services to the underserved by opening an additional outpatient clinic in the northwest region of Dallas County.

- Cumulative Quantifiable Patient Impact – 3,000
- 474 consumers enrolled as of May 6, 2015; DY4 – 1,000
  - Aggressive marketing campaign launched to increase consumer traffic
- Category 3 – Behavioral Health / Substance Abuse Care
  - IT-11.26.c – Adult Needs and Strengths Assessment (ANSA)
  - IT-11.26.d – Children and Adolescent Needs and Strengths Assessment (CANS)
- 100% milestone achievement

Integrated Primary and Behavioral Health Care Services at Metrocare - Pediatrics

Metrocare SERVICES

The Integrated Primary and Behavioral Health Care Services Program for Pediatrics provides a model of integrated behavioral and primary healthcare services in Metrocare clinics which serve children and adolescents.

- Cumulative Quantifiable Patient Impact – 4,100
- 1,164 consumers enrolled as of May 6, 2015; DY4 – 1,500
- Category 3 – Primary Care and Disease Chronic Management
  - IT-1.22 – Asthma Percent of Opportunity Achieved
- Second clinic scheduled to open Summer 2015
- 100% milestone achievement

Patient Navigation

The Patient Navigation Program facilitates discharges for high risk patients from an acute care setting to the community by linking them to a community mental health clinic in addition to local community supports and services.

- Cumulative Quantifiable Patient Impact – 2,589
- 130 consumers enrolled as of May 6, 2015; DY4 – 1,121
  - Expanded hospital collaborative efforts underway to increase consumer enrollment
- Category 3 - Patient Satisfaction
  - IT-6.2.a – Client Satisfaction Questionnaire 8 (CSQ-8)
- DY3 Carry-Forward Metric: QPI and Category 3 Baseline

Rapid Assessment and Prevention Team (RAP)

Metrocare SERVICES

The Rapid Assessment and Prevention Team Program is an intensive program targeting individuals returning to the community following a psychiatric hospitalization. The program goal is to prevent psychiatric re-admissions.

- Cumulative Quantifiable Patient Impact – 855
- 146 consumers enrolled as of May 6, 2015; DY4 – 360
- Category 3 – Quality of Life / Functional Status
  - IT-10.1.a.iv – Assessment of Quality of Life – AQoL-8D
- DY3 Carry-Forward Metric: Category 3 Baseline

Questions?

For questions, please contact:

Gala Dunn, MBA
Senior Project Manager
Metrocare Services

Gala.Dunn@metrocareservices.org
(214) 743-1267

BHLT Workgroup Recommendations for Action

BHLT Action Items

	Suggestions, Recommendations & Motions	Person Initiating	Workgroup/ Person Tasked	Plan for Accomplishment	Current Status	Follow-Up	Date Completed
9/11/2014	Tom Collins expressed concern with having to visit non-medical facilities (such as boarding homes) before referring Green Oaks clients. Mr. Collins proposed having a dedicated entity responsible for this task.	Tom Collins	Behavioral Health Housing Work Group (BHHWG)	The BHHWG will facilitate a community discussion on how to address this issue.			This is being addressed by BHHWG.
10/9/2014	BHLT members asked for a description of boarding home standards.	Tom Collins	Janie Metzinger	Janie Metzinger will provide BHLT with a document that reviews boarding home standards.	In progress		This is being addressed by BHHWG.
1/8/2015	Invite behavioral health providers to give status update on their 1115 Waiver projects	BHLT	Charlene Randolph	Charlene Randolph will invite providers to give updates	Green Oaks is scheduled to provide update on 4/7/2015; Metrocare 5/14/15		Parkland complete 3/12/15; Metrocare complete 5/14/15

Recent Completed BHLT Action Items

Date	Suggestions, Recommendations & Motions	Person Initiating	Workgroup/ Person Tasked	Plan for Accomplishment	Current Status	Follow-Up	Date Completed
4/9/2015	HHSC Health Plan Management presentation on Managed Care Organizations (MCOs) to BHLT	Commissioner Daniel/ Germaine White/ Ron Stretcher	Commissioner Daniel/ Germaine White/ Ron Stretcher	Germaine White will invite HHSC to present information on MCOs in Texas	Rudy Villarreal will attend BHLT and NTBHA 5/2015 to present information		

History of BHLT Action-Items and Accomplishments

On-Going & Accomplished Action Items	Date Completed	Current Status
Coordinate efforts of BHLT sub-committees, community agencies, and DSRIP projects to ensure collaboration and education	On-going	Charlene Randolph continues to monitor these efforts
Discuss crisis services, stabilizations, alternatives to care, and dynamics that lead to better outcomes in BHLT sub-committees	On-Going	ACOT routinely discusses this issue at monthly meetings
Educate DSRIP projects regarding their impact on ValueOptions NorthSTAR	On-Going	CSP discusses at RHP 9 Learning Collaborative events
Monitor DSRIP projects operations, focus, outcomes to help identify areas that need additional supports and shifting	On-Going	CSP receives information at RHP 9 Learning Collaborative events
Discuss Dallas PD concerns regarding clients being released from the hospital without a discharge plan	On-Going	ACOT routinely discusses this issue at monthly meetings
Receive information on the Regional Legislative Team Committee's identified priority issues	On-Going	Legislative Committee will routinely provide this information
Facilitate collaboration between NAMI and Dallas County Juvenile Department to implement stigma training (Ending the Silence) into The Academy of Academic Excellence and schools	On-Going	FACT routinely discusses and is helping to coordinate this activity.
Explore the availability of funding for supported services (i.e. case management) persons receiving DHA housing vouchers.	On-Going	BHHWG routinely discusses this issue.
Explore sustainability of 1115 Waiver Projects	On-Going	CSP and BHLT will continue to explore this issue
Invited Mr. Thompson join Councilwoman Davis' Workgroup	Complete	Jay Dunn addressed this issue
Wrote a response to House Bill (HB) 3793. HB 3793 (83rd Legislative session) that directs a plan for appropriate and timely mental health services and resources for forensic and civil/voluntary populations	12/12/13	
Documented who's responsible for each CSP milestone	1/17/14	
Shared creative options for utilizing DSHS housing funds to ValueOptions NorthSTAR	Complete	VO published guidelines based on suggestions
Established Behavioral Health Housing Workgroup	2/7/14	The workgroup continues to meet monthly.
Approved funding Care Coordinator position at ValueOptions to assist the CSP	2/24/14	

BHLT Workgroup Recommendations for Action

On-Going & Accomplished Action Items	Date Completed	Current Status
Applied for the SAMHSA Sequential Intercept Mapping workshop	2/13/14	BHLT was not a chosen participant
Provided BHLT will more information regarding Foster Care Redesign	3/25/2014	
Provided description for Specialty Court Case Coordinator Position	4/1/2014	
Provided BHLT members with information on the Qualifications of Homelessness and accessing ValueOptions Housing funds	5/8/2014	
Addressed patient complaints on Parkland police	5/16/2014	
Received update on Children's and Parkland's 1115 Waiver projects	6/12/2014	
Followed-up on DSHS Housing for HCBS-AMH	7/10/2014	Dallas County suspended its request
Distributed MHA Flyer on Teen MH Conversation	7/10/2014	
Received update on Green Oaks' and Baylor's1115 Waiver behavioral health projects	8/14/2014	
Received requested information on Dallas Marketing Group	7/18/2014	
Reviewed Janie Metzinger's response letter to Sunset Commission's review on the counting of mentally ill individuals in Texas	8/11/2014	
Distributed program overview and access information for Baylor's 1115 Waiver program to BHLT members	8/25/2014	
Adopted resolutions supporting Abilene Christian University research proposal and UTSW Homeless Services Project	9/11/2014	
Received update on Timberlawn's 1115 Waiver behavioral health projects	9/11/2014	
Approved legal research on Texas mental health funding laws	10/9/2014	
Received literature on nine models for integrating behavioral health and primary health care	10/10/2014	
Supported response letter to the Sunset Advisory report and voted to approve resolution declaring its support of NorthSTAR	10/15/2014	
Designated a 5-member committee to negotiate with HHSC to modify NORTHSTAR	12/11/2014	
Behavioral Health Housing Workgroup submitted		
Received a copy of Senate Bill 267 that addresses regulations for landlords renting to persons with housing choice vouchers	2/9/2015	
Received handout on MHA and NAMI's NorthSTAR legislative efforts	2/9/2015	
Approved After-Care Engagement Service Package to assist CSP	2/12/2015	
Approved submission of Preliminary Local Plan for Indigent Behavioral Health Services and designated NTBHA as a community health center	2/12/2015	
Provided SIP presentation to BHLT	3/12/2015	

Dallas County Behavioral Health Housing Work Group
Dallas County Administration, 411 Elm Street, 1st Floor, Dallas Texas 75202
April 23, 2015
Minutes

Mission Statement: The Dallas County BH Housing Work Group, with diverse representation, will formulate recommendations on the creation of housing and housing related support services designed to safely divert members of special populations in crisis away from frequent utilization of expensive and sometimes unnecessary inpatient stays, emergency department visits and incarceration.

Success will be measured in placement of consumers in housing and the decreased utilization of higher levels of care (hospitals and emergency care visits) and reduced incarceration in the Dallas County Jail. The Dallas County BH Work Group is committed to a data driven decision-making process with a focus on data supported outcomes.

ATTENDEES: Theresa Daniel, Commissioner; Holly Brock, VO; Zachary Thompson, DCHHS; Cindy Patrick, Meadows; Jim Mattingly, LumaCorp; Mamie Lewis, City of Dallas; Dr. Paul Scott, The Bridge; James McClinton, Metrocare; Ken Mogbo, Lifenet/Metrocare; Cindy Crain, MDHA; Teresa Scherrer, NTBHA ; Charlene Randolph, DCCJ; Blake Fetterman, Salvation Army; Charles Gulley, MDHA; Patricia Chen; UTD; Thomas Lewis, DCHHS; Christina Gonzales, DCCJ; Germaine White, Dallas County; Claudia Vargas, Dallas County; Terry Gipson Dallas, County; and JC Thomas, Dallas County.
GUESTS: John Greenan, Central Dallas CDC; Michael Nguyen, Atlantic Housing; Sherman Roberts, City Wide CDC;

CALL TO ORDER:
Commissioner Daniel opened the meeting by welcoming the group and reviewing the mission that was established. The Housing Work Group was formed to create housing and support services in order to divert special populations from the jails and emergency rooms to proper services. Commissioner Daniel recognized Holly Brock, the new CEO for ValueOptions and Cindy Crain, the new Executive Director of MDHA.

The previous meeting minutes were unanimously accepted with no changes. Commissioner Daniel requested introductions. The BH/HWG has been divided into subgroups to address major issues that have been identified and to focus on pipeline development. Developers were invited to attend the meeting today and to contribute to the conversation around permanent supportive housing for special populations. Commissioner Daniel stated that there are two important questions to focus on as the conversation develops. The first is to identify developers whose work contributes to an increase in the number of units of supportive housing. The second is to identify what information developers need and what barriers are encountered as we try to achieve our goal.

The BH/HWG has been looking at a variety of housing options in order to determine what resources are available. Those include individual homes, boarding homes, smaller apartment buildings, and larger properties. The question was raised whether boarding homes are ADA compliant. Daniel Byrd shared that the boarding homes on the Mental Health America (MHA) list should be ADA compliant because it is a requirement of their licensing process.

Charlene Randolph gave an update from Brooke Etie on the 400 housing vouchers that Dallas Housing

Authority (DHA) issued through the RFP process. It was reported that housing unit awards are still in the process of being updated and listed online. Additionally, it has not been determined if another RFP will be released.

Jim Mattingly submitted a public information request to review the list of proposals submitted and awarded by DHA. Mr. Mattingly commented that he understood that all new proposals awarded through the RFP were for new construction. A question was raised regarding the criteria DHA uses to distribute the housing vouchers. It was suggested that the BH/HWG become familiar with the process.

Charles Gulley, as well as other attendees, questioned the DHA housing voucher awardee list provided in the meeting packet. An explanation of how the list was compiled will be requested from DHA.

The developers invited to the BH/HWG meeting were John Greenan of Central Dallas CDC; Michael Nguyen of Atlantic Housing; and Sherman Roberts of City Wide CDC. Currently, Mr. Nguyen's company is not involved in any of the supportive housing projects but he would like to be involved in this market. Mr. Greenan shared that in his experience, there are two parts to the process: how to pay for the development and acquiring the property. Furthermore, Mr. Greenan shared that in his experience these types of housing projects are more expensive to maintain than a typical apartment complex; rents are not high enough to cover the debt. It is necessary to get substantial subsidies because 9% tax credit awards are not available in big cities like Dallas. The highest tax credit that has been awarded in Dallas is 4%. A pending lawsuit decision in June will affect where developers can build and might open up the possibility for being awarded a 9% tax credit. Mr. Greenan commented that supportive housing projects do not generate profits or benefits that would encourage developers to build. Mr. Sherman said that developers are interested in partnering with care providers to learn how to secure housing vouchers to build supportive housing. Units are empty but builders do not know how to fill them.

DHA is responsible for issuing the housing vouchers that entice developers to build. Currently there are not enough available. The time constraints associated with housing vouchers does not permit developers ample time to raise the necessary funds. It takes longer to get housing projects going and that creates a conflict with housing voucher guidelines. Charles Gulley said that while DHA is responsible for issuing a significant number of housing vouchers, the exact number of housing vouchers varies every year. Ultimately, the demand for vouchers exceeds the number of vouchers available. DHA is approached by many organizations that have an equal need for vouchers. Mr. Mattingly stated that while resources may be limited, it is really important to advocate for supportive housing or otherwise this population will continue to be left out of the process. It was noted that the Pipeline Development Sub-group will meet on April 30, 2015 at DHA.

The BH/HWG will continue to look into housing ideas and possibilities. Dr. Paul Scott shared information regarding a housing project by a developer in Austin using previously operating Extended-Stay hotels. Renovation costs have been very low because these units are already equipped with amenities such as kitchenettes. Mr. Sherman, Mr. Greenan, and Mr. Nguyen agreed that without tax credits or substantial subsidies, organizing these types of deals will continue to be a challenge and will be difficult to replicate in big cities like Dallas.

INDUSTRY UPDATES:

MDHA - Cindy Crain shared information regarding her meeting with Parkland and the PCCI team. They are working on a strategic plan to make IRIS the HMIS system. With 49 agencies to include, it will take up to a year to have the system complete and functional.

ValueOptions' NorthSTAR Supported Housing Report – Holly Brock, Acting CEO, presented the most recent data regarding the use of the funds. She anticipates an additional $200,000 will be used during May and June. ValueOptions' intent is to move individuals from unlicensed to licensed boarding home by providing rental assistance.

Doctor's Hospital/Dallas Medical Center, 7525 Scyene Road, Dallas 75227 – Charles Gulley distributed information regarding the potential use of this facility that is up for sale. Cindy Crain and Mr. Gulley had an opportunity to meet with the owners and tour the property. It has been abandoned for the past 15 years, however, in 2007, the property underwent minor repairs. The property could serve as a respite center. Several studies suggest that respite care centers facilitate the transition from the streets to public supportive housing and has been known to reduce the admissions to hospitals and the re-admission rate by 50%. Comments were made regarding the feasibility of this type of property for transitional housing. The facility should appeal to other hospital providers as well.

NEXT STEPS:

- Cindy Crain will continue to work with PCCI regarding the integration/development of the CAS and HMIS projects.
- Commissioner Daniel will follow-up with Rick Loessberg regarding the bond funding.
- Commissioner Daniel will follow-up with DISD regarding the developer's request for a 50% tax exemption. Germaine White will follow-up with Mr. John Ames.
- Ron Stretcher and Lori Davidson will continue to review and evaluate the City's and County's list of foreclosed properties.
- Charles Gulley will continue to explore the feasibility of Doctor's Hospital/Dallas Medical Center as a potential transitional housing or respite facility for those newly released from jail or the hospital.
    - Commissioner Daniel will follow-up with Councilman Rick Callahan regarding the City's interest in the property.
- Pipeline Development Committee will meet on April 30, 2015 at the Dallas Housing Authority office to discuss the latest information regarding the initial 400 vouchers RFP and discuss future opportunities with DHA.
- Commissioner Daniel will meet with MaryAnn Russ, DHA, regarding their overall voucher program and future plans.
- Michael Nguyen will forward a list of LIHTC (Low Income Housing Tax Credit) properties for review by the Housing Work Group.
- Develop a set of tools to bring a project to fruition.

The meeting was adjourned at 11:40 am by Commissioner Daniel.

Next Meeting: Thursday, May 28, at 10:00 am

Dallas County Administration Building, 411 Elm Street, 1st Floor, Allen Clemson Courtroom

If you need parking, please contact Germaine White

Crisis Services Project

Status Report and Next Steps

May 14, 2015

Implementation Activities

- Transicare
  - Transportation pilot project with Public Defenders Office
  - Forensic Competency at Terrell State Hospital
- Adapt
  - Timberlawn
- Forensic Diversion Unit
  - CSP/ Metrocare conduct monthly case review
- Value Options NorthSTAR Care Coordination
- After-care engagement
  - Commissioners Court Order 3/3/2015 ; VO contract with Metrocare has been executed
- Transitional housing
  - Salvation Army collaboration

IGT Status

- DY4:
  - Next match funds- January 30, 2016- approximately $5,224,400

Metrics and Milestones

- DY4:
  - Began October 1, 2014
  - Monthly Service Goal: 350 (4200 annual)
  - CJ Readmissions: Goal: 29% (represents a 5% reduction of baseline 34%)
    - As of 2/28/2015, 15%
  - 7-day Follow-up: 32%; 30-day Follow-up: 57%
    - As of 3/31/2015, 76%- 7 day; 83%- 30 day
- DY4 Midterm Status Report due April 30, 2015

Status Update

- Harris Logic (JIMI/ Stella)
- Central Dallas Community Development Corporation (Cottages at Hickory Crossing)
- CDC Case workers (SIP)

Anchor Information

- Wednesday, May 27 and Thursday, May 28: RHP 9 and RHP 10 Learning Collaborative Event, Hurst Convention Center

Dallas County 1115 Waiver- Crisis Services Project
Demonstration Year 4 Cash Flow

	Beginning	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Total
Funds on hand (beginning of month)	2,656,970.85	2,656,970.85	2,342,457.15	2,274,739.84	1,905,296.05	6,399,579.20	6,387,341.83	6,241,782.14	5,602,359.73	5,291,579.14	4,826,495.30	4,515,714.71	4,204,934.12	3,759,850.28	
CSP Revenue															
DY3- Continue Services					879,062.00									940,392.00	1,819,454.00
DY3- Improve CSP					879,062.00									940,392.00	1,819,454.00
DY3- Bi-weekly meetings					879,062.00									940,392.00	1,819,454.00
DY3- Test new ideas					879,062.00									940,392.00	1,819,454.00
DY3- Learning Collaborative					879,062.00									940,392.00	1,819,454.00
DY3- Category 3 (establish baselines)					244,184.00									522,440.00	766,624.00
TOTAL Revenue		0.00	0.00	0.00	4,639,494.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5,224,400.00	9,863,894.00
Total Funds available	2,656,970.85	2,656,970.85	2,342,457.15	2,274,739.84	6,544,790.05	6,399,579.20	6,387,341.83	6,241,782.14	5,602,359.73	5,291,579.14	4,826,495.30	4,515,714.71	4,204,934.12	8,984,250.28	
CSP Expenses															
Adapt		53,409.71	0.00	192,177.66	117,934.26	0.00	124,992.15	181,433.18	118,796.60	118,796.60	118,796.60	118,796.60	118,796.60		1,263,929.96
Transicare		110,960.41	61,445.14	151,655.99	0.00	0.00	0.00	207,764.01	127,233.58	127,233.58	127,233.58	127,233.58	127,233.58		1,167,993.45
Harris Logic- 2nd year license		0.00	0.00	0.00	0.00	0.00	0.00	0.00							0.00
Metrocare/ FDU (billed quarterly)		141,193.15	0.00	0.00	0.00	0.00	0.00	228,704.59		134,303.25			134,303.25		638,504.24
Value Options Care Coordinator		3,666.66	0.00	14,666.66	9,333.33	0.00	9,333.33	9,333.33	9,333.33	9,333.33	9,333.33	9,333.33	9,333.33		92,999.96
Serial Inebriate Program		0.00	0.00	0.00	0.00	0.00	0.00	0.00	10,833.33	10,833.33	10,833.33	10,833.33	10,833.33		54,166.65
Dallas County Salaries/ Benefits- Project Analyst, Administrative Assistant, and Court Appointed Care Manager (not hired to date)		4,968.00	6,272.17	10,943.48	17,943.26	11,637.30	11,234.21	11,234.19	12,458.42	12,458.42	12,458.42	12,458.42	12,458.42		136,524.71
Computer Hardware		0.00	0.00	0.00	0.00	0.00	0.00	0.00	833.33	833.33	833.33	833.33	833.33		4,166.65
Consulting Fee		0.00	0.00	0.00	0.00	0.00	0.00	0.00	416.67	416.67	416.67	416.67	416.67		2,083.35
Training Supplies		0.00	0.00	0.00	0.00	0.00	0.00	0.00	166.67	166.67	166.67	166.67	166.67		833.35
Business Travel/ Trainings		315.77	0.00	0.00	0.00	600.07	0.00	953.11	833.33	833.33	833.33	833.33	833.33		6,035.60
Bus Passes (5000 count)		0.00	0.00	0.00	0.00	0.00	0.00	0.00	1,250.00	1,250.00	1,250.00	1,250.00	1,250.00		6,250.00
Serial Inebriate Program		0.00	0.00	0.00	0.00	0.00	0.00	0.00	10,625.33	10,625.33	10,625.33	10,625.33	10,625.33		53,126.65
After-care Engagement Package		0.00	0.00	0.00	0.00	0.00	0.00	0.00	18,000.00	18,000.00	18,000.00	18,000.00	18,000.00		90,000.00
New Space Renovations/ Office Supplies (cubicles, wiring, phones, renovations, chairs, etc.)		0.00	0.00	0.00	0.00	0.00	0.00	0.00		20,000.00					20,000.00
TOTAL Expenses		314,513.70	67,717.31	369,443.79	145,210.85	12,237.37	145,559.69	639,422.41	310,780.59	465,083.84	310,780.59	310,780.59	445,083.84		3,536,614.57
Funds on hand (end of month)	2,656,970.85	2,342,457.15	2,274,739.84	1,905,296.05	6,399,579.20	6,387,341.83	6,241,782.14	5,602,359.73	5,291,579.14	4,826,495.30	4,515,714.71	4,204,934.12	3,759,850.28		

ACS 1115 CSP Monthly Production Report

	Past Year Average	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	AVERAGE	TOTAL
Total Service Episodes:	**449**	749	479	308	393	573	721	482	3,223
Total Unique Consumers:	**328**	746	445	239	274	466	553	426	2,723
Percentage Change to DY3		227.32%	135.60%	72.83%	83.49%	142.00%	168.51%		
Total Encounters by Type:									
Triage		749	479	308	393	573	721	537	3,223
Care Coordination		1420	1297	1441	1425	2160	3032	1796	10,775
F2F Encounter		157	145	173	190	247	310	204	1,222
TOTAL Encounters:		2326	1921	1922	2008	2980	4063	**2537**	**15,220**

Recidivism 10/1/14 - 2/28/15

Triages 12	2170
Bookins 12	314
Recidivism % 12 - 12	14.47%
Traiges 6	2170
Bookins 6	314
Recidivism % 6 - 6	14.47%
Traiges 6	2170
Bookins 12	314
Recidivism % 6 - 12	14.47%

Frank Crowley Specific Report

	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	AVERAGE	TOTAL
Service Episodes:	688	435	267	352	535	658	489	2,935
Unique Consumers:								
By N* ID	653	379	178	205	399	471	381	2,285
By Client ID	32	22	24	30	29	30	28	167
TOTAL Unique Consumers:	**685**	**401**	**202**	**235**	**428**	**501**	**409**	**2,452**
TOTAL Unique Consumers as %:	99.56%	92.18%	75.66%	66.76%	80.00%	76.14%		
Unique F2F:								
By N* ID	80	66	95	101	147	177	111	666
By Client ID	20	15	9	15	13	18	15	90
TOTAL Unique F2F:	**100**	**81**	**104**	**116**	**160**	**195**	**126**	**756**
TOTAL Unique F2F as a %:	93%	76%	76%	75%	76%	75%		
F2F Percentage:	15.70%	24.60%	50.94%	43.75%	39.44%	39.67%	33.29%	33.29%
Encounters by Type:								
Triage	688	435	267	352	535	658	489	2,935
Care Coordination	1057	1021	1157	1160	1929	2705	1505	9,029
F2F Encounter	108	107	136	154	211	261	163	977
TOTAL Encounters:	1853	1563	1560	1666	2675	3624	**2157**	**12,941**
Female:								
Black	131	81	51	38	78	120	83	499
White	56	33	17	20	34	36	33	196
Hispanic	33	8	6	9	21	22	17	99
Other	1			1	1	4	2	7
Unknown	1	3	1	2	3	1	2	
TOTAL Female:	222	125	75	70	137	183	**135**	**801**
Male:								
Black	300	199	78	108	195	203	181	1,083
White	94	49	27	33	49	67	53	319
Hispanic	63	20	11	20	35	40	32	189
Other	3	7	4	2	5	6	5	27
Unknown	3	1	7	2	7	2	4	22
TOTAL Male:	463	276	127	165	291	318	**273**	**1,640**

Timberlawn Specific Report

	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	AVERAGE	TOTAL
Service Episodes:	61	44	41	41	38	63	41	288
Unique Consumers:								
By N* ID	55	37	33	29	26	42	37	222
By Client ID	6	7	4	10	12	10	8	49
TOTAL Unique Consumers:	**61**	**44**	**37**	**39**	**38**	**52**	**23**	**271**
TOTAL Unique Consumers as %:	100%	100%	90%	95%	100%	83%	47%	94%
Unique F2F:								
By N* ID	45	33	32	27	24	37	33	198
By Client ID	3	5	2	7	11	8	6	36
TOTAL Unique F2F:	**48**	**38**	**34**	**34**	**35**	**45**	**20**	**234**
TOTAL Unique F2F as a %:	98%	100%	92%	94%	97%	92%	48%	96%
F2F Percentage:	80.33%	86.36%	90.24%	87.80%	94.74%	77.78%	85.07%	85.07%
Encounters by Type:								
Triage	61	44	41	41	38	63	48	288
Care Coordination	363	276	284	265	231	327	291	1746
F2F Encounter	49	38	37	36	36	49	41	245
TOTAL Encounters:	473	358	362	342	305	439	190	2279
Female:								
Black	14	6	9	7	7	12	9	55
White	4	7	2	6	3	5	5	27
Hispanic	8	7	2	7	7	3	6	34
Other	2			1		3	2	6
Unknown	2	2	2	3	1		2	
TOTAL Female:	30	22	15	24	18	23	**11**	**122**
Male:								
Black	17	14	8	6	8	12	11	65
White	7	3	4	2	8	7	5	31
Hispanic	6	5	4	5	3	7	5	30
Other	1		2		1	3	2	7
Unknown	1		4	2			2	7
TOTAL Male:	32	22	22	15	20	29	**12**	**140**
Age of Triage Encounters:								
Adult	39	30	30	24	32	32	31	187
Minor	21	11	5	10	5	17	12	69
Uncollected	2	3	2	5	1	3	3	16
TOTAL Age of Triage Encounters:	**62**	**44**	**37**	**39**	**38**	**52**	**39**	**272**
Age of F2F Encounters:								
Adult	31	30	29	24	31	30	29	175
Minor	17	8	5	10	4	15	10	59
Uncollected	0	0					0	0
TOTAL Age of F2F Encounters:	**48**	**38**	**34**	**34**	**35**	**45**	**33**	**234**
F2F Outcomes:								
23 hours obs								
Crisis Residential		2	5	1	3	3	3	14
Hotline/MCOT				1			1	
Inpatient- Civil	9	6	5	5	2	8	6	35
Intensive Outpatient	4	3	2	1	6	4	3	20
Left Against Clinical Advice			1				1	
Medical Referral	3	1	4	2	2		2	12
No Behavioral Health Services Indicated			1				1	
Other Higher Level of Care		1					1	1
Partial Hospitalization Program	1	1					1	2
Residential-CD	2	2					2	4
Residential-SUD/ COPSD		1	1	2	2	2	2	8
Routine Outpatient	25	20	12	19	15	19	18	110
School-based services			1			1	1	2
Unable to complete assessment						1	1	1
Urgent Care Clinic	4	1	2	3	5	7	4	22
TOTAL Outcomes	**48**	**38**	**34**	**34**	**35**	**45**	**20**	**231**
Diversion Rate	**81.25%**	**84.21%**	**85.29%**	**85.29%**	**94.29%**	**82.22%**		**84.85%**

Transicare Reporting
Crisis Services Project

		2014-10	2014-11	2014-12	2015-01	2015-02	2015-03
1	**Beginning Census**	**36**	**34**	**42**	**49**	**59**	**49**
2	REFERRALS	*18*	*27*	*42*	*31*	*7*	*53*
3	**Admissions**						
4	**Referred Admitted**	***4***	***8***	***12***	***12***	***2***	***21***
5	No Admit Client Refusal	1		1	1		
6	No Admit Criteria	6	7	8	9	1	9
7	No Admit Structural	1	6	6	4		2
8	Pending	6	6	15	5	4	21
9	*PRIOR PENDING*						
10	**Pending Admitted**		***5***	***4***	***7***	***3***	***4***
11	No Admit Client Refusal		1	3			1
12	No Admit Criteria	3	3		2	1	1
13	No Admit Structural		1	1	4		2
14							
15	**Total Admissions**	**4**	**13**	**16**	**19**	**5**	**25**
16							
17	**Discharges**						
18	Success Transfer	1	3	2	4	8	4
19	DC Midterm Disengage	1		1		1	1
20	DC Rapid Disengage	3	1	1	1	1	1
21	DC Structural	1	1	5	4	5	3
22	**Total Discharged**	**6**	**5**	**9**	**9**	**15**	**9**
23	Active End Of Month	34	42	49	59	49	65
24							
25	**Outcome Data**						
26	*Terrell State Hospital Linkages*						
27	≤7 Connect To Prescriber	2	4	4	2	3	7
28	≤30 Connect To Prescriber	2					
29	Missed Metric			4		1	0
30	Total Released	4	4	8	2	4	7
31							
32	**Cummulative ≤7 Connect %**	**50.0%**	**75.0%**	**62.5%**	**66.7%**	**68.2%**	**75.9%**
33	**Cummulative ≤30 Connect %**	**100.0%**	**100.0%**	**75.0%**	**77.8%**	**77.3%**	**82.8%**
34	**Missed Metric**	**0.0%**	**0.0%**	**25.0%**	**22.2%**	**22.7%**	**17.2%**
35	*Unduplicated Served*						
36	**Monthly Unduplicated**	**57**	**54**	**73**	**82**	**66**	**89**
37	DSRIP YTD Unduplicated Served	57	75	104	137	141	181
38							
39	*Encounter Data*						
40	F2F Encounter	297	226	451	497	376	409
41	Care Coord	174	138	177	209	178	177
42	Total	471	364	628	706	554	586

Forensic Diversion Unit (FDU) Report

	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Beginning Census	**40**	**39**	**38**	**39**	**39**	**35**			
Number of Referrals Received from CSP									
Adapt	1	2	2	1	1	0			
Metrocare	0	0	0	0	0	1			
Transicare	0	0	0	0	1	0			
Number of Admissions	**1**	**0**	**2**	**1**	**2**	**0**			
Number Discharged	**2**	**1**	**1**	**1**	**4**	**3**			
Number not admitted due to:									
Client qualifies for ACT	0	0	1	0	0	0			
Client qualifies for other programs	0	0	0	0	0	0			
Client didn't meet level of need required	0	0	0	0	0	1			
Other reasons	0	0	0	0	0	0			
Average Service Utilization:									
Average hours seen	10.72	8.76	7.8	8.3	9.2	7			
Encounter Breakdown:									
Face to Face	450	245	357	497	419	236			
Service Coordination	69	35	43	76	81	69			
Number of clients accessing:									
Emergency Room (medical)	1	1	0	0	0	0			
23-hour observation (psych)	1	1	1	0	0	1			
Inpatient (med/ psych)	8	0	2	2	1	2			
Jail book-in	2	4	1	1	0	0			
Reasons for Discharge:									
Graduate	0	0	0	0	3	0			
Client Disengagement	1	0	0	0	1	1			
Extended Jail stay (case-by-case basis)	1	0	1	1	2	0			
Other Intervening factors	0	1	0	0	0	0			
End of Month Stats:									
Number of Active FDU clients end of month	**39**	**38**	**39**	**39**	**37**	**34**			
Number of Unique Consumers	0	0	0	0	0	1			
Number of clients on Waiting List	0	0	0	0	0	0			
Average Length of stay on FDU (month)	11.72	12.38	12.07	12.45	12.15	12.49			
Maximum Census	**45**	**45**	**45**	**45**	**45**	**45**	**45**	**45**	**45**

Dallas County Behavioral Health Leadership Team (BHLT)
Adult Clinical Operations Team (ACOT) Committee Meeting
May 7, 2015

Attendees: Sherry Cusumano (Green Oaks), Daniel Byrd (VO), Doug Denton (Homeward Bound), Mary Ann Niles (Green Oaks), Jennifer Torres (Metrocare), Rick Davis (SABH), Buddy Detzel (Transicare), LaJuan McGowan (Transciare), Charlene Randolph (Dallas County), Brittony McNaughton (NTBHA), Dave Hogan (DPD Crisis Intervention), Jim Lindsey (Nexus), Kelsey Morgan (Metrocare), Greg Eastin (Parkland Population Med.)

Introduction and Approval of Minutes
Charlene Randolph called the meeting to order at 12:20 pm. The minutes were reviewed and approved by the committee without correction.

APOWWs
Dave Hogan provided an updated presentation on APOWWs. Mr. Hogan stated that as of March 2015, there have been 2,104 APOWWs given to 1,709 individuals in Dallas. Mr. Hogan reported that 395 of those individuals had two or more APOWWs and, 4 individuals had 7 or more APOWWs. In addition, 199 juveniles (16 years old and under) received APOWWs. According to Mr. Hogan, many parents of juveniles receiving APOWWs were already connected to many community services; however, they reported that their children were out of control and exhibiting mostly behavioral problems.

Case Presentation
Dave Hogan provided a case presentation on the highest APOWW utilizer. This client has had 29 APOWWs in 2015. At first glance, it appeared the client was on Metrocare ACT; however, the client actually did not qualify for ACT because he lacked the hospitalization requirement (the client only has 23-hour obs.). The client is reported to know how to "use the system" and often tells responding officers that he is not taking his meds and he is going to kill himself. Some committee members speculate that the client may swap the medicine he receives during 23-hour observation for his drug of choice- methamphetamines. The client does have a history of criminal justice involvement and has refused substance abuse services and APAA. Daniel Byrd, Dave Hogan, and other community providers will meet to develop a "united" service plan for this client. Per Mr. Byrd, it's possible that VO could authorize ACT for this client because of his high utilization of services.

Update on Research Regarding APOWWs and Additional Assistance for People in Contact with High Utilizers
Jennifer Torres stated that she conducted training for approximately 20 boarding home operators, in order to help prevent the overuse of 911 and APOWWs. Ms. Torres stated that it appeared boarding home operators were using emergency services appropriately; however, she did provide training on how to de-escalate crisis situations and tips on helping clients be successful residents. Ms. Torres provided a copy of the training for dissemination.

Other Issues
Brittony McNaughton stated that NTBHA has submitted a plan to the state for approval to use Penalty Incentive Funds (PIF) for supported housing (instead of transportation).

Greg Eastin reported that Medicaid has a transportation service; however, committee members clarified that clients must give a 48-hour notice to utilize this benefit.

Committee members also discussed developing guidelines and a list of after-hours crisis services for boarding home operators.

Sherry Cusumano provided a legislative update to the committee.

Meeting adjourned at 1:20 pm.

Section 1: Preventing a crisis- Nurturing relationships can be the key to a safe and happy home.

When a new resident moves in:

1. **Get to know your new residents well and ease any concerns they may have.**
    a. Sit down with your resident and have a 'getting to know you' face to face meeting. If you cannot do this in person within the first half hour after arrival, do this at least briefly by phone and specify a time later that day to meet in person.
        i. Start by reassuring that your home is a safe place and that you are there to provide support and assistance. Try to emphasize that you strive to run a safe and supportive home and that you encourage your residents to feel comfortable approaching you with any concerns. It may be helpful to explain that while things may not always run perfectly, the resident should feel comfortable in approaching you with their concerns and or ideas for any improvements.
        ii. Some open-ended questions you may wish to ask to get to know your resident:
            1. Can you tell me a little about yourself? *Encourage them to share as much or as little as they feel comfortable.*
            2. Is there anything I can do (within reason) to make your stay as most comfortable?
            3. How do you like to spend your time? Are you a person that prefers lots of activities & company, prefers more alone time, or somewhere in between? *Explain then the opportunities for each of these at your home. Encourage residents to keep as busy as possible with life-enriching activities of their choice.*
            4. Is there anything you would like me to know about your mental health condition? And, can you tell me some ways that I can help you if you are going through a hard time?
            5. Who are you biggest supporters? How often do you keep in touch? Is there anything I can do to help you maintain these relationships? *This may be a good time to encourage family visits, both away and at the facility, and explain access to a house phone if the client doesn't have a cell phone. Explain any computer access that may be available at your facility, especially for those that mention using email or Facebook to keep in contact with others.*
            6. What are you goals and how can I help you work toward them?
        iii. Spend time learning about the resident's treatment team. This will also help you to identify those residents that may have fallen out of services.
            1. What mental health clinic do they attend? When was the last time they attended that clinic?
            2. Do they have current medications?
            3. Do they know who your psychiatrist is? Do you have a case manager?

4. If the answer is no to any of the above, work to establish a plan for linking the resident back to outpatient services. Most clinics can accommodate walk-ins. If possible, offer to accompany the resident to their clinic on the following morning.
5. Encourage your resident to consider signing a Release of Information to give permission for the treatment team to communicate with you. Even though you may be a caregiver and sometimes a resident's representative payee, the clinic providers must still have the resident's written consent to share *any* healthcare information with you.

2. **Clarify your expectations and get some feedback.** After you have asked the resident to tell you about themselves, take some time to go over any written expectations/house guidelines. It is a good idea to stress that these guidelines were developed for the health, safety and consideration of all the residents and are based on mutual respect. Be sure to thoroughly explain how meals are handled and if arrangements can be made if the resident will be away at mealtime. For instance, how can they obtain a sack lunch if they'll be away at lunchtime? What arrangements can be made if they are delayed and miss the evening meal? Review the house policy on smoking, making sure to emphasize safety and clearly explain what areas smoking is permitted in. Be sure to emphasize your policy on the use of illegal drugs or alcohol and strongly encourage your residents to privately let you know if they observe others violating these policies.
    a. This would also be a good time to review the schedule you may have in place. It is generally beneficial for most to have some structure built into your program. The house schedule doesn't need to be too extensive and there should be some flexibility and accommodate those that may not be ready or able to follow along exactly. The suggested schedule should also include, at minimum, set meal times, some guidelines for how communal areas such as restrooms, TV, and laundry should be shared. I'd also recommend setting some hygiene expectations and basic guidelines for maintaining residents' personal space such as making bed after breakfast. It is a good idea to discourage oversleeping or taking long naps during the day unless your resident is not feeling well. Encourage good sleep hygiene through a regular bedtime and wake-up time. The schedule should include some set times that you will be on site and available to discuss issues residents may be having. It is a good idea to also hold a house meeting at least once a week where residents can be assured of having a place to hear updates, give feedback, voice concerns and/or work through some issues.
    b. Give your new resident written contact information. I recommend distributing wallet size cards or a small handout that lists the full physical address of the home, some basic directions/bus route #, the phone number for the home itself, and your cell number. Encourage the resident to carry this information with them at all times in case they should become disoriented or are asked to update their address/contact information when they are out in the community.

c. Post emergency contact numbers by the phone for easy accessibility (being sure to include resources for use prior to calling 911). I recommend including the main phone number for each area mental health clinic, Adapt Mobile Crisis, Social Security's Hotline, Parkland's nurse's line, Medicaid transportation, etc.). Try to always have note paper, writing utensils, a phone book, and a general resource guide nearby.

d. Post a list of nearby community activities/resources, encouraging your residents to get out into the community at least once a day. Some ideas:

   i. Organize an exercise group. Residents could go on group walks at set times, around the neighborhood or to a nearby park.

   ii. Include on the list plenty of nearby opportunities for residents to get more involved in the community. You may include places such as religious institutions, free or low cost exercise programs, 12 step meetings, libraries, GED classes or adult learning classes, activities through City Parks Department, community centers, YMCA, day centers, drop in programs, groups at their clinic, APPA, etc.

   iii. Schedule some regular outings if possible. This doesn't have to be fancy or expensive but try to plan at least a once a week activity that house members can look forward to.

   iv. It would also be very helpful to obtain and post a schedule of the groups offered at each mental health clinic and to encourage residents to attend at least one group per week.

3. **Pay attention to the needs of your residents.**

   a. Ask the resident to go over their medication bottles with you. Try to differentiate the medical medications from the psychiatric meds. Next try to determine if each set the medications are current and appear to be from a single source. If you see that there are many different prescriber names and prescription dates, chances are your resident may be confused about which medications are currently prescribed. Link the resident to their clinic right away when you find this. Your resident runs the risk of taking too many medications, which can be very dangerous.

   b. Review your house procedures on how medications are handled/stored.

   c. Take personal characteristics and any physical needs into consideration when making room/room-mate assignments. For instance, if you have a resident that tends to behave aggressively or may have a tendency to exploit others, do not pair up with a resident that is easily taken advantage of. If a resident has some difficulty walking or moving, do not assign to a top bunk.

   d. Try to encourage a buddy system for new residents. Ask a more experienced resident if they may be willing to look out for the new resident and 'show them the ropes'. Make introductions. Organize ice-breaker activities so that your residents get to know one another by name so friendships develop. Have games and cards available so that residents may socialize. Hold regular movie nights with popcorn or other treats to make it special.

e. Pay attention to changes in behavior and try to intervene before these changes reach a point of no return. Try to speak to the resident privately as soon as you notice any changes. Some signs to look out for are - resident may appear more withdrawn, reluctant to leave the house, appear to be sleeping more, you see changes in hygiene or appetite, or maybe there are more irritable, angry, confused, suddenly wants to flee the home, or they appear to be talking to self or gesturing oddly. These are all signs of psychiatric instability and probably warrant an urgent clinic visit. It is always best to error on the side of caution if you have any reason for concern.

4. **Help your residents stay organized.**
    a. Often times, individuals with mental health conditions have a challenging time keeping with appointments or planning ahead. Have a calendar available near the phone. Strongly encourage your residents to record their future plans on their own calendar/day planner or a shared one if they prefer. Remind your residents to regularly look ahead to upcoming events on their calendar and to make some specific plans about how they will insure they carry out the plan. Encourage them to put as many activities as they can on their calendars including things like picking up a medication refill from the pharmacy, paying rent or bill, attending a weekly group, a home visit from their case manager, correspondence due to Social Security, etc.
    b. Similarly encourage your residents in writing 'To-Do' lists. Many residents will take a lot of satisfaction in checking off tasks from their list. This may help to keep them more goal oriented, busier, and ultimately more satisfied.
    c. Look for other opportunities to help your residents develop healthy habits and make simple changes for the better. This can be through reminder signs or you can encourage behavior changes through simple organizational strategies. For instance, encourage residents to drink more water by labeling a water bottle in the fridge for each resident or creating a chart where residents can keep track of how many ounces of water they drank each day.
    d. Encourage your residents to budget their funds and to save for contingencies. It may be helpful to have each resident create a budget each month. This could be a good group activity to do for those that would like to participate. You are likely to find a wide range of ability in this area. For some, it may be an improvement just to learn how much income they receive. For those that currently don't have many budgeting skills, encourage them to build slowly each month.
        i. Some questions to use as a starting place:
            1. How much is your monthly income?
            2. What are your usual expenses?
            3. About how much do each of these expenses cost?
            4. Can you afford everything you really need? What happens if you cannot? What expense on your list can you cut if needed?
            5. Is there anything you wish to start saving up for? How much does it cost? How much can you save each month toward this?

Section 2: When incidents occur.

Despite a homes' best efforts to use the preventative strategies, it is likely you may still have some crisis situations of varying severity. When this happens, it is important that your staff have some options for dealing with the situation. When it is possible, try to use resources other than 911.

Examples of incidents and suggested responses: Keep in mind every person and situation is different and you may need to listen to your instincts in some situations. These are some possible scenarios and what action is typically appropriate.

e. **Category 1: House rule violations-**
   i. Address through a behavior plan/policy that you have developed for your home. For example, for less minor issues, resident may be issued two written warnings and upon third occurrence, is issued a notice to vacate by the end of the month. More serious violations
      1. Examples of house rule violations
         a. Resident returns after curfew
         b. Resident returns intoxicated but is cooperative and goes to bed without further disruption.
         c. Brings illicit substances
         d. Petty theft
         e. Verbal aggression or acts against property.
         f. Smoking in an unauthorized area.
         g. Knowingly disregards other house rules.
         h. Resident makes a threat but doesn't take any follow-up action and calms down and retracts the threat. This could also indicate some psychiatric instability, depending on the person.

f. **Category 2: Psychiatric symptoms that need attention within 24-48 hours-**
   i. Address through linking the resident to their outpatient mental health provider. If the incident occurs during normal business hours, call the clinic and ask for an appointment or to walk-in. If it evening time or a weekend, place this call first thing on the following business day.
      1. Examples of urgent but non-emergent symptoms:
         a. Resident feels hopeless
         b. Resident is more argumentative/irritable
         c. Resident has an increase in brief anger outbursts
         d. Resident is experiencing an increase in hearing voices or having visual hallucinations
         e. Resident makes false allegations /exhibits paranoid thoughts

f. Resident has run out of meds.

g. **Category 2: Psychiatric symptoms that need attention within 1-2 hours-**
    i. If you are reasonably confident, you can keep the resident safe in the meantime, first try to address through linking the resident to an after-hours mental health provider. Start by calling Adapt Mobile Crisis Team – 1-866-260-8000. They can provide some general guidance and send out an intervention team if that is needed. Other after hours resources include Southern Behavioral after Hours Clinic, ACT teams, RAP team, & Transicare PATS team.
        1. Resident seeks staff help after cutting him/herself and the wound is not deep.
        2. Resident seeks staff help because they feel suicidal.
        3. Resident is having some non-life threatening medication side effects.
        4. Resident is directable but reports hearing voices commanding him/her to do something bad or harmful.

h. **Category 3: Emergencies**
    i. If you cannot keep residents safe, call 911. There are many situations that might arise but the following are some:
        1. Resident has taken an overdose
        2. Resident returns intoxicated and assaultive
        3. Resident is combative/fighting or on a property destruction rampage.
        4. Resident loses consciousness or has suddenly become disoriented
        5. Resident complains of any severe physical pain or symptoms.
        6. Residents are physically fighting.
        7. Resident brandishes a weapon and/or makes serious threats.

Behavioral Health Steering Committee
Thursday April 16, 2015

Meeting called to order at 8:30am by Judge Wade.
Judge Wade introduced Dallas County Commissioner Dr. Theresa Daniels. Commissioner Daniels spoke on the importance of behavioral health in Dallas County, and thanked the BHSC for the work they are completing.

BHLT & CSP Update

Ron Stretcher completed an introduction for CSP agencies. Alyssa Aldrich, project manager for the ADAPT side of CSP coordinates the clinicians seeing the clients through the jail and tele-health, she is someone to reach out to in order to coordinate obtaining services. Janice Jefferies from Value Options is a liaison for both ADAPT and Transicare and the Northstar system, whom assists in the execution of program services. *(pgs 2-4, of February packet)*

Jail Reports

Hospital Movement- Brandy Coty reported for the month of March we ended the month 338 active comp cases, 176 in the hospital and 161 in jail, of the 161 in jail 74 of are waiting for a hospital bed, 47 hospital returns with cases still pending. Judge Skemp added that the numbers are a lower than usual; however, what he has noticed is that the clients are more symptomatic than before. Ron Stretcher brought up the problem of unauthorized departures from Terrell. Brandy is aware of the situation and is ensuring bench warrants are issued quickly to get the client back to the jail. Lyndsay Cherry is the liaison for all staff in and out of the jail. She coordinates with attorneys and judges to release clients out of the jail and become engaged in wrap around services. *(pg. 5, of April packet)*

Pregnant Women in Jail- Shenna Oriabure reported there are currently 33 pregnant women in jail; 7 sentenced, 17 have upcoming court dates, 1 waiting to go to the hospital, 1 parole hold and 4 without court dates. *(pg 6, of April packet*)

Homeless Population Quarterly Review – Christina Gonzales reported on a new report. The report compares the homeless population in jail over the first quarter of 2015 to the first quarter of 2014. Items reviewed are:

- Arresting agency
- Level of offense
- Time in jail
- Conditions of release

The report shows that overall there has been a decrease in arrests, however an increase in the length of time in jail. There is a possibility in the future to utilize the report to predict future needs

for specialty courts and open discussions for those in need of the services and are not receiving the help. *(pg 7 &8, of April packet*)

Problem Solving Courts

Specialty Court Census: Some Judges have noticed a decrease in the amount of people participating in specialty courts. A discussion began on ways to engage inmates to participate in a specialty court rather than taking their time. One concern from the public defender's office is the amount of time people would potentially receive if they were unable to complete the program. Lynn Richardson, reports that while some judges will take into account the amount of time the person participated in the program others do not. This would result in people failing the program, and then serving the maximum amount of time for the offense, as if they never participated in the program. She would like to see an agreement, with Judges of Specialty Courts that if someone fails out of the program they would not automatically receive the maximum sentence for their offense. Judge Skemp offered instead giving potential participants the choice of a specialty court or the maximum sentence for their offense. For some this may influence them to participate in the specialty court, instead of having to serve the maximum sentence. There is some concern with the lack of resources that aren't available to those participating in specialty courts. An example would be a lack of housing.

Housing: Sherri Lockhart, from Metrocare reported that housing is not as difficult for those clients that are with Metrocare. She reports there was recently an increase in funding available for Metrocare clients. Jay Meaders from the Bridge also reports that when clients come into the Bridge those that have incentive will routinely stick around and are more accountable rather than those that do not. A consensus was that there needs to be a common goal to be able to maintain the numbers that we have, and continue to grow the programs without slowing down the processes or increasing the amount of jail time client serve during this time. Commissioner Daniels spoke about innovative changes within Dallas County with partnering agencies to identify available housing anyone can utilize to assist clients in locating housing.

Sub-Committee: Judge Wade commissioned the creation of a sub-committee that will address the following concerns. Christina Gonzales, will contact the appropriate people and have the first meeting set up prior to the next BHSC. Committee members will include: Lynn Richardson, Vickie Rice, Christina Gonzales, Lee Pierson, Serena McNair. A judge will also need to sit on the sub-committee.

1. Increasing the outcomes reporting and overall accountability for the mental health specialty courts, especially from probation. The first priority is to resolve the allocation of TCOOMMI funded case managers
2. Review sentencing practices with the DA, especially for MB cases that typically get the 10 days in jail despite their history or service needs
3. Review attorney appointment processes to identify those defendants with a mental health need who should be assigned to a PD.

SPN Reports

Due to the limitation of time, not all reports were reviewed with the committee. Please refer to the packet for any information on the census of the specialty courts.

530 Sub-Committee

The 530 Sub Committee meeting was canceled on 04/08/2015, with no requests at this time. The budget is attached in the packet on page 22.

Announcements

District Attorney

There have been some changes in the District Attorney's Office.

- Kendall McKimmey is now the prosecutor in Judge Skemp's OCR court.
- Tonya Whitzel is the new prosecutor in Judge Wade's MHJD court.
- Lee Pierson is the Head of the Mental Health Division.
- John Carlough is the new Mental Health District Attorney.

IPS

Enrique Morris from IPS announced the introduction of their research program in March; they are looking to the target Specialty Court Participants. They hope to furnish research they have completed to the BHSC in the next month; in the future they may have the ability to perform research on the Specialty Courts themselves. The research is of course dependent on the availability of the data within the Specialty Courts.

Sherriff's Department Strategic Planning Committee-

Captain Carter-Bass announced the DSO 360 committee is looking at developing a program to redirect low case offenders (i.e. criminal trespass) from coming to the jail. The misdemeanor class C arrests have decreased as they are not being kept in jail. She is soliciting some help in order to get the program started. They are currently looking at Harris County, where the officers are on site.

Adjourn

The meeting was adjourned at 9:55am by Judge Wade.