Dallas County Behavioral Health Leadership Team
Thursday, October 12, 2017
Henry Wade Juvenile Justice Center
2600 Lone Star Drive, Dallas, TX
Room 203-A at 9:30am -11:00am.

I. Welcome and Call to Order

II. Review/ Approval of Minutes from last meeting*
- Minutes September 14, 2017*
- Proposed Representative Update*

III. Strategic Planning
- PEER Groups

IV. NTBHA Update

V. The Stepping Up/ Caruth SMART Justice Initiative Update

VI. Dallas County Behavioral Health Housing Workgroup

VII. 1115 Waiver Crisis Services Project Update
- 1115 Waiver Projections

VIII. Legislative Update

IX. Funding Opportunities
- SAMSHA Residential Treatment Grant Update
- Community Courts Grant Update (Public Defender's Office)

X. Upcoming Events and Notifications
- Housing Resource Workshop, October 17, 2017 at the Frank Crowley Court Bldg.

XI. Public Comments

XII. Adjournment

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

The following reports from BHLT Committees are included for your records: *ACOT*, *FACT*, *BHSC*, *Legislative Committee*, *PD Mental Health Stats*. Unless action is required, there will be no verbal updates from those committees.

Dallas County
Behavioral Health Leadership Team
Meeting Notes
Thursday, September 14, 2017

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

Introductions and Absent BHLT Members: Commissioner Price acknowledge that Dr. Jane LeVieux had been deployed with the National Medical Disaster Team in Florida and Dr. Ella Williams was covering for another physician at the hospital. Joe Powell was also absent due to a prior engagement. Commissioner Price opened up the floor for introductions from new attendees. The following individuals made introductions: Patrick Youg, NTBHA; Kristin Harris, Garland Behavioral Health; Krystal Lotspeich, City Square; Karin Petties, Prism Health; James Miller, Timberlawn. Commissioner Price also acknowledged Patrick LeBlanc for becoming the new City Councilman for Duncanville, TX.

Review/Approval of Minutes
The minutes of the BHLT meeting held on August 10, 2017 were included in the meeting packet (pg. 2-4). A motion was made by Tom Collins to accept the minutes and was seconded by Commissioner Dr. Theresa Daniel. The committee members voted to approve the minutes with no modifications.

Presentations:

1115 Waiver Project:
Christina Mintner, Vice President and Anchor for the 1115 Waiver, presented the Waiver Update for DY7-8 Proposal. The current DY6 Waiver will end December 31, 2017. Health Human Services (HHSC), has requested Clinical Management (CMS) approval for an additional 21 months of level funding for the Uncompensated Care (UC) and Delivery System Reform Incentive Payment (DSRIP), pools and a continuation of the managed care provisions of the 1115 Waiver, through September 20, 2019. The DSRIP pool allocation for DY7-8 would be $3.1 billion per DY. The UC pool allocation would be $3.1 billion per DY. Ms. Mintner stated that the DY7-8 serves as an opportunity for Performing Providers to move further towards sustainability of their transformed systems, including development of alternative payment models to continue services for Medicaid and low-income or uninsured individuals after the waiver ends.
Ms. Mintner also discussed the different categories for the propsed DY7-8. Category A requires reporting that includes progress on core activities, alternative payment model arrangements, costs and saving, and collaborative activities. Category B Medicaid and Low-income or uninsured (MLIU) and Patient Population (PPP) requires all performing providers to submit DY5 and DY6 total numbers of Medicaid and Low-Income or Uninsured (MLIU) individuals served by their system to establish baseline and DY7-8 MLIU PPP goals. Category C measure bundles, which consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. The measure bundle menu will be developed so that each bundle will connect to one or more DSRIP Category 1 or 2 project areas on the DSRIP. Category D is the Statewide Reporting for which each performing provider would be required to report on the statewide Reporting Measure Bundle according to the type of performing provider.This measure would be similar to the previous Category 4 population focused measures with additional measures developed for non-hospital performing providers with stakeholder involvement and feedback. Ms. Mintner also went over the timeline for the DY7-8 PFM and took a few questions. Commissioner Price informed the members that if they had additional questions for Ms. Mintner to please funnel them through Nakish.

Delivery System Reform Incentive Payment
Ms. Winburn, VP Behavioral Health Telepsychiatry and Ms. Wlyder, VP of Physician Services at Medical City Green Oaks Hospital, presented their 1115 Wavier Project. This project implements psychiatric telemedicine in medical settings such as emergency departments, medical hospital floor units and other identified areas of need. Ms. Winburn discussed the number of sites opened since 2014 and the number of consults expected by September 2018. She also presented the accomplishments and challenges for the project. For example, they have been successful in identifying providers, adding inpatient units, and creating healthstream courses amongst other accomplishments. Some of the challenges they have come across with this project has been, locating providers for coverage, vendor contracting, and credentialing with other hospitals.

Ms. Wlyder presented the intergrated clinic metrics for the integrated patient panel from DY3-DY6. Ms. Wylder and Mr. Collins also discussed the trend and how successful they have been with their no-show rate. Green Oaks Hospital has decreased their no-shows by implementinga automated phone call system, automated and manual phone calls, and are currently including text and email. Integrated "Mini Clinics", which began in January 2015, are a one-stop-shop and includes a psychiatrist, psych RN, and psych Mgr. The Mini Clinic accepts any patient without a primary provider and the visits take approximately 30 minutes. Ms. Wilder discussed some of the challenges for Green Oaks which included no-shows, coordination of care which, inability to provide pharmacy (drugs), and scheduling appointments with both medicine and psych on the same day. The accomplishments of this initiative includee hiring additional psych, completing policy and procedures, and implementing integrated care systems which support coordination of care daily meetings. Carol Lucky with NTBHA questioned what type of clients did they see (indigent, Medicaid or payers). Mr. Collins stated that they try to include all in a blended type of way. Another question was asked about client referrals after they leave the hospital. Mr. Collins explained that after they are released from the emergency room they are then referred to the mini clinic. Mr. Collins also informed the members the recidivism rate is more impactful when they are connected after they have been released.

The Economics of the Evolving System
Tom Collins, CEO of Medical City Green Oaks Hospital, discussed how he sees the Economics of the Evolving System and Value Options with the NorthSTAR contract. It was decided that they needed a "brain" for the system if Value Options was going to have to manage the care. Value Options recognized the importance of determining who really needed inpatient care and who could be treated and stabilized back to a lesser level of care, out of the need for that triaging function, PES was created. There were psychiatrists who were specially trained in emergency psychiatric medicine on duty 24 hour per day, seven days per week to triage and assess patients presenting in a psychiatric emergency room who they could observe, assess and attempt to stabilize people and make the determination of who would not be able to be stabilized. In that way, only patients who needed inpatient care were admitted for inpatient care. It worked very well for seventeen years. Too well for some. NorthSTAR counties, while providing immediate and efficient care, had more persons signed up for Medicare than other counties in the State. Since Texas did not take the Medicaid match, the State had to make up the Medicaid match dollars and NorthSTAR became very expensive for the State to maintain.

Then came the Sunset Commission report and a decision was made that we needed to look like the rest of the State. They decided to get rid of NorthSTAR and we ended up with a system that isn't really like the rest of the state, we have more of a hybrid plan with limited indigent funding that is managed by NTBHA as the local mental health authority instead of MHMR acting as the authority as in other parts of the State. Dallas also lacks a large capacity county psychiatric hospital like they have in Tarrant county in JPS. Green Oaks and PES have acted in that capacity to augment Parkland for the last 17 years. With the first year of NTBHA coming to an end, the stakeholders are meeting and trying to get input on redesigning our system for the coming year. Mr. Collins thinks that it is a good idea, to look at everything and consider all of the available options. One thing that really concerns him though is that there seems to have been a decision that has already been made to start sending all patients to medical ERs for their psychiatric emergency care. Medical Emergency Rooms are not equipped to deal with psychiatric patients. This is not good for patients or for the ERs where they are being held. NTBHA has stated that patients may just have to receive care in the ERs if funds are depleted. There is some thought that this will force Emergency Room physicians to learn to handle psychiatric care. That just seems to be an assumption that has been made and nobody is questioning that. Mr. Collins keeps hearing that HHSC was saying that we had to use the money in a specific way. He has called Sonja Gaines and asked her. She told him that the statements made were not true at all, it is totally up to us how we want to use the money in our region so the decision was not made because the State is making us do it according to what she told him. Mr. Collins has been told that training is being

provided about EMTALA and he is not sure why. Hospitals know what EMTALA is so he is not real sure who it's for. Mr. Collins also can't figure out where all of these patients are going to go and he isn't sure what the MedSurg ERs are going to do with the people when they show up. Where are they going to send people? Green Oaks has typically processed 10,000 indigent patients through PES per year. We have processed 8,000 YTD. Where are these patients going to go? As a tax payer, he want's to know who is going to care for these people? What happened to the tenets BHLT was founded on?

Strategic Planning:

- PEER Group

Joe Powell was not in attendance to give the update on the proposed committee. Commissioner Price stated that Mr. Powell wanted to remind the committee about the Rally for Recovery, September 16, 2017.

NTBHA Updates:

Carol Lucky, CEO of NTBHA. Informed the committee that the RFP is closed and all contracts with outpatient providers and CMHPs have been completed. Ms. Lucky stated that we know on the mental health side that we need to look at all processes for possible redesign. The outpatient system is not strong right now and if outpatient providers don't meet their outcomes we will start to be penalized. Ms. Lucky stressed the need to increase outreach to crisis service and outpatient as well as strengthen the backside of the process or we will continue to have people who rotate through. Last year NTBHA received $5.5 million from the state for inpatient treatment for an 8 month time period. This year we have $5.5 million to cover a full year which is a very minimal ability to put people in inpatient beds. Ms. Lucky stated that with this financial impact that we can't continue to use this money primarily for 24-hour observation and that we have to consider other options as a way to stretch these limited funds. Ms. Lucky expressed that some ways to stretch those funds was to better identify those in high need and determine who can you stabilize and place in outpatient and in SUD services. There are many things to look at to move people into the most appropriate services outside a hospital setting, such as acute care clinics which are more cost effective that the hospital. Commissioner Price asked how this is different than the 23-hour observation. Preston Looper, CEO of ACS, said that at the request of Value Options in the past and then NTBHA, ACS has been providing mental health evaluation, with a focus on suicide and violence risk assessments and then taking steps to intervene to provide less restrictive level of care. Mr. Looper did stated that developing a comfort level with the various hospitals is still a work in progress. For example, Mr. Looper stated that stimulant use is an issue that is responded to in different ways when presented and even world class medical hospitals aren't necessarily world class psychiatric centers. There was some discussion about the number of people who present at ERs with MH issues and the lack of information that NTBHA has on this information if it doesn't result in a request for inpatient hospital approval. Courtney Clemons stated that the goal is create a continuum of services, due to limited resources to save hospitalization for those who really need it. The 25-30 beds need to be reserved for the people with the highest acuity, and other options such as a respite centers could help a safe place for care. Herb Cotner of DPD mentioned that if an individual is medically compromised they will be taken to the ER. It was also stated by Commissioner Daniels and Carol Lucky that there is a 90 day extension with Green Oaks Hospital while NTBHA is working with the community and providers .

Stepping Up Initiative Update/Caruth Grant:

Dr. Jaqcualene Stephens with Meadows Mental Health Policy Institute (MMHPI) gave a short update and stated that MMHPI has their ACT/FACT team expanstion contracts executed (Transicare/Child and Family/Mental Health). Ron Stretcher is working to finalize the process for the teams who will be working with these clients. Mike Laughlin provided a summary update regarding the MMHPI Smart Justice Grant. The 5-year, $7 million Implementation Grant submitted by MMHPI was awarded in October 2016, leading to the $1.174 million sub-grant to Dallas Co. in Jan. 2017 to address Intercepts 2-4, and part of 5. Mike gave an update on the current status and upcoming actions related to the award. The beta test of the project began on April 17th and all the workgroups and sub-teams for the Intercepts 2-4 continue to meet/complete pre-implementation tasks related to procedures/forms, court orders, space/staff preparations, modified resource allocations, and training curriculums/plans. The full implementation launch began Aug. 14th, and program activity/performance data through June 30th included 2,456 individuals were screened MH positive, 488 ordered for assessment, 297 assessed, 90 presented to the Magistrate Court (60% felony), 77 granted release (5 denied/9 contested), and all 77 opened by Pretrial (13 to low level, 46 medium level,18 high level bond supervision). The next step will be completion of a full, start to finish, flowchart in October of the processes for everyone to commonly follow, along with a guide and an agreed set of data elements for tracking implementation progress and client/system outcomes among all parties. Additionally, MMHPI continues to meet and work with community providers to build up treatment resources related to Intercept 5 for referral and treatment connection upon release. Also, MMHPI is coordinating with the City and

others on Intercept 1 (police and EMT response options) with the first agreements with them approved by the Dallas City Council over the summer. They have established job descriptions, and are currently hiring staff for the emergency response RIGHT Care Teams.

Behavioral Health Housing Work Group (BHHWG) Update:
Commissioner Daniel stated that the Respite services are moving along, this is a partnership and pilot program for beds for individuals leaving psychiatric emergency rooms. This program is piloted by Salvation Army and NTBHA and should be up and running by January 1st. Commissioner Daniel and others attended the Data Driven Justice Institute initiative and their assessment was that Dallas County needs more funding and BHHWG needs to work on where they can obtain this funding. Closing on the Catholic Charities facility is expected to take place once the funding from the Dallas Housing Authority is released to the project. The Cottages continues to move along; however, there are a few vacancies that need to be filled. There are currently only 40 individuals housed at the Cottages, which is around a 20% vacancy rate. Commissioner Daniel and Commissioner Price are concerned with this percentage and the number of vacant beds. Mr. Collins as well as other committee members requested the screening process. Ms. Greer will email the Cottages screening process to the members as well as include it in next month's meeting packet.

1115 Waiver Crisis Services Project (CSP) Update:
Charlene Randolph, Department of Criminal Justice, stated that CSP is currently working on closing out the DY6 year which ends in September. Mrs. Randolph informed the committee that Dallas County (CSP) has 13 treshold points that they must meet and they have identified the measures to meet those points. CSP will also be submitting at the next Commissioners Court contract renewals for Adapt Community Solutions, Transicare, Forensic Diversion Services, and FACT.

Legislative Update:
Janie Metzinger acknowledged everyone that helped with the Hurricane relief, inspite of all the issues that occurred. Commissioner Price stated that the Dallas County was aware of the issues and there would be a debrief with the City of Dallas.

Funding Opportunities:

- **SAMSHA Grant Update**:

Laura Edmonds with the Criminal Justice Department stated that the numbers were located in the packet (pg. 16). The program goal is to send as many clients involved in the Specialty Courts to Nexus. The program has reached its yearly targeted goal and they are currently working on wraping up their 3 year project.

- **Community Courts Grant Update (Public Defender's Office):**

Chief Public Defender Lynn Richardson Informed the committee that she had nothing new to report.

Upcoming Events and Notifications:
Upcoming events were provided in the packet for review.

Adjournment:
The meeting was adjourned at 11:25 am with a motion made by Commissioner Daniel and seconded by Mr. Hikel.

Advocates		Initial Representative	Current Representative	Proposed Representative
Mental Health America	1	Janie Metzinger	Janie Metzinger	
NAMI Dallas	1	Ashley Zugelter	Marsha Rodgers	
NAMI Dallas Southern Sector	1	Anna Leggett-Walker	Sam Bates	
Child/Family	1	Vanita Halliburton	Patrick LeBlanc	
Consumer	1	Dedra Medford	Dedra Medford	
Category Subtotal	***5***			
County/City				
Jail Behavioral Health Services	1	Waseem Ahmed	Waseem Ahmed	
City of Dallas	1	New Seat	Nadia C. Hardy	
Sheriff Department	1	David Mitchell	Alice King	
CSCD (Adult Probation)	1	Teresa May-Williams	Dr. Jill Love-Johansson	
Juvenile Department	1	Desiree Fleming	Leslie Gipson	
Judicial Representative	1	New Seat	Kristin Wade	
District Attorney	1	Durrand Hill	Faith Johnson	
Public Defender	1	Lynn Richardson	Lynn Richardson	
Metro Dallas Homeless Alliance	1	Mike Faenza	Cindy Crain	
Dallas Housing Authority	1	Brooke Etie	Troy Broussard	
Law Enforcement	1	Herb Cotner	Herb Cotner	
Dallas County Health & Human Services	1	Zach Thompson	Zach Thompson	
School Liaison	1	New Seat	Dr. Michael Ayoob	
Category Subtotal	***13***			
Residential Facilities				
Parkland	1	Josh Floren	Dr. Celeste Johnson	
Green Oaks	1	Tom Collins	Tom Collins	
Timberlawn	1	Craig Nuckles	James Miller	
Terrell State Hospital	1	Joe Finch	Joe Finch	
Chemical Dependency Residential Center	1	Doug Denton	Doug Denton	
Veterans Affairs (VA)	1	New Seat	Tammy Wood	
Dallas Behavioral Health Hospital	1	Patrick LeBlanc	Selena Hammon	
Category Subtotal	***7***			
Outpatient Providers				
Alcohol and Other Drug (AOD) -(Residential/OP)	1	Rebecca Crowell	Rebecca Crowell	
The Bridge	1	Jay Dunn	Jay Dunn	Dr. David Woody, III
CMHP - Adult	1	Liam Mulvaney	Carol Lucky	Open
CMHP-Child Adolescent	1	Michelle Weaver	Michelle Weaver	
CMHP - Crisis	1	Preston Looper	Preston Looper	
Peer/Non-Clinical	1	Joe Powell	Joe Powell	
Non-CMHP Crisis	1	Ken Medlock	Ken Medlock	
Re-Entry	1	Michael Lee	Christina Crain	
Adult Clinical Operations Team	1	Renee Brezeale	Sherry Cusumano	
Child/Adolescent Clinical Operations Team	1	Summer Frederick	Jane LeVieux	
Parkland COPC	1	Jacqualane Stephens	Karen Frey	
Psychiatrist Leadership Organization	1	Judith Hunter	Judith Hunter	
Psychiatry Residency	1	Adam Brenner	Ella Williams	
Mental Retardation/Developmental Delay	1	James Baker	John Burruss	
Underserved Populations	1	Norma Westurn	Norma Westurn	
Primary Care Physicians	1		Dr. Sue S. Bornstein	Open
Category Subtotal	***16***			
Payers/Funders				
Meadows Foundation	1	New Seat	Jaqualene Stephens	
NTBHA	1	Alex Smith	Carol Lucky	
NTBHA Chair	1	New Seat	Gordon Hikel	
Commissioners Court	1	Ron Stretcher	Vacant	
Category Subtotal	***4***			
Membership Total	**45**			
Comprehensive Mental Health Provder		**CMHP**		
				Rev. 9/15/17

RESOLUTION

DALLAS COUNTY BEHAVIORAL HEALTH LEADERSHIP TEAM

RESOLUTION NO: **07-2017**

DATE: **October 12, 2017**

STATE OF TEXAS }

COUNTY OF DALLAS }

BE IT REMEMBERED at a regular meeting of the Dallas County Behavioral Health Leadership Team held on the 13th day of July 2017, the following Resolution was adopted:

WHEREAS, On January 4, 2011 Dallas County Commissioners Court was briefed to establish the Behavioral Health Leadership Team (BHLT); and

WHEREAS, the Dallas County BHLT was comprised of key stakeholders and organizations throughout the county, including the Dallas County Hospital District.; and

WHEREAS, the body is made up of five (5) Advocates, thirteen (13) County/City organizations, six (6) Residential Facilities, sixteen (16) Outpatient Providers, and three (3) Payers/Funders; and

WHEREAS, in the six years since the BHLT's inception, a number of membership seats have become vacant and additional stakeholder groups have been identified for representation in the BHLT; and

WHEREAS, the BHLT recommends the following changes and additions to the BHLT membership:

- Outpatient Provider-The Bridge (Dr. David Woody, III)

IT IS THEREFORE RESOLVED that the Dallas County Behavioral Health Leadership Team appoints the above listed individuals as active members of the BHLT.

DONE IN OPEN MEETING this the 12th day of October, 2017.

_____
John Wiley Price
Commissioner District #3
Dallas County

_____
Dr. Theresa Daniel
Commissioner District #1
Dallas County

DALLAS BHLT, PEER COMMITTEE OVERVIEW

Goal of Peer Committee:
To provide Peer Representation, Peer leadership and lived experience on the Dallas BHLT. Assist in providing a workforce that seats "recovery first" for a recovery oriented continuum of care. Ensure that Peer supports and services are non-clinical, evidence based, culturally competent, ethically supervised and safe for mental health and substance use recovery in Dallas County.

Peer Committee Chair – Joe Powell will provide a monthly report on the status of Peers engagement in Dallas County workforce, 2) provide peer connections and workforce opportunities for BHLT provider network 3) assist in the provision of Peer, professional education, supports and provide peer leadership to the Dallas BHLT.

A Peer Recovery Specialist is a trained individual who has lived experience with mental illness and/or addiction to alcohol and/or other drugs who provides one-to-one strengths-based support to peers in recovery. Peer Recovery Specialists work in a wide range of settings including community health and mental health centers, behavioral health programs, substance use treatment facilities, peer-run organizations, community-based organizations, emergency rooms, courts, homeless shelters and outreach programs. Sometimes, Peer Recovery Specialists are referred to as Peer Support Specialists.

- Guiding principles and aspects of recovery
- Roles and core values of peer recovery specialists
- Relationship building and communication skills
- Cultural competence in recovery support
- Boundaries and ethical issues in peer recovery support
- Trauma-informed approaches
- Recovery and wellness planning
- ROSC – Recovery Oriented System of Care Readiness
- First Responder
- Strength based practice

In 2015, SAMHSA led an effort to identify the critical knowledge, skills, and abilities (leading to Core Competencies) needed by anyone who provides peer support services to people with or in recovery from a mental health or substance use condition.
SAMHSA—via its Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) project—convened diverse stakeholders from the mental health consumer and substance use disorder recovery movements to achieve this goal.
SAMHSA in conjunction with subject matter experts conducted research to identify Core Competencies for peer workers in behavioral health. SAMHSA later posted the draft competencies developed with these stakeholders online for comment. This additional input helped refine the Core Competencies and this document represents the final product of that process. As our understanding of peer support grows and the

contexts in which peer recovery support services are provided evolve, the Core Competencies must evolve over time. Therefore, updates to these competencies may occur periodically in the future.
Core Competencies are intended to apply to all forms of peer support provided to people living with or in recovery from mental health and/or substance use conditions and delivered by or to adults, young adults, family members and youth. The competencies may also apply to other forms of peer support provided by other roles known as peer specialists, recovery coaches, parent support providers or youth specialists. These are not a complete set of competencies for every context in which peer workers provide services and support. They can serve as the foundation upon which additional competencies for specific settings that practice peer support and/or for specific groups could be developed in the future. For example, it may be helpful to identify additional competencies beyond those identified here that may be required to provide peer support services in specific settings such as clinical, school, or correctional settings. Similarly, there may be a need to identify additional Core Competencies needed to provide peer support services to specific groups, such as families, veterans, people in medication-assisted recovery from an SUD, senior citizens, or members of specific ethnic, racial, or gender-orientation groups.

BACKGROUND

What is a peer worker?

The role of the peer support worker has been defined as "offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations." Peer support has been described as "a system of giving and receiving help" based on key principles that include "shared responsibility, and mutual agreement of what is helpful."[1]
Peer support workers engage in a wide range of activities, including advocacy, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more. They may also plan and develop groups, services or activities, supervise other peer workers, provide training, gather information on resources, administer programs or agencies, educate the public and policymakers, and work to raise awareness.[2] 1 Mead, S., Hilton, D. & Curtis, L. (2001). Peer support: A theoretical perspective. Psychiatric Rehabilitation Journal, 25(2), 134-141.
2 Jacobson, N. et.al. (2012). What do peer support workers do? A job description. BMC Health Services Research. 12:205

As mentioned previously, the development of additional Core Competencies may be needed to guide the provision of peer support services to specific groups who also share common experiences such as family members. The shared experience of being in recovery from a mental or substance use disorder or being a family member of a person with a behavioral health condition is the foundation on which the peer recovery support relationship is built in the behavioral health arena.

What is recovery?

SAMHSA developed the following working definition of recovery by engaging key stakeholders in the mental health consumer and substance use disorder recovery communities:
Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.[3] Throughout the competencies, the term "recovery" refers to this definition. This definition does not describe recovery as an end state, but rather as a process. Complete symptom remission is neither a prerequisite of recovery nor a necessary outcome of the process. According the SAMHSA Working Definition of Recovery, recovery can have many pathways that may include "professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches." SAMHSA has identified four major dimensions that support a life in recovery:
1. Health—Learning to overcome, manage or more successfully live with the symptoms and making healthy choices that support one's physical and emotional wellbeing;
2. Home—A stable and safe place to live;
3. Purpose—Meaningful daily activities, such as a job, school, volunteer work, or creative endeavors; and,

increased ability to lead a self-directed life; and meaningful engagement in society; and
4. Community—Relationships and social networks that provide support, friendship, love, and hope
Peer workers help people in all of these domains.

What are Core Competencies?

Core Competencies are the capacity to easily perform a role or function. They are often described as clusters of the knowledge, skills, and attitudes a person needs to have in order to successfully perform a role or job or as the ability to integrate the necessary knowledge, skills, and attitudes. Training, mentoring, and supervision can help people develop the competencies needed to perform a role or job.[4][5] This will be the first integrated guidance on competencies for peer workers with mental health and substance use lived experience.

Why do we need to identify Core Competencies for peer workers?

Peer workers and peer recovery support services have become increasingly central to people's efforts to live with or recover from mental health and substance use disorders. Community-based organizations led by people who have lived experience of mental health conditions and/or who are in recovery from substance use disorders are playing a growing role in helping people find recovery in the community. Both the mental health consumer and the substance use disorder recovery communities have recognized the need for Core Competencies and both communities actively participated in the development of these peer recovery support worker competencies.

Potential Uses of Core Competencies

Core Competencies have the potential to guide delivery and promote best practices in peer support. They can be used to inform peer training programs, assist in developing standards for certification, and inform job descriptions. Supervisors will be able to use competencies to appraise peer workers' job performance and peers will be able to assess their own work performance and set goals for continued development of these competencies.

3 Substance Abuse and Mental Health Services Administration. SAMHSA's Working Definition of Recovery. PEP12-RECDEF, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2012.

4 Henandez, R.S., O'Connor, S.J. (2010). Strategic Human Resources Management in Health Services Organizations. Third Edition. Delmar Cengage Learning. P. 83.

5 Sperry, L. (2010). Core Competencies in Counseling and Psychotherapy: Becoming a Highly Competent and Effective Therapist. Routledge. P. 5.

Core Competencies are not intended to create a barrier for people wishing to enter the peer workforce. Rather they are intended to provide guidance for the development of initial and on-going training designed to support peer workers' entry into this important work and continued skill development.

Core Competencies, Principles and Values

Core Competencies for peer workers reflect certain foundational principles identified by members of the mental health consumer and substance use disorder recovery communities. These are:

RECOVERY-ORIENTED: Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.

PERSON-CENTERED: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific needs the individuals has identified to the peer worker.

VOLUNTARY: Peer workers are partners or consultants to those they serve. They do not dictate the types of

services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.
RELATIONSHIP-FOCUSED: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.
TRAUMA-INFORMED: Peer recovery support utilizes a strengths-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

Dallas BHLT Peer Committee Chair
Joe Powell LCDC, PRSS
President/CEO
APAA – Association of Persons Affected by Addiction

Dallas County Behavioral Health Housing Work Group
Dallas County Administration, 411 Elm Street, 1st Floor, Dallas Texas 75202
September 27, 2017 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 Housing Work Group is committed to a data driven decision-making process with a focus on data supported outcomes.

ATTENDEES: Dr. Theresa Daniel, Commissioner; Blake Fetterman, Salvation Army; Zachary Thompson, DCHHS; Thomas Lewis, DCHHS; James McClinton, MDHA; Shenna Oriabure, CJ; Charletra Sharp, City of Dallas; Dr. Jacqualene Stephens, MMHPI; Dr. David Woody, The Bridge; Joyce White, Transicare; Brianne Brass, CJ; Sibi Powers, NTBHA; Annie Lord, CitySquare; Joshua Cogan, Outlast Youth; Heloise Ferguson, VA; Myrl Humphrey, NTBHA; Ellen Magnis, Family Gateway; Jim Mattingly, LumaCorp; Ikenna Mogbo, Metrocare; Cindy Patrick, Meadows Foundation; Jari Mema, Catholic Charities; David Woodyard, Catholic Charities; Raymond Castilleja, Prism Health; Atoya Mason, VA; Tracy Holmes, City of Dallas; Rick Loessberg, Dallas County; Claudia Vargas, Dallas County; Walter Taylor, Dallas County; Cimajie Best, Dallas County; and Terry Gipson, Dallas County

CALL TO ORDER: Minutes approved as amended. Josh Cogan shared that the homeless youth count event name was changed from “Count Me In Dallas” to “Count Us In Dallas.”

GOVERNANCE
Dallas Area Partnership to End and Prevent Homelessness: The meeting scheduled for September 28th was not posted in time so is being rescheduled for as soon as possible.

Legislative Environment: No update was provided.

PRESENTATIONS
Community for Permanent Supported Housing (CPSH): Robin LeoGrande, Founder and President
CPSH actively helps individuals living with Intellectual and Developmental Disabilities (IDD) find affordable housing. In particular, IDD populations who are homeless, potentially homeless, or incarcerated. The organization works with families, property owners, service providers, and builders in a seven-county region. CPSH is a member of the TDHCA Housing and Services Partnership Academy and is collaborating with the North Texas Regional Housing Assessment to get feedback on the housing needs of IDD populations. Currently, there are approximately 44,000 individuals with IDD in Dallas County. Nationwide 3% of individuals who have IDD are incarcerated. Many choose not to receive SSI even though they may qualify. Only 3% of affordable housing in Texas is designated for individuals living with IDD, primarily through Medicaid waiver programs. Additionally, CPSH is advocating for better data collection for individuals with IDD because mental illnesses and IDD are routinely combined in data reports.
Ms. LeoGrande is looking for partner agencies to join CPSH’s request for an independent fair market rent (FMR) study for North Texas and will reach out to the North Texas Housing Association Consortium for help.

Commissioner Daniel explained that the BHHWG has been working on very similar interests. Zachary Thompson elaborated that the Dallas region continues to be locked into a Small Area FMR Demonstration imposed by HUD. Jim Mattingly added that the data used to determine FMR’s is lagging well behind the market, so housing vouchers are not competitive enough for builders and property owners. The BHHWG will renew efforts to engage HUD regarding relief to local communities for their low-income housing needs.

DEVELOPMENT

Crisis Residential and Respite Services:

- Sibi Powers, reporting on behalf of Courtney Clemmons, shared that NTBHA is still working on solidifying a location for respite services and crisis hub.
- Walter Taylor shared an email update from Doug Denton. Mr. Denton reports that Homeward Bound received zoning approval from the City of Dallas and is working on completing a checklist of requirements to be reinstated.

TDHCA 2016 Housing and Services Partnership Academy: James McClinton reported that continuation of the academy has not been announced.

Community Reinvestment Act (CRA): Walter Taylor reviewed that the CRA works to encourage depository institutions to invest in underserved communities or census tracts that have poverty levels above 20%. Other communities have created Community Development Financial Institutions (CDFI's) to impact economic growth. Housing is one avenue used to ensure credit flows into low income areas.

RESOURCES

Shelter Discussions: Blake Fetterman reported that local shelters recently met to continue working on streamlining shelter policies. One example is the inclement weather policy that relies on daily temperatures to determine inclement weather access. If changes to the inclement weather policy are adopted, instead homeless individuals will be able to access shelters around the clock during the winter season. Another priority for shelters is maximizing shelter space to make more room for families.

David Woody reported that Courtney Clemmons of NTBHA attended the shelter meeting to explain how to connect sheltered individuals with services. Shelter staff is interested in learning about the network of services and receiving training to facilitate the process.

Zachary Thompson reported that there is a Hepatitis A outbreak in some California shelters and would like to share prevention measures with the shelter group in Dallas as a precaution.

Family Shelters are collaborating to reduce barriers for families and diverting families from shelters into more appropriate housing whenever possible.

NTBHA: The new contract period began in September. NTBHA is contracting with Sundance, Green Oaks, and Dallas Behavioral for inpatient services. There is capacity for 10 beds in each hospital to divert patients with the most need. Care coordinators will be implemented at each hospital so there is better discharge planning and coordination for outpatient providers.

Housing Navigator: Joyce White shared that the housing resource training in August focused on attorneys: 58 attended the morning session and 40 attended in the afternoon session. Attorneys had the opportunity to hear presentations from local shelters and received CLE's for participating. The Fall training schedule is set. October's training will feature speakers on domestic violence. Data shows that victims of domestic violence have an increased likelihood of being incarcerated in the future. December's training will be geared towards the judiciary and judges. Ms. White is working with MMHPI to find ways to connect DCCJ clients with CoC dollars and on including DCCJ clients in the HMIS. MDHA will develop criteria for high utilizers in the jail system from data received from the housing navigator reports.

Caruth Smart Justice: A 5-year, $7 million Implementation Grant submitted by MMHPI to Caruth was awarded in October 2016, leading to a 2-year, $1.174 million sub-grant to Dallas County in January 2017 to address Intercepts 2-4, and part of 5. The beta test of the project began on April 17th, and all the workgroups and sub-teams for the Intercepts 2-4 continue to meet/complete pre-implementation tasks related to procedures/forms, Court orders, space/staff preparations, modified resource allocations, and training curriculums/plans. The full implementation launch began August 14th, and program activity/performance data through June 30th included 2,456 individuals who were screened MH positive, 488 ordered for assessment, 297 assessed, 90 presented to the Magistrate Court (60% felony), 77 granted release (5 denied/9 contested), and all 77 opened by Pretrial (13 to low level, 46 med. Level and to 18 high level bond

supervision). The next step will be completion of a full, start to finish, flowchart in October of the processes for everyone to commonly follow, along with a guide, and an agreed set of data elements for tracking implementation progress and client/system outcomes among all parties.

Additionally, MMHPI continues to meet and work with community providers to build up treatment resources related to Intercept 5 for referral and treatment connection upon release. Also, MMHPI is coordinating with the City and others on Intercept 1 (police and EMT response options) with the first agreements with them approved by the Dallas City Council over the summer. They have established job descriptions, and are currently hiring staff for the emergency response RIGHT Care Teams as well as 911 clinician imbeds.

PROJECTS AND INDUSTRY UPDATES

Coordinated Access System: Cindy Crain will provide an update at the next BHHWG meeting in November.

Homeless Jail Dashboard: Shenna Oriabure is working on the request to break down data by age and offense and will likely be able to start doing so by January 2018. The homeless jail report uses AIS data based on book-outs and releases in contrast to the jail pop report generated from book-in numbers. The jail pop report indicates that the homeless population in the jail is mainly in the 25-54 age group. It was noted that because the homeless report and jail pop reports use different data sets, the homeless jail report shows decreases in the number of homeless in jail while the jail pop report shows an increase.

The Cottages: Annie Lord, Chief Program Officer at CitySquare, reported that staff is still working on a process to fill vacancies at The Cottages. Four new clients recently moved in and there are 6 vacancies waiting to be filled. A full-time outreach staff person has been added and is developing a fully vetted waitlist.

Catholic Charities: Jari Mema reported that an official name has been selected for the housing project, St. Jude Center. The property has not closed but contracts for release of funds from the city and county are being processed. Staff is reaching out to partners to determine office and spacing needs for meeting rooms. A property manager will be hired soon. DHA has tentatively approved 103 project based housing vouchers; 13 of those spots are reserved for Dallas County. This made it possible to apply for CoC funding for social services. Charlene Randolph added that the Dallas County portion of funding will be up for a vote on the October 3rd Commissioners Court Agenda.

Hurricane Harvey Efforts: About 200 evacuees remain in one shelter which is due to be closed within the week. Salvation Army is working with Catholic Charities on a long-term recovery strategy for individuals who remain. An estimated 300 evacuees plan to stay in Dallas. Catholic Charities will help with rental assistance and job placement. Homeless evacuees will not get FEMA assistance because a home address is required. Agencies in Dallas are working to include these individuals in HMIS to begin documenting their needs.

NEXT STEPS

- Follow-up with HUD for additional funding for sustainable housing and TREC for additional housing resources.
- The November and December BHHWG meetings will be rescheduled due to conflict with the holidays. Proposed meeting dates are November 15, 2017 and December 13, 2017.
- Josh Cogan is working with MDHA to use their homeless count survey app and will include questions specific to homeless youth. The homeless youth count will overlap with the adult homeless count. Volunteers are still needed for the homeless youth count.

Next Meeting: Wednesday, October 25, 2017, at 10:00 am

Dallas County Administration Building, 411 Elm Street, 1st Floor, Allen Clemson Courtroom
If you need parking, please contact Walter Taylor

1115 Waiver DY7-8 valuation scenario

A. Total Available Funding **$6,302,327.02**

B. Category payment distribution

Category	Percentage		Valuation	
	DY7	DY8	DY7	DY8
RHP 9 Plan update	20%	NA	$1,260,465.40	NA
Category A: Core Activities, Cost Savings Plan	0%	0%	$0.00	$0.00
Category B: MLIU Patient Population by Provide	10%	10%	$630,232.70	$630,232.70
Category C: Measure Bundles and Measures	55%	75%	$3,466,279.86	$4,726,745.27
Category D: Statewide Reporting Measure Bund	15%	15%	$945,349.06	$945,349.05
	100%	100%	$6,302,327.02	$6,302,327.02

C. Category-C Valuation (Cat-C percentage: DCHHS = 30%, CJD = 70%)

Department	Measure ID	Points	DY7 Estimated VALUATION	DY8 Estimated VALUATION	Measure Title
DCHHS	L1-347	3	$945,349.08	$965,349.08	Latent Tuberculosis Infection (LTBI) treatment rate
DCHHS	TBD	1	$252,093.08	$376,139.61	TBD
CJD	**H3-257**	**1**	**$252,093.08**	**$376,139.61**	**Care Planning for Dual Diagnosis**
CJD	**M1-261**	**1**	**$252,093.08**	**$376,139.61**	**Assessment for Substance Abuse Problems of**
CJD	**M1-262**	**1**	**$252,093.08**	**$376,139.61**	**Assessment of Risk to Self/Others**
CJD	**M1-263**	**1**	**$252,093.08**	**$376,139.61**	**Assessment for Psychosocial Issues of Psychiatric Patients**
CJD	**M1-317**	**1**	**$252,093.08**	**$376,139.61**	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling**
CJD	**M1-319**	**1**	**$252,093.08**	**$376,139.61**	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eMeasure)**
CJD	**M1-340**	**1**	**$252,093.08**	**$376,139.61**	**Substance use disorders: Related to patients with a diagnosis of current opioid addiction**
CJD	**M1-341**	**1**	**$252,093.08**	**$376,139.61**	**Substance use disorders: Related to patients with a diagnosis of current alcohol dependence**
CJD	**TBD**	**1**	**$252,093.08**	**$376,139.61**	**TBD**
	Units	**13**	**$3,466,279.88**	**$4,726,745.18**	

D. Total Expected Payment

Category	DY7		DY8	
	DCHHS	CJD	DCHHS	CJD
Plan Update: $1,260,465.40 x 30% = DCHHS, 70%	$378,139.62	$882,325.78	$0.00	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$189,069.81	$441,162.89	$189,069.81	$441,162.89
Category C	$1,039,883.96	$2,426,395.92	$1,418,023.55	$3,308,721.63
Category D	$283,604.72	$661,744.34	$283,604.72	$661,744.33
Total	**$1,890,698.11**	**$4,411,628.93**	**$1,890,698.08**	**$4,411,628.85**

Crisis Services Project- FY'17 Cash Flow Worksheet

	FY 2017	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	
CSP Expenses	**Budgeted**													**Total spent**
Adapt	1,282,428.00	108,973.83	0.00	104,843.34	129,012.44	148,899.96	106,054.21	102,040.16	90,800.87	112,941.00	128,135.98	201,740.43	0.00	1,233,442.22
Transicare	2,017,480.00	11,626.22	295,262.79	22,225.68	0.00	418,283.00	0.00	195,817.90	306,683.44	0.00	0.00	159,703.40	173,278.50	1,582,880.93
Harris Logic- 2nd year license	260,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	250,000.00	250,000.00
Metrocare/ FDU (billed quarterly)	537,213.00	0.00	0.00	0.00	0.00	134,303.25	0.00	0.00	0.00	134,303.25	0.00	0.00	0.00	268,606.50
Cottages/ FDU	459,585.00	14,855.82	0.00	27,880.97	18,817.22	0.00	24,072.63	38,999.97	0.00	0.00	46,758.72	38,678.50	0.00	210,063.83
Value Options Care Coordinator	112,000.00	9,333.33	9,333.33	9,333.33	16,333.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	44,333.32
NTBHA Care Coordinator	82,000.00	0.00	0.00	0.00	0.00	0.00	12,147.66	6,985.00	13,200.00	0.00	6,600.00	6,600.00	0.00	45,532.66
Serial Inebriate Program (estimate)	150,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dallas County Salaries/ Benefits	300,000.00	9,522.33	19,044.62	26,528.78	13,921.17	13,171.18	15,615.96	16,838.38	18,956.45	28,278.21	18,852.13	15,155.73	11,663.23	207,548.17
Property less than $5,000		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Computer Hardware	10,000.00	0.00	0.00	0.00	0.00	295.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	295.20
Computer Software		0.00	0.00	590.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	590.40
Consulting Fee	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Training Supplies	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Business Travel/ Trainings	20,000.00	1,585.62	0.00	0.00	0.00	0.00	0.00	376.14	0.00	367.74	225.00	0.00	0.00	2,554.50
Bus Passes (5000 count)	15,000.00	0.00	0.00	3,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3,000.00
After-care Engagement Package	216,000.00	0.00	0.00	7,978.72	1,633.07	1,306.46	0.00	0.00	0.00	0.00	0.00	0.00	0.00	10,918.25
Speciality Court After-Care Engagement	224,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Army)	122,640.00	6,888.00	0.00	0.00	37,548.00	0.00	10,276.00	7,280.00	7,140.00	8,428.00	10,332.00	7,308.00	0.00	95,200.00
Transitional Housing- CSP (8 male beds at Salvation Army)	81,760.00	5,040.00	0.00	0.00	19,320.00	0.00	4,564.00	5,096.00	4,872.00	6,692.00	5,292.00	2,128.00	0.00	53,004.00
Housing Specialist (estimate)	65,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0
New Space Renovations/Office Supplies	20,000.00	0.00	0.00	0.00	0.00	20.52	0.00	0.00	0.00	0.00	0.00	730.96	1,445.86	2,197.34
SUBTOTAL	5,975,106.00	167,825.15	323,640.74	202,381.22	236,585.23	716,279.57	172,730.46	373,433.55	441,652.76	291,010.20	216,195.83	432,045.02	436,387.59	**4,010,167.32**

Department of Criminal Justice
FY2017 SAMHSA Grant Project

	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	FY2017 Total	FY2016 Total
Number of New Admissions	8	4	1	3	7	9	6	1	3	1	1	0	44	33
Number of Successful Completions	*3*	*6*	2	5	0	4	8	4	2	0	1	1	36	24
Number of Unsuccessful Completions	1	1	0	0	1	2	2	1	0	2	0	0	10	9
Average Days in Jail from Referral to Admission	5	6	3	4	6	9	10	6	8	12	7	0	7	4
Number of New Admissions on ELM	6	3	1	2	7	8	4	1	3	1	1	0	37	12
Program Referral Follow-Ups by Type (running total per grant year)														
Court Program Graduate													0	6
Active In Court Program													8	4
Active In Treatment at Nexus													2	N/A
In Jail													4	0
Re-Arrested and Released to Community													9	11
Re-Arrested and Released to Further Treatment													7	2
Released to TDCJ or State Jail													3	3
Active Warrant													11	7

Dallas County Behavioral Health Leadership Team (BHLT)
Adult Clinical Operations Team (ACOT) Committee Meeting
August 3, 2017

Attendees: James McClinton (MDHA), Janie Metzinger (MHA), Kurtis Young (PHHS), Jacob Twombly (UT Police), Charlene Randolph (Dallas County), Sherry Cusumano (Green Oaks/ NAMI), Jennifer Torres (Metrocare), Ashley Williams (CSCD Clinical), Brianne Brass (Dallas County), Ellen Duke (Hickory Trail), Michael Laughlin (Dallas County), Marie Ruiz (MetroCare), Jill J-Love (Dallas County CSCD), Lauren Roth (MMHPI), Mike Ayob (Counseling Institute of Texas), Mark Karaffa (Dallas Behavioral), Jarrod Gilstrap (Dallas Fire), Becca Crowell (Nexus), Dave Hogan (DPD Crisis), John Henry (NTBHA), Herb Cotner (Dallas PD)

Introductions and Minutes Approval

- Committee members made introductions.
- Meeting minutes from June 2017 were approved.
- Becca Crowell shared that Nexus is hiring for an Adolescent Program Director.

MetroCare Presentation

- Jennifer Torres provided an overview of the services provided by Metrocare.

- Location #8 Stemmons Center & Pharmacy is no longer existent.

- The Skillman and Grand Prairie facilities serve both adults and children.

- Each facility does take daily walk-ins and schedules.

-The Samuels location serves three levels of care.

Updates

- NTBHA is continuing to build relationships with the community as contracts are set up to being September 1st.

- NTBHA reported that 2017 fiscal year will end on August 31st.

Smart Justice Update

- Lauren Roth reported that Meadows is working on subcontractor agreements with providers, and have gotten all approvals from the City of Dallas.

-Mike Laughlin reported that Dallas County has released 70 individuals from jail on Mental Health Bonds, and will begin the full Caruth launch on August 14th.

Legislative Update

- Janie Metzinger provided the legislative update.

- Legislature is focusing on 20 priorities set by Governor.

Other

-Enrique Morris, Marlene Buchanan and Amy Cunningham will be invited to present on ACT/FACT in September.

-Dr. Jill J. Love volunteered to present in October.

The meeting was adjourned at 1:29 pm.

DALLAS COUNTY, TEXAS

Minutes of the Behavioral Health Steering Committee (BHSC) Meeting
Thursday, August 17, 2017

Call to order and Introductions

The meeting was called to order by Judge Wade at 8:38 am. 25 staff and agency representatives/providers were in attendance with names recorded on the meeting sign-in sheet.

Minutes review and approval

The **minutes** from the last bi-monthly BHSC meeting held on June 15, 2017 (packet pgs. 2-5), were reviewed with motion and second by Lee Pierson and Harry Ingram for acceptance. No discussion or corrections. Motion unanimously passed with minutes approved without objection.

No guest speakers presented on this occasion.

Caruth Grant: Mike Laughlin provided a July 2017 quarterly summary update regarding the MMHPI Smart Justice Grant with materials in the packet (packet pages 6-8). The 5-year, $7 million Implementation Grant submitted by MMHPI was awarded in October 2016, leading to the $1.174 million sub-grant to Dallas Co. in Jan. 2017 to address Intercepts 2-4, and part of 5. Mike gave an update on the current status and upcoming actions related to the award. The beta test of the project began on April 17th, and all the workgroups and sub-teams for the Intercepts 2-4 continue to meet/complete pre-implementation tasks related to procedures/forms, Court orders, space/staff preparations, modified resource allocations, training curriculums/plans culminating in this week's successful implementation launch. Mike also provided program activity/performance data through June 30th in a supplemental handout highlighting 2,456 were screened positive, 484 ordered for assessment, 297 assessed, 90 presented to the Magistrate Court (60% felony), 77 granted release (5 denied/9 contested), and all 77 opened by Pretrial (13 to low level, 46 med. Level and to 18 high level bond supervision).

Lynn brought up the MH screen cue is needing to capture more people, and asked about what we do with cases whose MH assessment leads to "no" or "diagnosed deferred". Lengthy discussion on this, and it was explained that this is "point in time evaluation and diagnosis that is based on history and symptoms presented at that time. It was agreed that ADAPT will set up a training session for everyone on what this means and how to use it.

Additionally, MMHPI continues to meet and work with community providers to build up treatment resources related to Intercept 5 for referral and treatment connection upon release. Marlene reported the contracts have been routed/signed on her end, but no referrals yet. She also reports that the receiving of warm handoffs is going well, though it was a little bumpy at the beginning. MMHPI is coordinating with the City and others on Intercept 1 (police and EMT response options) with the first agreements with them are going for approval before the full City Council this month. They have established job descriptions, and are currently hiring staff for the emergency response RIGHT Care Teams.

Data and Reports for BHSC – Judge Wade

Program and Department Updates: The program/outcome data, updates, and workload reports were presented and accepted via relevant dept./agency staff for the SAMHSA Grant, 530 Subcommittee, BHLT/CSP, Public Defenders, District Attorneys, CJ Dept. Jail reports, as well as provider reports (The Bridge, Metrocare, and IPS), and the various Problem Solving and Specialty Courts (see packet pgs. 9-63 for details).

Laura presented the SAMHSA Grant update along with the data and activities (see packet pg. 9).

Laura Edmonds also presented a summary of current 530 Subcommittee activities and expenses. The semi-monthly June 19th Committee meeting minutes and report were presented by Laura who also advised that there was some very good planning accomplished, and that there will be some new team members joining. Additionally, the 530 Subcommittee needs approval for $2720 expenditure from budget line items for inpatient treatment at Homeward Bound for individuals currently in need of an additional funding source beyond what is currently available. Motion made and seconded by Harry Ingram/Lee Pierson. Motion unanimously passed and approved without discussion or objection.

Laura also advised there will be an increase in training opportunities and focus for FY 2018 to include the National Assoc. of Drug Court Professionals Conference coming to Texas.

The 530 Subcommittee will also have their next lunchtime training Delightful Discussions on services at IPS on August 18th, in the Pretrial Conference Room.

CSP stats and metrics for June/July were presented/reviewed by Charlene (see packet pgs. 9-25), and they are exceeding YTD outcomes and DY6 metrics. There continues to be an uptick in the numbers due to the new Caruth MH PR Bonds. Terrell Hospital Connection Project for improved release planning continues to go well.

Charlene and CSP providers continue to communicate with NTHBA to facilitate the recent transition planning since the care manager and Specialty Court Aftercare Engagement Packages currently go through CSP and will now be coordinated through NTBHA. Process continues to go well. HHSC has submitted request for 21 month extension of CSP funding with an announcement on that by the end of the current calendar year. The Forensic Diversion Unit had 46 unique clients engaged, with some of those while still in custody.

Cottages Update: 26 unique consumers engaged by Dallas Metrocare. Census is not full at this time. Referral criteria include multi-bookins, MI diagnosis, and homeless. Also they are permitted to have income, but don't have to meet HUD definition, no sex offender cases, and Arson cases are reviewed individually. Lynn asked how long it takes, and Shenna explained that DHA processing can take some time I order to process the needed documents, verify homeless status, etc. City Square case workers will interview/screen and help to gather documents, etc.

Jail and hospital movement, pregnant defendants, and homeless and Veteran data and reports were presented by Laura Edmonds, Shenna Oriabure, and Janine Capetillo and are found in the meeting packet on pages 33-48. With the pregnant patients it was noted that some of these are for probation/parole violations, and most of them have an MI diagnosis per the Stella data and MH screenings. Veteran's prevalence continues to under report, and it was also noted that the Veterans continue to rapidly cycle out of the jail making it hard to get the designated staff catching them before release due to limited staffing. No other concerns or questions from the group on those items. Montgomery Hospital has begun to take clients again, but Lynn also noted that they continue to be very selective excluding those unlikely to regain, lower level cases, and to heavily scrutinize criminal records.

Monthly CCQ match: Mike Laughlin provided the MH prevalence which according to TLETS is still high 61% (packet pgs. 51-52). Several acknowledged that the Jail MH screen was still too inclusive, and that data sources are being reviewed with IT to refine the data feeds and hopefully resolve the issue soon. The NTBHA feed will also soon be added to the data collection process which should help in more accurate triaging and identification.

All other department and agency data reports and program updates were accepted as read, and can be reviewed in the meeting packet.

Lynn Richardson presented the **Public Defender** MH case data and reports (page 34 of packet) noting they will soon have the Smart Justice numbers added also. They are now also closely tracking all specialty court participants. No other comments at this time.

Lee Pierson provided the **DA data updates and report (see supplemental packet insert)** and advised that DA has reviewed the cases for Depression diagnosis, and is now taking them again. Cases with violence elements are also being carefully scrutinized.

Provider Reports

Kelly Lane from The Bridge reported their numbers (pg. 35) with no comments/concerns expressed. She advised Jay Dunn is no longer at the Bridge, and Dr. David Woody is interim CEO. She also advised that DHA is taking briefings again for placements for the first time since November 2016.

IPS: Supplemental insert was provided by IPS with no further comments.

NTBHA: John Henry reported that engagements are up, and some good things are happening with the expansion to include increased capacity for OCR and new money/collaboration to implement SB2 Collaborative locally.

Metrocare: Crystal Garland presented Metrocare data/reports (pg. 55) advising that Atlas numbers remain low but is being addressed. DDRC remains at full capacity.

Specialty Court: Janine presented OCR Court data (pg. 57). It was noted that Governor's Office is no longer funding attorneys for Specialty Courts. DIVERT Court numbers are on **(**pg. 58)**.** Rosa Sandles was present for Ms. McNair at which time the other Specialty Court numbers (pages 59-63) were presented noting that Atlas Court numbers are down, and that Judge Hawthorne was working to resolve the issue.

Funding: Everyone is encouraged to keep good track of program/outcome numbers to ensure they are accurate and that your target population makes up most of your slots and program effort. Judge Wade asked at the June meeting for all to consider setting up a separate BHSC focus meeting in near future to improve data/outcome tracking efforts and look at a periodic reporting that maybe can go before the Commissioners Court to show impact.

Announcements

Housing recent targeted housing training for attorneys went very well, and the next one for the bigger group will be in the Central Jury Room on August 25, 2017 from 11-230pm. Several commented that Metrocare has been a big help in identifying and processing candidates, and getting the latest funding spent on more people. Enrique commented that this will also help us justify future funding requests.

Shenna and Laura announced the next monthly "Delightful Discussions" brown bag in-service with information and guidance on IPS is on the August 18, 2017, from 1130-1215pm. It will be held in the in Pretrial Conference Rm. A9 on

the 1st floor. Judge Wade promoted this and encouraged everyone to attend and participate. Desert will be provided with door prizes. RSVP to Shenna via email.

Vickie Rice thanked the DA's Office for reconsidering handling of the mental health cases with Major Depressive Disorder (MDD) diagnoses. It was also mentioned that DA and Public Defenders Office are working on a joint intake process and more will be announced soon on that. It was also mentioned that the census and referral numbers for the Specialty Courts is way too low, and we need to consider a BHSC working group to address ways to improve this. Lastly, it was agreed that a BHSC service/responsibility contract directory needs to be developed for everyone to know what each other is doing and how to contact the right people for various needs. Mike and Vickie will work on this.

Adjournment

The meeting was adjourned by Judge Wade at 940am. The next bi-meeting is set for Thursday, October 19, 2017 at 830am in the same location. Reminder was provided to everyone to submit their monthly stats to Mike Laughlin via email by the 2nd Friday of each month for distribution.

HARRY INGRAM — **FY2017 ATLAS STATISTICS** — **203/HAWTHORNE**

MONTH	BEGINNING # OF PENDING CASES	+NEW CASES RECEIVED THIS MONTH	=TOTAL CASES	TBJ	TBC	PLEAS	REV	GRADUATES	PROBATION MODIFICATIONS	DISMISSALS	OTHERS	TOTAL DISPOSITIONS	ENDING # PENDING CASES **	CURRENT ATLAS PARTICIPANTS	CURRENT PARTICIPANTS IN CUSTODY	FORMER ATLAS PARTICIPANTS	BOND
September	26	7	33	0	0	0	0	0	0	0	4	4	29	22	0	0	0

HARRY INGRAM — **FY2017 MISDEMEANOR MENTAL HEALTH COURT STATS** — **CCCAP1/WADE**

MONTH	BEGINNING # OF PENDING CASES	Rediverts	+NEW CASES RECEIVED THIS MONTH	=TOTAL CASES	TBJ	TBC	PLEAS	DISMISSAL	OTHER	TOTAL DISPOSITIONS	ENDING # PENDING CASES **	CURRENT PARTICIPANTS	NUMBER OF GRADUATES	BOND***
September	124	0	5	129	0	0	3	0	7	10	119	26	0	26

HARRY INGRAM — **FY2017 S.E.T. STATISTICS** — **291st**

MONTH	BEGINNING # OF PENDING CASES	+NEW CASES RECEIVED THIS MONTH	=TOTAL CASES	TBJ	TBC	PLEAS	REV	GRADUATES	PROBATION MODIFICATIONS	DISMISSALS	OTHERS	TOTAL DISPOSITIONS	ENDING # PENDING CASES **	CURRENT PARTICIPANTS	CURRENT PARTICIPANTS IN CUSTODY	FORMER PARTICIPANTS	BOND
September	46	1	0	0	0	0	0	0	0	0	1	1	46	20	0	0	20

September — **FY2017 MHPD STATS**

MONTH	BEGINNING # OF PENDING CASES	+NEW CASES RECEIVED THIS MONTH	=TOTAL CASES	TRIALS	PLEAS	COND. DISM.	REVO-CATION	DISMISSALS	INCOMPETENT	REFERRALS	OTHER COUNSEL APPT.	TOTAL CLOSED
R. LENOX	188	28	216	2	6	5	5	1	0	0	9	28
L. TAYLOR	199	20	219	1	2	1	1	0	0	0	0	5

MALCOM HARDEN — **FY2017 FELONY COMPETENCY STATISTICS**

	BEGINNING # OF CASES	NEW CASES THIS MONTH	TBJ	TBC	Alt. Trial Dispos.	PLEAS	REVO-CATIONS	DISMISSALS	PROBATION	COMP. HRG.	EXTENSIONS	CIVIL COMMIT.	MHMR REFERRAL	CONSULTS	OTHER	ENDING # OF PEOPLE IN OCR
September	164	14	0	0	0	1	0	1	0	2	0	0	1	0	0	15

MALCOM HARDEN — **FY2017 MISDEMEANOR COMPETENCY STATISTICS**

MONTH	BEGINNING # OF CASES	NEW CASES THIS MONTH	TBJ	TBC	Alt. Trial Dispos.	PLEAS	REVO-CATIONS	DISMISSALS	PROBATION	COMP. HRG.	EXTENSIONS	CIVIL COMMIT.	MHMR REFERRAL	CONSULTS	OTHER	ENDING # OF PEOPLE IN OCR
September	140	22	0	0	0	2	0	22	0	18	4	1	0	0	0	18

September — **MI Court**

MONTH	TOTAL NEW CASES RECEIVED	NEW CLIENTS AT GREEN OAKS	NEW CLIENTS AT MEDICAL CENTER MCKINNEY	NEW CLIENTS AT PARKLAND	NEW CLIENTS AT DALLAS BEHAVIORAL HEALTH	NEW CLIENTS AT GARLAND BEHAVIORAL	NEW CLIENTS AT ZALE LIPSHY	NEW CLIENTS AT SUNDANCE BEHAVIORAL HEALTHCARE	NEW CLIENTS AT HICKORY TRAILS	NEW CLIENTS AT METHODIST RICHARDSON	NEW CLIENTS AT DALLAS PRESBYTERIAN	NEW CLIENTS AT VA	NEW CLIENTS AT WELLBRIDGE	NEW CLIENTS AT TIMBERLAWN	PROBABLE CAUSE HEARINGS HELD	NO CONTEST COMMIT	CONTESTED COMMIT	FORCED MEDS HEARING IN COURT
L. ROBERTS	131	82	6	0	0	7	0	25	0	5	0	0	0	5	3	0	8	7
L. TAYLOR	64	0	0	10	15	4	6	23	6	0	0	0	0	0	0	1	2	2
R. BLACK	19	0	0	0	18	0	0	0	9	0	0	0	0	0	1	0	0	0

September

RANDA BLACK — **MI COURT** — *Number of new cases decreased due to increase in 46B cases.

MONTH	NEW CLIENTS	PROBABLE CAUSE HEARINGS HELD	NO CONTEST COMMIT TO TSH	CONTESTED COMMIT TO TSH	RECOMMITMENTS	MEDICATION HEARINGS	OUTPATIENT	JURY TRIAL
September	17	1	3	7	1	5	0	0

MICHAELA HIMES — **MHPR BOND STATS**

MONTH	INITIAL ELIGIBILITY DAILY LIST	MHPR BOND APPOINTMENTS FROM DAILY LIST	MHPR BOND HEARING-GRANTED	MHPR BOND HEARING-DENIED	TOTAL HEARINGS
September	1440	188	62	5	67

	Past Year Avg	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	2017-08	2017-09	Average:	Sum:
Total Service Episodes:	768	704	717	551	694	900	1,191	959	846	806	776	855	702	**808.42**	**9,701**
Total Unique CID:	589	696	672	477	591	763	959	749	592	560	520	545	440	**630.33**	**7,564**
Total Unique SID:		695	671	476	590	762	957	747	592	560	519	545	440	**629.5**	**7,554**
% Change to DY 4 by CID		118.17%	114.09%	80.98%	100.34%	129.54%	162.82%	127.16%	100.51%	95.08%	88.29%	92.53%	74.70%		

Total Encounters by Type:		2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	2017-08	2017-09	Average:	Sum:
Triage		704	717	551	694	900	1,191	959	846	806	776	855	702	**808.42**	**9,701**
Care Coordination		2,736	2,532	2,304	2,626	2,588	2,943	2,239	2,330	2,689	2,225	2,721	2,304	**2,519.75**	**30,237**
F2F Encounter		242	255	252	211	237	292	301	361	403	344	468	401	**313.92**	**3,767**
Sum:		**3,682**	**3,504**	**3,107**	**3,531**	**3,725**	**4,426**	**3,499**	**3,537**	**3,898**	**3,345**	**4,044**	**3,407**	**3,642.08**	**43,705**

F2F Encounter		2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	2017-08	2017-09	Average:	Sum:
MHPR Bond								77	163	155	141	243	218	**166.17**	**997**
Non-MHPR		242	255	252	211	237	292	224	198	248	203	225	183	**230.83**	**2,770**
Sum:		**242**	**255**	**252**	**211**	**237**	**292**	**301**	**361**	**403**	**344**	**468**	**401**	313.92	3,767

	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	2017-08	2017-09	Average:	Sum:
Service Episodes:	704	717	551	694	900	1,191	959	846	806	776	855	702	**808.42**	**9,701**

Unique Consumers:	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	2017-08	2017-09	Average:	Sum:
By N* ID	602	598	423	500	531	626	529	460	444	373	395	238	**476.58**	**5,719**
By Client ID	94	74	54	91	232	333	220	132	116	147	150	202	**153.75**	**1,845**
TOTAL Unique Consumers:	**696**	**672**	**477**	**591**	**763**	**959**	**749**	**592**	**560**	**520**	**545**	**440**	**630.33**	**7,564**
TOTAL Unique Consumers as %:	**98.86%**	**93.72%**	**86.57%**	**85.16%**	**84.78%**	**80.52%**	**78.10%**	**69.98%**	**69.48%**	**67.01%**	**63.74%**	**62.68%**		

Unique F2F:	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	2017-08	2017-09	Average:	Sum:
By N* ID	185	186	165	118	111	154	179	209	227	177	224	139	**172.83**	**2,074**
By Client ID	40	37	30	34	66	75	63	79	68	74	108	134	**67.33**	**808**
TOTAL Unique F2F:	**225**	**223**	**195**	**152**	**177**	**229**	**242**	**288**	**295**	**251**	**332**	**273**	**221.69**	**2,882**
TOTAL Unique F2F as %:	**92.98%**	**87.45%**	**77.38%**	**72.04%**	**74.68%**	**78.42%**	**80.40%**	**79.78%**	**73.20%**	**72.97%**	**70.94%**	**68.08%**		

	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	2017-08	2017-09		Average:
F2F Percentages:	34.38%	35.56%	45.74%	30.40%	26.33%	24.52%	31.39%	42.67%	50.00%	44.33%	54.74%	57.12%		**39.76%**

Triage 12	7,549
Recidivism 12-12	1,969
Recidivism 12-12%	26.08%

Triage 6	4,148
Recidivism 6-6	555
Recidivism 6-6%	13.38%

Triage 6	4,148
Recidivism 6-12	1,434
Recidivism 6-12%	34.57%

	October	November	December	January	February	March	April	May	June	July	August	September
Year MO	2016/10	2016/11	2016/12	2017/01	2017/02	2017/03	2017/04	2017/05	2017/06	2017/07	2017/08	2017/09
Recidivism 12-12	9	66	128	203	345	552	745	971	1,182	1,432	1,701	1,969
Triage 12	695	1,365	1,841	2,431	3,192	4,148	4,894	5,486	6,046	6,564	7,109	7,549
Recidivism 12-12%	1.29%	4.84%	6.95%	8.35%	10.81%	13.31%	15.22%	17.70%	19.55%	21.82%	23.93%	26.08%

	October	November	December	January	February	March	April	May	June	July	August	September
Year MO	2016/10	2016/11	2016/12	2017/01	2017/02	2017/03	2017/04	2017/05	2017/06	2017/07	2017/08	2017/09
Recidivism 6-6	9	66	128	203	345	552	555	555	555	555	555	555
Triage 6	695	1,365	1,841	2,431	3,192	4,148	4,148	4,148	4,148	4,148	4,148	4,148
Recidivism 6-6%	1.29%	4.84%	6.95%	8.35%	10.81%	13.31%	13.38%	13.38%	13.38%	13.38%	13.38%	13.38%

	October	November	December	January	February	March	April	May	June	July	August	September
Year MO	2016/10	2016/11	2016/12	2017/01	2017/02	2017/03	2017/04	2017/05	2017/06	2017/07	2017/08	2017/09
Recidivism 6-12	9	66	128	203	345	552	732	906	1,044	1,180	1,317	1,434
Triage 6	695	1,365	1,841	2,431	3,192	4,148	4,148	4,148	4,148	4,148	4,148	4,148
Recidivism 6-12%	1.29%	4.84%	6.95%	8.35%	10.81%	13.31%	17.65%	21.84%	25.17%	28.45%	31.75%	34.57%

Transicare Reporting — Crisis Services Project

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Beginning Census	115	115	107	103	98	123	127	140	133	146	159
REFERRALS	46	33	32	23	42	56	79	76	78	78	75
Admissions											
Referred Admitted	**19**	**18**	**16**	**8**	**26**	**28**	**30**	**19**	**32**	**30**	**34**
No Admit Client Refusal	2	1	1	2	0	1	2	1	2	1	0
No Admit Criteria	1	1	3	0	1	0	1	0	3	0	3
No Admit Structural	2	6	2	2	2	3	5	5	1	2	5
Pending	22	7	10	11	13	24	41	54	40	23	33
PRIOR PENDING											
Pending Admitted	**12**	**17**	**2**	**4**	**8**	**11**	**17**	**18**	**23**	18	5
No Admit Client Refusal	3	3	4	1	0	0	0	1	0	2	1
No Admit Criteria	2	1	1	1	0	0	0	1	2	1	5
No Admit Structural	0	4	3	4	1	1	4	2	2	2	19
Total Admissions	**31**	**35**	**18**	**12**	**34**	**39**	**47**	**37**	**55**	**48**	39
Discharges											
Success Transfer	7	3	4	3	2	4	5	6	3	1	3
DC Midterm Disengage	12	16	6	2	4	4	4	13	12	11	23
DC Rapid Disengage	6	6	2	4	2	14	5	10	9	12	14
DC Structural	6	18	10	9	1	13	20	15	18	11	10
Total Discharged	**31**	**43**	**22**	**18**	**9**	**35**	**34**	**44**	**42**	**35**	50
Active End Of Month	115	107	103	97	123	127	140	133	146	159	
Outcome Data											
Terrell State Hospital Linkages											
≤7 Connect To Prescriber	1	6	2	1	4	6	2	4	5	3	5
≤30 Connect To Prescriber	0	1	0	0	0	0	0	0	0	0	
Missed Metric	1	3	0	1	3	3	0	1	0	0	0
Total Released	2	10	2	2	7	9	2	5	5	3	5
Cummulative ≤7 Connect %	50.0%	58.3%	64.3%	62.5%	60.9%	62.5%	64.7%	66.7%	70.5%	72.3%	75.0%
Cummulative ≤30 Connect %	50.0%	66.7%	71.4%	68.8%	65.2%	65.6%	67.6%	69.2%	72.7%	74.5%	76.9%
Missed Metric	50.0%	33.3%	28.6%	31.3%	34.8%	34.4%	32.4%	30.8%	27.3%	25.5%	23.1%
Unduplicated Served											
Monthly Unduplicated	**141**	**141**	**124**	**111**	**120**	**155**	**156**	**162**	**183**	**206**	**205**
DSRIP YTD Unduplicated Served	141	180	209	227	259	308	352	397	460	530	664
Encounter Data											
F2F Encounter	848	840	730	753	802	855	1019	1196	1333	1368	1375
Care Coord	198	138	113	82	30	117	119	108	53	58	63
Total	1046	978	843	835	832	972	1138	1304	1386	1426	1438

Forensic Diversion Unit (FDU) Report

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Beginning Census	**47**	**46**	**50**	**45**	**44**	**47**	**50**	**47**			
Number of Referrals Received from CSP											
Adapt	7	8	16	12	20	17	8	15			
Metrocare	0	0									
Transicare	0	0									
DA	0	0									
Number of Admissions	5	8	10	7	9	8	6	7			
Number Discharged	0	4	10	3	6	5	9	3			
Number not admitted due to:											
Client qualifies for ACT	0	0	0	2		4		1			
Client qualifies for other programs	1	0	0								
Client didn't meet level of need required	0	0	0				1	2			
Other reasons	0	0	0	3	7	5	1	5			
Average Service Utilization:											
Average hours seen	7.22	6.46	6.36	6.52	6.72	5.19	6.18	10.32			
Encounter Breakdown:											
Face to Face	254	275.25	245	264.25	269	240.28	298.75	324.54			
Service Coordination	193	225	215	188	296	210.25	239	181.75			
Number of clients accessing:											
Emergency Room (medical)	0	0	0		0	0	0	0			
23-hour observation (psych)	1	1	0	1							
Inpatient (med/ psych)	0	0	0		2	2	1	1			
Jail book-in	10	2	0	1	5	5	2	5			
Reasons for Discharge:											
Graduate		0	0		1	1	0	1			
Client Disengagement	2	3	0	3	3	1	7	2			
Extended Jail stay (case-by-case basis)		0	0		1						
Other Intervening factors		1	0	2	1	1	2	1			
End of Month Stats:											
Number of Active FDU clients end of month	**46**	**50**	**48**	**44**	**47**	**50**	**47**	**50**			
Number of Unique Consumers	2	0	2	0	47	50	47	50			
# of clients waiting to be released from jail	11	12	15	12	14	9	8	6			
Average Length of stay on FDU (month)	12.27	11.38	7.72	8.06	6.33	5.54	5.63	5.99			
Maximum Census	**46**	**46**	**46**	**46**	**46**	**46**	**46**	**46**			

SEPTEMBER 2017 Monthly Report

report reflects up to August 25th, 2017

Dallas County Crisis Services Program	Program Specific and Systems Update	Summary of NTBHA's Monthly Activities	Action Items/Concerns
1	**Adapt Community Solutions (ACS)** – Targets member released from jail using ACS to ensure continuity of care	Conducted case consultations on approximately 22 referrals.	Not Applicable
2	**Transicare Post Acute Transitional Services (PATS)** – Targets high utilizers released from jail with more intensive need to ensure continuity of care	Provided case consultation and clinical support during PATS/FACT case review. Completed hospitalization/benefit inquiries for 2 clients. Coordinated ACT referral for 1 client	Not Applicable
3	**ACT Forensic Diversion Unit (FDU)** – Provides ACT services for high utilizers of the legal system. Responsible for approving evaluations of FDU referrals and FDU oversight	Clinical review of cases for appropriate LOC recommendations on 10 FDU referrals, 9 of which were approved for FDU assessment. Reviewed 4 recovery plans. There was no MD consult during this reporting period.	Not Applicable
4	**Caruth Smart Justice**	No documented activities during this reporting period.	Not Applicable
5	**CSP – Cottages Project** – Housing complex of 50 cottages that provides housing, mental health assessments and counseling for clients categorized as high utilizers of MH and judicial systems	MOU between NTBHA and City Square executed. 9 candidates reviewed	Not Applicable

The Cottages: Monthly Metrics Summary			
Metric Criteria	**July**	**Aug**	**Notes**
Property Management Overview			
Beginning Census	**45**	**44**	
Evictions	**3**	**2**	
Terminations	**0**	**2**	
Move-ins	**2**	**0**	
Ending Census	**44**	**40**	
Lease Violations	**20**	**15**	*In August, by 13 residents*
***New screenings for waitlist**	**4**	**16**	
DHA Inspections	**2**	**0**	
Total residents housed since opening	**52**	**52**	
Residents in Cottages for less than 90 days	**2**	**2**	
Residents in Cottages 90-180 days	**14**	**8**	
Residents in Cottages 181 days or more	**36**	**42**	
Metrocare Cottages			
Encounter Breakdown			
Psychosocial Rehab Individual Sessions	**74**	**138**	*In August, by 28 unique residents*
CBT sessions	**10**	**18**	*In August, by 11 unique residents*
ychosocial Group Sessions (clinical groups only)	**38**	**8**	*In August, by 6 unique residents*
Appointments made with prescriber	**39**	**41**	
Appointments attended	**21**	**27**	*In Auagust, by 21 unique residents*
Residents that were prescribed medication	**19**	**23**	
Incident Reports by Category			
Medical	**2**	**3**	*In August, by 2 unique residents*
Psychiatric	**1**	**0**	
Agression towards another resident	**-**	**-**	
New Behavioral Contracts	**-**	**-**	
Residents Accessing Higher Level of Care			
Emergency Room (Baylor and Parkland)	**34**	**43**	*In August, by 11 residents*
Psychiatric (inpatient and 23 hour obs)	**5**	**2**	
Jail Book-In	**6**	**5**	*In August, by 5 unique residents*
SUD Treatment Centers	**2**	**1**	
CitySquare Case Management			
Residents receiving case management services	**33**	**38**	
Residents served by Community Nurse	**11**	**11**	
Residents served by CitySquare Clinic	**5**	**6**	
Residents attending Lifeskills Groups	**10**	**5**	
Residents attending Community Groups	**27**	**29**	

CONFIDENTIALITY / RELEASE OF INFORMATION

TO BE COMPLETED BY CASEWORKER:

Effective Date: _____ **Expiration Date:** _____ **Client Name:** _____

CLIENT INFORMATION

NAME: _____

ADDRESS: _____ APT NO. _____

CITY/COUNTY/STATE/ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

STATEMENT OF CONFIDENTIALITY:

It is the policy of the CitySquare to treat your records as confidential and not disclose them, without your written authorization, subject to certain disclosures that are permitted or required by law. This means that confidential information will not be disclosed (even to family or household members) without your authorization.

In an effort, though, to provide all the services for which you are eligible, it is necessary that we have your authorization to release information to other participating agencies/entities/persons involved in providing services to you. This information may be entered into a computer database that other social service agencies are able to access. Services will be contingent on the CitySquare's ability to share information with these other agencies/entities/persons.

AUTHORIZATION:

I understand that confidential information may be shared with the agencies/ entities/persons checked below, and that such agencies/entities/persons may share confidential information with us, for the purpose of providing program services.

- x Dallas County Criminal Justice Dept.
- x MetroCare
- x North Texas Behavioral Health Authority
- x ADAPT
- x The Bridge Homeless Recovery Center
- x Texas Dept. of State Health Services
- x U.S. Dept. of Housing & Urban Development
- x Dallas Housing Authority
- x Dallas County Health & Human Services
- x Baylor Health Care System
- x UT Southwestern
- x Baylor University Medical Center
- x Texas Department of Assistive & Rehabilitative Services
- x Parkland Memorial Hospital
- x Social Security Administration
- x Veteran's Administration
- x Metro Dallas Homeless Alliance (MDHA)
- x Landlord/Mortgage Company
- x Homeless Services and Shelter Agencies
- x Emergency/Alternate Contact (listed below)
- x Homeless Management Information System (HMIS)
- x The Cottages at Hickory Crossing
- x Molina Healthcare of Texas
- x Efforts to Outcomes Data Base (ETO)
- x Superior Healthplan
- x AARP Foundation SCSEP Dallas County

___ Family: _____

___ Family: _____

___ Friend: _____

___ Friend: _____

___ Other: _____

___ Other: _____

EMERGENCY/ALTERNATE CONTACT:
In the event of an emergency or in the event that CitySquare is unable to contact me, I authorize CitySquare to contact the person below:

NAME: _____

ADDRESS: _____ APT NO. _____

CITY/COUNTY/STATE/ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CONTACT WITH CLIENT:	YES	NO
I authorize CitySquare to contact me by mail.	_____	_____
I authorize CitySquare to contact me at my home phone.	_____	_____
I authorize CitySquare to leave a message on my answering machine.	_____	_____
I authorize CitySquare to contact me at my work phone.	_____	_____
I authorize CitySquare to leave a message at my work.	_____	_____
I authorize CitySquare to identify itself by name.	_____	_____

Other Instructions:

_____

_____

_____

By signing below, I, the Applicant, authorize CitySquare to share confidential information with the agencies/ entities/persons identified above. I acknowledge that I may withdraw this authorization at any time in writing. I further release the program from all legal responsibility and liability that may arise from the action I have authorized here.

_____ _____
SIGNATURE OF APPLICANT DATE

REVIEWED BY:

_____ _____
SIGNATURE OF CASEWORKER DATE

Initial Screening Checklist

Individual's Information:

First, Middle & Last Name:_____

DOB: _____ SSN:_____ Gender:_____ Race:_____

Phone Number Individual Can Be Reached:_____

Mailing Address Individual Can Be Reached:_____

If Phone and Address are unavailable, where can the individual be most often located?:

1. Has the individual been to the hospital and/or had an ambulance called in the last 6 months?: ☐Yes ☐No
2. Has the individual been Criminal Justice System involved, or APPOW'd** in Dallas County?: ☐Yes ☐No
   ***Apprehension by a Peace Officer without a Warrant.*
3. Does the individual have a history of chronic homelessness that can be substantiated?: ☐Yes ☐No
4. Does the individual have a documented Priority Population Mental Health Diagnosis?: ☐Yes ☐No
   Note: A diagnosis of a Personality Disorder alone, without an above mentioned diagnosis will disqualify individuals from participation.
5. Is the individual ambulatory and capable of living independently?: ☐Yes ☐No

Interviewer's Additional Notes and Relevant Information:

Interviewer/Agency:_____

Interviewer's Contact Information:

Phone:_____ E-Mail:_____

If the individual answers Yes to all 5 questions, they can then be referred to The Cottages at Hickory Crossing for a comprehensive screening to ascertain eligibility to become a Resident. Please forward completed Checklist to: cottagesreferral@citysquare.org

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