



**Texas Department of State Health Services**

**Crisis Services Redesign**  
**Implementation Overview**

**February 6, 2008**

## *Introduction*

### *Background*

Some people experiencing a mental health or substance abuse crisis in Texas lack basic services that would help them avoid longer and more costly treatment. This situation has significantly contributed to a growing burden on other state and local services, particularly local emergency rooms, hospitals, and law enforcement agencies. In the absence of appropriate services, individuals experiencing a behavioral health crisis often end up in local emergency rooms and jails.

In December 2005, DSHS convened a diverse committee of experts and stakeholders to assess crisis services and make recommendations for improvements. The resulting report (Crisis Services Redesign Report, September 2006) identified an array of crisis services that are community based, rapidly deployed and focused on diversion from more restrictive or inappropriate care settings

### *Need*

Texas is facing a growing demand for mental health and substance abuse crisis services.

- The number of persons **currently served** by the Local Mental Health Authority (LMHA) that receive crisis services despite ongoing services over the course of one year is projected to increase 6% among adults and 74% among children from 2006 to 2009.
- The number of persons who are **not currently served** by the LMHA that receive crisis services is projected to increase 47% among adults and 195% among children from 2005 to 2009.

### *Current Funding*

The 80<sup>th</sup> Legislature appropriated \$82 million for the FY 08-09 biennium. Guided by the Legislature and in response to Rider 69, these funds should allow the state to make significant progress toward improving the response to mental health and substance abuse crises. This was a major and unprecedented appropriation specifically for a redesigned crisis service system. The first phase of implementation will focus on ensuring statewide access to competent rapid response services, avoidance of hospitalization and reduction in the need for transportation.

## *Crisis Services*

### *Description of Services*

Crisis redesign funds will be used to support the array of services recommended by the Crisis Redesign Committee and outpatient competency restoration services allowed for under Senate Bill 867, 80<sup>th</sup> Texas Legislature. This overall effort is associated with transforming the mental health system in Texas. It also links to the many community organizations that play a role in mental health and the state's larger public health care system.

In addition, LMHAs may use some of the dollars to help defray transportation costs incurred by local law enforcement agencies related to behavioral health crises. Two processes will be used to distribute crisis redesign funds. A majority of the funds will be divided among the state's Local Mental Health Authorities (LMHAs) and added to their existing contracts to fund enhanced crisis services. In addition, a portion designated as Community Investment Incentive funding will be awarded on a competitive basis to communities who are willing to contribute at least 25% in matching resources. Funds will be available for the following services:

- **Initial crisis services.** The first priority for funds allocated directly to Local Mental Health Authorities (LMHAs) will be ensuring a minimum level of the critical crisis services that provide rapid and mobile response to crisis situations: Crisis Hotline and Mobile Outreach Services. This will provide every county with basic crisis response capabilities, including identification, screening and stabilization of patients who can be safely treated in the community.
  - **Hotline.** Crisis hotlines are a critical gateway to behavioral health services, offering continuously available, toll-free telephone service 24 hours per day, 7 days per week to clients of all ages. Hotlines will be staffed by trained and competent paraprofessionals that may answer the hotline and provide information and non-crisis referrals; however, trained and competent Qualified Mental Health Professionals (QMHP-CSs) will provide screening and assessment of the nature and seriousness of the call. As part of crisis redesign, all hotlines will become accredited by the American Association of Suicidology (AAS).
  - **Mobile Outreach.** Mobile outreach services operate in conjunction with crisis hotlines and provide emergency care, urgent care, and crisis follow-up in the child, adolescent, or adult's natural environment. Mobile services allow immediate access to assessment and crisis resolution, regardless of the time and place of the precipitating event or the individual's transportation resources. A mobile crisis outreach team may also provide temporary services in the community to individuals who need psychiatric treatment but will not use the traditional system to access care. Often these individuals have urgent needs but do not meet criteria for involuntary detention. Mobile outreach crisis teams work closely with law enforcement and other local crisis responders.
- **Enhanced local crisis services.** Once the minimum level of initial services has been achieved, local communities will come together to develop a plan to use their remaining funds to establish or expand additional crisis services recommended by the committee. This allows communities to enhance their crisis service infrastructure for more extensive response and stabilization options, such as:
  - **Outpatient Crisis Services.** Office-based outpatient services for adults, children and adolescents provide immediate screening and assessment and brief, intensive interventions focused on resolving a crisis and preventing admission to a more restrictive level of care. These services serve two purposes: ready access to psychiatric assessment and treatment for new patients with urgent needs, and

access to same day psychiatric assessment and treatment for existing clients. Additionally, these services provide treatment for patients who are not currently likely to hurt themselves or others but who might develop an emergency if they do not receive same-day services. Clinicians are available during appropriate hours to treat individuals with fairly severe needs if a brief, moderately intensive, intervention might reduce the need for a more intensive level of care. Available services may include brief therapy, pharmacotherapy, and case management services.

- **Children’s Outpatient Crisis Services.** Children’s outpatient crisis services provide flexible, multi-faceted, and immediately accessible services when children and adolescents are at high risk for hospitalization or out-of-home placement. These specialized services are provided in the child’s living environment or in other settings, primarily in the home, and are designed to be family-focused, intensive, and time-limited.
- **Extended Observation Units.** Extended observation is an essential component of the crisis service array that can reduce unnecessary incarceration and inpatient psychiatric interventions. It includes provision of comprehensive psychiatric emergency services with the goal of comprehensive assessment, rapid stabilization, and appropriate aftercare planning, and can include up to 23-48 hours of observation and treatment. These services provide immediate access to emergency care at all times and have the ability to safely and appropriately manage the most severely ill psychiatric clients. Services are delivered in a secure and protected environment that is generally co-located with a DSHS-licensed hospital or crisis stabilization unit.
- **Crisis Stabilization Units (CSU).** CSUs provide short-term residential treatment designed to reduce acute symptoms of mental illness. Services are provided in a secure and protected environment that is licensed under Chapter 577 of the Texas Health and Safety Code and Title 25, Part 1, Chapter 411, Subchapter M of the Texas Administrative Code (relating to Standards of Care and Treatment in Crisis Stabilization Units). CSUs are clinically staffed and psychiatrically supervised, and provide immediate access to emergency care.
- **Crisis Residential Services for Adults and Children.** Crisis residential services provide short-term, community-based residential, crisis treatment to adults, adolescents, and children with some risk of harm to self or others who may have fairly severe functional impairment. These facilities provide a safe environment with clinical staff on site at all times however they are not designed to prevent elopement and individuals must have at least a minimal level of engagement to be served in this environment. Utilization of these services is managed by the Local Mental Health Authority (LMHA) and is based on medical necessity. The recommended length of stay is from 1-14 days. In the event that these services are provided for all age groups, adults, adolescents, and children must be served in separate environments of care.

- **Crisis Respite for Adults and Children.** In contrast with crisis residential services, crisis respite services provide short-term, community-based residential, crisis treatment to persons who have low risk of harm to self or others and may have some functional impairment who require direct supervision and care but do not require hospitalization. These services can occur in houses, apartments, or other community living situations and generally serve individuals with housing challenges or assist caretakers who need short-term housing or supervision for the persons for whom they care to avoid a mental health crisis. Utilization of these services is managed by the LMHA based on medical necessity. Crisis respite services may occur over a relatively brief period of time, such as a 2-hour service to allow a caretaker to complete necessary tasks or on a full day basis.
  
- **Community Investment Incentive**
  - **Psychiatric Emergency Service Center with Extended Observation services.** A portion of the Community Investment Incentive funds will be used for Psychiatric Emergency Service Centers that provide intensive crisis services for one or more counties or local service areas. These sites will be co-located with a licensed hospital or CSU and be equipped to treat severely ill children, adolescents and adults. They will provide emergency psychiatric services with extended observation and, for individuals who cannot be stabilized within 23-48 hours, treatment in an inpatient hospital unit or CSU for up to 14 days. Establishing these facilities will substantially increase the number of communities and individuals with access to such services. It will also encourage communities to pool their resources to achieve economies of scale and ensure the most efficient capacity utilization.
  
  - **Projects for jail diversion or alternatives to State hospitalization.** Community Investment incentive funds may also be requested for other community based projects that focus on diverting individuals from incarceration or providing alternatives to State hospitalization. These projects include crisis residential services, Crisis Stabilization Units, 23-48 hour holds, crisis respite, purchasing or local hospital beds and associated services that provide residential alternatives to incarceration or State hospitalization. Jail diversion projects minimize officer wait time and divert individuals prior to booking.
  
  - **Outpatient Competency Restoration Services.** Additional Community Investment Incentive funds will support outpatient competency restoration services. DSHS proposes to extend its ability to provide competency restoration services beyond State Mental Health Hospital (SMHH) based programs through the development and enhancement of the mental health crisis system. It is expected that DSHS will partner in this program with Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI). A successful outpatient competency restoration program would enhance the ability of communities to provide effective treatments to individuals with mental illness involved in the legal system while reducing unnecessary burdens on jails and state

psychiatric hospitals. Competency restoration services provide psychiatric stabilization in conjunction with any needed training in courtroom skills and behavior.

It is anticipated that outpatient competency restoration programs established under this initiative will have available for use, as needed and appropriate, a curriculum adapted from the inpatient competency restoration curriculum used at North Texas State Hospital-Vernon Campus and the current DSHS community mental health Resiliency and Disease Management system. The model will require strong collaborative efforts among local judges, jail officials, community mental health systems, as well as community-based organizations providing support services. Additionally, DSHS is working with providers of outpatient competency restoration programs in other states to incorporate effective and successful strategies into the Texas model. Implementation will include judicial outreach and education as needed to support the initiative.

### ***Contractual Service Requirements***

Parameters and expectations for use of Crisis Redesign funding will be specified in LMHA performance contracts. There are two main expectations described in the proposed LMHA performance contract language: **local planning and maintenance of current crisis funds.**

#### ***Local Planning***

Funds will be distributed among the state's LMHAs, who will be responsible for working with other community stakeholders to determine the best use of those dollars to meet local needs. In the NorthSTAR area, the North Texas Behavioral Health Authority will be responsible for working with local stakeholders to develop a plan for utilization of the new dollars. Because of the organizational structure of the NorthSTAR initiative, however, funds will be given directly to Value Options, the managed care company that operates the NorthSTAR service delivery system.

While the new funding must be directed to the array of initial crisis services identified in the Crisis Services Redesign Report, the specific mix of services to be implemented will be based on a community's needs, priorities, and existing resources. Within the framework provided by the state, local decision-making will play a significant role in determining the final distribution of dollars among the identified service categories. This may result in some variance between the allocation of dollars presented in the state's initial legislative appropriations request and actual expenditures at the local level.

As part of its local planning process, every LMHA will be required to develop a local crisis services plan based on the needs and priorities of the community and designed to meet the following objectives:

- Rapid response
- Local stabilization when possible

- Jail diversion and reduced burden on local law enforcement
- Decreased utilization of other emergency healthcare resources (e.g., local emergency rooms)

Plans must describe how existing crisis services will be realigned to provide an integrated crisis system built around the recommended best practices. Stakeholder participation is a key feature of the planning process, and ideally should include representation from clients, family members and child and adult advocates, mental health service providers, emergency healthcare providers, representatives from the local public health department or Federally Qualified Health Center, substance abuse providers, and representatives from law enforcement, probation and parole departments, and the judiciary. Local crisis planning will be required to specifically address the needs of children and adolescents as well as adults and demonstrate strong coordination with law enforcement, healthcare, and child protective services.

At a minimum, local plans must ensure a basic infrastructure of crisis services to include:

- An AAS-accredited hotline with two or more qualified crisis workers on duty 24/7.
- Mobile crisis outreach services available with sufficient capacity to provide on-site response from one or more Qualified Mental Health Professionals.

Additional services to be provided will be determined by the LMHA based on local needs and priorities, existing infrastructure, available funds and current collaborative activities. Local plans must also describe strategies to maximize dollars available to provide crisis services, including collaborations with local and regional stakeholders and other LMHAs. Authorities are expected to examine opportunities to minimize overhead and administrative costs through cost sharing and joint service delivery.

Local crisis redesign plans will be due by mid October 2007 and must be approved by DSHS. It is expected that the LMHAs will begin to implement their initial approved plan by the second quarter of FY 2008. Local planning is essential for the maintenance and expansion of community investment in the crisis delivery system and is an ongoing process.

### ***Maintenance of Current Crisis Funds***

LMHAs currently invest significant dollars in their crisis systems. While these investments are significant, they are insufficient to support effective crisis services, which prompted DSHS' legislative request for crisis redesign. The intended use of the new dollars was articulated to the legislature as redesigning the crisis system by investing additional resources into crisis services to improve response and effectiveness rather than using the new funding to supplant funds currently spent on crisis services. If a re-deployment or removal of resources currently utilized for crisis services occurred, it would likely result in limited crisis services improvements from the new crisis funding.

To avoid this, language will be included in LMHA performance contracts requiring Centers to maintain current crisis services funding levels so that the new crisis services funding will be used for new and expanded services. The presence of performance

outcome measures and active local planning will encourage communities to maintain current spending levels to protect their state allocations and generate legislative support for continued and even increased levels of state investment.

## *Allocation of Crisis Services Funding*

### *Allocation Methodology*

The proposed allocation is consistent with the proposed use of funds described in the Legislative Appropriation Request (LAR). The new funds will be divided into four portions.

- **Equity Contribution.** The first portion (32%) will be used to improve equity in state funding allocations among LMHAs as required by the state legislature. Under the Department's long term plan, new funds are to be allocated in a way that improves equity. Funds in this category will be directed only to LMHAs with below average per capita funding levels.
- **Proportional Allocation.** The second portion (36%) will be divided proportionally among LMHAs, based primarily on the population of each local service area. This includes a basic allocation to ensure sufficient funding for each LMHA to implement the initial crisis service requirements.
- **Community Investment Incentive.** Most of the remaining funds (30%) will be offered to communities/regions willing to invest a significant level of local resources in the development of emergency psychiatric service centers, projects that focus on diverting individuals from incarceration or finding alternatives to State hospitalization, and outpatient competency restoration services. These funds will require a minimum 25% local match and will be awarded to LMHAs offering the best value to the State of Texas.
- **State Expenditures.** DSHS will reserve approximately 1.5% of the funds to cover state costs for crisis redesign implementation.

### *Equity*

There is great disparity across Texas in the per capita funding and availability of public mental health services. These inequities had their origins from the 1960's through the early 1980's as the allocation of funds was primarily driven by each local authority's ability to negotiate for available funding. In 1982, the Texas Department of Mental Health and Mental Retardation (TDMHMR) took the first step to address the funding inequities by allocating new dollars mainly on the basis of population. Because the allocation of new dollars to the state for mental health services has been relatively stable over the years, achievement of equity has been limited. Despite refinements in funding allocation methodology, substantial inequities remain.

The proposed methodology will allocate approximately 32% (approximately \$27 million) of the funds over the course of biennium to bring under-funded LMHAs up to the current state average of per capita funding. The 32% was arrived at after balancing many factors, including the effort to bring as many centers as possible up to the current state average per capita funding while trying to keep as close as possible to the roughly 1/3 allocation

for equity as outlined in the exceptional item request. Under this approach, all but two of the LMHAs will reach the current per capita average, and the rate for the remaining two will be over 90% of the current average. If these funds were not used to address equity, disparity among LMHAs allocations would become greater as a result of the allocation of the rest of the crisis services funds.

### ***Proportional Distribution***

Approximately 36% of the new funds (almost \$30 million) will be divided among all LMHAs in a proportional allocation. Under a simple per capita distribution of funds, many Centers would not receive sufficient dollars to allow full implementation of the required initial crisis services. Therefore, DSHS adopted a hybrid proportional allocation methodology. First, all Centers will be given an amount sufficient to implement the initial crisis services (hotline, mobile outreach). This amount was determined using cost models that account for differences between heavily populated urban areas and less populated rural areas. The remaining funds designated for proportional allocation will be distributed according to a straight per capita formula. This per capita distribution will be limited to LMHAs whose allocation for initial crisis services is less than the amount they would have received if all of the dollars designated for proportional allocation was distributed using the simple per capita formula. This necessary distribution is why more than 1/3 of the total crisis funds are allocated in this category.

### ***Community Investment Incentive***

To leverage the state's investment in crisis redesign services, around 30% of the funds (approximately \$24 million) will be used as a Community Investment Incentive. Communities willing to invest a significant level of new local resources to support crisis services will be eligible for these funds. These dollars will be awarded through a competitive process and will require communities to provide at least 25% in matching resources with the expectation that ongoing local funding will be available to these sites once selected.

Community Investment Incentive funds will be reserved for the establishment of Psychiatric Emergency Service Centers, projects focusing on diverting individuals from incarceration or alternatives to State hospitalization (26%) and Outpatient Competency Restoration programs (4%). These are highly specialized and resource-intensive services that serve severely ill psychiatric clients. Because it would not be cost-effective to establish these services in communities across the state, award criteria will be designed to ensure efficient utilization of these funds. Funding of all projects will be competitive and based on resource availability.

- **Selection of Psychiatric Emergency Centers.** All LMHAs will be eligible to compete for funding to establish Psychiatric Emergency Service Centers. However, to ensure the development of strategically located sites that serve the needs of a geographic area of one or more counties or local service areas and population base, applications may represent a collaboration of multiple authorities. Criteria used to evaluate proposals will include:
  - Extent of local and regional collaboration;

- Level of coordination with local and regional healthcare and law enforcement;
  - Program design, including integration with other local and regional crisis services;
  - Size of geographic area to be served;
  - Size of population to be served; and
  - Demonstrated need for 23-48 hour observation services, including utilization of existing capacity in the region.
- **Selection of Projects for Jail Diversion or Alternatives to State Hospitalization.**  
All LMHAs will be eligible to compete for funding for projects that focus on diversion from incarceration prior to booking or state hospitalization. Criteria used to evaluate proposals will include:
    - Minimization of officer wait time;
    - Local collaboration and support, or coordination with judiciary system and law enforcement;
    - Timeliness of implementation; and
    - Clinically appropriate program design.
- **Selection of Outpatient Competency Restoration Sites.** DSHS will support a limited rollout of the outpatient Competency Restoration program to meet both state and local goals. Four sites will be funded based on:
    - Demonstrated need;
    - Integration with existing services;
    - Level of coordination with judiciary system and law enforcement; and
    - Innovation and alignment with evidence-based practices including the integration of mental health, substance use treatment and physical health.

LMHAs will be eligible to compete for the outpatient competency restoration funds. It is anticipated that outpatient competency restoration programs will be active by the 3<sup>rd</sup> Quarter of FY08. Every effort will be made to make quality programs available as soon as possible.

### ***State Expenditures***

The remaining funds (1.5% or about \$1.2 million) will be used by DSHS to support the crisis redesign initiative over the biennium. Expenses include:

- Hotline training necessary for LMHAs to attain AAS accreditation (\$456,321 or .56%);
- Four DSHS staff positions to provide support, training, and oversight for crisis redesign (\$435,569 or .53%); and
- An independent evaluation of the crisis redesign project (\$350,000 or .43%).

## *Stakeholder Involvement*

In December 2005, DSHS convened the Crisis Services Redesign Committee to develop recommendations for behavioral health crisis services that are delivered through the local mental health authorities in Texas. Individuals and organizational representatives of law enforcement, the courts, emergency medicine, community services, and advocacy, consumer, and professional and provider organizations were invited to participate. The Committee released its report in September 2006. In developing the content of the report, the Committee used three primary sources of information:

- A study of current biomedical and social services literature;
- The results of a DSHS quality management review of crisis services completed in December 2005; and
- Input gathered through a series of statewide hearings conducted in February 2006.

Stakeholder concerns and recommendations were central to the committee's process for assessing services and formulating recommendations. A key component of the DSHS quality management review was a survey mailed to sheriff departments, police departments, and licensed hospitals throughout Texas to obtain information about their experience with coordination and delivery of crisis services provided by LMHAs. The committee traveled across the state to hear public testimony in locations representing the border (Harlingen), rural areas (Big Spring and West Texas), and urban areas (San Antonio). A hearing concerning statewide issues was also held in Austin.

Communication with stakeholders has been vital and ongoing throughout the agency's redesign process. In February 2007, DSHS staff presented a report at the Behavioral Health Consortium and brought back stakeholder input to the agency's crisis redesign workgroup. A similar forum was addressed at the Texas Council of Community MHMR Centers Conference in late June 2007. Throughout the spring of 2007, DSHS staff worked with representatives from the Texas Council of MHMR Centers through meetings, teleconferences, and electronic communication. Input was gathered from individual LMHAs through written surveys and requests for information on specific topics. DSHS staff also visited the crisis service delivery systems in San Antonio, Harris County, Tarrant County, and Beaumont, gather valuable information from LMHAs, law enforcement personnel, healthcare providers, and other stakeholders. In the month of July, further stakeholder input was obtained through additional meetings with Texas Council of MHMR Centers representatives and its committees and the Mental Health Planning Advisory Committee of DSHS.

The crisis redesign implementation plan developed by DSHS will be refined in collaboration with stakeholders in a variety of forums during Summer and Fall 2007. These will include meetings and teleconferences with members of the original Crisis Redesign Committee, the Texas Council of Community MHMR Centers' crisis redesign committee, representatives of the Behavioral Health Consortium, consumer and family representatives, and consumer advocates. DSHS will also hold informational sessions for

local stakeholders in conjunction with its LMHA Crisis Redesign Workshops in September. These events will allow DSHS to receive feedback from a variety of sources and make appropriate revisions to its implementation plans.

DSHS program staff are currently developing a strategy to provide an open line of communication between DSHS and stakeholders during the implementation phase. As part of this strategy, DSHS will hold regular implementation teleconference calls with LMHAs. Initially, calls will be scheduled biweekly, with the frequency adjusted as the project continues. Other stakeholders will be updated through organizations such as the Mental Health Planning Advisory Committee (MHPAC) and quarterly provider association meetings such as the Association of Substance Abuse Programs (ASAP). The agency's crisis redesign webpage will provide another avenue for information-sharing and stakeholder input.

## ***Accountability***

DSHS is putting measures into place to ensure that these crisis funds are used effectively and efficiently. Components of DSHS' plan for accountability include ongoing training and technical assistance for LMHAs, requirements related to adherence to LBB performance measures as well as performance contract measures required by DSHS contracts with LMHAs, and quality management oversight.

### ***Crisis Redesign Training***

DSHS will provide information, training, and technical assistance to support implementation of the crisis redesign initiative. In the initial phase of implementation, regional workshops will be conducted for LMHAs regarding the implementation of crisis redesign. These workshops will include informational sessions for other stakeholders as needed. Topics will include:

- Crisis redesign overview;
- Minimum crisis services infrastructure requirements;
- Hotline accreditation process;
- Minimum standards for crisis services delivery;
- Performance measures;
- Reporting requirements;
- Opportunities for regional service systems; and
- Age appropriate crisis assessment and intervention strategies.

Additional information and technical assistance will be provided to Centers through regular teleconference calls, which allow individuals from all LMHAs to participate in a single conversation. DSHS will also develop a webpage that will enable LMHAs and stakeholders to access information, materials, resources related to crisis redesign, and progress regarding implementation.

### ***Hotline Training***

To attain American Association of Suicidology (AAS) accreditation, hotlines must ensure staff have intensive training and demonstrate competency. The proposed training strategy accomplishes two key objectives:

- Immediate access to quality hotline training for LMHAs across the state; and
- Development of a sustainable training infrastructure.

After examining other options, a training plan utilizing AAS resources was selected as the best strategy. AAS has developed a curriculum for training hotline workers and a hotline trainer certification program. AAS will provide two tracks of training relating to hotline services: a three-day training for hotline workers that meets AAS Level IV training requirements, and two additional days of training designed specifically to train trainers to deliver the AAS hotline worker curriculum. LMHAs may adopt an alternative curriculum with prior approval from DSHS.

To ensure adequate access throughout the state, DSHS plans to host AAS hotline training events in FY 08, which will include the two tracks mentioned above. These AAS hotline training events will be held in four locations: Dallas, Houston, Austin, and Corpus Christi.

Each participant that passes the AAS trainer certification exam will be qualified to teach the AAS hotline worker curriculum. Beyond the DSHS-hosted AAS hotline training events, these local trainers will provide training for other hotline workers. AAS will continue to provide training materials and support (such as production of participant certificates) for local training events. Neighboring LMHAs/hotlines will be encouraged to share training resources to achieve greater efficiency. Select DSHS staff in the MHSA Training and Technical Assistance Department will complete the two tracks mentioned above. This will enable DSHS to provide additional training events around the state and at the Behavioral Health Institute, further expanding access to hotline training.

### ***Measures of Success***

DSHS will hold LMHAs accountable for effective and efficient use of crisis redesign funds through the DSHS Performance Contract. The Performance Contract will contain a balanced package of crisis response system measures that describe the outcomes, outputs, and efficiencies expected for each LMHA's crisis response system. These crisis response system measures include:

Rider 69(b) allows DSHS to work with the LBB to develop statewide performance measures that will be reported on a quarterly basis. DSHS will propose the following measures to the LBB in the first quarter of FY08:

No.	LBB Measure	Type	Reporting Frequency	Definition
1	Number of Persons Receiving Crisis Residential Services Per Year Funded by New Crisis Redesign GR	OUTPUT	Quarterly	Unduplicated year-to-date number of persons who receive a crisis residential service (i.e., respite, crisis residential, crisis stabilization unit, extended observation, or inpatient psychiatric room and board) from Community Mental Health Centers including NorthSTAR during the fiscal year, and whose services are funded by the New Crisis Redesign General Revenue (NEW CR-GR) appropriation.
2	Number of Persons Receiving Crisis Outpatient Services Per Year Funded by New Crisis Redesign GR	OUTPUT	Quarterly	Unduplicated year-to-date number of persons who receive a crisis outpatient service (i.e., mobile crisis outreach team, crisis outpatient, or crisis follow-up) from Community Mental Health Centers including NorthSTAR during the fiscal year, and whose services are funded by the New Crisis Redesign General Revenue (NEW CR-GR) appropriation.
1	Percent of Persons with Medicaid Receiving Crisis Services that is followed by an ER Visit within 30 days	OUTCOME	Annual	The percent of persons with Medicaid receiving crisis services at Community Mental Health Centers including NorthSTAR that is followed by an ER visit within 30 days.
2	Percent of Persons Receiving Crisis Services that is followed by a Psychiatric Hospitalization within 30 Days	OUTCOME	Annual	The percent of persons receiving crisis services at Community Mental Health Centers including NorthSTAR that is followed by a State or Community psychiatric hospitalization within 30 days.
3	Percent of Persons Receiving Crisis Services that is followed by a Jail Booking within 7 Days	OUTCOME	Annual	The percent of persons receiving crisis services at Community Mental Health Centers including NorthSTAR that is followed by a jail booking within 7 days.
1	Average Amount of New Crisis Redesign GR Spent Per Person for Crisis Residential Services	EFFICIENCY	Quarterly	Average amount of New Crisis Redesign General Revenue (NEW CR-GR) spent per person for a crisis residential service (i.e., respite, crisis residential, crisis stabilization unit, extended observation, or inpatient psychiatric room and board) from Community Mental Health Centers including NorthSTAR during the fiscal year.
2	Average Amount of New Crisis Redesign GR Spent Per Person for Crisis Outpatient Services	EFFICIENCY	Quarterly	Average amount of new Crisis Redesign General Revenue (NEW CR-GR) spent per person for a crisis outpatient service (i.e., mobile crisis outreach team, crisis outpatient, or crisis follow-up) from Community Mental Health Centers including NorthSTAR during the fiscal year.

The LMHA expenditure report will also be revised to include specific reporting of budget and costs related to each LMHA's crisis response system. This will allow DSHS to accurately account for all crisis redesign funds and calculate the general costs to deliver crisis services.

### ***Oversight***

Over the biennium, DSHS will oversee the utilization of crisis funds through its quality management program and analysis of information in the data warehouse. The following are the kinds of tools that DSHS employs to assure proper oversight of behavioral health programs:

- Data monitoring, which includes evaluation of both performance and outcome data to identify needs for further oversight or technical assistance.
- Desk reviews, which includes monitoring crisis hotline services and reviewing submissions related to crisis redesign implementation.
- Stakeholder satisfaction assessment, which is anticipated to include a follow-up survey of law enforcement and hospital stakeholders using databases from the DSHS Licensing and Regulatory and the Department of Public Safety.
- On-site reviews, which include both reviews to evaluate adherence to clinical design and reviews based upon information and analysis of data of providers implementing new crisis services. These visits will allow the department to address problem areas and identify successful implementation of best practices to assist other local authorities.

### ***Independent Evaluation***

DSHS will contract with an independent entity for an evaluation of community health crisis services, which will be conducted in FY 09. The external evaluator will submit a comprehensive plan for the evaluation, including the data collection protocols and data analysis methodology prior to initiating the evaluation. The resulting report will include an analysis of the implementation and impact of services on clients, local communities, mental health and health care providers, and law enforcement. The evaluation will include a review of structural and process changes to determine how the crisis response and service delivery system is affected by crisis redesign. The impact will be examined through an analysis of changes in service delivery patterns and outcomes before and after crisis redesign implementation, using data collected through the DSHS information systems and other available sources.

It is anticipated that the external evaluator will periodically conduct on-site reviews and surveys of the Local Mental Health Authorities (LMHAs) to assess the procedures and processes LMHAs have in place for implementing crisis services. It will compile information on best practices observed during the reviews and provide recommendations to DSHS on improvements to the current system. Progress will be reported quarterly, with a summary submitted to DSHS at the end of FY 09. In addition, the evaluator will prepare a status report which will be submitted by DSHS to the Legislative Budget Board, the Governor, and the standing committees of the Senate and House of

Representatives having primary jurisdiction over health and human services no later than January 1, 2009.

## ***Implementation Milestones***

The following timeline includes key milestones required for crisis redesign implementation.

### **Quarter 4, FY 07**

- Local crisis plan requirements released
- Crisis Redesign Committee reconvenes with Dr. Lakey
- Implementation teleconference calls begin

### **Quarter 1, FY 08**

- Crisis Redesign Training
- Local Crisis Redesign Plans due
- Hotline worker training
- Hotline trainer training
- Outpatient Competency Restoration curriculum complete

### **Quarter 2, FY 08**

- New local crisis redesign services begin
- Psychiatric Emergency Services Center requirements released
- Psychiatric Emergency Services Center/Project proposals due
- Outpatient Competency Restoration requirements released (including eligible applicants)
- Outpatient Competency Restoration proposals due

### **Quarter 3, FY 08**

- Psychiatric Emergency Services Center/Projects selected
- Outpatient Competency Restoration sites selected
- Outpatient Competency Restoration sites begin operation

### **Quarter 4, FY 08**

- Psychiatric Emergency Services Centers/Projects begin operation
- All hotlines accredited

### **FY 09**

- External Evaluator selected
- Crisis Redesign Evaluation Report submitted to 81<sup>st</sup> Legislature

## ***Implementation Milestone Update***

DSHS implemented the following in the first and second quarter of FY2008:

### **Crisis Redesign Training:**

#### Quarter 1

- October 3, 2007 weekly conference calls to support implementation began and were scheduled each Wednesday afternoon through November. These calls were topic driven and included discussion of standards, local crisis service planning, utilization management, reporting, training needs etc. Additional implementation support calls are being scheduled throughout the next quarter.
- October 12, 2007 DSHS staff participated in the Texas Council of MHMR Centers Roundtable on Crisis Redesign as panel members.
- October 18, 2007 LMHAs, NorthSTAR, AAS, and DSHS Conference call training provided on how to become an AAS accredited Hotline.
- October 22, 2007 A statewide Crisis Redesign Overview training was held in Austin and presented by DSHS staff members.
- November 29, 2007 Crisis Redesign Frequently Asked Question sent to be published on the DSHS Website

### **Psychiatric Emergency Services Center requirements released (including eligible applicants)**

#### Quarter 1

- December 13, 2007 the requirements for a Proposal for Contract Amendment (PCA) to seek funding for Psychiatric Emergency Services Center and Crisis Service Projects for LMHAs and NorthSTAR Contractors were released.

#### Quarter 2

- Planned submission date for PCAs for Psychiatric Emergency Services Centers/Projects is February 29, 2008.

### **Local Crisis Redesign Plans**

#### Quarter 1

- October 31, 2007 initial local Crisis Service Plans were submitted by LMHAs and NorthSTAR to DSHS.
- November 16, 2007 DSHS staff completed review of the initial Crisis Service Plans and provided consultation LMHAs and NorthSTAR on individual plans
- November 21, 2007 DSHS sent local Crisis Service Plan electronic responses to LMHAs and NorthSTAR by DSHS with local Crisis Service Plan updates submitted by December 31, 2007.

#### Quarter 2

- December 31, 2007 DSHS received Crisis Service Plan updates.
- January 2, 2008 DSHS staff began reviewing the updated plans.
- January 15, 2008 DSHS began providing consultation on updated plans to LMHAs and NorthSTAR.
- January 21, 2008 DSHS began sending electronic responses for acceptable Crisis Service Plans

### **Hotline worker training**

#### Quarter 1

- November 5-7, 2007 the first of 4 regional training for Hotline workers was held in Dallas.

Quarter 2

- DSHS held AAS Hotline worker trainings in Houston December 10-14, 2007, Austin January 7-11, 2008 and Corpus Christi January 21-25, 2008.

**Hotline trainer training**

Quarter 1

- November 5-9, 2007 the first of 4 regional AAS training for Hotline trainers was held in Dallas.

Quarter 2

- December 10-14, 2007 the second of 4 regional AAS Hotline trainings was held in Houston.
- DSHS held additional AAS Hotline trainer trainings in Austin January 7-11, 2008 and Corpus Christi January 21-25 2008.

**Outpatient Competency Restoration curriculum complete**

Quarter 1

- November 30, 2007 DSHS adopted two Outpatient Competency Restoration curricula that may be used as needed based on assessment of each individual in the Outpatient Competency Restoration program.

**Outpatient Competency Restoration requirements released (including eligible applicants)**

Quarter 2

- December 13, 2007 the requirements for a Proposal for Contract Amendment (PCA) to request competitive funds for an Outpatient Competency Restoration Program for LMHAs and NorthSTAR were released.
- 8 PCAs from LMHAs and NorthSTAR were submitted to DSHS on or before January 31, 2008.
- DSHS staff began the review process for Outpatient Competency Restoration PCAs February 1, 2008.

**Additional Implementation activities in FY2008**

Quarter 1

- Performance Contract Amendments related to Crisis Redesign with LMHAs were executed.
- LBB performance measures and outcomes developed in collaboration with LBB.
- RFP for External Evaluation of Community Mental Health Implementation of Crisis Redesign was published and proposal submitted on October 31, 2007.

Quarter 2

- DSHS staff and external stakeholders reviewed External Evaluation proposal submitted
- DSHS selected External Evaluation proposal

## *Appendices*

***List of Acronyms***

AAS Association of American Suicidology  
CSU Crisis Stabilization Unit  
DSHS Department of State Health Services  
LAR Legislative Appropriations Request  
LBB Legislative Budget Board  
LMHA Local Mental Health Authority