

**2012 Houston Area Comprehensive HIV Services Plan
GAPS IN CARE AND OUT-OF-CARE WORKGROUP**

KEY QUESTIONS FOR EXPLORATION

DATA COLLECTION PACKET

October 21, 2011

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CPCDMS Client Registration Process Ryan White Part A

All clients are required to register in the CPCDMS in order to be eligible for Ryan White Part A services. Listed below are the steps required to complete the registration. **Registration information is confidential; no personal information (name, street address, phone number, etc.) is stored in the database.**

1. Client signs completed **Consent for Services** form.
2. Agency staff completes registration form with the client.
3. Agency staff screens the client for **Part A eligibility** (see below).
4. If the client provides **all necessary eligibility documentation** (HIV+ diagnosis, identity residency, income), the agency serves client.

NOTE: Part A primary care providers can only register/update clients receiving primary care from their primary care site.

Part A Eligibility Requirements

All persons seeking services must provide the documentation below in order to be eligible for services. All documentation presented during eligibility verification must be current - no greater than one year of the pre-printed date on the document or the date of original signature.

Required Documentation

Acceptable Forms of Documentation

HIV+ diagnosis¹ Acceptable signatories

- A licensed physician
- A licensed physician assistant
- A licensed nurse practitioner
- A registered nurse working under the supervision of a physician
- A licensed Master's level social worker (LMSW) working under the supervision of a physician (**only acceptable by Harris County – Ryan White Grant Administration**)

- A computer-generated HIV+ laboratory test (with confirmatory Western Blot or detectable viral load) with the individual's name pre-printed.
- A statement or letter signed by a medical professional indicating that the individual is HIV+, including the individual's name and the phone number of the medical professional.
- A medical progress note, hospital discharge paperwork, or other document signed by a medical professional indicating that the individual is HIV+, including the individual's name and the phone number of the medical professional.
- An anonymous HIV test result containing identifying information sufficient to ensure a reasonable certainty as to the identity of the test subject, e.g. gender and date of birth (**valid for only 60 days from the start of services at the agency**).

NOTE: Proof of HIV+ diagnosis does NOT have an expiration date and does NOT need to be updated. Proof of HIV+ diagnosis must be presented at all agencies where services are accessed.

¹ For services available to non-HIV+ persons, documentation of the client's relationship to an HIV+ person and the HIV+ person's diagnosis must be provided.

**Harris County Public Health & Environmental Services,
Ryan White Grant Administration Services**

CPCDMS Client Registration Process - Ryan White Part A

Required Documentation

Acceptable Forms of Documentation

**Verification
of identity**

- Texas Driver's License (Primary & Preferred ID)
- Texas Identification Card
- Texas Department of Corrections identification card
- Employment badge with picture
- Student ID with picture
- U.S. immigration documents with picture
- Credit card with picture
- Metro picture ID
- U.S. naturalization, citizenship, passport or other Federal documents with picture
- Driver's license or identification card issued by another US state
- A government-issued ID from a country other than the U.S.
- Birth certificate (cannot be used by married women)
- Social Security card
- Medicaid/Medicare card
- Letter on letterhead from another Social Service Agency
- Veterans Administration ID Card

**Verification
of residency
within
funding
source's
catchment
area**

Residency documentation for minors is required for a parent or guardian with whom the minor resides. Acceptable residency documentation:

- Valid copy of "CPCDMS Client Verification" form (Agencies Online who are NOT Record Owners)
- Current lease in the name of the client or listing the client as an occupant
- Property tax documents
- Utility/phone/cable/credit card bill in the name of the client
- Letter on company letterhead signed by the director of a recognized group home, care home or transitional living facility
- Business correspondence with the client's name and address pre-printed, e.g. auto registration, insurance, bank/brokerage statement, food stamp letter, Social Security letter, Medicaid letter
- Temporary agency affidavit signed and dated by client
- Letter on letterhead from a social service agency
- Supporter Statement with address and valid signature of client's supporter
- Payroll stub/copy of payroll check/bank statement - showing address

**Harris County Public Health & Environmental Services,
Ryan White Grant Administration Services**

CPCDMS Client Registration Process - Ryan White Part A

Required Documentation

Acceptable Forms of Documentation

**Verification
of household
income**

All clients must be screened for financial eligibility for Ryan White Part A funded services. Services should not be provided to clients whose household income exceeds the cap established by the Ryan White Planning Council for each service category.²

Documentation of income must be provided for all members of the client's household.³ Income documentation for minors is required for the parent(s) or guardian(s) with whom the minor resides.

Acceptable income documentation:

- Valid copy of "CPCDMS Client Verification" form (Agencies Online who are NOT Record Owners)
- Payroll stub/copy of payroll check/bank statement showing direct payroll deposit
- Letter from employer on company letterhead indicating weekly or monthly wages
- Unemployment benefits letter/copy of check
- IRS 1040 form (tax return)/W2 form/1099 form
- Social Security award letter
- VA benefits letter
- Private disability/pension letter on company letterhead
- Medicaid letter
- Child or spousal support order with judge's signature and date
- Food stamp award letter (TANF: Temporary Aid to Needy Families)

The following documentation is acceptable only for clients claiming no income:

- Agency temporary affidavit signed and dated by the client (valid for only 60 days from initial service date)
- Proof of application for Social Security (valid for 6 months only)
- Client living off savings: bank/investment account statements from 3 consecutive months showing withdrawals for living expenses
- Client being supported by someone else: statement signed and dated by the supporter, which includes the amount and type (room only, room and board, cash assistance, etc.) of support and the supporter's phone number for verification
- Homeless client: Verification letter on company letterhead from homeless services

² See the US Dept. of Health and Human Services Poverty Guidelines for the current year and the "Ryan White Federal Poverty Guidelines" table.

³ As per Federal definition, a same sex spouse or partner is not considered to be a household member.

**Harris County Public Health & Environmental Services,
Ryan White Grant Administration Services**

CPCDMS Client Registration Process - Ryan White Part A

RYAN WHITE PART A REGISTRATION SITES

AGENCY	REGISTRATION CONTACT	PHONE #
AIDS Foundation Houston		(713) 623-6796
Baylor College of Medicine	Kristin Close	(832) 322-1366
Bering Omega – Hospice Care	Sandy Stacy	(713) 341-3781
City of Houston	Cathy Wiley	(713) 794-2980
Fort Bend Family Health Center	Sylvia Teeple	(832) 342-0529 x138
Harris Co. Hospital District – HIV Services	William Slaughter	(713) 873-4183
Harris Co. Sheriff’s Office (jail)	Sam Lopez	(713) 426-0211
Houston Area Community Svcs	Ernesto Macias	(713) 426-0027
Legacy Community Health Svcs	Xiomara Espinal	(713) 830-3000
Montrose Counseling Center	Ryan Crawford	(713) 529-0037 x319
Saint Hope Foundation	Timika Sam	(713) 778-1300
UT Health Science Center (pedi)	Kecia Graham	(713) 500-6443
Veteran’s Administration	Belinda Essien Rainer	(713) 791-1414 x5292

Notes / Notas

Harris County Hospital District Gold Card

Gold Card del Distrito Hospitalario del Condado de Harris

How do I apply for a Gold Card?

Fill out the application: www.hchdonline.com/patient/Application283117-Eng-FINAL-05-2011.pdf

Mail the application to:

HCHD Financial Assistance Program
c/o Patient Eligibility Services Administration
PO BOX 300488
Houston, TX 77230

If you are a renewing patient, you can complete your renewal by mail. We will contact you if further information is needed to complete your application. If you need further assistance, please call 713-566-6509.

¿Cómo puedo obtener una Gold Card?

llene la solicitud: www.hchdonline.com/patient/Application283137-Span-FINAL-05-2011.pdf

Envíe la solicitud por correo a:

HCHD Financial Assistance Program
c/o Patient Eligibility Services Administration
PO BOX 300488
Houston, TX 77230

Si desea una renovación, puede realizar la renovación por correo. Nos pondremos en contacto con usted si necesitamos más información para completar su solicitud. Si necesita más ayuda, llame al 713-566-6691.

What to Mail in With Your Application:

To establish your eligibility requirements for an HCHD Gold Card, you will need to provide proof for the following six items. By providing these six items you will help ensure your Gold Card application goes smoothly. If you are having difficulty finding or providing any of the mentioned items, refer to the alternative proof links below, or call the nearest eligibility center to ask about other documents or proofs you may submit.

If you need help getting proof, the person interviewing you will help. Below is the list of items and alternative proofs needed to process your application:

Your Identity & Identity of Family Members

Possible proof: Driver's license or Texas Identification card, student ID with picture, employee job badge with picture, passport with picture, U.S. Immigration documents with picture, credit card with picture, ID issued by foreign consulates, marriage license, birth certificates, Social Security card, U.S. naturalization, citizenship or other federal documents, hospital or birth records, adoption papers or records, voter's registration card, or wage stubs,

Where You Live and Plan to Continue Living

You will need one proof: one dated within the past 60 days. Possible proof: utility bills; lease

Qué Debe Enviar con su Solicitud:

Para determinar si cumple con los requisitos para una Gold Card del HCHD, debe proporcionar comprobantes de los siguientes seis elementos. Esto ayudará a que su solicitud de la Gold Card se procese sin problemas. Si tiene problemas para encontrar o proporcionar alguno de los elementos mencionados, consulte los enlaces de comprobantes alternativos a continuación, o llame al centro de registro más próximo para preguntar qué otros documentos o comprobantes puede presentar.

Se le puede pedir que compruebe lo que haya escrito en su solicitud o lo que le haya dicho a la persona que lo entrevistó. Si necesita ayuda para conseguir los comprobantes, la persona que realiza la entrevista lo puede ayudar. O bien, puede pedir ver al director en el lugar de la entrevista. Éstos son algunos ejemplos de lo que se le puede pedir y cómo puede comprobarlo:

Su Identificación y la de los Miembros de su Familia

Como comprobantes, puede usar: su licencia de manejo o la credencial de identificación de Texas, una credencial de estudiante con fotografía, el gafete de empleado de su compañía con fotografía, un pasaporte con fotografía, los documentos de inmigración de EE.UU. con fotografía, una tarjeta de crédito con fotografía, una tarjeta de identificación emitida por un consulado extranjero, una licencia de matrimonio, actas de nacimiento, tarjeta de la seguridad social, documentos de naturalización o ciudadanía de EE.UU. u otros documentos federales, registros hospitalarios o de nacimiento, documentos o

Harris County Hospital District Gold Card Gold Card del Distrito Hospitalario del Condado de Harris

agreement; school records for minor children; mortgage coupon; rental verification form; Department of Motor Vehicles record; credit card statement; property tax statement; automobile insurance documents; automobile registration; printout from IRS of current tax year filing; certification documents or benefits checks from the Social Security Administration or Texas Workforce Commission; certification documents from Food Stamps, Medicaid or Medicare; letter from recognized social services agency; mail addressed to you or your spouse; statement from child care provider; current voter's registration card; Texas driver's license; ID card issued by the Department of public safety; domicile verification form completed by a reliable third person, post office records; city or criss-cross directory; telephone directory; or church records.

Domicile Verification Form:

www.hchdonline.com/patient/onecard/forms/HCHDDomicileVerificationENG.pdf

Household Income for the Past 30 Days

Possible proof: pay check stubs; pay checks; W-2 tax forms; wage verification letter; current year 1040 tax form; benefit letters; retirement checks or statements.

Statement of Support:

www.hchdonline.com/patient/onecard/forms/StatementofSupport-Eng-5-18-11.pdf

Self Employment Worksheet:

www.hchdonline.com/patient/onecard/forms/SelfEmploy283131-Eng-05-2011.pdf

HCHD Wage Verification Form:

www.hchdonline.com/patient/onecard/forms/wage283129-Eng-5-2011.pdf

HOUSEHOLD COMPOSITION (who lives with you)

Possible proof: birth certificate; baptismal record; most recent IRS 1040 form; Social Security Award letter for dependents; school documents; insurance documents; U.S. Immigration application; divorce or child support decree; baby's Popras form, birth fact record, or hospital armband); proof of school enrollment for students aged 18-23.

registros de adopción, tarjeta de registro de votante o comprobantes de nómina.

Su Domicilio y Dónde Tiene Previsto Seguir Viviendo

Necesita dos comprobantes: uno con fecha de los últimos 60 días y otro de hace un año. Comprobantes posibles: recibos de servicios; contrato de alquiler; registros escolares de menores; recibo de la hipoteca, forma de verificación de la renta, registro del departamento de vehículos automotores, estado de cuenta de la tarjeta de crédito, declaración del impuesto de propiedad, documentos del seguro del coche, registro de automóviles, copia impresa del IRS del registro del ejercicio fiscal en curso, documentos de certificación o cheques de prestaciones de la administración de la seguridad social o de la Texas Workforce Commission; documentos de certificación de Food Stamps, Medicaid o Medicare; carta de una agencia de servicios sociales reconocida, cartas dirigidas a usted o a su cónyuge, declaración de un proveedor de asistencia a menores, tarjeta de registro de votantes vigente; licencia de manejo de Texas; tarjeta de identificación emitida por el departamento de seguridad pública, forma de verificación del domicilio, que haya llenado una tercera persona de confianza, registros de correos; directorios cruzados o de la ciudad, directorio telefónico o registros de la iglesia.

Formulario para Verificación de Residencia:

www.hchdonline.com/patient/onecard/forms/Residence283130-Span-05-2011.pdf

Ingresos Familiares Durante los Últimos 30 Días

Comprobantes posibles: talones de los cheques de pago, cheques de pago, formas de impuestos W-2, carta de verificación de salario, forma 1040 de pago de impuestos del año en curso, cartas de prestaciones, cheques de pensión o estados de cuenta.

Apoyo de Sostenimiento:

www.hchdonline.com/patient/onecard/StatementofSupport-Span-5-18-11.pdf

Trabajo por Cuenta Propia Hoja de Cálculo:

www.hchdonline.com/patient/onecard/forms/SelfEmploy283131-Span-05-2011.pdf

Verificación de Salario:

www.hchdonline.com/patient/onecard/forms/Wage283139-Span-05-2011.pdf

Harris County Hospital District Gold Card Gold Card del Distrito Hospitalario del Condado de Harris

Immigration Status

You do not have to be a U.S. citizen to qualify for financial assistance. However, if you are not a citizen, and you have documentation from the INS, it must be presented to determine your eligibility for assistance.

Other Health Care Coverage

Possible proof: award or claim letters; insurance policies; court document; other legal papers.

Resources

If you have Medicare coverage and you want to apply for a discount on services and fees not covered by Medicare, you must provide proof of your resources and liabilities.

Medicare Asset Determination:

www.hchdonline.com/patient/onecard/forms/MedicareAssets283174-Eng-05-2011.pdf

Information on race and sex is voluntary. Information on Social Security Numbers should be given if available. These types of information will not change your eligibility.

You must give information about medical insurance and other third party financially liable for medical services paid under this program for yourself and members of your household. By signing and submitting this application, you are agreeing to give HCHD the right to recover the cost of health care services provided by HCHD from any third party.

You will be asked to apply for Medicaid, TANF (Temporary Assistance for Needy Families) or SSI (Supplemental Security Income) benefits. If you are asked to apply for one of these programs, you may still be eligible for assistance from HCHD for a limited period of time. If you cooperate with the application process and your application is denied, you may continue to be eligible for assistance from HCHD. However, if it is determined that you did not cooperate with the application process, you will no longer be eligible for assistance from HCHD.

After turning in your application, you must report within 14 days any changes in your address, income, people living with you, or application for (or receipt of) SSI, AFDC, or Medicaid. Failure to report these changes may result in losing your assistance from HCHD.

Composición Familiar (personas que viven con usted)
Comprobantes posibles: acta de nacimiento, fe de bautismo, forma IRS 1040 más reciente; carta de dependientes de la seguridad social; documentos escolares, documentos del seguro, solicitud al departamento de inmigración de EE.UU., sentencia de divorcio o de pago de alimentos a menores, forma Popras del nacimiento, registro de nacimiento o banda de identificación del hospital, comprobante de inscripción escolar, para estudiantes de 18-23 años.

Situación Migratoria

No tiene que ser ciudadano de EE.UU. para poder solicitar la ayuda económica. No obstante, si no es ciudadano y tiene documentos del Servicio de Inmigración y Naturalización (INS), debe presentarlos para determinar si cumple con los requisitos para recibir ayuda.

Otros Seguros Médicos

Posibles comprobantes: carta de solicitud o concesión del seguro, póliza, documento judicial u otros documentos legales.

Recursos

Si tiene cobertura de Medicare y desea solicitar un descuento para los servicios y gastos que Medicare no cubre, deberá proporcionar los comprobantes de sus recursos y responsabilidades.

Determinación de Medicare:

www.hchdonline.com/patient/onecard/forms/MedicareAssest283200-Span-05-2011.pdf

La información sobre la raza y el sexo es voluntaria. Si dispone de números de la seguridad social, debe proporcionarlos. Este tipo de información no afectará a su elegibilidad.

Debe proporcionar la información acerca de sus seguros médicos y sobre terceras personas con responsabilidad financiera por los servicios médicos pagados por ese programa para usted y los miembros de su familia. Al firmar y remitir esta solicitud, acepta otorgar al HCHD el derecho a recuperar el costo de los servicios médicos proporcionados por el HCHD de algún tercero.

Se le puede pedir que solicite Medicaid, TANF (asistencia temporal para familias necesitadas) o prestaciones de SSI (ingreso suplementario de seguridad). Si se le pide que solicite entrar en uno de estos programas, es posible que continúe siendo elegible para recibir ayuda financiera del HCHD por un periodo de tiempo limitado. Si no cumple los requisitos para esos programas y respondió a todas las preguntas de la solicitud y entregó todos los comprobantes necesarios, su solicitud está completa.

Harris County Hospital District Gold Card *Gold Card del Distrito Hospitalario del Condado de Harris*

If you are qualified for financial assistance and it is later determined that the information or proof you provided on this application was false, you may lose your financial assistance, may be barred from reapplying for six months, and be required to repay HCHD for any services rendered. You may also be charged with criminal and/or civil penalties.

Después de entregar su solicitud, debe informar en un plazo de 14 días cualquier cambio de domicilio, ingresos, personas que viven con usted o en el estado de sus solicitudes al SSI, AFDC o Medicaid. Si no comunica estos cambios, puede perder la ayuda que recibe del HCHD.

Si reúne los requisitos para la ayuda financiera y posteriormente se determina que la información o los comprobantes presentados eran falsos, puede perder la ayuda y se le puede impedir que la vuelva a solicitar durante un periodo de seis meses; asimismo, se le puede pedir que pague al HCHD los servicios recibidos. También puede ser objeto de sanciones penales o civiles.

Eligibility Centers / *Centros de Elegibilidad*

Acres Home Eligibility Center

818 Ringold Street
Houston, TX 77088-6368
713-566-6509

East Mount Houston Eligibility Center

11737B Eastex Freeway
Houston, TX 77039
713-566-6509

South Loop Eligibility Center

3550-A Swingle Road
Houston, TX 77047
713-566-6509

Southwest Eligibility Center

8901-B Boone Road
Houston, TX 77099
713-566-6509

Strawberry Eligibility Center

925 Shaw Road
Pasadena, TX 77506
713-566-6509



Art by Kevin



Art by Kevin

Medicare & Medicaid / Medicare y Medicaid

MEDICARE

The Centers for Medicare & Medicaid Services (CMS) runs the Medicare and Medicaid programs - two national health care programs that benefit about 95 million Americans. All persons receiving Social Security Disability (SSD) are automatically enrolled in Medicare after 29 months of being disabled (usually 24 months receiving SSD + the first five months of disability). There are no exceptions to this rule!

COBRA. The COBRA Health Benefit Provision allows disabled persons to keep the health insurance they had through their employer for 18 months (or up to 29 or 36 months in some cases) if they have received a medical disability decision from SSA. The premiums are usually higher than the group rate and you will be expected to pay them yourself. However, the Ryan White funded Health Insurance program at Legacy Community Health Services may be able to help pay your premiums and will answer your questions about COBRA and keeping your insurance.

** You must give your employer a copy of your SSA award letter as soon as possible. If you do not, your COBRA benefits will end after 18 months and you will have no medical coverage until Medicare begins 11 months later!

Medicare is divided into several parts which help cover specific services if you meet certain conditions. Part A (Hospital Insurance) helps cover inpatient care in hospitals. Helps cover skilled nursing facility, hospice and home health care. Part A coverage is free of charge for most people because they paid Medicare taxes while working.

Part B (Medical Insurance) helps cover doctors' services and outpatient care. Part B also helps cover some preventive services to help maintain your health and to keep certain illnesses from getting worse. Part B, which is optional, requires a monthly premium.

Part C (Medicare Advantage Plans) is a health coverage choice (similar to an HMO or PPO) run by Medicare-approved private companies that limits membership to people with specific diseases or conditions, such as diabetes, congestive heart failure or HIV/AIDS; people who live in certain institutions (like a nursing home) or who live at home but need the same care as someone living in a nursing home; and people who have both Medicare and Medicaid. Part C includes Part A, Part B, and usually other coverage including prescription drugs (Part D). Premiums vary by company and plan.

MEDICARE

Los Centros de Servicios de Medicare & Medicaid (CMS) dirigen los programas de Medicare y Medicaid - dos programas nacionales del cuidado médico que benefician a cerca de 95 millones de estadounidenses. Medicare está disponible a todas las personas que reciben el Seguro Social por Discapacidad (SSD), pero no antes de 29 meses de estar incapacitado (generalmente 24 meses de recibir el SSD y los primeros cinco meses de discapacidad). ¡No hay excepciones a esta regla!

COBRA. La Provisión de Beneficios para la Salud COBRA permite a personas discapacitadas mantener sus seguros de salud (el que tuvieron durante el empleo) por 18 meses (o hasta 29 ó 36 meses en algunos casos) si recibieron una decisión de discapacidad médica por la Administración del Seguro Social (SSA). La prima del seguro es usualmente más elevada que la de grupo, y usted debe pagarla. Sin embargo, el programa de seguro médico ofrecido por Legacy Community Health Services y financiado por Ryan White podría asistirle con el pago de la prima, y además puede asistirle con otras preguntas que tenga sobre COBRA.

** Ud. deberá entregarle a su empleador una copia de la carta de beneficios de la SSA lo más pronto posible. Si no lo hace, sus beneficios terminarán después de 18 meses y no tendrá más beneficios hasta que empiece la cobertura con Medicare, que son 11 meses más tarde.

Medicare consiste de varias partes y asiste en cubrir servicios específicos si cumple con ciertas condiciones. La parte A (seguro para hospitalización) asiste con el pago del cuidado del paciente externo en los hospitales, el cuidado de salud en domicilio, en hospicios, y en localidades con enfermeras profesionales. La Parte A es gratis para la mayoría de las personas quienes pagaron impuestos para el Medicare cuando trabajaron.

La Parte B (seguro médico) asiste con el pago de los servicios ofrecidos por los médicos y el cuidado del paciente externo, servicios preventivos que asisten en mantener una buena salud, y evitar que ciertas enfermedades empeoren. La Parte B es opcional y requiere un pago mensual de una prima.

La Parte C (Planes de Ventaja) es una cobertura de elección (similar a un HMO o PPO) administrado por compañías privadas y aprobadas por Medicare, que limitan a las personas con enfermedades o condiciones específicas, así como la diabetes, la insuficiencia cardíaca congestiva, o el VIH/SIDA; personas quienes viven en ciertas instituciones (así como en hogares de cuidados médicos) o quienes viven en sus domicilios pero quienes necesitan el mismo cuidado que aquellos en hogares de cuidados médicos; y personas quienes tienen ambos-- Medicare y Medicaid. La Parte C incluye la Parte A, la Parte B, y usualmente otras coberturas incluyendo medicamentos recetados (Parte D). La prima varía dependiendo del plan y la compañía.

MEDICARE

Medicare Part D (Medicare Prescription Drug Coverage) helps cover the cost of prescription drugs. Part D may help lower your prescription drug costs and help protect against higher costs in the future. Premiums vary by company and plan.

Medicare will pay for much, but not all, of your health care costs. Medicare recipients have to pay limited deductibles and co-payments. Medicare does not pay for long-term care.

If you receive SSD but don't receive Supplemental Security Income (SSI), and your income falls below a certain level, you may qualify for help paying your Medicare costs through either the QMB (Qualified Medicare Beneficiary) or the SLMB (Specified Low-income Medicare Beneficiary) program.

These helpful programs, administered by Texas Health and Human Services, pay the Medicare part B monthly premiums, and QMB also covers part A monthly premiums as well as all deductibles and co-payments. Call the Texas Department of Aging and Disability Services at 713-692-1635 or 1-800-213-8471 for information about QMB and SLMB. If you receive both SSD and SSI and have been disabled for at least 29 months, you are eligible for both Medicare and Medicaid.

MEDICARE

La Parte D (medicamentos recetados) asiste en el pago de dicha medicina. La Parte D puede que le ayude a reducir este costo y prevenir un alto costo en el futuro. La prima varía de acuerdo al plan y la compañía.

Medicare pagará por mucho pero no todo el costo del cuidado médico. Los pacientes con Medicare deben pagar los deducibles y copagos limitados. Medicare no paga el cuidado de largo plazo.

Si usted recibe SSD pero no recibe SSI, y su ingreso es reducido a cierto nivel, usted puede calificar para recibir ayuda con el pago de los costos de Medicare a través de los programas QMB (Beneficiario Calificado) o SLMB (Beneficiario Calificado de bajo ingreso).

Estos programas de ayuda, pagan mensualmente la prima de la Parte B, y QMB cubre la prima de la Parte A y los deducibles y los copagos. Llame al 713-692-1635 ó 1-800-213-8471 para información sobre QMB y SLMB. Si usted recibe ambos—SSD y SSI y ha estado discapacitado por lo menos 29 meses, usted es elegible para recibir Medicare y Medicaid.

Medicare Prescription Drug Plans / Plan de Medicare Para Recetas Médicas

What is a Medicare Prescription Drug Plan?

Starting January 1, 2006, new Medicare Prescription Drug Plans will be available to all people with Medicare.

How does the Original Medicare Plan work with a Medicare Prescription Drug Plan?

- You pay a separate monthly premium for your prescription drug plan.
- You pay a co-payment or co-insurance, and deductible for your prescription drugs.
- You get a prescription card from your Medicare Prescription Drug Plan. Show it when you get your prescriptions filled.
- You must go to pharmacies that belong to (are in the network of) the Medicare Prescription Drug Plan that you join. If you go to a pharmacy that isn't part of the plan you join, in most cases, your drug won't be covered and you will have to pay the full cost of the drug.
- Each Medicare Prescription Drug Plan has a list of covered prescription drugs which may vary from plan to plan. In most cases, only drugs on this list will be covered.

¿Qué es un plan de Medicare para recetas médicas

A partir del 1 de enero de 2006, los planes de Medicare para medicamentos recetados estarán disponibles para todos los beneficiarios de Medicare.

¿Cómo funciona el Plan Original de Medicare con los planes de Medicare para recetas médicas?

- Usted paga una prima mensual separada por el plan para medicamentos recetados.
- Usted paga un co-pago o co-seguro y el deducible del plan para medicamentos recetados.
- Usted obtiene una tarjeta del plan que debe mostrar cuando compra su medicamento.
- Usted debe ir a farmacias que pertenezcan a la red del plan de Medicare para recetas médicas en el que se ha inscrito. Si compra en una farmacia que no pertenece a la red del plan de Medicare, en la mayoría de los casos, el medicamento no estará cubierto y tendrá que pagar el precio total del mismo.
- Cada plan de Medicare para recetas médicas tiene una lista de los medicamentos recetados cubiertos y la misma puede variar con cada plan. En la mayoría de los casos, sólo estarán cubiertos los medicamentos de la lista.

What if I have a limited income and can't afford a Medicare Prescription Drug Plan?

People with Medicare and Medicaid, and other people with limited income and resources can qualify for help paying their Medicare Prescription Drug Plan costs. You might also want to join a Medicare Advantage Plan or other Medicare Health Plan.

Remember: If you have drug coverage through a previous or current employer or union, contact your benefits administrator before you make any changes to your prescription drug coverage.

MEDICAID

Medicaid is a state program administered by Texas Health and Human Services (THHS). Everyone receiving SSI benefits, whether or not they are also receiving SSD, is covered by Medicaid. Medicaid covers both acute care (doctor visits, lab work & x-rays, hospitalization, etc.) and long-term care (nursing home, attendant services, etc.). Beginning October 1, 2005, Medicaid clients age 21 years and older may receive the following benefits: eyeglasses, contact lenses if medically necessary, hearing aids, services provided by a chiropractor and services provided by a podiatrist. There are no changes to benefits for Medicaid clients under 21 years old.

Medicaid in the Harris County area (Brazoria, Fort Bend, Galveston, Harris, Montgomery and Waller Counties) is now being provided through two managed care programs: Star and Star+Plus. People receiving TANF benefits enroll in the Star program and people receiving SSI enroll in the Star+Plus program (Star+Plus includes long-term care, but Star does not).

This means that everyone receiving Medicaid is now required to select an HMO (listed below) and a primary care physician who has signed up with the HMO. Once you choose a primary care physician, you will go to this doctor for all your medical care, unless he or she refers you to a specialist or you choose a different primary care physician. However, you do have the right to access psychiatric or chemical dependency treatment directly - from a doctor or facility listed in your HMO's directory - without first going through your primary care physician.

Doctors and clinics frequently sign up with more than one HMO. When you qualify for Medicaid through THHS, you will receive an enrollment packet for the Star or Star+Plus program. This will include "provider directories" for each HMO and a Health Plan Comparison Chart. You can then either fill out the forms and mail them in or you can call the enrollment broker, Maximus, and enroll over the phone. The number to call is listed below.

Updates: www.rwpcHouston.org

¿Qué ocurre si mis ingresos son limitados y no puedo pagar por un plan de Medicare para recetas médicas?

Las personas que tienen Medicare y Medicaid y otros con ingresos y recursos limitados podrían ser elegibles para recibir ayuda para pagar por los costos del plan para recetas médicas. También podría inscribirse en un Plan Medicare Advantage u otro Plan de Salud de Medicare.

Recuerde: Si tiene cobertura de medicamentos recetados a través de su empleador pasado o actual o sindicato, comuníquese con el administrador de beneficios antes de hacer cualquier cambio a su cobertura de recetas médicas.

MEDICAID

Medicaid es un programa estatal administrado por los Servicios de Salud y Humanos de Texas (THHS). Todo aquel que recibe beneficios del SSI, esté o no recibiendo también el SSD, está cubierto por Medicaid. Medicaid cubre tratamientos agudos (consultas médicas, exámenes de laboratorio, rayos-x, hospitalización, etc.) y trata-mientos a largo plazo (cuidado, servicios de asistencia, etc.). A partir del 1° de octubre de 2005, los clientes de Medicaid de 21 años y mayores podrán recibir los siguientes beneficios: anteojos, lentes de contacto si son médicamente necesarios, audífonos, servicios prestados por un quiropráctico y servicios prestados por un podiatra. No habrá cambios en los beneficios para clientes de Medicaid menores de 21 años.

En la area del Condado Harris (los condados Brazoria, Fort Bend, Galveston, Harris, Montgomery y Waller) se ofrece Medicaid a través de dos programas de cuidado administrativo: Star and Star+Plus. Las personas que reciben beneficios TANF se inscriben en el programa Star y personas que reciben SSI se inscriben en el programa Star+Plus (Star+Plus incluye cuidado de largo plazo, sin embargo Star no).

Esto significa que todos aquellos que reciben Medicaid deben elegir un HMO (Organización de la Administración de la Salud, alistados a continuación) y un médico general que esté inscrito con el mismo. Al elegir a un médico, él o ella se encargará de todas sus atenciones de salud, a no ser que lo dirija a un especialista o Ud. elija otro médico general. Sin embargo, tiene el derecho de solicitar tratamiento psiquiátrico y de abuso de drogas directamente con un médico o un centro inscrito con su HMO, sin tener que acudir antes a su médico general.

Los médicos y las clínicas generalmente tienen convenios con más de un HMO. Cuando Ud. califica para Medicaid a través de THHS, recibirá un paquete de inscripción para el programa Star o Star+Plus. El paquete incluye una lista de proveedores en cada HMO y una Tabla de Comparación de los Planes de Salud. Ud. puede llenar los formularios y enviarlos por correo o contactar a la compañía encargada de las inscripciones, Maximus, e inscribirse por teléfono (vea a continuación).

Medicare & Medicaid / Medicare y Medicaid

MEDICAID

If you do not make a selection within thirty days, a primary care physician (and an HMO) will be chosen for you. If this happens, you will probably not be allowed to see your regular doctor and your medical care may be interrupted. If you are assigned a health plan you may still choose your own health plan and primary care provider, but until you have formally made that change, you will receive services through the plan and provider to which you were assigned. STAR+PLUS members may change health plans as often as once a month.

MEDICAID

Si usted no selecciona un médico de cuidado primario (y un HMO) en un periodo de 30 días, uno será seleccionado para usted. Si esto ocurre, probablemente no será permitido ver a su médico regular y su cuidado médico puede ser interrumpido. Si usted es asignado un plan de salud puede seleccionar su propio médico y plan de salud, pero hasta que no haya hecho este cambio formalmente recibirá servicio bajo el plan y el proveedor con quien ha sido asignado. Beneficiarios de STAR+PLUS pueden cambiar planes de salud una vez por mes.

Important Star and Star+ Plus Numbers

Call to enroll or ask questions / Llame a inscribirse o hacer preguntas:

MAXIMUS (enrollment broker)

Toll Free: (800) 964-2777

Questions about the programs? / ¿Preguntas acerca de los programas?

Star & Star+Plus Helpline (Línea de ayuda)

Toll Free: (800) 964-2777

Medicaid Managed Care Helpline

The Medicaid Managed Care Helpline (formerly STARLink) is designed to help people who are already on Medicaid but need help accessing health care services. A priority is placed on individuals with urgent or complex health care needs.

Help includes:

- Information about coverage.
- Guidance on how to access services.
- Referrals to the right place to get help.
- Direct assistance to resolve a problem.

The Medicaid Managed Care Helpline also provides general information about managed care programs.

Toll Free: (866) 566-8989

TTY: (866) 222-4306

La línea de ayuda de Medicaid

Llamada Medicaid Managed Care Helpline (conocida antes como STARLink), esta línea está diseñada para ayudar a las personas que ya tienen Medicaid pero necesitan asistencia en acceder los servicios médicos. Se da prioridad a individuos con necesidades de urgencia o de un cuidado complejo.

Help includes:

- Información sobre cobertura.
- Una guía de cómo acceder a los servicios.
- Referencias apropiadas a los recursos.
- Asistencia directa para resolver un problema.

Esta línea de ayuda además provee información general sobre programas administrativos del cuidado.

Toll Free: (866) 566-8989

TTY: (866) 222-4306

HARRIS EXPANSION SERVICE AREA (Brazoria, Ft Bend, Galveston, Harris, Montgomery & Waller Counties)

Plan Name	Plan Phone Number
AmeriGroup Community Care (Star & Star+Plus)	1-800-600-4441 / 1-800-855-2880 TTY
Community Health Choice (Star)	713-295-2294 or 1-888-760-2600 1-800-518-1655 TTY
Evercare of Texas (Star+Plus)	1-888-887-9003
Molina Healthcare of Texas (Star & Star+Plus)	1-866-449-6849 1-800-735-2989 TTY-English 1-800-662-4954 TTY-Spanish
Texas Children's Health Plan (Star)	1-866-959-2555 / 1-800-735-2989 TTY
United Healthcare-TX (Star)	1-800-213-5846 / 7-1-1 TTY

**Harris County Hospital District
Community Health Program**

Process Guidelines for the Screening HIV Positive Clients

Definitions:

New Client – An HIV positive client who has not been seen for HIV services in the Harris County Hospital District Community Health Program.

Return to Care Client - An HIV positive client who has been seen for HIV services in the Harris County Hospital District Community Health Program, but has been out of care for 9 months or longer.

Eligibility – The establishment of the following criteria:

- If client has insurance, Medicare or Medicaid, that it is current
- If client does not have medical coverage, a gold card is initiated, or updated as needed
- Registration in CPCDMS is complete

Process for New Client Screening:

1. Appointment is made for eligibility

713-873-4188

713-873-4092

713-873-4020 (Spanish speaking)

Assign a medical record number if client is not currently in the HCHD system

713-873-4120

2. Visit 1

Eligibility

CPCDMS

Screening team makes future appointments for the following:

Screening nurse, medical case manager, client advocate, educator, dietician, physical therapy, Labs, per standing order (11:30 or later), X-Ray

3. Visit 2

Screening nurse (medical history and assessment), medical case manager (brief and readiness assessments completed and medical case manager assigned based on physician assignment), client advocate (psychosocial assessment), Labs (11:30 or later), X-Ray

4. Visit 3

Educator, dietician, physical therapy, MD

Referrals from BTGH and LBJ Linkage Workers

Linkage workers at LBJ and BTGH will initiate CPCDMS registration and call to set up an eligibility appointment. The client will report 30-60 minutes prior to eligibility appointment and the linkage worker will complete the CPCDMS registration at that time. Continue with steps 2-4 of the screening process.

Harris County Hospital District
Community Health Program

Process Guidelines for the Screening HIV Positive Clients

Process for Return to Care

Visit 1

Eligibility is verified?

(scenario 1) Client is ambulatory – The screening team will schedule labs for next available 11:30 or later, per standing orders, and schedule a return appointment with their previous physician, if available. If a new physician is assigned, a new client appointment will be made.

or

(scenario 2) Client presents ill and needs stretcher – The client will be taken to the treatment room and sent to the hospital via the treatment room team. Screening will be deferred until client is well enough to return to the clinic. ??

Visit 2

(scenario 1) Labs drawn

Visit 3

(scenario 1) Physician visit

Do we have a process in place for follow up for no shows?



**The 2009
Comprehensive HIV Services Plan
for the Houston Area**

Through December 31, 2011

Effective January 1, 2009

Mission Statement

We, the Houston Comprehensive Planning Committee, have come together to update the Comprehensive HIV Services Plan for the Houston EMA/HSDA guided by the following mission:

We will provide a plan that will be inclusive of the entire continuum of care to improve the quality of life for those infected with and/or affected by HIV/AIDS in the Houston EMA/HSDA by taking a leadership role in the planning and assessment of HIV resources, resulting in the delivery of prevention and care services that are accessible, efficient and culturally affirming until the end of the epidemic is realized.

Vision Statement

From 2009 to 2011, the community will continue to work together to improve and expand a coordinated system of HIV/AIDS prevention and care in order to improve the quality of life for communities affected by HIV and AIDS.

Shared Values

The following Shared Values outline the GUIDING PRINCIPLES that planners, service providers, consumers and community leaders agree will guide the development and delivery of HIV Services within the geographic area. The guiding principles are informed by the Health Resources and Services Administration's (HRSA) focus on uninsured, underserved and special needs populations, as defined by the following goals:

- Goal 1: Improve Access to Health Care**
- Goal 2: Improve Health Outcomes**
- Goal 3: Improve the Quality of Health Care**
- Goal 4: Eliminate Health Disparities**
- Goal 5: Improve the Public Health and Health Care Systems**
- Goal 6: Enhance the Ability of the Health Care System to Respond to Public Health Emergencies**
- Goal 7: Achieve Excellence in Management Practices**

Section II

WHERE DO WE NEED TO GO?

CHAPTER 7: CONTINUUM OF CARE FOR HIGH QUALITY CORE SERVICES

A Shared Vision

From 2009 to 2011, the community will continue to work together to improve and expand a coordinated system of HIV/AIDS prevention and care in order to improve the quality of life for infected and affected communities. The realization of this vision is informed by the Houston area Continuum of Care.

Operational Definition of Continuum of Care

The ideal continuum of care represents a comprehensive range of services needed by individuals and families at-risk infected and affected by HIV/AIDS. The Houston Area Continuum of Care model describes an ideal system of care that bridges prevention services with care and treatment, and responds to dynamic community needs in a holistic, coordinated, and timely manner.

The Continuum of Care model is a framework for decision-making, and can be used to inform and guide planning bodies, providers, community leaders and consumers in setting priorities and allocating funds for HIV/AIDS services. The Continuum can also guide the Houston area HIV community toward the following objectives:

1. Reduce redundancy of administrative burden and services in the system while ensuring adequate access to those who live in distant areas.
2. Provide adequate input of services through multiple points of access. Think of this as designing a ticketing facility. For HIV and AIDS services, we need not only direct outlets (testing), but adequate links to emergency rooms, drug treatment, STD clinics, and acute care facilities.
3. Facilitate services while not overburdening the staff and capacity of the system.
4. Ensure continuity of services so that consumers find that they are able to move around the system and will not be stuck at any one station.

Elements of the Continuum of Care

The Houston area Continuum of Care takes into account several factors: 1) the mission and vision statements of the various planning bodies; 2) the goals and objectives of the planning bodies; 3) the services available in the delivery system; 4) the linkages necessary to ensure efficiency and effectiveness; and 5) the coordinating mechanisms that can be utilized to ensure effective linkages are established and maintained.

The Continuum of Care is characterized by a range of elements that inform the development and delivery of services in the Houston area. These elements include:

- Identifying and addressing needs of unserved/underserved populations
- Including prevention and care services
- Providing services in an efficient and effective manner
- Providing services in a seamless manner as a person moves among the different levels of care
- Providing high quality and culturally appropriate services
- Advocating for PLWHA service needs
- Encouraging cooperation in the coordination/delivery of services
- Assuring that the community in need is aware of available prevention and care resources
- Promoting the dissemination of information to all constituencies
- Identifying needs, gaps and barriers
- Planning capacity to meet needs
- Improving the quality of life
- Assuring that the system is free of discrimination based on race, color, creed, gender, religion, sexual orientation, disability, or age
- Assuring that PLWHA, the general public, and providers are included in the process

The Houston area Continuum of Care encourages service linkages as the mechanism for creating a seamless system of services that enables clients to easily navigate within different levels of care. The Continuum model illustrates how services can be linked among the wide range of service providers in Houston.

Table 9: Continuum of Care Tracks

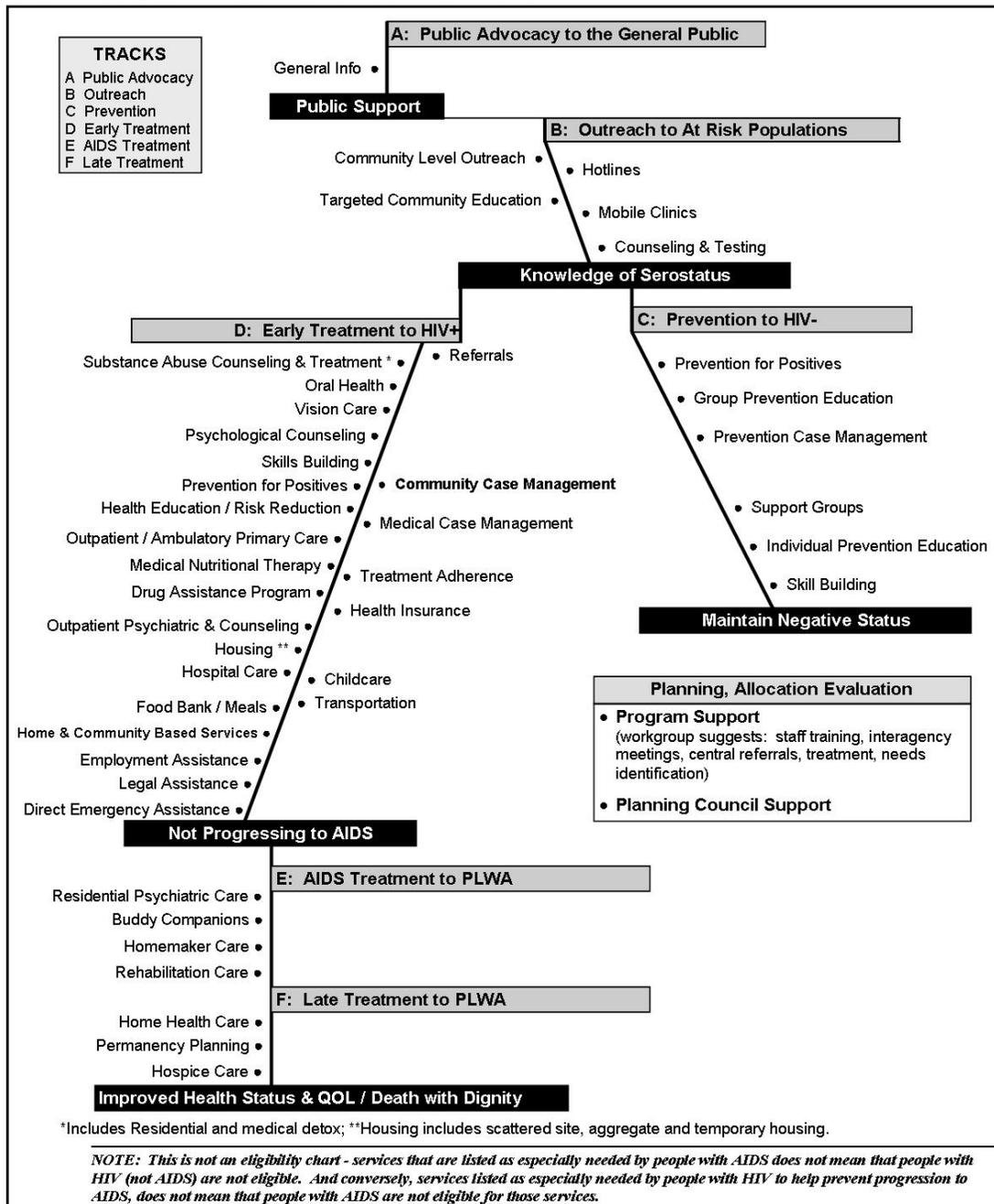
TRACK	START	DESTINATION
A. Public Advocacy to the General Public	No awareness of AIDS	Support for HIV/AIDS services
B. Outreach to at Risk Populations	No awareness of serostatus	Awareness of serostatus
C. Prevention to HIV-	Aware of negative status	Maintenance of negative status
D. Early Treatment to HIV+	Awareness of infection	No progression to AIDS
E. AIDS Treatment to PLWA	AIDS diagnosis	Improved health status and quality of life or death with dignity

The Houston Area Continuum of Care is shown on the following page (Figure 5). The Houston area Continuum of Care is characterized by three main features. First, it has several tracks, each of which is defined by its outcomes. Second, consumers can enter the system at any point on the track. Third, each track runs both ways – consumers can travel up or down each track.

Five attributes can be applied to the Continuum. Referred to as the “5 A’s”, the delivery system is designed to be:

- Available to meet the needs of the PLWHA and their caregivers
- Accessible to all populations infected or affected by HIV/AIDS
- Affordable to all populations infected or affected by HIV/AIDS
- Appropriate for different cultural and socio-economic populations and care needs
- Accountable to the funders and clients for providing contracted services at high quality

Figure 5: Houston Area Continuum of Care



Operational Definition of Core Medical Services

Core Medical Services refer to those services deemed by the Ryan White HIV/AIDS Treatment Modernization Act as most necessary to ensure good medical outcomes for people with HIV / AIDS. The Core Medical Services are defined as:

- outpatient and ambulatory health services;
- pharmaceutical assistance;
- substance abuse outpatient services;
- oral health;
- medical nutritional therapy;
- health insurance premium assistance;
- home health care;
- hospice services;
- mental health services;
- early intervention services; and
- medical case management, including treatment adherence services.

Congress wants to ensure that Ryan White Federal funds are used to pay for essential medical care; thus, areas receiving Ryan White funds under Parts A, B, and C must spend at least 75% of funds on core medical services.

The remaining 25% of funds may be spent on support services. Support services are defined as services that improve access to the core medical services, and directly contribute to achieving positive clinical outcomes for persons with HIV/AIDS. Support services are defined as:

- outreach;
- medical transportation;
- language services;
- respite care for persons caring for individuals with HIV/AIDS; and
- referrals for health care and other support services.

A Shared Set of Values

The Houston area HIV/AIDS community shares a set of values that guide the development and delivery of HIV Services within the geographic area. These values, as informed by HRSA guidelines, address disparities in HIV care, access, and services among affected subpopulations and historically underserved communities; establish and support an HIV care continuum; coordinate resources among other Federal and local programs; and address the needs of those who know their HIV status and are not in care as well as the needs of those who are currently in the care system.

Guiding Principles

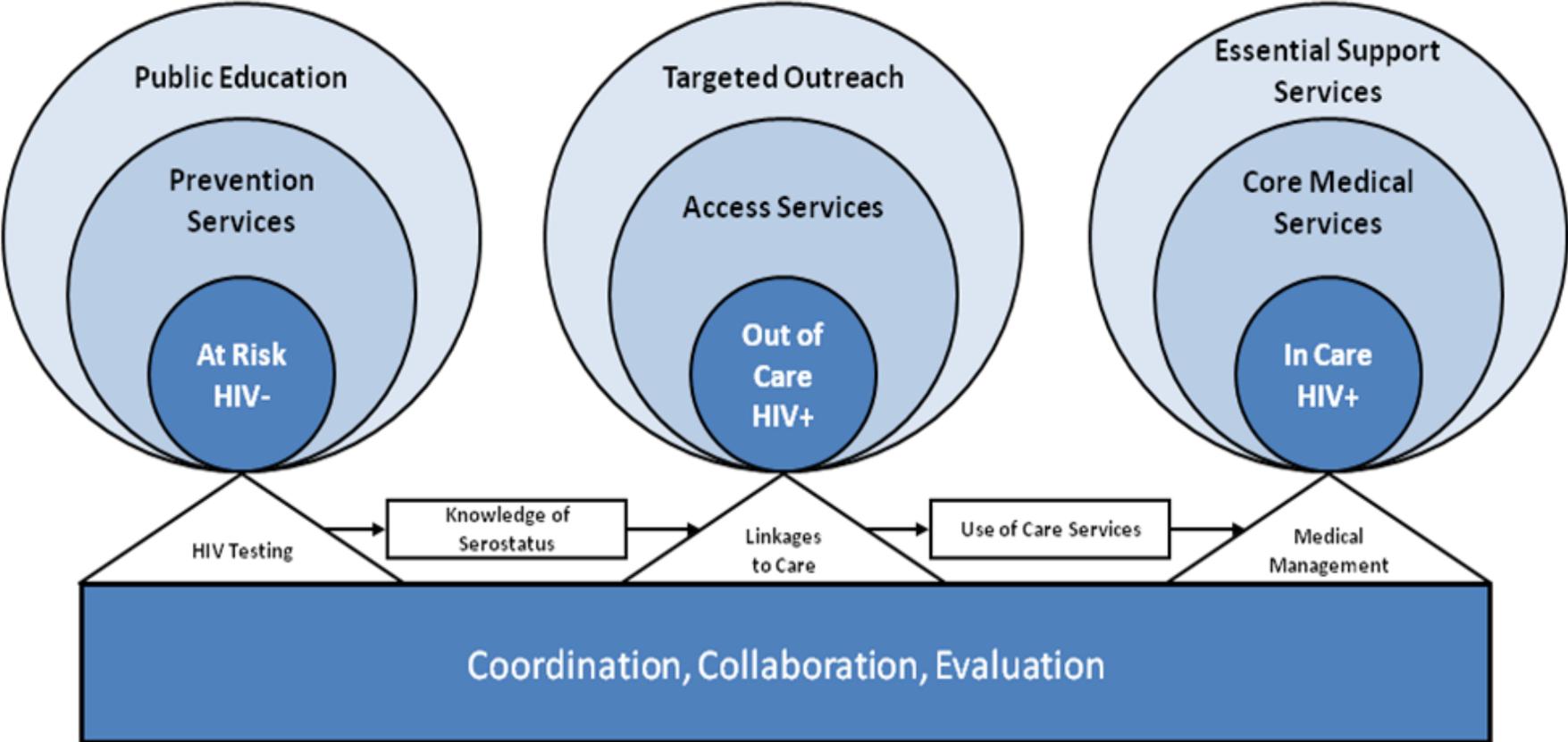
The guiding principles for the Houston Area HIV/AIDS Comprehensive Plan are informed by the Ryan White reauthorization principles which are intended to strengthen federal HIV treatment programs. The reauthorization principles include a focus on primary care and treatment, efforts to increase flexibility to target resources and ensuring accountability using sound fiscal management and tools to evaluate program effectiveness

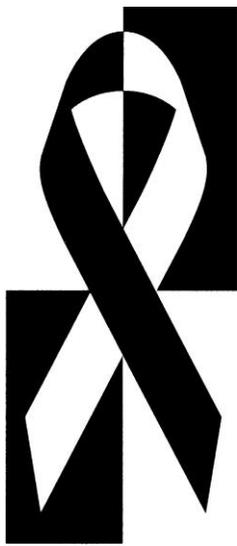
As such, the guiding principles used by the Houston HIV/AIDS community are as follows:

1. Better serve the underserved in response to the HIV epidemic's growing and widespread impact among minority and hard-to-reach populations.
2. Ensure access to effective HIV/AIDS prevention and care services to make a difference in the lives of people infected and affected by HIV and AIDS.
3. Adapt to changes in the health care delivery system and the role of the Ryan White Treatment Modernization Act in filling service gaps.
4. Accurately document service outcomes and demonstrate the effectiveness of treatment, care and prevention strategies.
5. Respond to and advocate for consumer needs.
6. Provide services that are sensitive to the cultural and linguistic needs of specific communities.

EAST TEXAS CONTINUUM of CARE MODEL

Goal: To Improve Health Outcomes





**THE
RESOURCE
GROUP**

HOUSTON
REGIONAL
HIV/AIDS
RESOURCE
GROUP, INC.

**500 Lovett Blvd.
Suite 100
Houston
Texas
77006**

**713 526-1016
FAX 713 526-2369
www.hivresourcegroup.org**

Harris County Jail Recently Released Fact Sheet

- HIV testing is routine, opt out and is done upon 14 day physical. Testing can also be requested by an inmate. If an individual test is positive for HIV while incarcerated at HCJ they are linked with Ryan White Early Intervention Services (EIS).
- Once linked with EIS, the individual is given ongoing medical treatment, is registered in CPCDMS and signed up for the Texas HIV Medication Program. A Mini Blue Book resource guide is also issued.
- All HIV medications are Keep On Person while in HCJ starting with the one month supply. When discharged the consumer will take all remaining months' HIV medications with them.
- A consumer can meet with a case manager or linkage worker from the community provider their choice while incarcerated. A uniform referral form is sent to the community provider of the client's choosing by the EIS team.
- Discharges happen between 6:00 and 8:00 a.m. and a consumer can request a bus pass from a member of the EIS team to get to their first appt at the community provider.
- Most Ryan White primary care clinics have dedicated staff and are encouraged to see the recently released consumer in an expedited appointment when possible.
- The Serving the Incarcerated and Recently Released (SIRR) Partnership of Greater Houston is a group of area wide service providers and consumers who meet monthly to discuss the needs and reduce barriers of the recently released and HIV+. The group meets the 4th Weds of the month at 9:00 at the GLBT Community Center, 401 Branard St. If interested in attending the group please contact Anna Langford at 713-526-1016 or email at alangford@hivresourcegroup.org

10/10/11



Early Identification of Individuals with HIV/AIDS

Where Care Meets Prevention

Administrative Overview Ryan White Part A
June 14, 2011

Marcus Jackson
Project Officer, Western Service Branch

Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau



Definitions

□ Unaware of HIV Status:

- Any individual who has NOT been tested for HIV in the past 12-months, any individual who has NOT been informed of their HIV result (HIV positive or HIV negative), and any HIV positive individual who has NOT been informed of their confirmatory HIV result.



Definitions

- **Referral to care/services:**
 - **The provision of timely, appropriate, and pre-established guidance to an individual that is designed to refer him/her to a specific care/service provider for the purpose of accessing care/services after the individual has been informed of their HIV status (positive or negative).**



Definitions

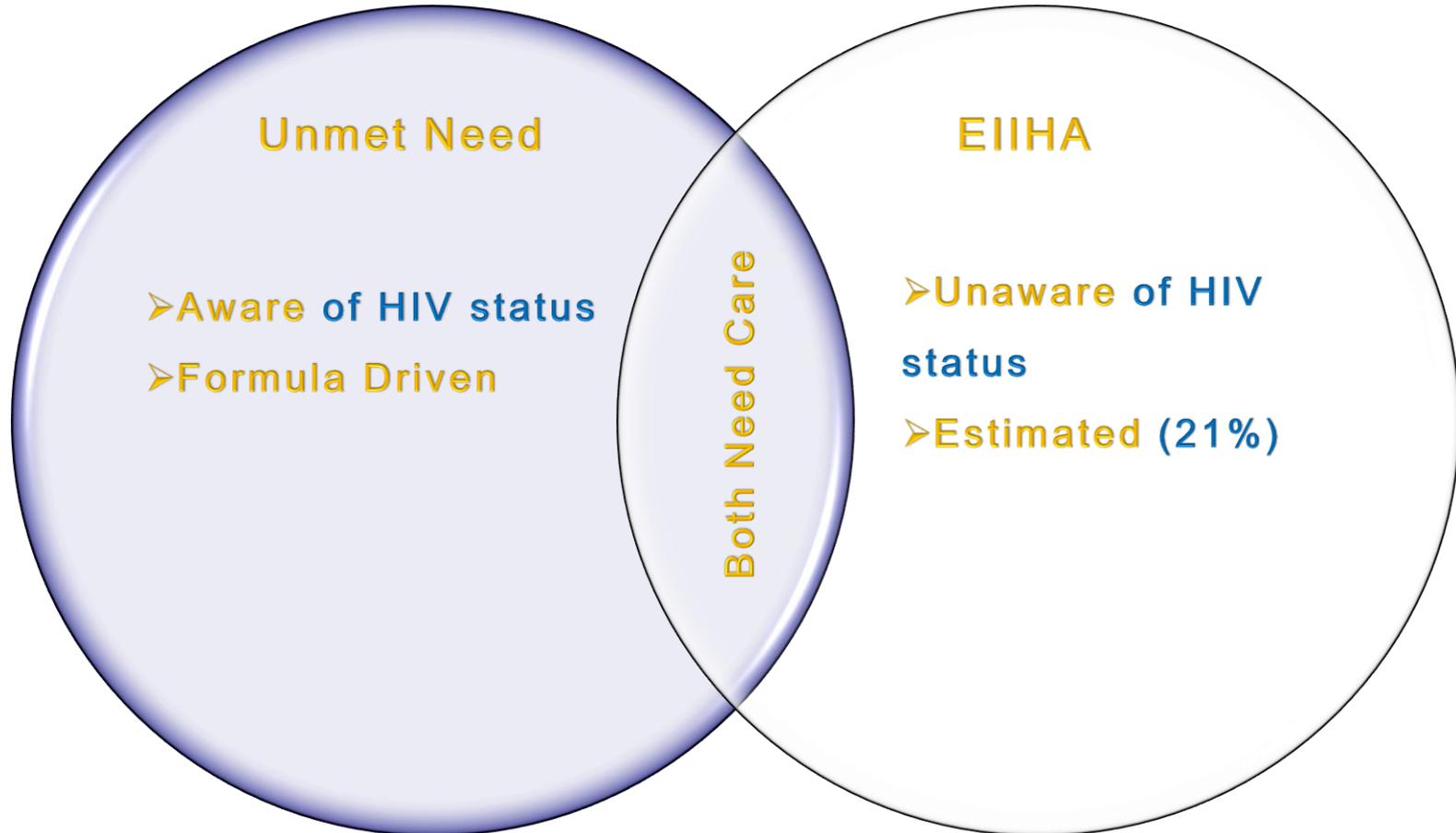
□ Linkage to care:

- The post-referral verification that care/services were accessed by an HIV positive individual being referred into care.
 - Example: Confirmation first scheduled care appointment occurred.

■ Definition Comparison

- **Unmet Need Definition:** HIV+ individuals who are **AWARE** of their HIV status but not in primary medical care.
- **EIHA Definition:** HIV+ individuals who are **UNAWARE** of their HIV status and therefore not in primary medical care.

EIIHA VS. Unmet Need





EIS: Service Category Definition



HRSA Service Category Definition: For Parts A and B, includes *counseling* individuals with respect to HIV/AIDS; *testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, and tests to provide information on appropriate therapeutic measures)*; *referrals*; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic measures.



Linkage to Care



- Linkage Agreements (*MOU/MOA*)
- Create connections between services
- Create connections between and funding streams
- Routine provider meetings
- HRSA's definition of "Linkage to Care" should be reflected in contract language and scopes of work.



Key Points of Entry



- Health Departments
- Emergency Rooms
- Substance Abuse Programs
- Mental Health Programs
- Detention Facilities
- STD Clinics
- Homeless Shelters
- Counseling and Testing Sites
- Federally Qualified Health Centers
- Healthcare Points of Entry Specified by Eligible Areas
- Entities that Maintain Referral Relationships



Uses of EIS



- Used to implement EIIHA (unaware) strategies and plans
- Used to implement Unmet Need strategies



EIS Vs. Outreach



EARLY INTERVENTION SERVICES

Core Service

Can include HIV Testing

Works with key points of entry

Combination of services

Can assist in addressing unmet need and the unaware

OUTREACH

Support Service

Does not include testing

Directs individuals to key points of entry

Only one service

Can assist in addressing unmet need and bring unaware to testing



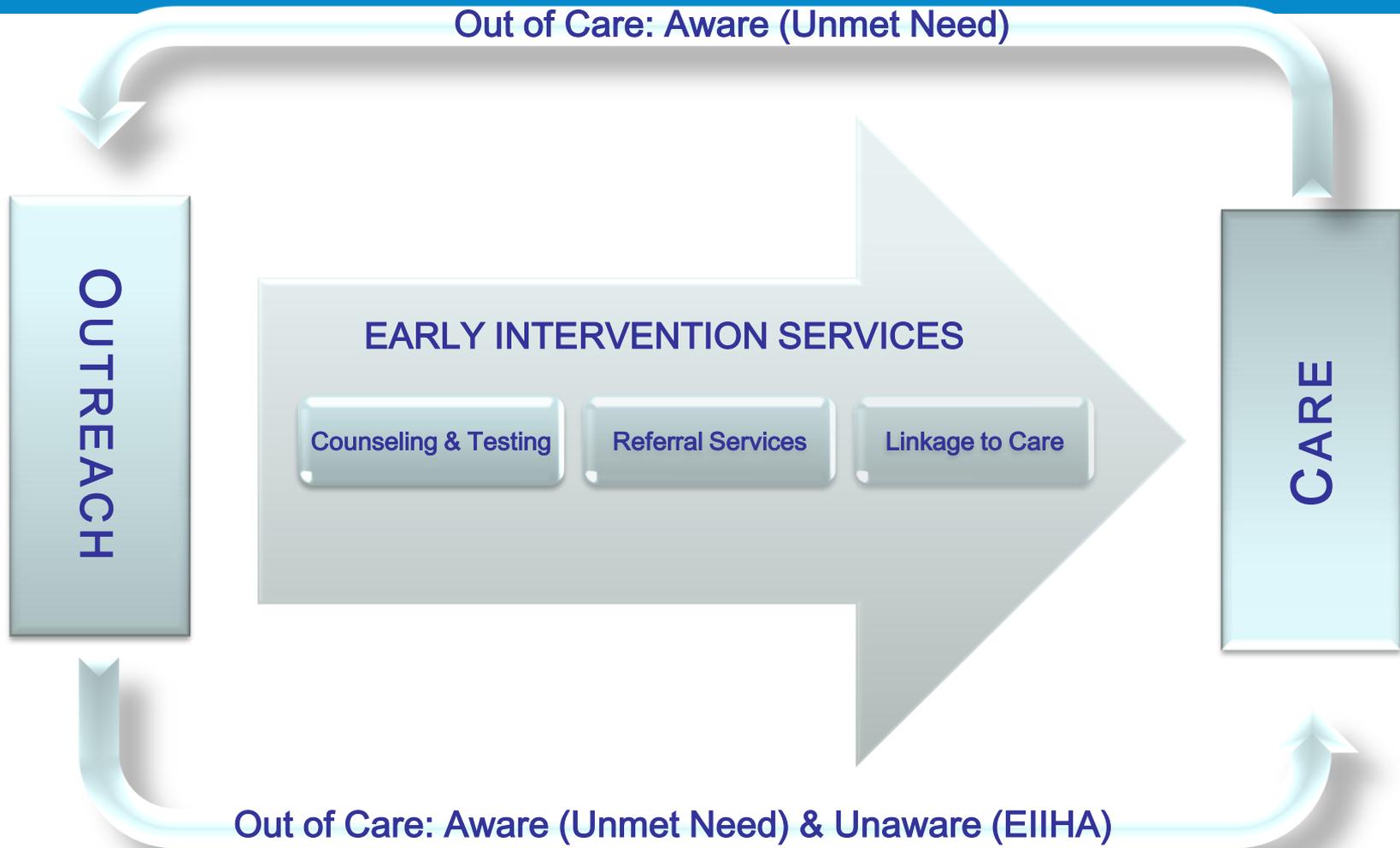
Service Category Definition: Outreach Services



Programs that have as their principal purpose *identification* of people with *unknown HIV disease OR* those *who know their status* (ie., case finding) so that they may become aware of, and may be enrolled in, care and treatment services. Outreach services *do not include* *HIV counseling and testing OR HIV prevention education*. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.



Outreach, EIS, and Care



FY 2012 Medical Case Management, Clinical Case Management and Service Linkage

This document includes three separate service definitions

Council approved 06-11

MEDICAL AND NON-MEDICAL/SERVICE LINKAGE CASE MANAGEMENT BUNDLED WITHIN PRIMARY CARE (Revision Date:06/10/11)	
Target Population:	<ul style="list-style-type: none"> a. Public Clinic: Persons Living with HIV and AIDS (PLWHA), ages 13 or older and Female PLWHA b. Community Based Clinics: <ul style="list-style-type: none"> <i>i. Targeted to African American:</i> African American PLWHA ages 13 or older <i>ii. Targeted to Hispanic:</i> Hispanic PLWHA ages 13 or older <i>iii. Targeted to White:</i> White (non-Hispanic) PLWHA ages 13 or older c. Targeted to Rural: PLWHA, ages 13 or older, residing in Counties other than Harris
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Provider <u>must</u> adhere to Targeting requirements and Budget requirements as applicable.
Budget Type: RWGA only	Hybrid Unit Cost
Service Unit Definition/s: RWGA only	1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
Financial Eligibility:	No Financial Cap
HRSA Service Category Definition: No changes permitted	<i>Case Management (non-Medical)</i> includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Service to be Provided:	<p>Medical Case Management: The program must utilize a state licensed Social Worker to provide Medical Case Management Services. Provider must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/10, and thereafter within 30 days after hire. The Provider must maintain the assigned number of Medical Case Management FTEs throughout the contract term.</p> <p>Service Linkage: The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Provider must provide to RWGA the names of each Service Linkage Worker and</p>

FY 2012 Medical Case Management, Clinical Case Management and Service Linkage

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	<p>the individual assigned to supervise those Service Linkage Workers by 03/30/12, and thereafter within 30 days after hire. Provider must maintain the assigned number of Service Linkage FTEs throughout the contract term.</p> <p>Supervision: The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Provider and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.</p>
<p>Local Service Category Definition:</p>	<p>Medical Case Management Services: Services include screening all primary medical care patients to determine each patient’s level of need for Medical Case Management services, performing a comprehensive assessment and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care compliance. The <i>Medical Case Manager</i> serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. The Medical Case Manager will perform, or contribute to, <i>Readiness Assessments</i> in accordance with RWGA Quality Management guidelines in order to assess a patient’s readiness for HAART.</p> <p>Service Linkage: The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of <i>Medical Case Management</i> per RWGA Quality Management guidelines. Service Linkage is primarily office-based, however Service Linkage Workers are expected to coordinate activities with programs where newly-diagnosed or not-in-care PLWHA may be referred from, including 1:1 case conferences to ensure the successful transition into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual’s initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients</p>

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	<p>who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Provider must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing “hands-on” outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.</p>
<p>Staff Requirements:</p>	<p>Medical Case Management: The program must utilize a state licensed Social Worker to provide Medical Case Management (MCM) Services. The Provider must maintain the budgeted number of medical case management FTEs throughout the contract term.</p> <p>Service Linkage: The program must utilize Service Linkage Workers (SLW) who at a minimum have a Bachelor’s degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH/A may be substituted for the Bachelor’s degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Provider must maintain the budgeted number of service linkage FTEs throughout the contract term.</p> <p>Supervision of Case Managers: The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Provider and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.</p>
<p>Special Requirements: RWGA only unless otherwise specified</p>	<p>Provider <u>must</u> provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program services <u>unless otherwise specified</u>.</p> <p>Maintaining Referral Relationships (Point of Entry Agreements) Provider must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris County Hospital District and other Houston EMA-located emergency</p>

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rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Provider and appropriate point of entry entities and are subject to audit by RWGA. Provider and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS.

Use of CPCDMS Data System: Provider must comply with CPCDMS business rules and procedures. Provider must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Provider must perform semi-annual Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Provider is client's CPCDMS record owning agency.

THE FOLLOWING IS DISTRIBUTED BY THE CASE MANAGERS AND SERVICE LINKAGE WORKERS:

Bus Pass Distribution: The County will provide Provider with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Provider may only issue METRO bus pass vouchers to clients wherein the Provider is the CPCDMS record owning Provider. METRO bus pass vouchers shall be distributed as follows:

Gas Cards: Rural Primary Medical Care Providers must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines.

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	CLINICAL CASE MANAGEMENT (CCM) AT MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT PROGRAMS
Budget Type: (RWGA Only)	Unit Cost
HRSA Service Category Definition: (RWGA Only)	<p><i>Medical Case Management services (including treatment adherence)</i> are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client’s and other key family members’ needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.</p>
Local Service Category Definition:	<p>Clinical Case Management: Identifying and screening clients who are accessing HIV-related services from a clinical delivery system that provides Mental Health treatment/counseling and/or Substance Abuse treatment services; assessing each client’s medical and psychosocial history and current service needs; developing and regularly updating a clinical service plan based upon the client’s needs and choices; implementing the plan in a timely manner; providing information, referrals and assistance with linkage to medical and psychosocial services as needed; monitoring the efficacy and quality of services through periodic reevaluation; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies.</p>
Target Population (age, gender, geographic, race, ethnicity, etc.):	<p>Services will be available to eligible HIV-infected clients residing in the Houston EMA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with</p>

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	<p>HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling (i.e. professional counseling), substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility.</p> <p><i>Clinical Case Management</i> is intended to serve eligible clients, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.</p>
<p>Services to be Provided:</p>	<p>Provision of Clinical Case Management activities performed by the Clinical Case Manager.</p> <p><i>Clinical Case Management</i> is a working agreement between a client and a Clinical Case Manager for a defined period of time based on the client's assessed needs. <i>Clinical Case Management</i> services include performing a comprehensive assessment and developing a clinical service plan for each client; monitoring plan to ensure its implementation; and educating client regarding wellness, medication and health care compliance in order to maximize benefit of mental health and/or substance abuse treatment services. The <i>Clinical Case Manager</i> serves as an advocate for the client and as a liaison with mental health, substance abuse and medical treatment providers on behalf of the client. The Clinical Case Manager ensures linkage to mental health, substance abuse, primary medical care and other client services as indicated by the clinical service plan. The Clinical Case Manager will perform <i>Mental Health and Substance Abuse/Use Assessments</i> in accordance with RWGA Quality Management guidelines. Service plan must reflect an ongoing discussion of mental health treatment and/or substance abuse treatment, primary medical care and medication adherence, per client need. <i>Clinical Case Management</i> is both office and community-based. Clinical Case Managers will interface with the primary medical care delivery system as necessary to ensure services are integrated with, and complimentary to, a client's</p>

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	medical treatment plan.
Service Unit Definition(s): (RWGA Only)	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	No Financial Cap
Client Eligibility:	HIV-infected individuals residing in the Houston EMA.
Agency Requirements:	<p><i>Clinical Case Management</i> services will comply with the HCPHES/RWGA published Clinical Case Management Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system</p> <p><i>Clinical Case Management Services</i> must be provided by an agency with a documented history of, and current capacity for, providing mental health counseling services (categories b., c. and d. as listed under <i>Amount Available</i> above) or substance abuse treatment services to PLWH/A (category a. under <i>Amount Available</i> above) in the Houston EMA. Specifically, an applicant for this service category must clearly demonstrate it has provided mental health treatment services (e.g. professional counseling) or substance abuse treatment services (as applicable to the specific CCM category being applied for) in the previous calendar or grant year to individuals with an HIV diagnosis. Acceptable documentation for such treatment activities includes standardized reporting documentation from the County’s CPCDMS or Texas Department of State Health Services’ ARIES data systems, Ryan White Services Report (RSR) for 2010, SAMSHA or TDSHS/SAS program reports or other verifiable <u>published</u> data. Data submitted to meet this requirement is subject to audit by HCPHES/RWGA prior to an award being recommended. Agency-generated non-verifiable data is not acceptable. In addition, applicant agency must demonstrate it has the capability to continue providing mental health treatment and/or substance abuse treatment services for the duration of the contract term (3/1/12 – 2/28/13) and any subsequent one-year contract renewals. Acceptable documentation of such continuing capability includes <u>current</u> funding from Ryan White (all Parts), TDSHS HIV-related funding (Ryan White, State Services, Substance Abuse Services), SAMSHA and other ongoing federal, state and/or public or private foundation HIV-related funding for mental health treatment and/or substance abuse treatment services. Proof of such funding must be documented in the application and is subject to independent verification by HCPHES/RWGA prior to an award being recommended.</p> <p>Loss of funding and corresponding loss of capacity to provide mental health counseling or substance abuse treatment services</p>

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	<p>as applicable may result in the termination of Clinical Case Management Services awarded under this service category. Continuing eligibility for Clinical Case Management Services funding is explicitly contingent on applicant agency maintaining verifiable capacity to provide mental health counseling or substance abuse treatment services as applicable to PLWH/A during the contract term.</p> <p>Applicant agency must be Medicaid and Medicare Certified* *Clinical Case Management services are not currently billable under Medicaid/Medicare. However, this service is intended to “wrap-around” and extend the capability of mental health therapy and/or substance abuse treatment providers to effectively serve PLWHA with mental health and/or substance abuse co-morbidities. Ryan White Program grant rules mandate that outpatient primary medical care, mental health therapy and substance abuse treatment services be provided by entities with the documented capability to bill Medicaid, Medicare and other third party payers for allowable services provided to eligible PLWHA.</p>
<p>Staff Requirements:</p>	<p>Clinical Case Managers must spend at least 42% (867 hours per FTE) of their time providing direct case management services. Direct case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the Centralized Patient Care Data Management System (CPCDMS) according to CPCDMS business rules.</p> <p><i>Must comply with applicable HCPHES/RWGA Houston EMA Part A/B Ryan White Standards of Care:</i></p> <p><u>Minimum Qualifications:</u> Clinical Case Managers must have at a minimum a Bachelor’s degree from an accredited college or university with a major in social or behavioral sciences and have a current and in good standing State of Texas license (LBSW, LSW, LMSW, LCSW, LPC, LPC-I, LMFT, LMFT-A or higher level of licensure). Clinical Case Managers must have a minimum of one (1) year paid work experience with People Living with HIV/AIDS (PLWHA). The Clinical Case Manager may supervise the Service Linkage Worker. CCM targeting Hispanic PLWHA must demonstrate both written and verbal fluency in Spanish.</p> <p><u>Supervision:</u> The Clinical Case Manager (CCM) must function with the clinical</p>

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	<p>infrastructure of the applicant agency and receive supervision in accordance with the CCM’s licensure requirements. At a minimum, the CCM must receive ongoing supervision that meets or exceeds HCPHES/RWGA published Ryan White Part A/B Standards of Care for Clinical Case Management. If applicant agency also has Service Linkage Workers funded under Ryan White Part A the CCM may supervise the Service Linkage Worker(s). Supervision provided by a CCM that is <u>not</u> client specific is considered indirect time and is not billable.</p> <p>a. Untargeted Clinical Case Management in a Substance Abuse Treatment Setting (CCM/SA): Clinical Case Management services provided within a licensed clinical substance abuse treatment setting (does <u>not</u> include substance abuse prevention programs) to eligible PLWH/A. The expectation is that a single CCM can serve approximately 150 PLWHA during the contract term. Applicant must justify the number of positions requested.</p> <p>b. Untargeted Clinical Case Management in a Mental Health Treatment Setting (CCM/MH): Clinical Case Management services provided within a clinical mental health treatment setting (i.e. professional counseling) to eligible PLWH/A. The expectation is that a single CCM can serve approximately 150 PLWHA during the contract term.</p> <p>c. Clinical Case Management in a Mental Health Treatment Setting (CCM/MH) targeting African American. Clinical Case Management services provided within a clinical mental health treatment setting (i.e. professional counseling) to eligible African American PLWH/A. The expectation is that a single CCM can serve approximately 150 PLWHA during the contract term.</p> <p>d. Clinical Case Management in a Mental Health Treatment Setting (CCM/MH) targeting Hispanics. Clinical Case Management services provided within a clinical mental health treatment setting (i.e. professional counseling) to eligible Hispanic PLWH/A. Services <u>must</u> be provided by a CCM that is fluent in both English and Spanish. The expectation is that a single CCM can serve approximately 150 PLWH/A during the contract term.</p>
<p>Special Requirements: (RWGA only)</p>	<p>Contractor must employ full-time Clinical Case Managers. Prior approval must be obtained from RWGA to split full-time equivalent (FTE) CCM positions among other contracts or to employ part-time staff.</p> <p>Contractor must perform CPCDMS new client registrations and semi-annual registration updates for clients needing ongoing case</p>

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	management services as well as those clients who may only need to establish system of care eligibility. Contractor must issue bus pass vouchers and gas cards in accordance with HCPHES/RWGA policies and procedures.
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<p>HRSA Service Category Title:</p>	<p>NON-MEDICAL CASE MANAGEMENT TARGETING YOUTH AND AT TESTING LOCATIONS</p>
<p>Local Service Category Title:</p>	<p>A. Service Linkage targeted to Not-In-Care and Newly-Diagnosed PLWHA in the Houston EMA/HDSA</p> <p>Not-In-Care PLWHA are individuals who know their HIV status but have not been actively engaged in outpatient primary medical care services for more than six (6) months.</p> <p>Newly-Diagnosed PLWHA are individuals who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system.</p> <p>B. Youth targeted Service Linkage, Care and Prevention: Service Linkage Services targeted to Youth (13 – 24 years of age), including a focus on not-in-care, newly-diagnosed and at risk Youth in the Houston EMA.</p> <p>*High-risk Youth are Youth who engage in behaviors that may place them at risk for HIV exposure. *Not-In-Care PLWHA are Youth who know their HIV status but have not been actively engaged in outpatient primary medical care services in the previous six (6) months. *Newly-Diagnosed Youth are Youth who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system.</p>
<p>Budget Type:</p>	<p>Unit Cost</p>
<p>Budget Requirements or Restrictions:</p>	<p>Early intervention services, including HIV testing and Comprehensive Risk Counseling Services (CRCS) must be supported via alternative funding (e.g. TDSHS, CDC) and may not be charged to this contract.</p>
<p>HRSA Service Category Definition:</p>	<p>Case Management (non-Medical) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.</p> <p>Early intervention services (EIS) include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.</p>

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<p>Local Service Category Definition:</p>	<p>A. <i>Service Linkage:</i> Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or <i>Not-In-Care</i> PLWHA who know their status but are not currently enrolled in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies.</p> <p>B. <i>Youth targeted Service Linkage, Care and Prevention:</i> Providing Ryan White Program appropriate outreach and service linkage activities to high risk HIV–negative Youth and newly-diagnosed and/or not-in-care HIV-positive Youth who know their status but are not currently enrolled in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on their behalf to decrease service gaps and remove barriers to services; helping Youth develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies. Provide comprehensive medical case management to HIV-positive youth identified through outreach and in-reach activities.</p>
<p>Target Population (age, gender, geographic, race, ethnicity, etc.):</p>	<p>A. <i>Service Linkage:</i> Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain</p>

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	<p>financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility.</p> <p>Service Linkage is intended to serve eligible clients in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.</p> <p>B. Youth targeted Service Linkage, Care and Prevention: Services will be available to eligible HIV-infected and at-risk HIV-negative Youth (ages 13 – 24) residing in the Houston EMA/HSDA with priority given to clients most in need. All Youth who receive services will be served without regard to age (i.e. limited to those who are between 13- 24 years of age), gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income Youth at risk for, or living with, HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target Youth who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility.</p> <p>Youth Targeted Service Linkage, Care and Prevention is intended to serve eligible youth in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.</p>
<p>Services to be Provided:</p>	<p>Goal (A): Service Linkage: The expectation is that a single Service Linkage Worker FTE targeting Not-In-Care and/or newly-diagnosed PLWHA can serve approximately 80 PLWH/A per year.</p> <p>The purpose of Service Linkage is to assist clients with the</p>

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	<p>procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Community Case Manager (COCM) for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. The purpose of Service Linkage is to assist clients who do not require the intensity of <i>Clinical or Medical Case Management</i>, as determined by RWGA Quality Management guidelines. Service Linkage is primarily office-based and includes the issuance of bus pass vouchers and gas cards per published guidelines. Service Linkage targeted to Not-In-Care and/or Newly-Diagnosed PLWHA extends the capability of existing programs with a documented track record of identifying Not-In-Care and/or newly-diagnosed PLWHA by providing “hands-on” outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services.</p> <p>In order to ensure linkage to an ongoing support system, eligible clients identified funded under this contract, including clients who may obtain their medical services through non-Ryan White-funded programs, must be transferred to a Ryan White-funded Primary Medical Care, Clinical Case Management or Service Linkage program within 120 days of initiation of services as documented in the CPCDMS data system. Those clients who choose to access primary medical care from a non-Ryan White source, including private physicians, <u>may receive ongoing service linkage services from provider</u> or must be transferred to a Clinical (CCM) or Primary Care/Medical Case Management site per client need and the preference of the client.</p> <p>GOAL (B): This effort will continue a program of <i>Service Linkage, Care and Prevention to Engage HIV Seropositive Youth</i>, specifically: Support of a project targeting youth (ages 13-24) with a focus on Youth of color. This service will support an innovative service model designed to reach HIV seropositive youth of color not engaged in clinical care and to link them to appropriate clinical, supportive, and preventive services. The specific objectives are to: (1) conduct outreach (service linkage) to assist seropositive Youth learn their HIV status, (2) link HIV-infected Youth with primary care services, and (3) prevent transmission of HIV infection from targeted clients.</p>
Service Unit Definition(s):	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	No financial cap.
Client Eligibility:	A. Not-In-Care and/or newly-diagnosed HIV-infected individuals residing in the Houston EMA.

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	<p>B. High Risk HIV-negative, not-in-care and/or newly-diagnosed HIV-infected Youth residing in the Houston EMA.</p>
<p>Agency Requirements:</p>	<p>Service Linkage services will comply with the HCPHES/RWGA published Service Linkage Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system.</p> <p>Service Linkage targeted to High Risk HIV-negative, Not-In-Care and/or newly diagnosed PLWHA must be planned and delivered in coordination with local HIV prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Contractor must document established linkages with agencies that serve HIV-infected clients or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV/AIDS primary care providers.</p>
<p>Staff Requirements:</p>	<p>Service Linkage Workers must spend at least 42% (867 hours per FTE) of their time providing direct client services. Direct service linkage and case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the Centralized Patient Care Data Management System (CPCDMS) according to CPCDMS business rules.</p> <p><i>Must comply with applicable HCPHES/RWGA published Ryan White Part A/B Standards of Care:</i></p> <p><u>Minimum Qualifications:</u></p> <p>Service Linkage Workers must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH/A may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA.</p>

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	<p><u>Supervision:</u> The Service Linkage Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds HCPHES/RWGA published Ryan White Part A/B Standards of Care for Service Linkage.</p>
Special Requirements:	<p><u>Contractor must be have the capability to provide Public Health Follow-Up by qualified Disease Intervention Specialists (DIS) to locate, identify, inform and refer newly-diagnosed and not-in-care PLWHA to outpatient primary medical care services.</u></p> <p>Contractor must perform CPCDMS new client registrations and, for those newly-diagnosed or out-of-care clients referred to non-Ryan White primary care providers, semi-annual registration updates for those needing ongoing service linkage services as well as those clients who may only need to establish system of care eligibility. Contractor must issue bus pass vouchers and gas cards in accordance with HCPHES/RWGA policies and procedures.</p>

The Role of the Harris County Hospital District
Testing & Linkage HIV Service Linkage Worker (SLW)

The role of the Service Linkage Worker (SLW) is vital to our efforts to identify newly HIV-diagnosed patients, as well as return-to-care patients, and facilitate their linkage into appropriate primary health care. The method in which an HIV + diagnosis is delivered and the manner in which post-test counseling is provided, can greatly affect the success rate of linkage to care.

HCHD HIV Service Linkage Workers are required to have:

- A Bachelors Degree in an appropriately related field
- Predetermined number of years paid HIV work may be substituted for a degree.
- Extensive training in Protocol-Based Counseling techniques
- Extensive training in Motivational Interviewing techniques
- Continuing Education
- LMSW collaborative case supervision 4 hours monthly

HCHD HIV Service Linkage Workers provide:

- Delivery of HIV + diagnosis
- Post-Test Counseling
- Assessment of Care Needs & Coordination of Resources
- Access to Eligibility
- Access to Screening
- Follow up
- Required Documentation
- ADAP Application Assistance
- Billing Opportunities

Delivery of HIV + diagnosis: The delivery of an HIV + diagnosis can bring about a wide range of reactions from the patient, especially if the patient did not come in to the pavilion with the sole intent of being tested for HIV. Reactions can range from despair, feeling of doom, or anger at the person who infected them, to anger at the person delivering the results. On occasion, patients react violently when given their results. SLWs are prepared to use appropriate techniques to defuse such situations.

Post-Test Counseling: This is a crucial moment in the linkage to care process. The ability to provide appropriate, up-to-date information and to answer all patients' questions is essential to providing a sense of hope and successfully linking the patient into care. The first encounter after a positive diagnosis should be with a staff member specifically trained to deliver HIV test results such as our SLW. This is also an opportunity for the SLW to do an informal assessment of the patient's psychosocial needs and referral into appropriate follow-up care. The SLW will also talk with the patient regarding the importance of adherence to care.

Assessment of Care Needs & Coordination of Resources: The SLW works collaboratively with the Medical Case Management Teams at BTGH, LBJ, Thomas Street Health Center, Northwest Health Center, and Settegast to ensure that a patient's barriers to care are addressed. These can include; psychosocial needs, transportation challenges, family support issues, homelessness, etc. The SLW uses both internal and external resources to assist the patient. If a patient wishes to receive primary care from an agency outside of the District, the SLW can assist with referral and access.

Eligibility: The SLW is directly connected to the Eligibility team at TSHC, where the process is somewhat more extensive than at other HCHD sites. In addition to establishing eligibility for HCHD's Gold Card, patients register in the CPCDMS (Centralized.....) in order to receive services provided by Ryan White funds. The SLW helps newly diagnosed patients schedule appointments with Eligibility, as well as helping them, when possible; to assemble all the documentation they will need for both processes. This reduces the patient's wait time for services.

Screening: Each new and returning-to-care patient's needs are assessed by a Screening Team at TSC so that the entire range of their medical and psychosocial status can be determined. SLWs schedule this screening appt when they meet initially with a patient, which significantly reduces the length of time a patient waits to be seen.

Follow up: The SLW maintains contact with the patient until the patient is seen by an HIV provider to encourage adherence to appointment date(s). The SLW maintains contact to assist the patient with any new developments that might hinder that patient's ability to present. Having a familiar voice (*often the person who delivered the results and provided initial counseling*) is reassuring to the patient and provides the patient with a connection regarding their HIV care. Provided that patient contact information is correct and the patient can be reached; the SLW will place a reminder call to patient prior to screening/eligibility appointments and prior to their initial provider appointment. The SLW will also place a follow-up call with the patient after their initial provider visit to insure adherence/compliance as well as patient satisfaction. Contact is also routinely initiated by the patient who has multiple options for making contact with the SLW should that patient have needs or questions.

Documentation: This is an extremely important piece of the process. Patient encounters by our SLW must be documented and reported in several different places. Detailed EPIC notes must be completed on all patient encounters. In addition, the Harris County Public Health & Environmental Services (Part A Funding Source) requires that we report encounters with HIV + patients in the HCPHES database known as CPCDMS. All CPCDMS entries must have a corresponding EPIC entry.

Funding sources

Several different sources outside HCHD – including Ryan White Parts A and C, CDC, and Texas DSHS – provide all the funding utilized for SLWs. By combining these resources, we are able ensure a seamless route from testing into primary and specialty health care for newly diagnosed and returning to care patients. Additionally, the SLWs work closely with City of Houston DIS staff to locate and contact patients.

Table 1. Percentage of 2010 Newly Diagnosed Individuals Linked into Care within Three Months of Diagnosis

	Total		Austin TGA		Dallas EMA		Fort Worth TGA		Houston EMA		San Antonio TGA		Other Texas		TDCJ	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Total	2180	68.6	138	79.8	627	76	132	71.7	650	65.1	139	69.2	431	65.6	63	45
Sex																
Female	534	72.3	27	87.1	139	78.1	39	75	162	66.1	28	80	130	75.6	9	34.6
Male	1646	67.5	111	78.2	488	75.4	93	70.5	488	64.7	111	66.9	301	62.1	54	47.4
Race/Ethnicity																
White	569	72.6	60	77.9	187	82	51	79.7	117	66.9	30	65.2	115	69.3	9	32.1
Black	889	64.5	31	81.6	293	73.1	56	64.4	329	61	22	62.9	124	60.2	34	46.6
Hispanic	677	70.7	44	81.5	133	73.5	21	75	192	71.1	81	71.1	187	68.5	19	50
Other	33	80.5	2	100	8	88.9	4	100	10	83.3	6	100	3	37.5	.	.
Unknown	12	70.6	1	50	6	100	.	.	2	66.7	.	.	2	50	1	100
Age																
0-1	4	80	.	.	1	100	1	100	2	66.7	.	.	.	.	.	.
02-12	2	66.7	.	.	.	.	.	.	1	50	.	.	1	100	.	.
13-24	456	63.7	28	75.7	138	69	26	70.3	123	57.5	36	69.2	95	61.3	10	47.6
25-34	668	69.1	39	78	191	75.2	38	74.5	200	67.6	42	63.6	132	67	26	49.1
35-44	543	70.8	38	82.6	169	81.3	34	65.4	172	67.2	28	70	85	66.9	17	44.7
45-54	382	70.9	27	84.4	99	79.2	22	73.3	111	67.3	22	78.6	91	68.4	10	38.5
55+	125	68.7	6	75	29	78.4	11	84.6	41	65.1	11	73.3	27	61.4	.	.
Mode of Transmission																
MSM	1331	69.1	93	79.3	438	76.7	75.9	70.8	378	65.2	90	69.5	229	63.3	27	46
IDU	165	59.9	14	86.7	23.4	69.4	11.3	78.5	32.9	51.1	20	74.8	44.4	61.2	20	41
MSM/IDU	60.1	63.9	4.6	59	11.1	73.5	3.5	61.4	11.9	58.1	5.9	46.8	17.8	78.8	5.3	54.6
Heterosexual	618	70.6	27	83	153	75.1	40.3	72.4	224	68.1	24	71.7	139	69.7	10	46.8
Pediatric	6	75	.	.	1	100	1	100	3	60	.	.	1	100	.	.
Late Diagnosis (<1 year between HIV and AIDS)																
Not a Late DX	1422	61.9	103	77.4	406	70	87	68.5	402	57.3	88	62.4	282	58	54	42.2
Late DX	758	85.9	35	87.5	221	90.2	45	79	248	83.5	51	85	149	87.1	9	75
HIV/2010 STI Coinfection																
No HIV/STD coinfection	1936	68.5	114	79.2	554	76.9	120	74.1	578	64.2	116	69.1	393	65.9	61	44.9
HIV/STD coinfection	244	69.3	24	82.8	73	69.5	12	54.6	72	73.5	23	69.7	38	62.3	2	50

Table 2. Percentage of 2010 Newly Diagnosed Individuals Linked into Care within Three Months of Diagnosis by Race/Ethnicity and Sex

	Total				Austin TGA				Dallas EMA				Fort Worth TGA				Houston EMA				San Antonio TGA				Other Texas				TDCJ			
	Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%		
Total	534	72.3	1646	67.5	27	87.1	111	78.2	139	78.1	488	75.4	39	75	93	70.5	162	66.1	488	64.7	28	80	111	66.9	130	75.6	301	62.1	9	34.6	54	47.4
<i>Race/Ethnicity</i>																																
White	88	73.3	481	72.4	9	81.8	51	77.3	15	93.8	172	81.1	14	77.8	37	80.4	15	51.7	102	69.9	6	100	24	60	27	81.8	88	66.2	2	28.6	7	33.3
Black	320	69.7	569	61.9	11	100	20	74.1	106	76.8	187	71.1	18	69.2	38	62.3	115	64.6	214	59.3	9	75	13	56.5	56	68.3	68	54.8	5	41.7	29	47.5
Hispanic	113	78.5	564	69.3	7	77.8	37	82.2	16	76.2	117	73.1	3	75	18	75	31	83.8	161	69.1	12	75	69	70.4	42	84	145	65	2	28.6	17	54.8
Other	10	76.9	23	82.1	.	.	2	100	1	50	7	100	4	100	.	.	1	100	9	81.8	1	100	5	100	3	60	.	.	.	.	.
Unknown	3	100	9	64.3	.	.	1	50	1	100	5	100	.	.	.	.	.	.	2	66.7	.	.	.	.	2	100	.	.	.	1	100	

Table 3. Percentage of 2010 Newly Diagnosed Individuals Linked into Care within 3 Months of Diagnosis by Race/Ethnicity & Mode of Transmission

		Total		Austin TGA		Dallas EMA		Fort Worth TGA		Houston EMA		San Antonio TGA		Other Texas		TDCJ	
		#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Total		2180	68.6	138	79.8	627	76	132	71.7	650	65.1	139	69.2	431	65.6	63	45
MSM	White	417	73.5	45.1	78.4	161	81.1	31.3	80.3	91.6	71.6	19.6	60.5	65.8	66.3	2.4	18.8
	Black	413	62.5	14.8	78.3	158	71.6	27.9	62.7	144	57.3	9.1	61.9	45.2	53.6	14.8	52.9
	Hispanic	473	71.6	29.9	81.5	109	76.8	16.7	73.6	133	70.2	57.2	73.2	118	67.8	9.4	52.8
	Other	19	84.1	2	100	5.6	100	.	.	7.4	86.1	4	100	.	.	.	.
	Unknown	8.4	64.1	1	52.6	4.7	100	.	.	2	66.7	.	.	.	.	0.7	100
	Total	1331	69.1	92.8	79.3	438	76.7	75.9	70.8	378	65.2	89.9	69.5	229	63.3	27.3	46
IDU	White	45.3	65.8	3	90.9	6.3	85.1	5.1	91.1	7.6	47.8	4.8	82.8	14.2	68.3	4.3	43
	Black	78.1	56.5	5.6	76.7	14.2	71	3.2	56.1	20.9	50.7	4.9	60.5	18.2	64.3	11.1	40.2
	Hispanic	38.8	59.5	5.1	98.1	1.7	33.3	2.4	96	4.4	62	9.9	80.5	10.7	49.3	4.6	40.7
	Other	1.1	68.8	.	.	0.2	100	0.6	100	.	.	.	.	0.3	50	.	.
	Unknown	2.1	95.5	.	.	1	100	.	.	.	.	.	.	1	90.9	0.1	100
	Total	165	59.9	13.7	86.7	23.4	69.4	11.3	78.5	32.9	51.1	19.6	74.8	44.4	61.2	20.1	41
MSM/IDU	White	26.5	65.9	4.3	67.2	6.2	82.7	0.7	35	3.6	51.4	2	48.8	8.5	80.2	1.2	46.2
	Black	20.4	70.3	.	.	3.4	85	2.5	73.5	6.8	69.4	0.4	50	5.5	85.9	1.8	50
	Hispanic	12	51.1	0.3	75	1.4	40	0.3	100	1.5	40.5	2.5	37.3	3.8	69.1	2.2	64.7
	Other	1	90.9	.	.	.	.	.	.	.	.	1	100	.	.	.	.
	Unknown	0.2	100	.	.	0.1	100	.	.	.	.	.	.	.	.	0.1	100
	Total	60.1	63.9	4.6	59	11.1	73.5	3.5	61.4	11.9	58.1	5.9	46.8	17.8	78.8	5.3	54.6
Hetero	White	79.2	74.4	7.6	77.6	13.3	92.4	12.9	78.7	14.2	58.9	3.6	97.3	26.5	74.9	1.1	42.3
	Black	373	68.6	10.6	98.2	118	75.1	22.4	67.1	155	66.5	7.6	66.7	54.1	63	6.3	45.7
	Hispanic	152	73.2	8.7	74.4	19.9	67.7	1.6	64	53.1	76.1	11.4	67.9	54.7	75.9	2.8	50.9
	Other	11.9	75.8	.	.	2.2	68.8	3.4	100	2.6	81.3	1	100	2.7	55.1	.	.
	Unknown	1.3	86.7	.	.	0.2	100	.	.	.	.	.	.	1	90.9	0.1	100
	Total	618	70.6	26.9	83	153	75.1	40.3	72.4	224	68.1	23.6	71.7	139	69.7	10.3	46.8
Pediatric	White	1	100	.	.	.	.	1	100	.	.	.	.	.	.	.	.
	Black	4	66.7	.	.	.	.	.	.	3	60	.	.	1	100	.	.
	Hispanic	1	100	.	.	1	100	.	.	.	.	.	.	.	.	.	.
	Total	6	75	.	.	1	100	1	100	3	60	.	.	1	100	.	.

Table 4. Percentage of 2010 Newly Diagnosed Individuals Linked into Care within Three Months of Diagnosis by Mode of Transmission, Race/Ethnicity and Sex

		Total				Austin TGA				Dallas EMA				Fort Worth TGA				Houston EMA				San Antonio TGA				Other Texas				TDCJ					
		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		Male							
		#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%						
Total		534	72.3	1646	67.5	27	87.1	111	78.2	139	78.1	488	75.4	39	75	93	70.5	162	66.1	488	64.7	28	80	111	66.9	130	75.6	301	62.1	9	34.6	54	47.4		
MSM	White	.	.	417	73.5	.	.	45	78.4	.	.	161	81.1	.	.	31	80.3	.	.	91.6	71.6	.	.	20	60.5	.	.	65.8	66.3	.	.	2.4	18.8		
	Black	.	.	413	62.5	.	.	15	78.3	.	.	158	71.6	.	.	28	62.7	.	.	144	57.3	.	.	9.1	61.9	.	.	45.2	53.6	.	.	15	52.9		
	Hispanic	.	.	473	71.6	.	.	30	81.5	.	.	109	76.8	.	.	17	73.6	.	.	133	70.2	.	.	57	73.2	.	.	118	67.8	.	.	9.4	52.8		
	Other	.	.	19	84.1	.	.	2	100	.	.	5.6	100	.	.	.	.	.	.	7.4	86.1	.	.	4	100	.	.	.	.	.	.	.	.
	Unknown	.	.	8.4	64.1	.	.	1	52.6	.	.	4.7	100	2	66.7	0.7	100	
	Total	.	.	1331	69.1	.	.	93	79.3	.	.	438	76.7	.	.	76	70.8	.	.	378	65.2	.	.	90	69.5	.	.	229	63.3	.	.	27	46		
IDU	White	26.4	66.7	18.9	64.7	2.9	96.7	0.1	33.3	3.6	92.3	2.7	77.1	2.2	81.5	2.9	100	4.8	45.7	2.8	51.9	4	100	1.2	54.6	8.2	72.6	6	63.2	1	23.9	3.2	59.3		
	Black	33.4	62.7	44.7	52.7	2.5	100	3.1	64.6	7.8	72.9	6.4	68.8	1.5	60	1.7	53.1	5.7	41.3	15.2	55.5	3	73	2.2	50	11	70.1	7.2	57.1	2	50	8.9	38.4		
	Hispanic	12.2	72.2	26.6	55.1	1.3	100	3.8	97.4	0.1	8.33	1.6	41	2	95.2	0.4	100	0.4	57.1	4	62.5	5	100	5.2	68.4	3.3	86.8	7.4	41.3	0	12.9	4.2	51.2		
	Other	1	100	0.1	16.7	0.1	100	0.1	100	0.6	100	0.3	100	
	Unknown	2	100	0.1	50	1	100	1	100	0.1	100
	Total	75	66.5	90.4	55.4	6.7	98.5	7	77.8	12.6	74.6	10.8	64.3	6.3	79.8	5	76.9	10.9	43.6	22	55.8	11	91.7	8.6	60.6	23.8	74.1	20.6	51	4	30.6	16	44.4		
MSM/IDU	White	.	.	26.5	65.9	.	.	4.3	67.2	.	.	6.2	82.7	.	.	0.7	35	.	.	3.6	51.4	.	.	2	48.8	.	.	8.5	80.2	.	.	1.2	46.2		
	Black	.	.	20.4	70.3	.	.	.	.	3.4	85	.	.	2.5	73.5	.	.	2.5	73.5	6.8	69.4	.	.	0.4	50	.	.	5.5	85.9	.	.	1.8	50
	Hispanic	.	.	12	51.1	.	.	0.3	75	.	.	1.4	40	.	.	0.3	100	.	.	1.5	40.5	.	.	2.5	37.3	.	.	3.8	69.1	.	.	2.2	64.7		
	Other	.	.	1	90.9	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	1	100	.	.	.	.	.	.	.	.
	Unknown	.	.	0.2	100	0.1	100	0.1	100
	Total	.	.	60.1	63.9	.	.	4.6	59	.	.	11.1	73.5	.	.	3.5	61.4	.	.	11.9	58.1	.	.	5.9	46.8	.	.	17.8	78.8	.	.	5.3	54.6		
Hetero	White	60.6	76.3	18.6	68.9	6.1	76.3	1.5	83.3	11.4	94.2	1.9	82.6	11	75.5	2.1	100	10.2	55.1	4	71.4	2	100	1.2	92.3	18.8	86.6	7.7	56.2	1	37.5	0.2	100		
	Black	285	70.9	88.5	62.1	8.5	100	2.1	91.3	98.2	77.1	19.4	66	17	70.2	5.9	59.6	108	67.2	46.2	65.1	6	75.9	1.3	41.9	44	67.4	10.1	49	3	36.8	3.5	56.5		
	Hispanic	101	79.3	51.4	63.7	5.7	74	3	75	15.9	80.3	4	41.7	1	52.6	0.6	100	30.6	84.3	22.5	67.2	7	64.6	4.1	74.6	38.7	83.8	16	61.8	2	41	1.2	75		
	Other	9	75	2.9	78.4	.	.	.	.	0.9	47.4	1.3	100	3.4	100	.	.	1	100	1.6	72.7	1	100	.	.	2.7	57.5	.	.	.	.	.	.
	Unknown	1	100	0.3	60	0	.	0.2	100	1	100	0.1	100	
	Total	456	73.4	162	63.6	20	83.9	6.6	80.5	126	78.5	26.8	62.6	32	73.6	8.6	68.3	150	69.2	74.3	66.2	17	73.9	6.6	66.7	105	75.7	33.8	55.9	5	38.1	5	61.7		
Pediatric	White	1	100	1	100	
	Black	2	50	2	100	.	.	.	.	.	.	.	.	.	.	.	.	1	33.3	2	100	.	.	.	.	1	100	.	.	.	.	.	.
	Hispanic	.	.	1	100	1	100	
	Total	3	60	3	100	.	.	.	.	.	.	1	100	.	.	.	.	1	33.3	2	100	.	.	.	.	1	100	.	.	.	.	.	.

2012 Houston Area Comprehensive HIV Service Plan GAPS IN CARE AND OUT-OF-CARE WORKGROUP

KEY QUESTIONS FOR EXPLORATION

Education to Positives

- How many education programs are specifically targeting PLWHA regarding entry to, retention in, and return to care?

ENTRY TO Care:

- | | |
|--|-------------------------|
| 1. HDHHS (SLW) | 7. Next Step (LEGACY) 3 |
| 2. HACS (SLW) | 8. |
| 3. LEGACY (SLW) | 9. |
| 4. ST. HOPE (SLW) | 10. |
| 5. ST. HOPE (BRO FOR LIFE/
FUSION PROGRAMS) 1 | |
| 6. HCHD | |

RETENTION IN CARE:

- | | |
|--------------------------|--|
| 1. HDHHS (SLW) | 8. ST. HOPE (BRO FOR LIFE/
FUSION PROGRAMS) |
| 2. HACS (SLW) | 9. HEALTH RELATIONSHIPS 5 |
| 3. LEGACY (SLW) | (LEGACY) |
| 4. ST. HOPE (SLW) | 10. POSITIVE OPTIONS 6 |
| 5. HCDH (SLW) | (LEGACY) |
| 6. GET STARTED (AFH) 4 | |
| 7. POSITIVE VIBE (AFH) 5 | |

RETURN / REENGAGEMENT IN CARE:

- 1. MCM/M and NMCM.**

In Primary Medical Care Services.



Return to Care Collaborative Austin TGA

Purpose

As part of ongoing quality management efforts, several AIDS service organizations in the Austin TGA are working together to identify clients who are out of care, and those who are at risk for being out of care.

Rather than relying solely on their own organization's data, administrators are utilizing the "shared" function in ARIES to communicate with other agencies that might have had more recent contact with clients.

Method

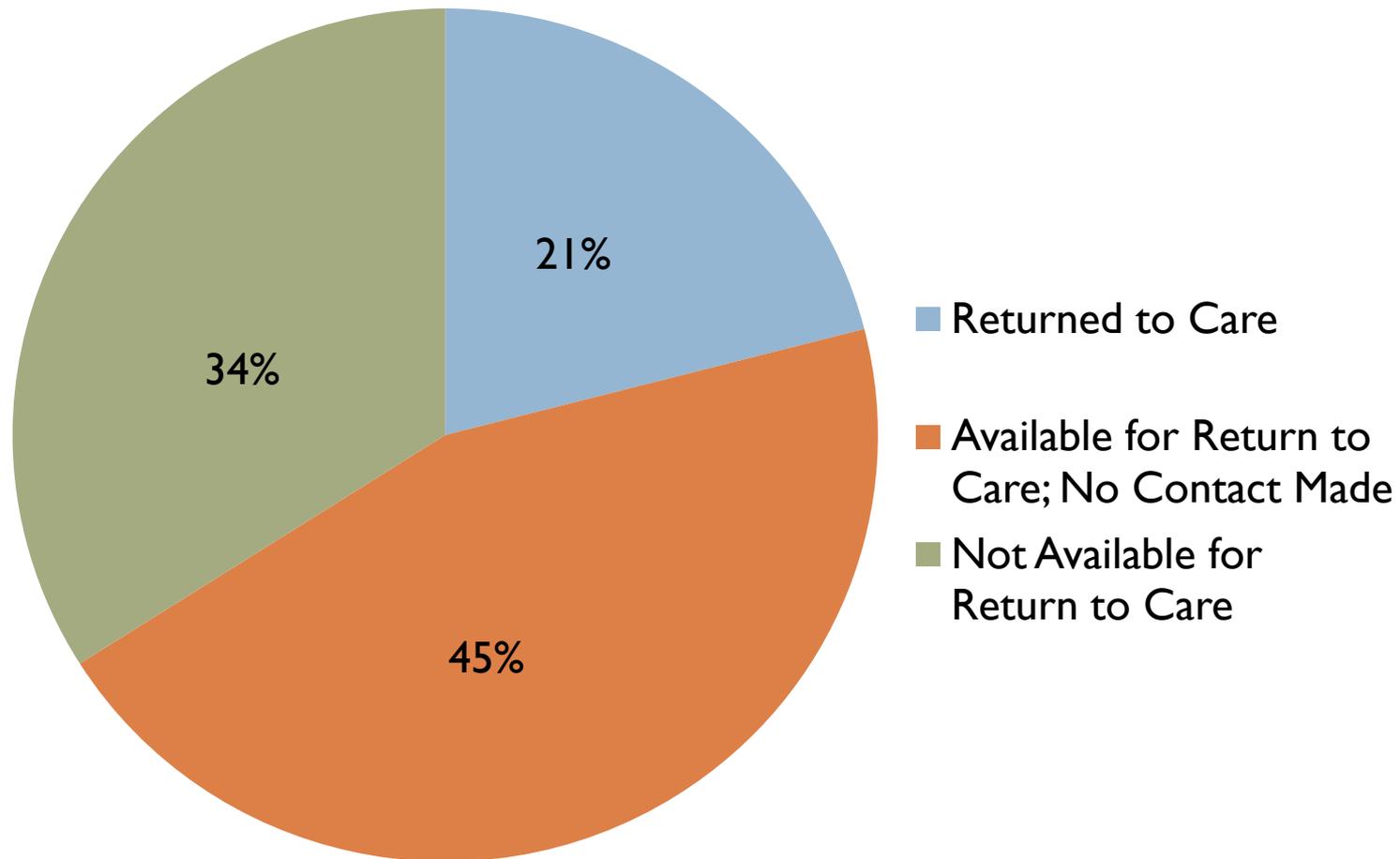
- One central agency, the David Powell Clinic, looks through their records for clients who have been lost to contact for six months or more.
- The Data Manager at David Powell then checks to see what other agencies the client also receives services from.
- Lists of out-of-care/at-risk clients are provided to each agency once a month in order to attempt to locate clients and bring them back in to care.

Results as of 1/13/10

155 Clients Identified

- 21% (32 clients) were successfully scheduled for an appointment
- 6% (9 clients) were discharged from services
- 3% (4 clients) were incarcerated
- 14% (22 clients) relocated
- 10% (15 clients) transferred to another provider
- 25% (38 clients) were unable to be contacted
- 21% (32 clients) were left messages
- 1% (1 client) either declined, were in ASH, or were deceased.
- Patients identified: active patients with at least one missed provider appointment
- Appointment scheduled
- Discharged: haven't been seen in over a year, must go through RTC intake appointment if they come back (truly out-of-care)
- Relocated: moved out of HSDA
- Transferred: still living in area, receiving services from another provider
- Unable to contact: no phone available or phone number provided was disconnected

Results Continued



Not available for Return to Care are clients who relocated, transferred, are deceased, incarcerated, hospitalized, etc. NOT who we're concerned about.

Lessons Learned

- The agency was able to dispel the notion that the majority of “lost” clients had been incarcerated.
 - DPC has a good working relationship with local jails and utilizes inmate search function for TDCJ.
- Initially, the agency discovered a surprising amount of identified clients were deceased.
- Most of the clients identified were not really out of care, just unaccounted for in ARIES.
- DPC is working on identifying and deleting duplicate entries, as this has impacted the number of clients identified as out-of-care.

Next Steps

- As the number of identified clients decreases, the RTC Collaborative is shifting its focus to preventing clients from being lost to care.
- Agencies are attempting to identify commonalities among clients, and address barriers that may exist.
 - Return to Care Intakes are specifically designed to ask questions about why a client dropped out of care, what brought them back in, and what can be improved to prevent others from dropping out of care for similar reasons.

Next Steps Continued

- I suggested to other committee members that BVCOG, as an AA, be provided a list like the agencies.
 - As an AA, we have data for clients in 43 counties. If we were provided a list, we could at least look for clients in ARIES and report back that they were accounted for. Confidentiality would be maintained, since we wouldn't disclose where the client was.
- BVCOG contacted DSHS, to make sure we weren't breaking any ruled, and Darla said she would also be able to look for clients and account for their whereabouts if provided with a list of client names and ID numbers.

Social Support & Activities

Apoyo Social y Actividades

Many people in the Houston area volunteer their time to help HIV infected persons and their families. Some volunteers serve as “buddies” by developing one-on-one relationships with HIV+ persons who need additional social or emotional support. “Phone buddies” provide support through telephone contact. “Care Teams” are groups of volunteers who provide companionship. Some volunteers help with food preparation, transportation, and running errands. Call one of the following agencies if you need this type of assistance. Also, there are many activities for HIV+ people and opportunities to meet others in the Houston area.



Art by Mauricio

Muchos en Houston son voluntarios y ayudan a las personas infectadas con el VIH y sus familiares. Algunos toman el papel de “amigo” al desarrollar una relación con la persona VIH+ quien necesita apoyo social o emocional. Los “Amigos telefónicos” proveen apoyo por medio del teléfono. “Equipos de apoyo” son grupos de voluntarios que proveen compañía. A veces, los voluntarios ayudan con transporte, mandados o la preparación de alimentos. Llame si necesita este tipo de asistencia. En adición, hay muchas actividades y oportunidades donde una persona VIH+ puede conocer a otras en Houston.

Agency / Agencia	Phone / Teléfono	Location / Localizado	Legend / Tabla	Page #
Art League Houston HIV+ Healing Art Group	(713) 523-9530	(C) Montrose	All, Free, Walk-ins, Call for class location.	93
Covenant House Texas	(713) 523-2231	(C) Montrose	Y (13 - 18), W (18-21), Free, Esp, Walk-ins, Parenting/pregnant moms under 21	102
Harmony Health Recovery Center	(713) 237-1765	(C) Memorial/Washington	M only, Free, Lim, CD, Homeless & TB	111
HCHD - Northwest Community Health Center	(713) 861-3939	(NW) Oak Forest	M, W, Free, S\$, Med, Appt/Walk-ins, HIV+ only	112
HCHD - Thomas Street Health Center	(713) 873-4000		M, W, Free, S\$, Med, HIV+ only Gold card, Esp	113
HCHD - Women’s Program	(713) 873-4511	(C) Near Northside	W, Free, S\$, Med, HIV+ only , Gold card, Esp.	113
Houston Humane Society - Burnie’s Buddies	(713) 433-6421	(S)	All, HIV+ only , Flat fee, Appt req, Esp	119
Houston Humane Society - Paw Prints	(713) 433-6421	(S)	All, HIV+ only , Flat fee, Appt req, Esp	119
Interfaith CarePartners® AIDS Care Team®	(713) 682-5995	(W) Memorial	All, Free, Walk-ins, Accepts rural collect calls, Esp.	121
LIVE Consortium	(713) 861-5483	(C) Midtown	All.	124
Living Without Limits, Living Large, Inc.	(832) 545-5689	(N) Homestead	Infected/affected heterosexuals (M & W), Free	124
Pet Patrol	(281) 733-7696	All	All (low income & disabled), Free, Appt Req, Call for intake.	132
Positive Brothers United	(713) 454-7548	(C) Montrose	M, W, HIV+ only , Free, Walk-ins.	132
Resurrection Metropolitan Community Church	(713) 861-9149	(C) Heights	All, Appt req, ID.	133
SEARCH	(713) 739-7752	(C) Midtown	All, I/RR, Free, Walk-ins, CD, Homeless only, Esp	135

Support Groups / Grupos de Apoyo

HIV+ individuals may feel alone, depressed, confused or even guilty. Sometimes help is needed to sort out these emotions. Support groups are available for people with HIV and their loved ones. These services are frequently either free of charge or based on the client's income

Personas con el VIH pudiesen sentirse solas, deprimidas, confusas o hasta culpables. A veces se necesita ayuda para enfrentar estos sentimientos. Los grupos de ayuda están disponibles para estas personas y sus familiares y muchas veces son gratuitos o basados en el ingreso del cliente.

SUPPORT GROUPS / GRUPOS DE APOYO

Agency / Agencia	Phone / Teléfono	Location / Localizado	Legend / Tabla	Page #
Bay Area Turning Point, Inc.	(281) 338-7600	(SE) Webster	HIV+ only , Free, Families, All, Appt Req, M, W.	94
Bering Support Network	(713) 526-1017 Ext 206	(C) Montrose	M, W, Walk-ins, Free, Flat fee, Infected/affected	97
Bridge Over Troubled Waters, Inc., The	(713) 472-0753	(SE) Pasadena	W, Fam, All, Appt req, Esp	98
Catholic Charities AIDS Ministry	(713) 874-6624	(C) Midtown	Adults, Families, Free, Walk-ins, HIV+ only , I/RR, Immigrants, Esp	99
HCHD - Adolescent Program	(713) 873-4100	(C) Near Northside	Y, Free, S\$, Med, HIV+ only , Esp, Gold card.	111
HCHD - Thomas Street Health Center	(713) 873-4000	(C) Near Northside	M, W, Free, S\$, Med, HIV+ only , Esp, Gold card.	113
HCHD - Women's Program	(713) 873-4511	(C) Near Northside	W, Free, S\$, Med, HIV+ only , Esp, Gold card.	113
Inner Door Counseling and Rehabilitation Center	(713) 278-8870	(SW) Sharpstown	All, S\$, Ins, Med, CHIP, Appt/Walk-ins	120
InnerWisdom Counseling Center	(713) 592-9292	(C) Medical Center	M, W, Fam, All, Med, S\$, Self pay, Walk-ins, Esp	120
InnerWisdom Wellness Center	(713) 592-9294	(C) Medical Center	M, W, All, S\$, Med, Appt Req, Esp	120
Living without Limits, Living Large, Inc.	(832) 545-5689	(C) Third Ward	Infected/affected heterosexuals (M & W), Free	124
New Hope Counseling Center	(713) 776-8006	(SW) Sharpstown	M, W, All ages, HIV+ only , Free, Walk-ins, CD	129
Northwest Assistance Ministries	(281) 885-4555	(N) Bammel	Families, Free, Appt Req, Esp	130
PFLAG Houston	(713) 46P-FLAG	(C) Hermann Park	All, Free	132
Positive Brothers United	(713) 454-7548	(C) Montrose	M, W, HIV+ only , Free, Walk-ins	132
Triangle AIDS Network, Inc.	(409) 832-8338	(E) Beaumont	Appt req, Free, S\$, HIV+ only , UTMB affiliate, Esp	144

Support Groups / Grupos de Apoyo

12-STEP PROGRAMS & SUPPORT GROUPS / PROGRAMAS "12-STEP" Y DE GRUPOS DE APOYO

Agency / Agencia	Phone / Teléfono	Location / Ubicación	Legend / Tabla	Page #
First Intervention Counseling	(281) 994-7857	(W) Addicks/ Park 10	All, S\$, Appt/Walk-ins, Referral req, call for intake.	105
Gulf Coast Center, The	(800) 643-0967	(S) Alvin	All, S\$, Appt req, CD, Esp	108
Inner Door Counseling and Rehabilitation Center	(713) 278-8870	(SW) Sharpstown	All, S\$, Ins, Med, CHIP, Appt/Walk-ins	120
Intergroup Association, Inc.	(713) 686-6300	(NW) Inwood Forest	All, I/RR, Free, Lim, CD, Esp	121

Support Groups / Grupos de Apoyo

12-STEP PROGRAMS & SUPPORT GROUPS / PROGRAMAS "12-STEP" Y DE GRUPOS DE APOYO

Agency / Agencia	Phone / Teléfono	Location / Ubicación	Legend / Tabla	Page #
LAMBDA Center	(713) 521-1243	(C) Montrose	Not specified.	122
Memorial Hermann Prevention & Recovery Ctr	(713) 939-7272	(W) Spring Shadows	Adults / adolescents, Flat fee, Ins, Private Pay, Walk-ins, CD.	127
Palmer Drug Abuse Pgm (PDAP)	(281) 589-4832	All	Y (ages 12-25), Free, Walk-ins, CD . .	131
PDAP Age 12 to 17 group	(713) 668-0133	(C) Bellaire	Y (ages 12-17), Free, Walk-ins, CD . .	131
PDAP Age 12 to 17 group	(281) 870-9311	(NW) Addicks/ Park 10	Y (ages 12-17), Free, Walk-ins, CD . .	131
PDAP Age 12 to 17 group	(281) 870-9311	(W) Memorial	Y (ages 12-17), Free, Walk-ins, CD . .	131
PDAP Age 12 to 17 group	(281) 528-7908	(N) Spring	Y (ages 12-17), Free, Walk-ins, CD . .	131
PDAP Age 18 to 25 group	(713) 857-2648	(W) Memorial	Ages 18-25, Free, Walk-ins, CD. . .	131
PDAP Age 18 to 25 group	(713) 857-2648	(W) Memorial	Ages 18-25, Free, Walk-ins, CD. . .	131
PDAP Age 18 to 25 group	(281) 857-7874	(N) Spring	Ages 18-25, Free, Walk-ins, CD. . .	131
PDAP Age 18 to 25 group	(281) 857-7874	(N) Spring	Ages 18-25, Free, Walk-ins, CD. . .	131
PDAP Age 18 to 25 group	(281) 857-7874	(N) Spring	Ages 18-25, Free, Walk-ins, CD. . .	131
St. Hope Foundation	(713) 778-1300	(SW) Sharpstown	All, I/RR, Free, Appt/Walk-ins, Esp, HIV+ only	139
Texas Prevention Network	(713) 981-6063	(SW) Fondren SW	All, S\$, Flat fee, Appt/Walk-in, Referral req.	144

Transportation / Transporte

For HIV infected persons without their own transportation, it can be very hard to access services. The following agencies offer help with transportation to medical and/or social service providers, but you may have to make reservations well in advance of when you need transportation and other restrictions may apply. Be aware that not all agencies will service your area, and that Metro offers special van services for the disabled individual. Part A clients may be eligible to receive an annual bus pass, see your case manager for details.

Para muchas personas infectadas con el VIH que no tienen su propio transporte les es muy difícil el acceso a los servicios. Las siguientes agencias ofrecen transportación con destino a servicios médicos y/o sociales, pero podría tener que hacer reservaciones mucho antes al día que necesite el transporte, y otras restricciones podrían aplicar. Metro ofrece transporte de grupos a personas discapacitadas. Los clientes del Parte A pueden ser elegibles a recibir un pase anual de Metro. Hable con un administrador de casos para más detalles.

Agency / Agencia	Phone / Teléfono	Location / Localizado	Legend / Tabla	Page #
AIDS Coalition of Coastal Texas	(409) 763-2437	(SE) Galveston	All, HIV+ only , Free, CD, Esp.	88
AFH Project "Need A Ride"	(713) 623-6796	(C)	HIV+ only , W, C, Y, Free, Referral required	91
Gulf Coast Center, The	(800) 643-0967	(S) Alvin	All, S\$, Appt req, CD, Esp	108
GCCSA - Gulf Coast Community Svcs Assoc.	(713) 393-4700	(C) Lawndale	All, Free (income limit), Appt/Walk-in, Esp	109
GCCSA - Acres Home Multi Service Center	(713) 692-1046	(NW) Acres Home	All, Free (income limit), Appt/Walk-in, Esp	110
GCCSA - Haverstock Family Center	(281) 449-1303	(NE) IAH Airport	All, Free (income limit), Appt/Walk-in, Esp	110
GCCSA - JD Walker Multi Service Center	(281) 426-4757	(E) Baytown	All, Free (income limit), Appt/Walk-in, Esp	110
GCCSA - JW Peavy Multi Service Center	(713) 674-1301	(C) Fifth Ward	All, Free (income limit), Appt/Walk-in, Esp	110

Legal Services / Servicios Legales y Defensa Pública

ADVOCACY / DEFENSA

Agency / Agencia	Phone / Teléfono	Location / Ubicación	Legend / Tabla	Page #
Advocacy, Inc.	(713) 974-7691	(C) Midtown	CD, Appt req, Families, Free	87
Aid to Victims of Domestic Abuse	(713) 224-9911	(C) Downtown	Adults, Families, S\$, Walk-ins, Esp.	87
Houston Volunteer Lawyers AIDS Project	(713) 228-0735	(C) Downtown	All, Families, Free, HIV+ only , Filing fees, Esp	120
NAACP Legal Redress Clinic	(713) 526-3389	(C) Third Ward	All, Free, Appt req, HIV+ only , Esp	129
Southeast Texas Legal Clinic	(713) 523-7852	(C) Montrose	All, Families, Walk-ins, Free, HIV+ only , Esp.	138

IMMIGRATION / INMIGRACIÓN

Agency / Agencia	Phone / Teléfono	Location / Ubicación	Legend / Tabla	Page #
Alliance for Multicultural Community Services	(713) 776-4700	(SW) Sharpstown	HIV+ only , Immigrants/Refugees, Free, Appt required, Referral required, Lim, Esp	92

Medical Equipment / Equipo Médico

The agencies listed below may be able to help you get items such as wheelchairs, walkers, canes and potty chairs. These items also may be available through your home health company if you have Medicare or private insurance.

Estas agencias podrán ayudarlo a conseguir silla de rueda, andador, bastón y otros artículos. También pueden ser obtenidos por medio de la compañía que le brinda servicios de salud en la casa si tiene Medicare o un seguro privado.

Agency / Agencia	Phone / Teléfono	Location / Ubicación	Legend / Tabla	Page #
AIDS Coalition of Coastal Texas	(409) 763-2437	(SE) Galveston	All, HIV+ only , Free, CD, Esp.	88
Care Group of Texas	(713) 383-2100	(C) Astrodome/ S. Loop	All, Med, Ins, Workers comp, Managed care, Esp.	98
Claude's Pharmacy	(281) 447-7648	(NW) Acres Home	M, W, Med, Walk-ins, Esp	101
Medco Medical Supply, Inc.	(713) 956-5288	(NW) Cy-Fair	All, Med, Ins, Esp	126
South Side Pharmacy	(713) 660-8890	(C) Braeswood	All.	138

Mental Health Services / Servicios de Salud Mental

HIV+ individuals may feel alone, depressed, confused or even guilty. Sometimes professional help is needed to sort out these emotions. Individual counseling is available for people with HIV and their loved ones. These services are frequently either free of charge or based on the client's income. Many hospitals and clinics also provide psychiatric care.

Personas con el VIH pudiesen sentirse solas, deprimidas, confusas o hasta culpables. A veces se necesita ayuda profesional para enfrentar estos sentimientos. Se dispone de consejería individual para estas personas y sus familiares y muchas veces son gratuitos o basados en el ingreso del cliente. Muchos hospitales y clínicas también proveen cuidado psiquiátrico.

NOTE: The Texas Department of Family and Protective Services has a 24-hour toll free hotline to report abuse, neglect or exploitation in Mental Health/Mental Retardation facilities in Texas: (800) 647-7418.

TOME EN CUENTA: El Servicio a la Familia y de Protección del Departamento de Texas tiene una Línea de Ayuda Telefónica disponible las 24 horas del día donde usted puede llamar gratuitamente a reportar abuso, negligencia o explotación en instalaciones o centros de Salud Mental/Retraso Mental en Texas: (800) 647-7418.

Please see page 75 for Support Group listings

Consulte la página 75 para la lista de Grupos de Apoyo

Mental Health Services / Servicios de Salud Mental

COUNSELING / CONSEJERÍA

Agency / Agencia	Phone / Teléfono	Location / Ubicación	Legend / Tabla	Page #
3 "A" Bereavement Foundation (3ABF)	(713) 649-3232	(SE) OST/ South Union	All, Income-based eligibility, Free	87
Bering Support Network	(713) 526-1017 Ext 206	(C) Montrose	M, W, Families, Flat fee, Free, Infected/affected	97
Centerpointe Counseling Services, Inc.	(713) 528-7007	(C) Midtown	M, W, Y, C (6-12), S\$, Med, Appt req, CD.	100
Chews Wellness Incorporated Marriage and Single Relationships Education	(713) 742-0200	(N) Northside	M, W, Fam, Free, Appt Req, Call for intake.	100
Chews Wellness Incorporated Project Youth and Family Matter	(713) 742-0200	(N) Northside	Appt req, call for intake	100
Compass Counseling Solutions, Inc.	(281) 807-9252	(NW) Champions	All, Medicaid, Ins, Call for intake, Esp.	102
DePelchin Children's Center	(713) 730-2335	(E) Baytown	C, Y (ages 13 - 18), Appt req, S\$, Med, Ins, CHIP.	104
DePelchin Children's Center	(281) 730-2335	(W) Brookshire	C, Y (ages 13-18), Appt req, S\$, Med, Ins.	104
DePelchin Children's Center	(713) 730-2335	(SE) Clear Lake	C, Y (ages 13 - 18), Appt req, Med, Ins, CHIP, S\$.	104
DePelchin Children's Center	(713) 730-2335	(C) Memorial Park	C, Y (ages 13 - 18), S\$, Med, Ins, CHIP, Appt req.	104
DePelchin Children's Center	(281) 730-2335	(SW) Stafford	C, Y (ages 13 - 18), S\$, Med, Ins, CHIP	104
DePelchin Children's Center	(281) 730-2335	(N) Woodlands	C, Y (ages 13 - 18), S\$, Med, CHIP, Appt req, Ins.	104
FamilyTime Crisis and Counseling Center	(281) 446-2615	(N) Humble	All, Free, S\$, Appt req (Walk ins-crisis only).	105
Ft. Bend County Women's Center	(281) 342-4357	(SW) Rosenberg	M, W, Y (ages 13 - 24), Free, Appt/Walk-ins, Esp	106
Good Shepherd Mission Counseling Center	(936) 291-8156	(N) Huntsville	All, Free, Walk-ins, CD	108
Gulf Coast Center, The	(409) 763-2373	(S) Alvin	All, S\$, Appt req, CD, Esp	108
HCHD - Thomas Street Health Center	(713) 873-4000	(C) Near Northside	M, W, Free, S\$, Medicaid, Medicare, HIV+ only , Appt Req, Walk-ins, Esp, gold card	113
HACS - Impact Mental Health Counseling	(713) 426-0027	(C) Timbergrove	M, W, All, Free, HIV+ only , MH diagnosis, African American, Hispanic, Esp.	117
Houston Area Women's Center	(713) 528-6798	(C) Montrose	W, C, Y, Free, Esp	118
Inner Door Counseling and Rehabilitation Center	(713) 278-8870	(SW) Sharpstown	All, CD, S\$, Ins, Med, Walk-ins.	120
InnerWisdom Counseling Center	(713) 592-9292	(C) Medical Center	M, W, All, Med, S\$, Self pay, Walk-ins, Esp	120
InnerWisdom Wellness Center	(713) 592-9294	(C) Medical Center	M, W, All, S\$, Med, Appt req, Esp	120
Jewish Family Service	(713) 667-9336	(C) Meyerland	M, W, All, S\$, Appt req	122
Legacy CHS Professional Mental Health Counseling	(713) 830-3000	(C) Montrose	M, W, S\$, Flat fee, Appt Req	123

Mental Health Services / Servicios de Salud Mental

COUNSELING / CONSEJERÍA

Agency / Agencia	Phone / Teléfono	Location / Ubicación	Legend / Tabla	Page #
Legacy CHS Psychiatric Services	(713) 830-3000	(C) Montrose	M, W, Y, All, Med	123
Medcare Pediatric Group	(713) 773-5100	(E) Channelview	C, Y, Med, Private Pay, Ins, Appt Req, Esp, Call for intake . . .	126
Medcare Pediatric Group	(713) 773-5120	(N) Spring	C, Y, Med, Private Pay, Ins, Appt Req, Esp, Call for intake . . .	126
Medcare Pediatric Group	(713) 773-5100	(SW) Stafford	C, Y, Med, Private Pay, Ins, Appt Req, Esp, Call for intake . . .	126
Montrose Counseling Center, Inc.	(713) 529-0037	(C) Montrose	M, W, Families, I/RR, Free, Walk-ins, HIV+ only , CD	128
New Hope Counseling Center	(713) 776-8006	(SW) Sharpstown	M, W, All, HIV+ only , Free, Walk-ins, CD	129
New Horizon Family Center	(281) 424-3300	(E) Baytown	W, C, Y, All, Free, Appt req, Lim, Esp	129
Northshore Counseling Center	(713) 637-6000	(E) Northshore	All, Med, Private pay, Ins.	129
Pet Bereavement Counseling Services	(713) 522-8344	(C) Greenway	All, Appt req.	132
St. Hope Foundation	(713) 778-1300	(SW) Sharpstown	All, I/RR, Free, Appt/Walk-ins, Esp, HIV+ only	139
Texas DFPS Report Abuse in MHMR Facilities	(800) 647-7418	Statewide	All, Free.	143
Texas DFPS Runaway Hotline	(888) 580-HELP	Statewide	C, Y, Families, Free, Esp	143
Texas DFPS Youth Hotline	(800) 210-2278	Statewide	C, Y, Families, Free, Esp	143
Texas Prevention Network	(713) 981-6063	(SW) Fondren Southwest	All, S\$, Flat fee, Appt/Walk-in, Referral Req, Call for intake	144
Triangle AIDS Network, Inc.	(409) 832-8338	(E) Beaumont	Appt req, Free, S\$, HIV+ only , UTMB affiliate, Esp	144
Unlimited Visions Aftercare Inc.	(713) 921-2276	(C) Harrisburg	M, W, S\$, Appt req, CD, TCADA, Esp.	146
UT Substance Abuse Research Center	(713) 486-2800	(C) Medical Center	M, W, Free, Appt/Walk-ins, CD	146

INPATIENT TREATMENT / TRATAMIENTO PACIENTES INTERNOS

Agency / Agencia	Phone / Teléfono	Location / Ubicación	Legend / Tabla	Page #
DAPA - Acute Inpatient Program (AIP)	(713) 783-8889	(C) Medical Center	M, W, Families, CD, I/RR.	103

OUTPATIENT TREATMENT / TRATAMIENTO PACIENTES EXTERNOS

Agency / Agencia	Phone / Teléfono	Location / Ubicación	Legend / Tabla	Page #
DAPA - Partial Hospital Program	(713) 783-8889	(NW) Fairbanks/ NW Crossing	M, W, Families, CD, I/RR Walk-ins, CD, Esp	103

2010 Support Group List

Women Only

Thomas Street Health Center
 Monday 1 pm – 3pm
 2015 Thomas St
 Jeff Benavides
 (713)873-4026

Men Only

Montrose Counseling Center
 401 Branard St
 Gay Men Long-term survivors
 Thursdays; 1:30-3:00
 (713) 529-0037 X 326
 Intake required

Heterosexual Men's Support Group
 Thomas Street Health Center
 Every 2nd Wednesday & 3rd Friday of
 month
 10am – 11:00am – large conf room, 3rd
 floor
 2015 Thomas Street
 Jeff Benavides
 (713) 873-4026

Referred due to illness

Bering Support Network
 1440 Harold St
 Tuesday's 11:00am
 Lunch Bunch
 Support group followed by lunch at a local
 restaurant at cost to participants
 (713) 526-1017 X 206
peggym@beringumc.org

All Inclusive Groups

Cocaine Anonymous/HIV
 Thomas Street Health center
 Every Monday 10:00 – 11:00 AM
 713-873-4026

Thomas Street Health Center

HepC & HIV+
 2nd & 4th Tues 11am-12pm
 Jeff Benavides
 (713) 873-4026

Thomas Street Health Center
 SAFETalk

Last 2 Tuesdays of the month 1:00-3:00pm
 Jeff Benavides
 (713) 873-4026

Positive Broth United
 Health Center

HIV+ men and women
 Tuesday of the Month
 873-4026

7.572-3740

Living Large
 HIV + & educational groups

Deonna Smith
 Call for info 832-545-5689

St. Hope Foundation
 Support groups for HIV+ & high risk HIV individuals
 6200 Savoy, Ste 540 deonna@offeringhope.org
 Call for details 713-778-1300 X 237

Montrose Counseling Center
 HIV+
 401 Branard St, 2nd floor
 Wed 9:30 – 11:00 (intake required)
 713-529-0037

Christian Groups

Catholic Charities AIDS Ministry
 326 S. Jensen, Houston, TX 77003
 Topics of discussion change monthly
 Karin Boeringa
 (713) 874-6675

2010 Support Group List

Bering Spiritual Support Group
 Bering Memorial United Methodist
 Wednesdays 6:30pm to 8:30pm
 Potluck supper followed by discussion
 (713) 526-1017 X 206
 peggym@beringumc.org

Smoking Cessation (HCHD Patients only)
 Thomas Street Health Center
 Thursday 10:00-11:00am
 Jeff Benavides
 (713) 873-4026

HIV Education Group
 Thomas Street Health Center
 2nd Friday of month; 12:00-1:00pm
 Jeff Benavides
 (713) 873-4026

PES Group
 Thomas Street Health Center
 Thursday 10:00-11:30am
 Jeff Benavides
 (713) 873-4026

Latinos Apoyo Latinos
 1710 W. 25th St, 77008
 Last Thur of the month; 6:30 – 8:30 pm
 Spanish Speaking
 713-426-0027 (call for info)

Social Groups

BHIV – social group of HIV heterosexuals
 Get together and have various events around town
 Need computer access, if you do not have, the Center for
 AIDS will provide
 You with computer access and your own email acct
 Log in to: <http://health.groups.yahoo.com/group/houbhive>

HIV Straight
www.geocities.com/gene316
 HIV info and social groups that meet around town

HIV meet up
hiv.meetup.com
 Social and support groups that meet around town

Dating

PozConnect.com
 Online dating for HIV+

POZ.com

Apositiveoutlook.com
 Online dating and lifestyle resource for people with HIV

Chatmag.com

Center
HIV
Support
Group



Thursdays from 6:00-8:00 pm

The Houston GLBT Community Center is moving
*** Center HIV Support Group is moving ***

Last day at present location of 3400 Montrose,
Suite 207, was Thursday October 21, 2010.

Group will resume weekly on October 28 at the
Historic Dow School in Old Sixth Ward Historic
District 1900 Kane Street, Houston, Texas 77007
Lubbock Wing, Corner of Silver and Lubbock

The Center HIV Support Group includes facilitated
discussion, educational presentations from local
agencies & pharmaceutical companies. We have
monthly potluck/socials and other events.

Group Facilitator: Chris Escalante
Email: chris77038@yahoo.com
Cell: 713-965-4483 713-965-HIV3



MENTAL HEALTH MENTAL RETARDATION
AUTHORITY OF HARRIS COUNTY

Mental Health Local Service Plan

July 2010



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MHMRA of Harris County

Local

Service Planning

MENTAL HEALTH LOCAL PLAN 2010-2011

Section 1: Community Input Process

After the planning cycle of 2007, DSHS abandoned the Planning Advisory Council(s) mechanism, established in earlier years by TDMHMR. Since then, MHMRA of Harris County relies on three venues for obtaining input and suggestions regarding how to improve and expand services for persons with mental illness in Harris County. These are: (1) Program managers interfacing with consumers and collaborative providers; (2) periodic direct Family and Stakeholder Survey (via the internet); and (3) Participation in inter-agency or multi-purpose city and county task forces and planning committees.

1. Service Provider and Consumer Interface

We estimate that each week, mid-management staff and program managers (about 40 persons) spend about 25% of their time to meet face-to-face, telephonically, or via the web with families, consumers, and other providers of health and human services. These encounters are then passed on to higher levels of management and eventually to the Executive Committee levels for considerations. Changes in service delivery methods, hours of operation, training, etc. are then considered and implemented within feasibility and fiscal constraints.

2. Direct Family and Stakeholder Surveys

Attached as Exhibit II is a summary of the findings from the latest Survey administered in February 2010, based on 264 respondents, of which 70 are from consumers. An overwhelming majority (68%) considered choice of provider to be extremely important. Forty-two percent viewed expansion of provider of medical services to be important. These and other responses provide input into the MHMRA Mental Health Local Authority to plan its future actions concerning its management and expansion of provider pool.

3. Collaborative and Joint Planning Participation

The Planning Process at MHMRA of Harris County is a continuous process, just like its quality improvement process. New programs, beyond those mandated by the RDM requirements, are constantly considered or reconsidered, planned, and implemented throughout the years. As shown in Table 2, more than 30 programs have been added above and beyond the RDM model. Many of these have been implemented only within the last nine months. This continuous planning process relies heavily on community input from citizens and sister agencies who are concerned about quality and adequate care for persons with mental illness. The majority of the programs are targeted at persons with mental illness who suffer other deleterious conditions, such as substance abuse, chemical dependence, homelessness, involvement with the criminal justice or juvenile justice systems, family dysfunctions, etc. Table 1 lists the different community-based planning bodies and task forces where there is active MHMRA presence, both for the purpose of providing input into the coordinated county-wide planning process as well as for obtaining insight and information about new issues that MHMRA must

understand in order to develop appropriate programmatic responses or improvement. The rightmost column of Table 1 provides a succinct summary of the concerns or issues for each involvement area.

**Table 1:
MHMRA PARTICIPATION IN INTER-AGENCY COLLABORATIVE TASK
FORCES/COMMITTEES**

Inter-Agency Committee & Task Force	MHMRA Person(s) Attending **	Meeting Frequency	Purpose/Issues
1. Homeless Youth Network Board meeting	ED,	4 th Monday every two months	Homelessness and mental illness intervention and intervention
2. AAFS Board meeting	ED, DECS	3 rd Tuesday every month	Asian American mental health issues
3. Harris County Healthcare Alliance Board Meeting	ED,	4 th Thursday every month	Integration of health care and prevention in Harris County
4. Youth and Family Services Meeting	ED,	4 th Monday every month	Youth and family issues across all agencies serving youths and families
5. Children at Risk Institute Meeting	ED,	3 times per year	State of health, economic, and well-being of Harris County children and families
6. Joint City County Commission on Children Health Subcommittee	ED,	as needed	Comprehensive review of state of health for Houston and Harris County youths
7. Joint City County Commission on Children Policy Subcommittee	ED,	as needed	Comprehensive review of policies to enhance health and well-being for Houston and Harris County youths
8. MH Needs Council	ED, DDMH, MDCPEP,	1 st Wednesday every month	Comprehensive review regarding services, policies, mandates, state of business for public and private providers of mental health services in Harris County
9. MH/Jail Task Force Meeting (Sheriff's Task Force)	ED,	1 st Wednesday every month	Coordination of mental health care for persons involved with criminal justice system

10. Infants and Toddlers Court Team Meeting	ED, DEDS	2 nd Tuesday every month	Design and support a special court to deal with infants and toddlers of criminally charged persons
11. Systems of Hope Fiscal/Sustainability Workgroup	ED,	2 nd Tuesday every month	Systems of Hope
12. Network of Behavioral Health Providers	ED,	2 nd Wednesday every month	Coordination of mental health and chemical dependence services and policies
13. Harris County Healthcare Alliance Membership Meeting	ED,	2 nd Wednesday each quarter	Integration of health care and prevention in Harris County
14. HCPC Joint Quality Council	ED, MHMD, MHDD, CPEPMD, DDCPEP,	2 nd Friday every month	Coordination of outpatient and inpatient clinical care for persons with mental illness
15. TRIAD Executives Meeting	ED,Asst DMH	quarterly, as needed	Coordination of juvenile justice, protective services, and mental health services for children and adolescents
16. Agency CEO/Board Chair Council on Homelessness	ED,	3 rd Thursday every month	Broad and multi-disciplinary coordination of services for homeless persons
17. Harris County Alliance Legislative Meeting	ED,	3 rd Friday every month	Review and formulation of policies and laws affecting mental health services in Harris County
18. Systems Design Team/Quad Agency Meeting	ED,	3 rd Friday every month	Coordination of policies, programs, and services among the four health related public agencies in Harris County
19. Joint City County Commission on Children	ED,	2 nd Thursday each quarter	Comprehensive review of policies, programs, and services to enhance health and well-being for Houston and Harris County youths
20. Juvenile Detention Alternative Initiative (JDAI) Executive Steering Committee Meeting	ED,	quarterly, as needed	To identify and implement strategies that divert juvenile offenders from detention
21. Texas Council of Community Centers-Medical Services	DN, MDMH, MDCPEP, MDIDD	quarterly	Interface with DSHS and DADS to discuss issues that impact medical and nursing services in the community mental health and mental retardation

Consortium-Nursing Committee			centers
22. DSHS Nursing Leadership Council	DN	quarterly and as needed	Supports the role of professional nurses in implementing the agency (DSHS) mission to improve health and well-being in Texas
23. Nursing Internship Program for New Registered Nurse Graduates	DN	as needed	To offer 18 weeks of supervised mentored learning experiences in psych mental health to new nursing graduates and IDD nursing
24. Mental Health Court Task Force	ED, DEDES, MDMH, MDCPEP, DDMH, JMA	May-Nov2009	To design a mental health court for the Harris County criminal justice system
25. Consumer Councils	Dir. Consumer Services	Monthly	To encourage consumer participation in center policies and practice. Completes consumer surveys re: consumer/family satisfaction
26. Cost-of-Homeless Task Force	DEDS	as needed	To examine the impact of homeless on different service sectors in Harris County, and to design prevention strategies to reduce homeless and enhance health and human services
27. Veteran's Initiative	JMHA, JPM	May – Nov 2009	To determine the initial points of contact for Veterans with the criminal justice system with the goal of diversion. Resulted in the establishment of Harris County Veteran's Court in November 2009.
28. Services for Incarcerated Recently Released (SIRR) Persons	JPM	4 th Wednesday of every month	To address issues related to individual's recently released from incarceration who has a diagnosis of HIV or dually diagnosed with MH issues.
29. Mental Health America Houston Veteran's Behavioral Healthcare Task Force	JMHA, JPM	Monthly	To development countywide agency support for Veteran's returning to the community with mental health and substance abuse issues.
30. Health Care of the Homeless Advisory Council	CPEPPD	Every other month	To identify healthcare needs of the homeless in Houston and to share new resources that develop
31. Coalition for the Homeless Houston Advisory Council	CPEPPD, DDCPEP	Monthly	To identify resources and gaps in services for the homeless community in Houston

32. South-Central HPD Outreach Project	CPEPPD	Quarterly	Discuss outreach efforts to assist homeless people to engage into services instead of arresting or ticketing the homeless for trespassing
33. United Way Community Resource Meeting	CPEPPD	Monthly	To identify, share and problem solve for needed resources for low income or indigent people and families in the Houston Area
34. Jackson Hinds Gardens Providers meeting	CPEPPD	Quarterly	Meeting to address the needs of the formerly homeless residents that currently live at Jackson Hinds Garden's (Houston's first model where many PATH people receive placement when the program opened)
35. HCPC Recidivism Group	CPEPPD	Monthly	HCPC and MHMRA of Harris Co staff to problem solve new actions to take for the patients with the highest rates of recidivism to HCPC
36. Northline SAMSHA Grant Partners Collaboration	CPEPPD, DEDS	Monthly	Meeting with SEARCH, MHMRA, and Career and Recovery to evaluate and update the progress mad toward goals of this project
37. Houston Homeless Run Committee	CPEPPD	Monthly	Meeting to organize and find sponsorship for the annual race that highlights the plight of the homeless in Houston and hope to be able to raise enough funds to assist paying for placement in personal care homes for housing the mentally ill homeless in Houston
38. Ben Taub Hospital Leadership	DDCPEP, MDCPEP, CPEPPD	Quarterly	Meeting is in regards to NPC/PES patients sent to Ben Taub ER for medical clearance
39. NPC, HCPC and Constable	MDCPEP, CPEPPD	Monthly	The transferring of patients from PES

** Abbreviations and acronyms for Table 1:

ED = Executive Director; DDMH = Deputy Director, MH; MDMH = Medical Director, MH; DDCPEP = Deputy Director, CPEP; MDCPEP = Medical Director, CPEP; MDIDD= Medical Director, IDD; DN = Director of Nursing; DEDS = Director, Executive Decision Support; JMHA = Jail Mental Health Administrator; JPM – Jail Program Manager , CPEPPD = CPEP Program Director

Section 2: Service Array Description

MHMRA operates a two-tier mental health service delivery system. The first tier consists of programs and services mandated by DSHS on the basis of its Resilience and Disease Management (RDM) philosophy and models. These RDM services are provided at four major clinical environments, covering following four quadrants of the Harris County: Northwest, Central, Southeast and Southwest.

The second service delivery tier consists of non-RDM programs that are either innovative or viewed as necessary by the community. These are value-added programs that MHMRA in conjunction with the community deems necessary for Harris County. The majority of these programs (mostly those related to crisis services) have been in existence even before the State provided special funding for them. Other programs are grant funded. Most of these programs have historically or currently been funded by other sources than DSHS. These value-added programs are listed in Table 2 by name, with a brief description of the basis nature and aims of their services.

**Table 2:
LIST OF MHMRA SERVICE PROGRAMS THAT ARE ADDITIONAL TO THE
RDM COMPONENTS**

1. Psychiatric Emergency Service (PES).	The primary program for face-to-face crisis assessment, initial stabilization, and disposition to further services. Law enforcement officers bring individuals to the program on warrantless detention and the community may also walk in voluntarily seeking crisis services.
2. Mobile Crisis Outreach Team (MCOT)	Serves as both a primary intervention in the field and also as a follow-up crisis resolution option for individuals coming out of the PES or HCPC. MCOT staff either resolves the situation at the scene, or transports the individual to the PES.
3. Crisis Intervention Response Team (CIRT)	Serves as first responders in conjunction with law enforcement to psychiatric crises in the field, either resolving the situation at the scene, or transporting the individual to the PES. The program pairs a police officer and an MHMRA LPHA as a team on the street, responding to crises that require a police presence. There is 1-3 teams on the street at all times.
4. 23-Hour Observation Unit (23 Obs):	A psychiatric intensive care unit within the PES, and staffed by PES clinicians, that served over 800 Harris County residents in the last 12 months. This unit is designed to treat and stabilize acutely mentally ill consumers who upon admission to the unit meet full criteria for psychiatric hospitalization. Many of the consumers treated in this program were brought in by law enforcement on an involuntary basis.

5. Crisis Stabilization Unit (CSU),	is a 16 bed state-licensed CSU program provides hospital-like services in a less costly, less stigmatizing, and less restrictive setting than inpatient hospitalization. The program is designed to serve voluntary adult patients who can be stabilized within a three to five day length of stay, and who can then be linked to community supports. The unit is staffed by a psychiatrist, nurses, LPHAs, psychiatric technicians and a peer navigator.
6. Crisis Residential Unit (CRU),	This program has been designed to serve voluntary consumers who can be stabilized and linked to community supports within seven to fourteen days of treatment while living in a residential setting that also provides psychosocial treatment and supports. The CRU is accredited through the Commission on Accreditation of Residential Facilities (CARF).
7. Crisis Counseling Unit (CCU),	Is operated in conjunction with the CRU to provide time-limited outpatient therapy during the initial days of a psychiatric crisis, preventing deterioration leading to a full-blown psychiatric illness. The CCU serves many non-target population consumers as well as those on “waitlist” to be seen in RDM clinics.
8. Crisis Respite	Located at a small efficiency apartment complex accommodating 16 beds, it provides 24/7 supervision and daily case management for consumers coming out of crisis and/or out of Rusk State Hospital. Length of stay is up to 30 days. During this time the program strives to link the residents into ongoing services, helps them apply for benefits, assists them in improving daily living skills as needed, and helps them successfully locate more permanent living arrangements.
9. Critical Time Intervention (CTI)	emphasizes short-term (9 months), intensive case management for consumers who are homeless, refractory and have been unable to engage in traditional mental health services. CTI is comprised of three 3-month phases of decreasing intensity and involvement by the case manager. The case manager actively engages consumers in connecting, developing and strengthening relationships with family, friends, neighbors and community providers who will ultimately replace the role of the case manager and serve as the consumer’s primary support system.
10. Co-Occurring Disorders Program.	Is a three month substance abuse residential treatment program enhanced by intensive mental health case management for individuals with co-occurring psychiatric and substance use disorders who are at considerable risk of expensive jail, hospital and emergency room services.
11. Mental Health First Aide	Provides MHFA training for agencies and organizations throughout Harris County. This consists of 12-hour course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis.

12. Peer Navigators	are self-identified consumers who are in recovery. The Peer Navigator performs a wide range of tasks to assist other consumers in regaining control over their own lives and over their own recovery process. They are able to teach and role model the value of every individual’s recovery experience and model effective techniques and self-help strategies by lending their unique insight into mental illness.
13. Chronic Consumer Stabilization Initiative (CCSI):	Is collaboration with the Houston Police Department (HPD) and the City of Houston Health Department in a process to identify and engage adults with mental illness who frequently utilize city law enforcement services. The goal is to enroll these individuals in ongoing mental health treatment through the provision of intensive crisis intervention and wrap around case management services.
14. Criminal Justice and Community Transition Teams	Funded by the Rider 65 fund allocation, this program collaborates with the Harris County Jail and Harris County Psychiatric Center (HCPC) to identify and engage adults with mental illness who are frequently incarcerated for minor offenses in the jail or who are high recidivists at HCPC and the MHMRA Psychiatric Emergency Service (PES). Through the provision of intensive intervention and wrap around crisis relapse and prevention services, the program engages each individual in ongoing mental health treatment and reintegration within the community.
15. Supportive Employment Initiative for Outpatient Services (CFA)	<ul style="list-style-type: none"> • Via an MOU with Gulf Coast Community Services Association provides job readiness activities, incorporating job retention and placement for MHMRA job ready candidates. • Developed a Business Advisory Group known as “The BAG” consisting of local businesses and community organizations committed to equity and access in the employment arena for ALL Houston/Harris County residents. Quarterly BAG meetings instituted. • Promote business interest in hiring MHMRA consumers • CFA partnered with Jobing.com, Neighborhood Centers and Workforce Solution to sponsor the CFA 1st annual job fair. Over 800 job seekers, 36 employment vendors including Comcast, City of Houston, HEB participating. • In partnership with the RISE program, assists MHMRA job seekers with subsidies for rent
16. “In-Reach” Program (Healthcare for the Homeless Houston)	Via a contract with Healthcare for the Homeless Houston (HHH) , provides “in reach” (up to two visits) in the jail to inmates who have a mental health diagnosis and who will be homeless upon release from jail, and up to one month of follow-up post release in the HHH clinic (providing mental health case management and initial mental health assessment, and attempting to link to MHMRA if qualified or Hospital District if not qualified).

<p>17. Bristow Homeless Program (PATH funded)</p>	<p>This is a federally funded program that provides outreach, case management, and clinic services to homeless individuals diagnosed with a mental illness, to increase their environmental and psychiatric stability. The Outreach team also interfaces with area Shelters to identify eligible individuals and facilitate access to services. Consumers identified as homeless and mentally ill are then assigned a Case Manager who assists them in meeting their identified needs through support & encouragement, as well as assistance in applying for and accessing mental health & social services. The clinic component of the Program provides basic services to consumers such as sack lunches, showers, laundry services & use of a phone, as well as Medication Management, Nursing Assessments, Group & Individual Counseling & Drug & Alcohol counseling.</p>
<p>18. Safe Havens Rehab Services</p>	<p>Psychiatric treatment , medication monitoring, psychosocial rehabilitation , case management services, and safe, low-cost housing for chronically homeless adult clients.</p>
<p>19. FACT (Forensic Assertive Community Treatment)</p>	<p>FACT is a program to provide jail/court based services to persons with psychiatric disorders who are arrested on minor offenses. The primary function of the program is to facilitate access to appropriate mental health services by providing assessment, treatment planning and monitoring, medication related services, skills training, family education, crisis intervention and transportation. This program enrolls county jail inmates with mental illness and at high risk of criminal recidivism into ACT services after release from jail. Program evaluation reflected a reduction in the following for FACT inmates released from the Harris County Jail to the FACT program: (1) a reduction in the mean number of bookings when comparing bookings post FACT with pre FACT involvement. (2) a reduction in the number of criminal charges and (3) a reduction in the number of jail days post FACT when compared with pre FACT involvement.</p>
<p>20. Juvenile Justice - Institution Programs</p>	<p>Psychiatric evaluation with diagnosis, rehabilitation skills training for active consumers, medication, and resource referral to juvenile offenders ages 10-17 years institutionalized at one of the following facilities:</p> <ul style="list-style-type: none"> • Burnett Bayland Reception Center, 6500 A Chimney Rock, Houston, TX 77081 • Burnett Bayland Home, 6500 Chimney Rock, Houston, TX 77081 (Girls) • Harris County Leadership Academy, 9120 Katy Hockley Rd., Katy, TX 77493 • Harris County Youth Village, 210 J.W. Mills Dr., Seabrook, TX 77586 • Psychiatric Stabilization Unit, 6500 A Chimney Rock, Houston TX. 77081 • Harris County Juvenile Detention Center, 1200 Congress,

	Houston, TX. 77002
21. Juvenile Justice - Community Unit Probation Services (CUPS) Program	Psychiatric evaluation with diagnosis, clinical assessments, treatment planning, community-based rehabilitation skills training and counseling for active consumers, medication, and resource referral services to juvenile offenders ages 10-17 years of age with mental illness and involvement with a CUPS Unit.
22. Juvenile Justice – Alternative Education Program	Psychiatric evaluation with diagnosis, rehabilitation skills training for active consumers, medication, and resource referrals to juvenile offenders ages 10-17 years expelled from their home schools: <ul style="list-style-type: none"> • Juvenile Justice Alternative Education Program South, 2525 Murworth, Houston, TX 77054 • Juvenile Justice Alternative Education Program North, 11947 N. Freeway, Houston, TX 77092
23. Juvenile Forensic	This unit provides psychological, psychiatric and family assessments to children between the ages of 10 and 17 who are referred under the jurisdiction of the Harris County Juvenile Court System upon request from the Harris County Juvenile Probation Department or the Juvenile Courts.
24. NEW START: Intensive Rehabilitation/Service Coordination & Court Resource Program & New START Atascocita	Services include referral and screening, crisis services, community based counseling, medication training, intensive rehabilitation, skills training and socialization activities, intensive & transitional case management, court advocacy, continuity of care for offenders with mental impairments and were convicted and sentenced to TDCJ, and approved for Special Needs Parole/Probation. Court Resource Program provides Pre-Trial Diversion services to three Harris County Felony Mental Health Courts. These services are provided to the mentally impaired defendant. Individuals receiving services tend to have a moderate to severe level of need and / or a history of multiple hospitalizations. The general focus of services is to stabilize symptoms, improve and sustain functioning, increase community tenure and establish support networks via intensive skills training.
25. Adult Forensic – Front Door Services	The Front Door Services Department provides psychiatric evaluations, medication maintenance, and crisis intervention to all inmates in Harris County Jail. It responds to mental health needs and provides timely access to care to patients/inmates at their initial point of incarceration. It aims to assess patient/inmates in a prompt and thorough manner, and make recommendations to affect appropriate interventions that would satisfy the need for reducing adverse symptoms caused by mental illness; and to assist with housing assignments.

<p>26. Adult Forensic – Mental Health Infirmiry Services 2102(2C, 2P and CBT), 2105(HCPC)</p>	<p>The Mental Health Infirmiry is comprised of 2 housing units within Harris County Jail (2C & 2P) and one unit within Harris County Psychiatric Center (HCPC).</p> <ul style="list-style-type: none"> • All three units operate 365 days a year 24 hours a day. Psychiatric Nurses, Technicians, and Specialized Mental Health Deputies are on site 24/7. Physician coverage is on site for 2C & 2P from 6am-5pm Monday – Friday. • Harris County Psychiatric Center (HCPC) provides all the staff for their unit, except for HCSO Specialized Mental Health Deputies and one (1) MHMRA Case Manager who is the liaison between all three entities. • <u>2C</u> –Located @ 1200 Baker St, Houston, TX ; 713-755-7388 or 7233 --2C consists of 70 beds (25 female/45 male). Services include: treatment planning, medication management, and substance abuse counseling. These services are provided through a multidisciplinary team approach involving psychiatrists, nurses, psychiatric technicians, a Licensed Chemical Dependency Counselor (LCDC) and case managers.
<p>27. Texas Correctional Office For Offenders With Medical or Mental Impairment (TCOOMMI)</p>	<p>Psychiatric evaluation with diagnosis, intensive community-based rehabilitation skills training, psychotherapy, and intensive case management for active consumers, medication, resource referral and linkage, to juvenile offenders ages 10-18 years. In addition, the program conducts advocacy and weekly parent support group facilitated by the Parent Partners through the Harris County Alliance.</p>
<p>28. The Triad Mental Health</p>	<p>In home family based counseling, family assessment, school advocacy, individual and family therapy, referrals, case management. Triad Mental Health also serves as the local liaison for Waco Center for Youth. The Triad Mental Health is a family centered approach based upon the family’s needs. The needs of the family guide the interventions and approaches that are used. Flexibility and creativity is key. The goal of Triad is to allow youth with mental health issues to remain in a home setting by providing family preservation services; establishing stable home environments and obtaining required community based support services for each family.</p>
<p>29. Adult Forensic Unit Court Services – Competency & Sanity; 21 Day State Hospital Diversion</p>	<p>Competency & Sanity (C & S) evaluations are conducted for defendants housed in Harris County Jail as well as those released on bond. Evaluations are to determine whether the defendant is competent to stand trial, and to determine mental state at the time of the alleged offense (sanity). C & S is designed o provide the courts, defense attorneys and prosecutors with assistance in determining a defendant’s competency and/ or sanity.</p> <p>Competency -To determine whether defendants understand the charges made against them and whether they are capable of participating in their defense.</p> <p>Sanity – To determine whether defendants were sane at the time of</p>

	<p>the alleged offense.</p> <p>State Hospital Diversion (21 Day) – Psychiatric assessments are conducted on defendants who indicate or appear mentally unstable during their first court appearance.</p>
30. Adult Forensic Unit Court Services – 21 Day State Hospital Diversion	<p>21 Day program is designed to determine for the courts, as well as, the defense attorneys whether a defendant may be in need of outpatient psychiatric treatment. The program’s aims are: 1) to provide information to the courts regarding the current psychiatric stability of a defendant and 2) to reduce the number of bed days utilized by Forensic admissions from Harris.</p>
31. Children and Adolescent Services-Assertive Community Treatment (CAS-ACT)	<p>Services are provided based on the appropriate level of CARE recommended and authorized in accordance with the Adult Texas Recommended Assessment Guidelines. CAS-ACT services are offered to a limited caseload managed and monitored by a multidisciplinary team which provides pharmacological management, psychosocial rehabilitative services such as medication training and support, intensive case management, psychoeducation, parent and child skills training (behavior management training), counseling (cognitive behavioral therapy) and parent to parent peer support.</p>
32. Adult Forensic-Mental Health Infirmery Service Cognitive-Behavioral Therapy (CBT) Program 2P2 and 2B1A	<p>Initial assessments are made to ascertain whether male consumers are appropriate for the CBT Program. Services are coordinated with jail psychiatrists, nurses, counselors, caseworkers, deputies, and/or other medical and allied health personnel. Individual and Group Cognitive-Behavioral Therapy (CBT) sessions as well as Life Skills (L.S.) Groups are provided for consumers. Therapy is designed to address behavioral problems, mental health problems, and/or substance abuse problems demonstrated by the consumers. Staff are to process with consumers how to make positive, constructive changes in their thinking and their beliefs in order to improve their emotional consequences and exhibit more appropriate behaviors or achieve more desirable life outcomes. The goal is for consumers to learn to think more clearly and rationally in order to feel better and not react so impulsively or exacerbate existing mental health problems.</p>

<p>33. Community Based Stabilization Unit- Juvenile Justice Aftercare Unit</p>	<p>Provides psychiatric evaluation with diagnosis, intensive community-based rehabilitation skills training, psychotherapy, intensive case management for active consumers, medication, resource referral and linkage, to juvenile offenders ages 10-18 years. The CBSU works with client's who have recently been released from juvenile probation institutions. The program provides intensive community-based mental health services/supervision in the school and home by a licensed professional and probation officer. The clinical staff works collaboratively with the Harris County Probation Department to ensure that the child/adolescent is stabilized, does not re-offend, and learns appropriate coping/decision making skills to become a productive and law abiding citizen. The goal is to control symptoms of mental illness through medication and other therapies, provide support and coordination, intensive supervision, develop a network of agency and community resources; reduce recidivism; increase awareness through consumer and family education.</p>
<p>34. Co-Location Programs (Pasadena, Magnolia, Sheldon, Alief ISDs)</p>	<p>Serve children/adolescents between 3-17 years with a DSM IV Axis I diagnosis of mental illness who exhibit serious emotional, behavioral or mental disorders and who have a serious functional impairment (CGAF of 50 or less) or are severely emotionally disturbed as assessed by the school's special education program, or at risk of out-of-home or child care placement due to psychiatric symptoms.</p> <p>Services are provided based on the appropriate level of CARE recommended and authorized in accordance with the Adult Texas Recommended Assessment Guidelines for children and adolescents. The assessment determines identified service needs and appropriateness of the service modality. Services may include evidence-based services and supports such as crisis services, child or parent skills training, parent/family support, family partner, family psycho-education, counseling, intensive case management, care coordination (routine case management type service), medication management intervention and medication training and support. Services and supports will be provided within the financial resources available.</p> <p>The focus is on providing quality services delivered in a systematic, collaborative team based approach emphasizing the prevention of relapse and complications utilizing evidence-based practice guidelines and encouragement of empowerment of the patient through self management education and utilization of strengths of the child and family to meet unmet needs. The goal is to improve overall consumer's mental health and functioning by controlling symptoms of mental illness through evidence based services and supports and increased awareness and consumer involvement through consumer and family education.</p>

<p>35. Supportive Services For Homeless Persons (SAMSHA Grant—Partners)</p>	<p>Funded by a SAMHSA grant for five years, this program is a service and research endeavor jointly operated by MHMRA, Search, Inc, and Career & Recovery Services Inc. It provides intensive supportive and case management services including psychosocial rehab to chronically homeless residents at the two “housing-first” facilities in Houston. All enrollees, beside having a homeless history, are also dually suffering from mental illness and substance abuse. Many also have extensive criminal justice involvement history. The goals are to reduce jail recidivism, decrease chemical dependence, decrease use of intensive psychiatric emergency and hospitalization, and increase linkage with outpatient and rehabilitative outpatient mental health services.</p>
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Exhibit II provides recent examples of the accomplishments of the different components of the Mental Health Sector of MHMRA during fiscal year 2009.

EXHIBIT I

LPND Consumer Family and Stakeholder Survey

Cross Tab Report

Date: 4/8/2010 8:19 AM PST

Responses: Completes

Filter: No filter applied

1. Please indicate which best describes your relationship with MHMRA of Harris County (Check only one box).	Number	Percent
I Receive Services at a Clinic	253	70%
I have a family member or friend who gets services at MHMRA of Harris County	58	16%
I am a Community Provider	12	3%
A Member of Advocacy Group	7	2%
An Interested Citizen	12	3%
Center Staff	6	2%
Other, please specify	16	4%
Total	364	100%
2. At which clinic do you receive services?		
Northwest Clinic	183	42%
Ripley	7	2%
Southeast Clinic	136	31%
Southwest Clinic	105	24%
UT/HPCPC Outpatient Clinic	2	0%
Total	433	100%
3. Are you a Harris County Resident?		
Yes	440	96%
No	17	4%
Total	457	100%
4. Are you aware that all Centers are now required by state law to explore contracting services they currently provide to interested third parties?		
Yes	154	34%
No	300	66%
Total	454	100%
5. If you answered "No" to Question 4, would you like to receive additional information regarding changes that may affect the services at the Center?		
Yes	196	54%
No	170	46%
Total	366	100%

7. On the list below, please identify the THREE most important factors you consider when choosing a provider for services:		
Convenient Location	258	56%
Pharmacy on site	154	34%
Transportation available	160	35%
Length of appointment	76	17%
Clean Environment	141	31%
Wait time to see the doctor	166	36%
Cost of services	115	25%
Bilingual Services and materials	21	5%
Religious and spiritual values	39	9%
Cultural/Ethnic Sensitivity & Knowledge	31	7%
Reputation of Provider	66	14%
All services at the same location	122	27%
Availability of crisis services	69	15%
Other, please specify	16	4%
8. What service(s) would be most important for you to have a wider pool of providers to choose from?		
Crisis Services	119	28%
Respite Services	27	6%
Help to find and get a job	108	25%
Doctor Services for MHMR	181	42%
Counseling	165	38%
Help to find and get a place to live	98	23%
Learning the skills to take care of your self and live a better life	138	32%
9. How important is a choice of providers to you?		
Not Important At All	17	4%
Not Very Important	8	2%
No Opinion	33	7%
Somewhat Important	87	19%
Very Important	304	68%
Total	449	100%
PLEASE ANSWER THE FOLLOWING QUESTIONS ONLY IF YOU OR A FAMILY MEMBER RECEIVE SERVICES FROM MHMRA OF HARRIS COUNTY		
10. From which clinic do you or your family member receive services?		
Northwest Clinic	176	43%
Southwest Clinic	94	23%
Ripley	7	2%
Southeast Clinic	129	32%
UT/HCP Outpatient Clinic	2	0%
Total	408	100%

15. On a scale of 1 to 5 how satisfied are you with the services you receive at MHMRA?		
Very Unsatisfied	14	3%
Somewhat Unsatisfied	14	3%
Neutral	45	10%
Somewhat Satisfied	103	24%
Very Satisfied	260	60%
Total	436	100%
PLEASE ANSWER THE FOLLOWING QUESTIONS ONLY IF YOU HAVE MADE APPLICATION OR CONSIDERED MAKING APPLICATION AS AN EXTERNAL PROVIDER		
16. How did you hear about MHMRA's RFA?		
Word of mouth	16	26%
MHMRA Website	3	5%
MHMRA Employee	9	15%
Advertisement	0	0%
State website	5	8%
MHMRA Client/Patient	12	19%
Professional Publication	6	10%
Other, please specify	18	29%
17. Have you made application to be an External Provider for MHMRA?		
Yes	17	25%
No	52	75%
Total	69	100%
18. If you answered "No" to Question 17, do you intend to make application?		
Yes	11	20%
No	44	80%
Total Responses	55	100%
19. If you have considered applying to be an External Provider but did NOT apply, what were your reasons?		
Application process too lengthy	9	17%
Application was too difficult to understand	7	13%
Did not meet criteria to apply	5	9%
Difficulty with getting information to apply	4	8%
Reimbursement for services too low	9	17%
Found other more appealing opportunities	4	8%
Disagreed with service philosophy	0	0%
Prefer to work with different population	3	6%
Do not believe I would qualify	11	21%
I will apply in the future	12	23%
Other, please specify	14	26%

For more information please contact us at the number below or visit our website at www.mhmraharris.org or send us your concerns or questions at mhnetworkdevelopment@mhmraharris.org.

THANK YOU FOR YOUR HELP WITH THIS SURVEY - YOUR OPINION COUNTS!

MHMRA of Harris County MH Network Management 7011

Southwest Freeway Houston, TX 77074

713.970.3400 Telephone

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Exhibit II

Mental Health Services Accomplishments

MHMR AUTHORITY OF HARRIS COUNTY

FY 2009

Psychiatric Emergency Services (PES)

- The PES is a psychiatric emergency service staffed 24-hours a day with psychiatrists, registered nurses, clinical social workers, licensed professional counselors and psychiatric technicians.
- Consumers are assessed and treated and may be referred to other services as needed.
- Individualized clinical service plans which incorporate medication administration, reinforcement of coping skills, and close observation by clinical staff, family meetings, and determination of appropriate community supports are implemented.
- Added a Division Nurse Manager to manage all of CPEP nursing staff and further improve the best patient outcomes.
- PES increased the RN staffing level by 2.8% due to increased volume of consumers served and the redesign which will increase the triage capacity.
- Added an additional CPEP training staff to aid in training compliance for CPEP employees.
- Served 12,723 Harris County residents in the past twelve months. Sixty-three percent of them were indigent or uninsured.
- There was a 24% increase with the numbers served at the PES in fiscal year 2009.
- Over 500 were children or adolescents.
- Over 3,930 people were brought in by law enforcement.
- Referred 2,007 consumers to ongoing outpatient treatment.
- Transitioned 60% of the consumers who were served in NPC emergency program in the past twelve months. They were able to return to the community without incurring the cost of inpatient hospitalization with.
- Remained operational throughout Hurricane Ike, assessing serving those in crisis.
- Added a designated CPEP IT staff member to coordinate IT needs for the CPEP division.

23-48 Hour Observation Unit

- This is a psychiatric intensive care unit within the PES staffed by PES clinicians.
- This unit is designed to treat and stabilize acutely mentally ill consumers who upon admission to the unit meet full criteria for psychiatric hospitalization but are determined to have a condition which could improve without hospitalization given intensive treatment.
- Many of the consumers treated in this program were brought in by law enforcement on an involuntary basis.
- Served over 600 Harris County residents in the last 12 months.
- Transitioned 64% of the consumers who were served in the 23-48 Hour Observation program in the past twelve months. They returned to the community without incurring the cost of an inpatient hospitalization.

Crisis Stabilization Unit (CSU)

- This is a 16 bed program located at NPC that provides hospital-like services in a less costly, less stigmatizing, and less restrictive setting than inpatient hospitalization.
- The program is designed to serve voluntary adult patients who can be stabilized within a three to five day length of stay, and who can then be linked to community supports.
- Served over 1,200 Harris County residents during the past 12 months.
- Served an average of 100 consumers per month who have received treatment in the CSU, with an average length of stay of 4 days, compared to 10 days average length of stay at a psychiatric hospital.
- Approximately 72% were referred to further outpatient treatment with 46% successfully linking with an outpatient clinic through the Eligibility Center.
- Remained operational throughout Hurricane Ike and its aftermath.

Mobile Crisis Outreach Team (MCOT)

- The program provides crisis intervention and follow-up services to individuals in the community experiencing a mental health emergency.
- Clinicians travel to locations in Harris County to evaluate persons, both adults and children, who cannot or will not access traditional psychiatric care.
- Inpatient hospitalization and incarceration are avoided through the use of preventative medicine, intensive case management and brief therapy, therefore reducing the likelihood that a person would require a higher level of care.
- Follow-up visits are provided to ensure linkage into ongoing mental health and social services. MCOT works closely with the Houston Police Department and the Harris County Sheriff's Department.
- Served 2,344 Harris County residents which is an average of 195 consumers per month.
- Provided an average of 8 services per consumer with an average time per consumer limited to one month.
- Services provided included triage, psychosocial assessment, intensive case management, counseling, medication management, nursing services, referrals and linkage to ongoing mental health and social services.
 - 37% of those served were linked into MHMRA outpatient clinic services
 - 5% to substance abuse programs
 - 24% to other agencies or providers
 - 10% required linkage to a more restrictive level of care (inpatient hospitalization)
- Provided psychiatric intervention to consumers awaiting involuntary beds at Harris County Psychiatric Center.
- Screened indigent consumers seeking admission to Harris County Psychiatric Center after hours and on weekends.
- Trained Houston Police Department CIT officers and Harris County Sheriff's Department officers.
- Provided consultation services to area law enforcement agencies.

- Increased Psychiatrist availability within the program.
- Participated in HPD Southwest and Central Locations Community Forums.
- Provided education and information on MCOT to internal and external service providers.

Crisis Help Line

- Crisis Help Line is a 24-hour-a-day telephone service which provides a crisis hotline and information and referral services for all Harris County residents needing emergent or urgent psychiatric services.
- Began operations in June of 2003.
- For many consumers needing psychiatric services, it serves as the first point to obtain the necessary and appropriate services.
- Help Line staff work with the caller to determine the appropriate next step, and make referrals to the necessary services.
- The Crisis Help Line helps decompress the Neuropsychiatric Center and Ben Taub psychiatric emergency services by triaging non-emergent problems to routine outpatient treatment centers.
- Provided telephone assessments, screenings, crisis counseling, and appropriate referrals, including MCOT, CIRT, CIT and PES referrals when indicated.
- Answered approximately 16,000 calls per month addressing consumer questions and providing information about MHMRA or other community resources, and routine business calls.
- Maintained contracts with six other community mental health centers to answer their hotlines as well as answering the National Suicide Prevention Lifeline for Harris County and Partnership Counties.
- Implemented a new web-based documentation software system called iCarol to track all incoming and follow-up calls.
- Implemented new call recording software to help provide better quality assurance and training on the Help Line
- The Help Line is coming to completion of a 2 year study sponsored by SAMHSA and conducted by Columbia University.
- They have been monitoring calls made to the National Suicide Prevention Lifeline and 1800-SUICIDE and making follow-up calls to callers who consent to determine our baseline crisis/suicide intervention skills.

There are 17 hotlines participating in the project across the county.

- In July 2009, the Help Line Director and Assistant Director were trained as Trainers in Applied Suicide Intervention Skills Training (ASIST) and brought this training back to MHMRA. They were required by the study to train our staff participating in the study so the monitors could study whether there is a difference in outcomes pre and post ASIST Training. As of December 2009 they have offered 3 ASIST trainings to Help Line staff, other MHMRA staff and some community members.

Crisis Residential Unit (CRU)

- The CRU provided community-based crisis residential services for approximately one-third the cost of traditional inpatient hospital beds.
- The program has been designed to serve voluntary consumers who can be stabilized and linked to community supports within seven to fourteen days of treatment while living in residential settings.
- The CRU is focused on individuals who have had repeated admissions to expensive services such as emergency rooms, jails and hospitals.
- CRUs are well established nationally as effective alternatives to hospitalization for many patients experiencing a psychiatric emergency who do not need (and may not respond well to) the more restrictive settings of inpatient or crisis stabilization units.
- Therapeutic interventions in the CRU are limited to evidence-based treatment models including cognitive behavioral therapy, dialectical behavioral therapy, problem-solving, Good Chemistry (a nationally recognized program for alcohol and drug addiction), skills training, and individual, solution-focused therapy.
- The CRU is staffed by master's level, licensed clinicians, an RN and a medical director. In addition, a part-time physician provides limited services and may also provide brief consultations to consumers in the co-located Bristow Homeless Program.
- Over the past 13 months, the CRU has served 613 clients with an average length of stay of 11.2 days.
- In the past 13 months, most consumers (97%) reported improvement in their condition either to "much improved" or "very much improved" as measured on the Clinical Global Impression (CGI).
- Over 87% of the consumers discharged from the CRU were linked with outpatient or other community services, including housing and health care.
- In the last 13 months, the CRU has served many non-target population consumers who might not otherwise receive services. In addition, the CRU has served many consumers who have been "waitlisted" due to lack of capacity in the clinic system.
- In 2009, the CRU earned a 3-year accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF). CARF is the JACHO equivalent for rehabilitation facilities and this makes the CRU one of the few CARF-certified programs in Harris County.
- In the 2009 CARF survey, the CRU received an outstanding commendation for the manner in which it cared for clients during Hurricane Ike and the aftermath.
- The Crisis Counseling Unit (CCU) is operated in conjunction with the CRU and by the same masters' level clinicians. The CCU provides time-limited outpatient therapy during the initial days of a psychiatric crisis, preventing deterioration leading to a full-blown psychiatric illness.
- CCU services are available to any Harris County resident who is indigent/uninsured and experiencing a psychiatric crisis. (The cost for Crisis

Counseling is included in the cost of the Crisis Respite Beds and the CRU staff provides the services.)

- The CCU serves non-target population clients, as well as those who have been waitlisted for access to the MHMRA clinic system and those who have been disengaged from other systems and services.
- The CCU also serves as a resource for HCHD consumers and MHMRA clinic consumers who are not eligible for therapy services.

New programs implemented in 2009

In addition to the ongoing programs listed above, a further significant CPEP accomplishment during the past year has been the implementation of ten (10) new programs and contracts utilizing state Crisis Redesign funds.

(1) Crisis Intervention Response Team (CIRT)

- This is a new program that has been developed in collaboration with Houston Police Department and MHMRA.
- MHMRA received authorization to utilize state Crisis Redesign funds for the clinical staff and Houston Police Department provided funding for the police officers and patrol cars.
- The program partners a CIT trained police officer with an MHMRA licensed mental health professional.
- One or two teams each shift work together in an unmarked police car. They respond to mental health calls, SWAT team calls, and other related calls. They also respond to the MHMRA MCOT teams when a situation warrants it.
- The program has been well received, and plans are under way to expand the day shift from two teams to three.
- Responded to nearly 300 calls per month, with an average of only three interactions requiring arrest.
- Provided the program with quarterly training for the teams.
- The team has been recognized with the Chief of Police Unit Citation Award both team and individual.
- Featured media coverage: Aljezeer Press interview, Houston Press article, Fox News feature, Houston Chronicle feature.

(2) Co-Occurring Disorders Program (COD)

- The COD is a new program being implemented through the use of state Crisis Redesign funding.
- Individuals with co-occurring psychiatric and substance use disorders are considerably more likely to access expensive jail, hospital and emergency room services. In addition, they are a more unstable and potentially lethal population.
- In response to the significant problems associated with obtaining substance abuse treatment for MHMRA-eligible individuals with co-occurring disorders, the co-occurring disorders program was created and operationalized in a record time of 2 months.
- The co-occurring disorders program is staffed by a LPHA Supervisor, Program Manager and four case managers.
- MHMRA CPEP Division was able to negotiate 6 contracts with various local chemical treatment providers to offer up to thirty days of intensive residential treatment and as much as sixty days of supportive residential treatment.

- Consumers admitted to this program receive MHMRA outpatient clinic services and intensive case management from the co-occurring disorders staff.
- The Co-Occurring Disorders Program has a current bed capacity of 46. This represents an increase of 6 beds in the current fiscal year.
- With some exceptions due to attrition, all of the COD beds have remained at or near full capacity at all times.
- Since the beginning of the program in June, 2008, 256 clients have been served and 123 have successfully completed the program (significantly higher than the national averages for residential treatment programs).
- In the last 12 months, the COD program has served 221 clients with 109 successful completions.
- Utilized approximately 10,000 supportive residential bed days serving 221 consumers in fiscal year 2009.

(3) Critical Time Intervention Program (CTI)

- Crisis Redesign Funded
- CTI is an evidenced based program that emphasizes short-term (9 months), intensive case management for consumers who are homeless, refractory and have been unable to engage in traditional mental health services.
- CTI is comprised of three, 3-month phases of decreasing intensity and involvement by the case manager.
- The case manager actively engages consumers in connecting, developing and strengthening relationships with family, friends, neighbors and community providers who will ultimately replace the role of the case manager and serve as the consumer's primary support system.
- The CTI program began as a new Program within the Comprehensive Psychiatric Emergency Program (CPEP) Division in September 2008, and over the last twelve months we have achieved the following:
 - Served a total of 83 clients
 - Average number of services per client, per month: 20
 - Average number of services provided per day: 25
 - Average monthly caseload was 30
 - Current number of contracts with housing Providers: 7
 - Acquired housing during Phase I for 77 clients
 - Successfully graduated 9 clients
 - Percentage of referrals from:
 - Hospitals: 6%
 - Jail: 4%
 - CPEP: 77%
 - Other programs (clinics): 13%
 - Presentations on CTI Program provided to:
 - Forensic Unit staff
 - Jackson Hinds Gardens staff
 - Housing Providers

- MHMRA Clinics staff
- CPEP Programs
- HCPC staff

- By collaborating closely with other CPEP programs, CTI has provided continuity of care and early intervention to maintain stability and prevent crisis.
- Number of clients that:
 - Obtained employment: 27
 - Obtained their own apartments: 9
 - Obtained Social Security benefits: 21
 - Obtained Food Stamps: 15
 - Obtained Gold Card: 14
 - Obtained supportive, long-term housing: 16
 - Obtained citizenship: 1
 - Began attending school: 5
 - Reconnected with their family: 16

(4) Branard Street Crisis Respite (Branard)

- Beginning in December, 2008, a small efficiency apartment complex accommodating 16 beds and already owned by MHMRA and previously used for a now-abandoned purpose was converted to use as a crisis respite program, providing 24/7 supervision, programming and daily case management for consumers coming out of various crisis services, incarceration and/or out of Rusk State Hospital.
- Clients are able to remain in respite, as needed, for up to 30 days – an appreciable period in which to stabilize and link with essential outpatient health services and other resources. During this time the program strives to link residents into ongoing services, help them apply for benefits, assists them in improving daily living skills as needed, and successfully locating more permanent living arrangements giving consumers sufficient time to apply for benefits, health care services and/or seek employment and more permanent housing.
- Since its opening, Branard Street has served 223 clients. One hundred ninety five of the clients served were successfully discharged (in that they completed the program and were linked to other programs or placed in the community).

(5) Children’s Crisis Residential

- MHMRA of Harris County developed a contract with Depelchin Children’s Center to provide brief crisis residential treatment followed by up to one month of in-home family therapy for children and adolescents in behavioral/mental health crises.
- Residential/Respite services provided to 20 children.
- Total bed days for the year: 447

- 30 days post discharge in-home treatment provided to 18 children

(6) Inpatient Crisis Services

- MHMRA is contracting with local psychiatric hospitals to provide brief inpatient care to indigent patients when Harris County Psychiatric Center has reached capacity and the MHMRA Psychiatric Emergency Center is in danger of going on diversion. So far there are contacts with two hospitals.
- 32 cases were sent to Private Inpatient Hospitals
- 191 Bed Days utilized
- Diversion from the PES decreased from 34 instances in 2008 to only 25 instances in 2009.
- The average diversion period decreased from 12.49 hours in 2008 to only 10.36 hours in 2009.

(7) Mental Health First Aid

- Mental Health First Aid is an evidenced based 12-hour training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis.
- The evidence behind the program demonstrates that it makes people feel more comfortable managing a crisis situation and builds mental health literacy — helping the public identify, understand and respond to signs of mental illness.
- Provided training to 452 participants.
- Completed 31 classes.

(8) Healthcare for the Homeless Houston

- MHMRA is contracting with Healthcare for the Homeless Houston (HHH) for them to provide “in reach” (up to two visits) in the jail to inmates who have a mental health diagnosis and who will be homeless upon release from jail, and up to one month of follow-up post release in the HHH clinic (providing mental health case management and initial mental health assessment, and attempting to link to MHMRA if qualified or Hospital District if not qualified).
- Program has served 219 consumers.
- Has opened for follow-up 123 consumers.
- Has provided crisis follow-up to 123 consumers.

(9) Peer Navigators

- Program staff are self-identified consumers currently in recovery.
- Two full-time employees and five part-time positions were hired for this program.
- These positions are housed at the following locations, PES, CSU, Branard and CRU.
- This is the first time that this program has been implemented in emergency services. Peer Navigators received intensive training prior to their initial

interactions with consumers including Mental Health First Aid and Focus for Life Consumer Training.

- One of the goals of the Peer Navigators in CPEP is the conveyance that recovery is possible and obtainable. The Peer Navigators perform a wide range of tasks to assist consumers in regaining control over their own lives and their own recovery process. Some of these tasks include:
 - Greeting consumers at the PES.
 - Provide resource information regarding the Eligibility Center process and linkage into a clinic.
 - Explain the initial intake/screening process of PES.
 - Hold peer support groups.
 - Peer Navigators teach and role model the value of every individual's recovery experience.
 - Model effective techniques and self-help strategies by lending their unique insight into mental illness.

(10) Chronic Consumer Stabilization Initiative (CCSI)

- The Chronic Consumer Stabilization Initiative (CCSI) is a collaborative program between the Houston Police Department, The Mental Health Mental Retardation Authority of Harris County (MHMRA), and The City of Houston Health and Human Services Department.
- This joint collaboration program was designed to identify, engage, and provide services to individuals who have been diagnosed with a serious and persistent mental illness, and who have frequent encounters with the Houston Police Department.
- The main goal of this program is to divert these chronic individuals away from their routine and repetitive encounters with law enforcement, reduce excessive calls for service to the 9-1-1 system, and provide them with opportunities to lead a more stabilized life.
- Reduced the number of interactions between individuals diagnosed with serious and persistent mental illness and the Houston Police Department.
- Identified unmet needs and barriers in the community that contribute to an individual's inability to engage and remain in mental health treatment.
- Linked and coordinated individuals with mental health treatment and other social needs.
- Provided support and education to individuals and family members to minimize contact with law enforcement resulting from noncompliance with mental health treatment.

Federally funded Projects for Assistance in Transition from Homelessness (PATH) Grant

Bristow Homeless Program

- MHMRA of Harris County has implemented a federal grant Program known as Projects for Assistance in Transition from Homelessness (PATH).
- The program is under the direction of the Comprehensive Psychiatric Emergency Programs Division leadership.
- This program is housed in the same building as several other CPEP programs such as Mobile Crisis Outreach Team, Crisis Residential Unit, Crisis Intervention Response Team, and Co-Occurring Disorders; thus allowing PATH to work closely with all of the above CPEP program components.
- The PATH program also has built up a significant community network collaborating with other community homeless service providers to provide more resources for the homeless population while decreasing the difficulty in accessing these services.
- The PATH program provides outreach, assessment, case management, nursing, LCDC services in addition to medication management to homeless individuals diagnosed with a mental illness, to increase their environmental and psychiatric stability.
- The outreach team also partners with area shelters to identify eligible individuals and facilitate access to services. Consumers who have been identified as needing services are then referred to the PATH program for an extended assessment of needs.
- Consumers identified as homeless and mentally ill are then assigned a Case Manager who assists them in meeting their identified needs through support & encouragement, as well as assistance in applying for and accessing mental health and social services.
- The drop-in center component of the program provides basic services to consumers such as sack lunches, showers, laundry services, clothing closet, use of a locker and use of a phone, as well as clinical services such as Medication Management, Nursing Assessments, Group & Individual Counseling and Drug and Alcohol counseling.
- Renewed grant for the current fiscal year and is expected to provide outreach to at least 2,752 homeless persons with mental illness.
- In the past twelve months, PATH has provided an estimated 15,000 ancillary services such as lunches, laundry and showers to the 707 persons admitted for services.
- The PATH program enrolls approximately 70 new clients each month for clinic services, for a year end total of 840 newly enrolled clients.
- The program maintains a caseload of 200 enrolled clients.
- Approximately 30% of the persons admitted for services will be successfully linked for continued mental health services.
- Program administrators collaborates monthly with HPD Outreach, Coalition for the Homeless, Healthcare for the Homeless Advisory Counsel, Houston Homeless Resource Guide Committee, Houston Homeless Run Committee, Jackson Hines Gardens, Northline SRO, HCPC Recidivism, Homeless Court, and the United Way Community Resource Committee.
- Program Director participates in the following community support activities:

- A. Board Member of:
 - The Houston Homeless Resource Guide
 - The Houston Homeless Run
- B. Advisory Council Member:
 - Health Care for the Homeless Houston
 - Jackson Hinds Gardens
 - My Fellow Man Alliance
 - Houston Police Department's Outreach Project
 - HCPC's Recidivism Meeting
 - Coalition for the Homeless Advisory Council
 - Returning Veterans Mental Health Initiative
- C. Participates in:
 - Coalition for the Homeless Annual Street Count
 - Homeless Court Project
 - United Way Community Resource Meetings
 - Northline/SEARCH SAMHSA Grant

MENTAL HEALTH AUTHORITY SERVICES

Utilization Management – State Mental Health Facility (SMHF) Trust Fund

- Exhibited reliable Trust Fund utilization reporting accuracy to within <1% when cross-referenced with financial data provided by the state; benchmark - within 5% of State report
- Provided oversight and coordination to support the successful management of the agency's 18.9 million dollar trust fund with total utilization projected at to be at 100% and well under the 110% over-utilization amount which would warrant sanctions. The agency consistently ranked among the top 3 MHMR centers statewide for effective trust fund utilization and 1st among large metropolitan centers with allotments greater than 10 million dollars concerning the ability to maximize use of allotted state hospital funding.
- Achieved a 100% success rate regarding the coordination of resident county changes with other MHMR centers for erroneous state hospital utilization fees charged toward Harris County; the total estimated value of savings in this domain was approximately 2.1 million dollars.
- Achieved a 100% success rate with requests submitted to state hospital utilization review staff for a reduction in inpatient level of care status, leading to an estimated value of 1.1 million trust fund dollars in this domain.
- Saved an additional \$121,000.00 in state hospital trust fund dollars for the agency via staff tracking and monitoring of ancillary utilization costs.
- Concerning SMHF, the UM department continued its effort in successfully reducing the long-term civil census from 24 to 18 (25% reduction) in FY'09, freeing up approximately \$657,000.00 trust fund dollars for other Harris consumers in the state hospital setting.

Utilization Management – Resiliency and Disease Management (RDM)

- Continued to exceed the goal of authorizing all routine RDM authorization requests within 1 business day. The UM Department staff completed a total of 65,137 provider requests for RDM service authorization with an overall average turnaround time of 1 business day.
- Exceeded in appropriateness of authorization for >89% of completed service authorization requests; the state benchmark was 85%.
- Maintained previous high staff productivity levels in authorizing RDM service authorization requests (average of 283 authorizations per day). The benchmark was >200 authorizations per day, and the previous fiscal year daily average was 284.
- 0 formal appeals - appeals target @ <1/1000

Utilization Management – Crisis Redesign

- Initiated UM review of all contract program referrals within 24 business hours.
- Assisted in provider relations development and utilization review training for both the Inpatient diversion and DePelchin Crisis Respite contract expansions.
- 0 formal appeals - appeals target @ <1/1000
- Managed a total of 287 cases for the authorization of 10,711 bed days for inpatient and residential services and for 70 relapse prevention service interventions with contracted facilities and providers.
- Provided accurate utilization reporting for all contracts managed to help ensure that spending did not exceed allotted costs.

Credentialing Department

- Credentialing Department start up-hiring staff, developing committee, writing Operational guideline (purpose-expedite credentialing of providers as a means to reduce service write-off's)
- Credentialed over 300 providers
- Began Delegated Credentialing negotiations with 3rd party payors.

Continuity of Care (COC)

- Provided 94% of patients with face-to-face needs assessment prior to discharge from acute care; contract requires 75%
- Ensured 97% of patients had a qualifying state discharge status; contract requires 95%

Network Management

- Developed Local Plan for Network Mgmt with over 160 stakeholders-obtained pan approval
- Revised Local contracts to meet new TAC requirements
- Posted first procurement package under new Local Plan
- Continued monitoring of external contract-training/claiming issues
- Completed Case Management and Monitoring for over 400 consumers in external provider network

- Hiring/training new staff for implementation of Local Plan

Eligibility Center (EC)

- Development of Quad Eligibility Software- set for go-live FY 2010
- Development/implementation of pilot program for remote eligibility for HCPC

Consumer Benefits Office (CBO)

- Development of Quad Eligibility Software
- Development of PAP application process beginning at the EC
- Increased average monthly benefit application submissions by 20%
- Planning electronic application processing with DARS

MENTAL HEALTH OUTPATIENT SERVICES

Outpatient Clinical Services

- Met the performance contract target established by the Department of State Health Services Resiliency and Disease Management model of care by providing the minimum number of hours of service required based on service intensity need-**Exceeded adult target by 4% and child and adolescent target by 8%**
- Established forum for receiving input on housing needs through community forum
- Established an additional co-location school based clinic through KIPP academy
- Collaborative participation with “Gift of Hearts” which provides community service opportunities and education through to teach life skills, encourage self-confidence and create social awareness
- Provided statewide decision making input on the Texas Department of State Health Service’s Oversight Committee through the division’s Medical Director’s active participation
- Collaborative education of health care providers through UT Psychiatry Grand Rounds participation by the division’s Medical Director
- Secured outside grant funding to complete a mental health policy analysis on “Consequences of Untreated Mental Illness in Houston”
- Completed program evaluation on the Forensic Assertive Community Treatment program (intensive outpatient program providing jail/court based services)

Supportive Employment Initiative for Outpatient Services (CFA)

- Establishment of a MOU with Gulf Coast Community Services Association to provide job readiness activities, incorporating job retention and placement for MHMRA job ready candidates.

- Development of Business Advisory Group known as “The BAG” consisting of local businesses and community organizations committed to equity and access in the employment arena for ALL Houston/Harris County residents. Quarterly BAG meetings instituted
- Kick off breakfast, May, 2009 to promote business interest in hiring MHMRA consumers held at the Embassy Suites with City of Houston Councilperson, Wanda Adams, keynote speaker.
- CFA partnered with Jobing.com, Neighborhood Centers and Workforce Solution to sponsor the CFA 1st annual job fair. Over 800 job seekers, 36 employment vendors including Comcast, City of Houston, HEB participating.
- CFA Information Forum Breakfast "Employment and Empowerment through Collaboration" held on October 29, 2009 at the United Way of Greater Houston. Jarvis Johnson, City Council Member served as the Moderator for this event.
- Partnering with the RISE program to assist MHMRA job seekers with subsidies for rent

FACT (FORENSIC ASSERTIVE COMMUNITY TREATMENT) PROGRAM

- Program evaluation reflected a reduction in the following for FACT inmates released from the Harris County Jail to the FACT program: (1) a reduction in the mean number of bookings when comparing bookings post FACT with pre FACT involvement. (2) a reduction in the number of criminal charges and (3) a reduction in the number of jail days post FACT when compared with pre FACT involvement.

JUVENILE JUSTICE PROGRAMS

- All JJ programs are fully staffed, no vacancies, including TCOOMMI
- Harris County Probation has provided funding for 6 staff (3 LPHA and 6 QMHP) to work closely with the kids in Institutions to provide group and individual counseling, case management, crisis intervention and COC linkage.
- Harris County Probation has provided funding for an additional LPHA for the Psychiatric Stabilization Unit
- Our Business Office staff are equipped with scanners and signature pads which will eliminate having other departments help with scanning JJ financial documents
- TCOOMMI staff have received new computer equipment

FORENSIC OUTPATIENT SERVICES

NEWSTART (Specialized Team of Advocates and Rehabilitation Therapists)

- Served 8045 defendants in the Jail Diversion Program
- Served 4717 in the Continuity of Care Program

- Served 570 in Intensive Case Management and Intensive Rehabilitation Program
- New START Peden Substance Abuse Treatment Program opened 2/1/08 and accepted mentally impaired co-occurring disorder probation. YTD served is 113 unduplicated. The program capacity is 70 beds.

HARRIS COUNTY JAIL BEHAVIOR HEALTH PROGRAM

JAIL BASED SERVICES

- **Front Door Clinic**
 - Number of Psychiatric Evaluations completed at the Front Door during FY09 = 10,692
 - Number of Psychiatric Evaluations completed FY10 through October = 7,983
- **Outpatient Services**
 - Hired LPHA to assist with reevaluation of patients waiting to go to the state hospitals for competency restoration
 - Implemented court ordered medication (civil process) for patients found incompetent to stand trial, waiting for the state hospital and refusing medications
 - Hired LPHA to assist with discharge planning for patients returning from state hospitals Not Guilty by Reason of Insanity, Not Competent – Not Likely to Regain Competency and other difficult cases, i.e., medical conditions with mental health issues
 - Established Chronic Care Clinic for ongoing outpatient services

- **Mental Health Infirmery Units** (2C, 2P)
 - Decreased the Length of Stay (LOS)- began @ 16 days per patient; ended FY09 at 15.25 days per patient;
 - Hired Utilization Management LPHA to assist in monitoring Length of Stay
 - Decreased number of patients placed in seclusion from 4.4 to 1.9 per month
 - 415 referrals to the HCPC Forensic Unit in FY09
- **Cognitive Behavioral Therapy Program** (Designed to address behavioral problems manifested in mental health patients at Harris County Jail)

Program evaluation of the Cognitive Behavior Therapy program reflected the following findings:

- Statistically significant improvement in the average rates of occurrences per person within a year's time when examining bookings, charges and misdemeanors for both pre and post CBT criminal justice activities
- A significant reduction in the number of felonies
- Conducted presentations discussing benefits of CBT program on three (3) different occasions
 - National Commission on Correction Healthcare
 - Texas Psychological Association
 - Women in Law Enforcement
- **Project HELP** – Effectively closed grant funded program for Katrina & Rita evacuees;
 - Total Referrals for service - 570
 - Total patients assessed - 422
 - Total qualified and served - 213
 - Katrina – 198
 - Rita - 15
- **Legal Community Involvement**
 - Participated in establishing multiple Mental Health Courts
 - Veteran's Court – Judge Carter
 - Mental Health Court – Judge Krockner
 - Mental Health State Hospital Docket – Judge Ellis

STAFF TRAINING

- Certification for Mental Health First Aide trainers obtained. (Totaling 5 for the agency).
 - Instituted Mental Health First Aid training for all new hires.
 - Implemented Mental Health First Aid training for existing staff.

- Over 200 Mental Health Services Division staff completed training
- Developed new Recovery and Clinical Engagement material to include state-mandated Motivational Interviewing and implemented the new material with both new and existing staff
- Implemented ongoing supervision model for motivational interviewing skills to ensure consistent implementation.
- Implemented new COPSD material now provided in an online format including providing CEU's to licensed participants.
- Updated and/or continued MH Clinical Training for new hires that include:
 - Basic MI Competency Training - Continued
 - TRAG Competency Training - UPDATED
 - COPSD Competency Training - UPDATED
 - TIMA PFEP Competency Training – Continued
 - Rehab Competency Training - Continued
 - Case Management Competency Training - Continued
 - Treatment Planning Competency Training - Continued
 - Recovery & Clinical Engagement Competency Training - Updated
 - Administrative Functions – Updated to include information on organization and self-management
 - Progress Note Writing
 - Concurrent Documentation
 - Mental Health First Aid - NEW
- Updated and/or continued Annual Competency Training for existing staff that include:
 - Basic MI Competency Training - Continued
 - TRAG Competency Training - UPDATED
 - COPSD Competency Training - UPDATED
 - TIMA PFEP Competency Training - Continued
 - Rehab Competency Training - Continued
 - Case Management Competency Training - Continued
 - Treatment Planning Competency Training - Continued
 - Recovery & Clinical Engagement Competency Training - Updated
 - Mental Health First Aid – NEW

CONSUMER ADVISORY COUNCIL (CAC)

AWARDS\RECOGNITION:

Awarded Mental Health America Consumer of the Year, June 2009
 Two Consumer Advisory Council members hired as Peer Navigators, June 2009

TRAINING AND PRESENTATIONS:

- Mental Health First Aid Training Course, May 2009

- Computer Training to facilitate electronic communication with MHMRA staff and other entities, July 2009
- 3 day training to learn how to share personal stories-“In Our Own Voice” by NAMI, July 2009
- NAMI Advocacy Training, April 2009
- Understanding Major Depression-June 2009
- Dual Diagnosis, July 2009
- Signs and symptoms of relapse, January 2009
- Building self-esteem, January 2009
- Training with Peer-to-Peer Facilitator, August 2009
- Trained new Helpline staff on the roles of the Consumer Advisory Council
- Presentation to new employees every 2 weeks (Consumers share their stories about recovery)

COLLABORATIVE PARTICIPATION:

Participation in the NAMI National Conference
 Participation in the NAMI Texas Conference
 Participation in Network Development Committee
 Advocacy for consumers monthly in meetings with practice managers at each clinic
 Input in clinics’ quarterly staff meetings
 Joint meetings with the Veterans Administration Consumer Council
 Completed surveys soliciting consumer opinions about clinic services

Increased community resource materials in each clinic’s waiting room
 Provided assistance during Hurricane Ike to Ripley consumers.

Pharmacy Services

Overview:

MHMRA of Harris County has 4 retail and 1 hospital pharmacy that provide services to the consumers who utilize case management or physician services within the agency. Our pharmacies, located in the Medical Center, Southwest, Southeast, Northwest and Downtown areas dispense approximately 200,000 prescriptions per year for over 14,000 consumers with major depression, bipolar disease and schizophrenia. Each of our retail pharmacies are supported by a sophisticated Pharmacy Assistance Program which enables many of the MHMRA consumers to access to free medication from participating pharmaceutical companies.

Volume Statistics:

	2004	2005	2006	2007	2008	2009
Purchased	\$9,164,883	\$11,084,066	\$8,024,904	\$6,251,162	\$6,387,414	\$ 4,417,577
Free	\$5,006,009	\$6,488,022	\$8,818,018	\$8,764,538	\$8,380,601	\$11,938,621
% Free	35%	37%	52%	58%	57%	73%

2009 Projects Undertaken:

- ◆ Re-bid wholesaler contract
- ◆ Re-bid “relief pharmacy” contract
- ◆ Re-bid GPO contract
- ◆ Evaluated all 53 PDP Part D Plans in Harris County to determine which plans best fill the needs of the agencies population for 2009
- ◆ Cross training of PAP and Pharmacy technicians
- ◆ Reduce 1 FTE in PAP by consolidating New Start and SW Pap Process
- ◆ Consolidate the PAP office into the pharmacy suite to improve communication and efficiencies

Results:

- ◆ Increase the amount of free drugs attained for our patients by \$3.5 million dollars over last year
- ◆ Reduction of 3% in our wholesaler pricing on drugs
- ◆ Reduction of 3.2% per hour in relief pharmacist rates
- ◆ GPO bid process completed for 5 year period
- ◆ Analysis of 2009 Medicare Part D plans completed and shared with agency providers
- ◆ 80% of all Pharmacy techs have been trained to do PAP
- ◆ PAP staff was given tools to study for pharmacy tech exam and all PAP staff will have to have a pharmacy tech certification by 12/31/09 to remain working in the pharmacy department.
- ◆ SW, SE and NW Pharmacies were built out to accommodate the PAP staff moving into the pharmacy

Overall, the pharmacy department continues to be clinically and financially high functioning with little voluntary turnover.

Nursing Leadership/Management-Statewide Activities

- Nursing Director participates in the quarterly Texas Council of Community Centers-Medical Services Consortium meetings in Austin. Director of Nursing in conjunction with the Director of Nursing from Tarrant County is a Co-Leader of the nursing group. The Medical Services Consortium meets with Department of State Health Services’ leadership to discuss issues that impact medical and nursing services in the community mental health and mental retardation centers.
- The Director of Nursing has been appointed by the Commissioner of the Department of State Health Services (DSHS) to serve on the DSHS Nursing Leadership Council. The Council includes nursing leaders from the Public Health Regions throughout the state, state psychiatric hospital chief nursing officers and nursing academia. The Director of Nursing’s appointment was supported by the Texas Council of CMHMR Centers and she represents the Council for the

community mental health and mental retardation centers. The purpose of the Nursing Leadership Council is to support the role of professional nurses in implementing the agency (DSHS) mission to improve health and well-being in Texas.

Schools of Nursing Affiliations

- MHMRA provided clinical sites for nursing students' psychiatric nursing learning experiences with three University Colleges of Nursing and one Community College Associate Degree School of Nursing. Provided Center information regarding services and orientation to over 150 nursing students. Over one hundred nursing students completed their clinical practicae in mental health nursing in Center service sites and programs. It is noteworthy that nursing students completed clinical practicae in the Psychiatric Emergency Services including the Mobile Crisis Outreach (MCOT) Program. The Center continues to receive request for additional learning experiences for nursing students such as the Chamberlin College of Nursing in Indiana who will be implementing a 3 year BSN nursing program in the Houston area in 2010.

Community Initiatives

- Partnered with the Methodist Hospital and twelve other community healthcare, academic entities and Houston Work Source to develop and submit to the Department of Labor a grant entitled "Expanded Education and Training for RN's LVN's and Mental Health Technicians in the Specialty Areas of Gerontology, Behavioral Health and Rehabilitation". The purpose of the grant is to develop internships for new nursing graduates and training programs for areas that do not traditionally attract new graduates. In addition training opportunities will be provided to increase skill sets for persons' working in the above referenced areas. The grant request was for \$4.7 million dollars and activities must be completed within 18 months after the grant has been approved. MHMRA will participate in the internship program for new nursing graduates and as a training site for mental health technicians. The Department of Labor will send notification in January 2010 if the grant has been funded.
- Represented the Center at the [*Mental Health: Engaging Communities to Reduce the Mental Health Stigma*](#) forum on November 5, 2009 at the Texas Southern University in Houston, Texas sponsored by the National Black Nurses Foundation (NBNF) and co-sponsored by Texas Southern University H.O.T.E.P. Mental Health Pilot. MHMRA was identified as a community sponsor on promotional materials and during the program. Center information on programs and services was made available to program attendees. Joycelyn Elders, MD the 17th Surgeon General of the United States was the keynote speaker. Conference planners noted that this program had the largest number of attendees of the 3 previous conferences held in other parts of the country.

Nursing Education

- Coordinated, made application for and implemented the process for Continuing Nursing Education (CNE) credits for the June 2009 24th Annual Texas Council

Community Center's Training in Fort Worth. Center Director of Nursing participated as a member of the state-wide conference program committee. Presentations were approved by the Texas Nurses Association and 9 continuing nursing education credits were awarded.

H1N1 Response

- Participated in the Department of State Health Services-State Operations Center weekly calls from April through November regarding H1N1 preparedness and response. Provided weekly updates to the Disaster Command Staff-Incident Command and in conjunction with Human Resources, the Infection Control Professional, the Medical Directors and Executive Staff formulated and implemented Center response. Center response included implementation of an education program that focused on prevention and disease management, dissemination of education information, provision of consumer materials in multiple languages, building signage, employee incentives for early seasonal and H1N1 vaccination and letters to consumers and families in Spanish and English.

MHMRA of Harris County

Crisis Services Plan

Harris County Crisis Service Plan, February 2010

a.) Illustrate a flow of crisis services designed to assure rapid response to persons in crisis and local stabilization when possible.

MHMRA of Harris County has developed and implemented all the components of a Comprehensive Psychiatric Emergency Program (CPEP). The CPEP model represents the standard of care in large, urban settings in the United States and is designed to utilize the least restrictive means possible in stabilizing and treating consumers so they may return to the community, develop networks of human relationships, and remain out of hospitals and out of jails. MHMRA received Crisis Redesign funding from the Department to expand crisis services and several additional programs were then implemented. The following illustrates the flow of crisis services:

The HelpLine, a crisis hotline service, conducts telephone suicide assessments and crisis intervention, and provides community referrals when appropriate to the various other crisis programs within MHMRA or to law enforcement. When possible, the HelpLine attempts to resolve the crisis by phone thereby avoiding the need to have the caller utilize other services this is done through careful assessment of risk, de-escalation techniques, connection to other community referrals, and continued follow-up calls until the crisis is resolved.

The primary program for face-to-face crisis assessment, initial stabilization, and disposition to further services is our Psychiatric Emergency Service (PES). Law enforcement officers bring individuals to the program on warrantless detention and the community may also walk in voluntarily seeking crisis services. At times the criminal courts dismiss misdemeanor charges and order individuals to the PES for a mental health evaluation. Our Mobile Crisis Outreach Team (MCOT) and Crisis Intervention Response Team (CIRT) also serve as first responders to psychiatric crises in the field, either resolving the situation at the scene, or transporting the individual to the PES.

For crisis resolution, follow-up and transition MHMRA of Harris County has a variety of options for the individual, depending on the nature and severity of the crisis.

MCOT serves as both a primary intervention and also as a follow-up crisis resolution option for individuals coming out of the PES or HCPC. The program works closely with law enforcement.

CIRT is a specialty program that is an off-shoot of MCOT. The program pairs a police officer and an MHMRA LPHA as a team on the street, responding to crises that require a police presence. There is 1-3 teams on the street at all times.

Also available for further stabilization are the Crisis Stabilization Unit, the Crisis Residential Unit, Crisis Respite, Critical Time Intervention, and the Co-Occurring Disorders program. Each program serves a unique niche in the continuum of crisis services provided by MHMRA of Harris County.

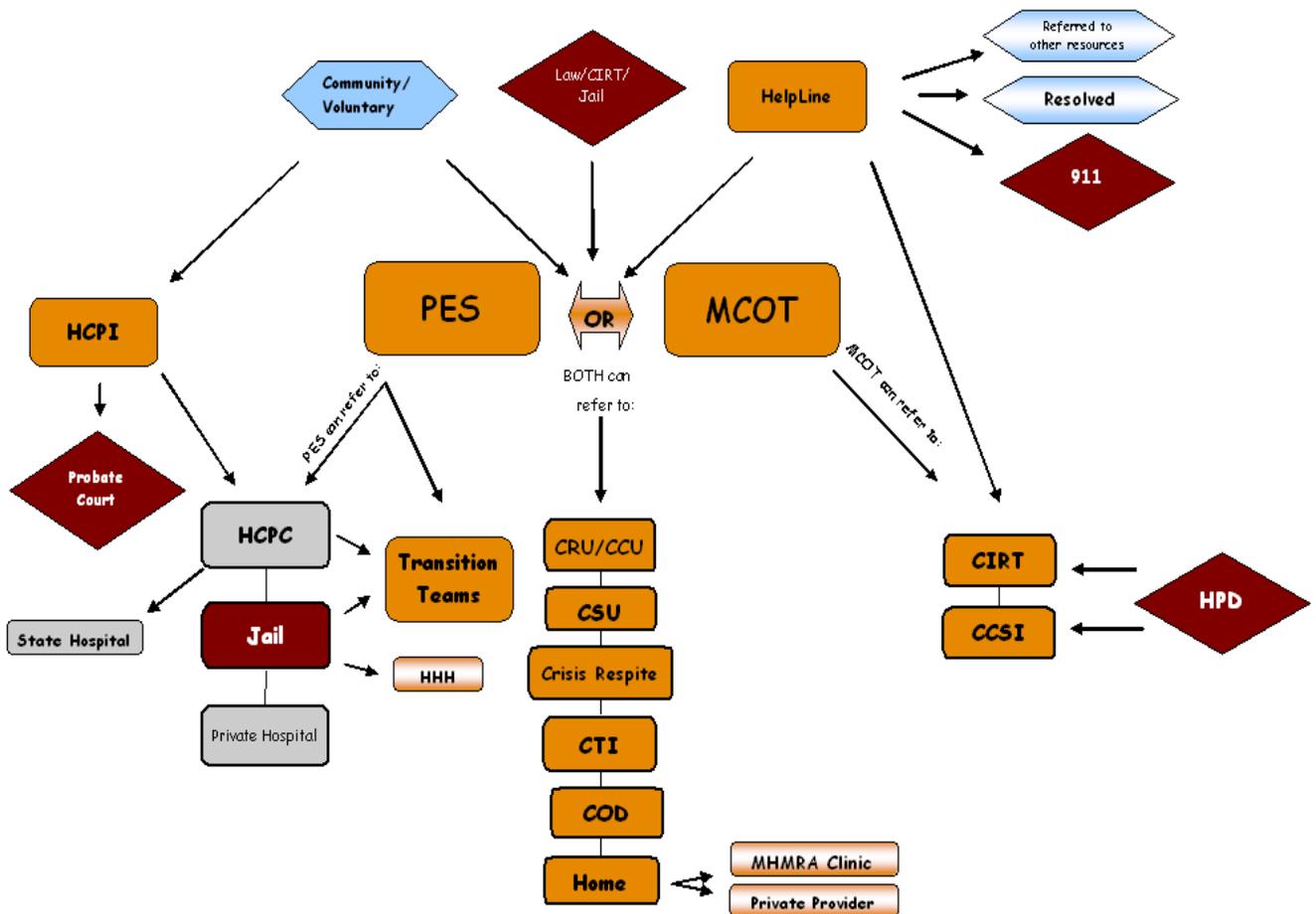
On rare occasions after assessment in the PES, law enforcement takes the detainee on to the Harris County Jail, depending on the nature of the crime and the result of the assessment.

Harris County Psychiatric Center serves as the psychiatric acute care hospital for us. No patients are sent directly to Rusk State Hospital without first attempting to stabilize at HCPC, and since September of 2009 there have been no civil commitments that transferred from HCPC to Rusk. MHMRA of Harris County also contracts with four private psychiatric hospitals. Those beds are used only when HCPC is at capacity and our PES is nearing diversionary status.

MHMRA of Harris County is in the process of implementing Transition Teams that will initiate contacts with individuals in the jail, HCPC and the PES and then provide follow-up services and supports for up to three months in the community. There is also has a contract with Healthcare for the Homeless Houston (HHH) to provide jail in-reach and brief community follow-up upon discharge from the jail.

In an effort to educate the community at large, MHMRA has two staff trained in Mental Health First Aid. They conduct MHFA training for agencies and organizations throughout Harris County.

CPEP Referral Process



b.) Describe the components of the crisis services system

- Crisis HelpLine is a 24-hour-a-day telephone service providing a crisis hotline and information and referral services for all Harris County residents seeking emergent or urgent psychiatric services. It began operations in June of 2003 and has been accredited with the American Association of Suicidology for over 6 years. For many consumers in need of psychiatric services, it serves as the initial contact to obtain the necessary and appropriate services. HelpLine staff work with the caller to determine the appropriate next step, and make referrals to the necessary services. The Crisis HelpLine also helps decompress the MHMRA PES and Ben Taub psychiatric emergency services by triaging non-emergent problems to routine outpatient treatment options. The HelpLine also has a contract with the National Suicide Prevention LifeLine to answer calls to their line for our area, and with six other community mental health centers to answer their crisis hotlines. The phone counselors are bachelor level QMHPs.
- Psychiatric Emergency Services (PES) is 24-hour a day psychiatric emergency service located at the Neuropsychiatric Center (NPC). The objective of the Psychiatric Emergency Service is to promptly and accurately assess and evaluate consumers in Harris County experiencing a mental health crisis. The PES strives to utilize the least restrictive means possible in stabilizing and treating consumers so they may return to the community, develop networks of human relationships, and remain out of hospitals and out of jails. Services also include an extended observation component which provides intensive psychiatric treatment and observation in a safe and secure environment, with the expectation that the crisis can be resolved in less than twenty-four hours. Services available include medication administration, meetings with extended family, close observation by clinical staff, reinforcement of coping skills, and assistance in determining appropriate family and community supports. Extended observation is designed for those individuals who may be stabilized quickly and thus avoid hospitalization. No target population diagnosis is required and the PES provides thorough psychiatric evaluations and initial treatment to children and adults, including those brought in by law enforcement on a warrantless detention. Depending on the results of the evaluations and initial treatment, consumers may be referred to an MHMRA outpatient clinic, private provider, admitted to the extended observation program, admitted to another MHMRA crisis service program, or transferred to an inpatient facility. The unit is staffed continuously by psychiatrists, registered nurses, clinical social workers and licensed professional counselors, and psychiatric specialists. Peer Navigators are available on a daily basis.
- Mobile Crisis Outreach Team (MCOT) provides emergency and urgent crisis outreach and follow-up by traveling to locations and evaluating persons, both adults and children, in the community who cannot or will not access traditional psychiatric emergency room care. Teams may also go to schools to provide interventions, which allow the student to stay in school. Inpatient hospitalization is avoided through the use of preventative medicine, reducing the likelihood that a person will become dangerous to self and others before getting help. Follow-up visits are provided to insure linkage into outpatient services. This program interfaces with and complements the Houston Police Department Crisis Intervention Team Program (CIT) by intervening with those consumers who do not warrant detention, or before emergency detention becomes necessary. They also assist HCPC by providing on-site evaluation/screening of consumers who “walk in” to HCPC during the evening

and weekend hours seeking hospitalization, with the expectation that a percentage of those consumers can be diverted to a less restrictive and less expensive level of care. The program is staffed by psychiatrists, registered nurses, clinical social workers and licensed professional counselors, and psychiatric specialists.

- Crisis Intervention Response Team (CIRT) is a program that has been developed in collaboration with Houston Police Department and MHMRA. MHMRA received authorization to utilize state Crisis Redesign funds for the clinical staff and Houston Police Department provided funding for the police officers and patrol cars. It is a program that partners a CIT trained police officer with an MHMRA licensed mental health professional. There are currently seven teams that work together in unmarked police cars (two teams per 8 hour shift plus one team the works across the day and evening shift). They respond to calls with mental health related issues, SWAT team calls, and other related calls. They also respond to the MHMRA MCOT teams when a situation warrants it and provide follow up to previous calls they have made when indicated. The program has been well received by HPD and based on quality surveys sent out to police officers who called upon a CIRT unit, 92% stated that the CIRT program is a valuable resource, and 98% stated they would request CIRT again when dealing with a difficult crisis situation. The program received further validation at the national Crisis Intervention Team conference, as two of the seven national awards were awarded to individuals involved in development of the program: Behavioral Health Professional of the Year, and Officer of the Year.
- Crisis Stabilization Unit (CSU) is a 16 bed state-licensed CSU program located in the same building as the PES. It provides hospital-like services in a less costly, less stigmatizing, and less restrictive setting than inpatient hospitalization. The program is designed to serve voluntary adult patients who can be stabilized within a three to five day length of stay, and who can then be linked to community supports. The unit is staffed by a psychiatrist, nurses, LPHAs, psychiatric technicians and a peer navigator.
- Crisis Residential Unit (CRU) program has been designed to serve voluntary consumers who can be stabilized and linked to community supports within seven to fourteen days of treatment while living in a residential setting that also provides psychosocial treatment and supports. CRU's are well established nationally as effective alternatives for many consumers experiencing a psychiatric emergency who do not need the more restrictive settings of hospital or crisis stabilization units. Therapeutic interventions include cognitive behavior therapy, dialectical behavioral therapy, problem-solving, communication skills training, psychosocial rehabilitation, Good Chemistry (a nationally recognized program for alcohol and drug addiction), skills training, and individual therapy. The CRU is accredited through the Commission on Accreditation of Residential Facilities (CARF). Crisis Counseling Unit (CCU), which is operated in conjunction with the CRU utilizing the same LPHAs, provides time-limited outpatient therapy during the initial days of a psychiatric crisis, preventing deterioration leading to a full-blown psychiatric illness. The CCU serves many non-target population consumers as well as those on "waitlist" to be seen in clinics.
- Co-Occurring Disorders Program (COD) It is a three month substance abuse residential treatment program enhanced by intensive mental health case

management. Individuals with co-occurring psychiatric and substance use disorders are considerably more likely to access expensive jail, hospital and emergency room services. In addition, they are a more unstable and potentially lethal population. In response to the significant problems associated with obtaining substance abuse treatment for MHMRA-eligible individuals with co-occurring disorders, the co-occurring disorders program was created. This program is staffed by an LPHA supervisor, a Clinical Services Team Leader and four case managers. MHMRA CPEP Division contracts with various local chemical treatment providers to offer thirty days of intensive residential treatment and as much as sixty days of supportive residential treatment. Consumers admitted to this program receive MHMRA outpatient clinic services and intensive case management from the co-occurring disorders staff.

- Critical Time Intervention Program (CTI) is an evidenced based program that emphasizes short-term (9 months), intensive case management for consumers who are homeless, refractory and have been unable to engage in traditional mental health services. CTI is comprised of three 3-month phases of decreasing intensity and involvement by the case manager. The case manager actively engages consumers in connecting, developing and strengthening relationships with family, friends, neighbors and community providers who will ultimately replace the role of the case manager and serve as the consumer's primary support system.
- Crisis Respite (Branard) is located at a small efficiency apartment complex accommodating 16 beds. This location is being used for a crisis respite program, providing 24/7 supervision and daily case management for consumers coming out of crisis and/or out of Rusk State Hospital. Length of stay is up to 30 days. During this time the program strives to link the residents into ongoing services, helps them apply for benefits, assists them in improving daily living skills as needed, and helps them successfully locate more permanent living arrangements.
- Inpatient Crisis Services MHMRA contracts with Harris County Psychiatric Center (HCPC) and also with four private psychiatric hospitals to provide inpatient care for indigent consumers at the same bed day rate as HCPC. The private hospital contracts are only accessed when we are nearing diversion in our Psychiatric Emergency Service (PES) and HCPC has no appropriate beds available.
- Peer Navigators are self-identified consumers who are in recovery. The Peer Navigator performs a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process. They are able to teach and role model the value of every individual's recovery experience and model effective techniques and self-help strategies by lending their unique insight into mental illness. Peer navigators are assigned to four of the crisis programs: the PES, CSU, CRU, and Crisis Respite at Branard Street Apartments.
- Harris County Psychiatric Intervention and Court Liaison Services (HCPI) is co-located with HCPC and the Probate Court, and assists the Probate Court with processing mental health warrants, orders of protective custody, probable cause/final commitment hearings, civil commitments and transfer of consumers to state hospitals. Staff members also complete psycho-social assessments on indigent

consumers who walk in to HCPC during the day requesting inpatient hospitalization services. This program often fields questions, in person or by telephone, concerning hospitalization, other mental health issues and community referrals. The philosophy of HCPI is to promptly and accurately assist family members, significant others, community professionals and the Probate Court in recommending the most appropriate yet least restrictive disposition required for treatment and stabilization.

- Chronic Consumer Stabilization Initiative (CCSI): The Mental Health Mental Retardation Authority of Harris County (MHMRA) is collaborating with the Houston Police Department (HPD) and the City of Houston Health Department in a process to identify and engage adults with mental illness who frequently utilize city law enforcement services. The goal is to enroll these individuals in ongoing mental health treatment through the provision of intensive crisis intervention and wrap around case management services. Eligibility criteria (must meet 2 of the four): 1) Three or more admissions per year to the Neuropsychiatric Center by Houston Police Department Officers; 2) Excessive number and high frequency of phone calls made to the Houston Police Department; 3) High frequency of contact with Houston Police Department Officers; 4) High frequency of contact with the Crisis Intervention Response Team.
- Healthcare for the Homeless Houston: MHMRA is contracting with Healthcare for the Homeless Houston (HHH) for them to provide “in reach” (up to two visits) in the jail to inmates who have a mental health diagnosis and who will be homeless upon release from jail, and up to one month of follow-up post release in the HHH clinic (providing mental health case management and initial mental health assessment, and attempting to link to MHMRA if qualified or Hospital District if not qualified).
- Transition Teams With the most recent Rider 65 fund allocation, The Mental Health Mental Retardation Authority of Harris County (MHMRA) has begun collaboration with the Harris County Jail and Harris County Psychiatric Center (HCPC) to identify and engage adults with mental illness who are frequently incarcerated for minor offenses in the jail or who are high recidivists at HCPC and the MHMRA Psychiatric Emergency Service (PES). Through the provision of intensive intervention and wrap around crisis relapse and prevention services, the program’s goal is to engage each individual in ongoing mental health treatment and reintegration within the community. Additional objectives of this program include, but are not limited to:
 - Obtaining and maintaining a stable living environment
 - Access to Primary Health Care and Substance Abuse Treatment, as indicated
 - Benefit Acquisition
 - Re-Engagement with Family and/or Community
 - Access to Community Resources
 - Treatment Compliance

Services are intended to be time limited (up to three months) during which time the individuals are transitioned into traditional community and behavioral health services.

- Mental Health First Aide is an evidenced based 12-hour training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind the

program demonstrates that it makes people feel more comfortable managing a crisis situation and builds mental health literacy — helping the public identify, understand and respond to signs of mental illness.

c.) Detail the source of funds for each service

HELPLINE FY 2010	Total Budget
LOCAL HARRIS COUNTY / MCOT/HLINE	644,386
LOCAL MISCELLANEOUS	4,500
HELPLINE CONTRACTS	225,000
TOTAL LOCAL REVENUE	873,886
STATE GEN REVENUE - CRISIS REDESIGN	217,154
TOTAL STATE GENERAL REVENUE	217,154
TOTAL 3RD PARTY BILLINGS	285,451
TOTAL REVENUE	1,376,491

PSYCHIATRIC EMERGENCY SERVICES (PES) FY 2010	Total Budget
LOCAL HARRIS COUNTY / MCOT/HLINE	2,912,556
LOCAL HARRIS COUNTY RLM	2,364,818
LOCAL INTEREST / MEDICAL RECORDS / DONATIONS	11,300
LOCAL DONATIONS	150
DRUG PAP/SAMPLES	82,050
TOTAL LOCAL REVENUE	5,370,874
STATE GEN REVENUE - MH CHILD	600,000
STATE GEN REVENUE - MH ADULT	1,584,990
STATE GEN REVENUE - CRISIS REDESIGN	935,466
STATE GEN REVENUE - NGM	505,000
TOTAL STATE GENERAL REVENUE	3,625,456
TOTAL 3RD PARTY BILLINGS	779,597
TOTAL REVENUE	9,775,927

MOBILE CRISIS OUTREACH TEAM (MCOT) FY 2010	Total Budget
LOCAL HARRIS COUNTY / MCOT/HLINE	855,498
LOCAL INTEREST	6,675
DRUG PAP/SAMPLES	15,100
TOTAL LOCAL REVENUE	877,273
STATE GEN REVENUE - MH ADULT	16,010
STATE GEN REVENUE - CRISIS REDESIGN	2,186,201
TOTAL STATE GENERAL REVENUE	2,202,211
TOTAL 3RD PARTY BILLINGS	1,075
TOTAL REVENUE	3,080,559

CRISIS INTERVENTION RESPONSE TEAM (CIRT) FY 2010	Total Budget
STATE GEN REVENUE - CRISIS REDESIGN	818,991
TOTAL STATE GENERAL REVENUE	818,991
TOTAL REVENUE	818,991

CRISIS STABILIZATION UNIT (CSU) FY 2010	Total Budget
LOCAL HARRIS COUNTY / MCOT/HLINE	2,311,310
LOCAL INTEREST	2,675
DRUG PAP/SAMPLES	37,500
TOTAL LOCAL REVENUE	2,351,485
STATE GEN REVENUE - CRISIS REDESIGN	233,423
TOTAL STATE GENERAL REVENUE	233,423
TOTAL REVENUE	2,584,908

CRISIS RESIDENTIAL UNIT (CRU) FY 2010	Total Budget
LOCAL HARRIS COUNTY	1,604,177
LOCAL INTEREST	5,350
DRUG PAP/SAMPLES	26,400
TOTAL LOCAL REVENUE	1,635,927
STATE GEN REVENUE - CRISIS REDESIGN	122,144
TOTAL STATE GENERAL REVENUE	122,144
TOTAL REVENUE	1,758,071

CO-OCCURRING DISORDERS PROGRAM (COD) FY 2010	Total Budget
STATE GEN REVENUE - CRISIS REDESIGN	1,470,874
TOTAL STATE GENERAL REVENUE	1,470,874
TOTAL REVENUE	1,470,874

CRITICAL TIME INTERVENTION (CTI) FY 2010	Total Budget
STATE GEN REVENUE - CRISIS REDESIGN	697,525
TOTAL STATE GENERAL REVENUE	697,525
TOTAL REVENUE	697,525

CRISIS RESPITE (BRANARD) FY 2010	Total Budget
DRUG PAP/SAMPLES	630
TOTAL LOCAL REVENUE	630
STATE GEN REVENUE - CRISIS REDESIGN	865,115
TOTAL STATE GENERAL REVENUE	865,115
TOTAL REVENUE	865,745

PRIVATE HOSPITAL CONTRACTS FY 2010	Total Budget
STATE GEN REVENUE - CRISIS REDESIGN	231,506
TOTAL STATE GENERAL REVENUE	231,506
TOTAL REVENUE	231,506

PEER COUNSELORS FY 2010	Total Budget
LOCAL MISCELLANEOUS	9,150
TOTAL LOCAL REVENUE	9,150
STATE GEN REVENUE - CRISIS REDESIGN	178,630
TOTAL STATE GENERAL REVENUE	178,630
TOTAL REVENUE	187,780

HARRIS COUNTY PSYCHIATRIC INTERVENTION (HCPI) FY 2010	Total Budget
LOCAL HARRIS COUNTY	582,091
TOTAL LOCAL REVENUE	582,091
TOTAL REVENUE	582,091

CHRONIC CONSUMER STABILIZATION (CCSI) FY 2010	Total Budget
LOCAL HARRIS COUNTY	18,720
LOCAL MISCELLANEOUS	116,600
TOTAL LOCAL REVENUE	135,320
STATE GEN REVENUE - CRISIS REDESIGN	3,659
TOTAL STATE GENERAL REVENUE	3,659
TOTAL REVENUE	138,979

HEALTH CARE FOR THE HOMELESS CONTRACT (HHH) FY 2010	Total Budget
STATE GEN REVENUE - CRISIS REDESIGN	50,656
TOTAL STATE GENERAL REVENUE	50,656
TOTAL REVENUE	50,656

TRANSITIONAL SERVICES, JAIL, HCPC, PES FY 2010	Total Budget
LOCAL HARRIS COUNTY	105,489
DRUG PAP/SAMPLES	7,850
TOTAL LOCAL REVENUE	113,339
STATE GEN REVENUE - CRD TRANSITIONAL SVCS	1,884,114
TOTAL STATE GENERAL REVENUE	1,884,114
TOTAL REVENUE	1,997,453

MENTAL HEALTH FIRST AID FY 2010	Total Budget
LOCAL MISCELLANEOUS	5,850
TOTAL LOCAL REVENUE	5,850
STATE GEN REVENUE - CRISIS REDESIGN	148,726
TOTAL STATE GENERAL REVENUE	148,726
TOTAL REVENUE	154,576

d.) How are special populations served, including but not limited to veterans, children/adolescents, and victims of trauma.

The MHMRA of Harris County HelpLine, PES and MCOT programs as detailed above serve all community members experiencing a mental health crisis, including children and adolescents, and HCPC has a child/adolescent unit within their hospital. Individuals identified as veterans who receive initial assessment and stabilization and require inpatient hospitalization are transferred to the VA hospital located in Houston. MHMRA has also applied for both a DSHS Incentive Grant and Competitive Grant to enhance Vet to Vet programs, Family to Family programs, and trauma therapy for veterans.

MHMRA of Harris County

Jail Diversion Plan

**Diversion Action Plan
Harris County
June, 2010**

Description of Program:

Beginning in FY 2005, the Mental Health and Mental Retardation Authority of Harris County (MHMRA) established a Jail Diversion Committee as an outgrowth of a Task Force formed by County Judge Eckels that was charged to look at the complex problem of increasing numbers of individuals with mental illness, mental retardation, and/or substance abuse issues being arrested and incarcerated in criminal and juvenile justice settings. This Task Force, sponsored by the Mental Health Association of Greater Houston, and funded through a grant from the Substance Abuse and Mental Health Administration, used a two year consensus building process to guide the design and implementation of the Crisis Intervention Team program of the Houston Police Department. This program, which utilizes specialist officers to respond to mental health calls, has resulted in significantly improved outcomes for individuals with mental health issues who come into contact with law enforcement in Harris County. As an outgrowth of this task force, MHMRA of Harris County organized a Jail Diversion Committee comprised of consumers, people from the advocate committee, law enforcement, other health and human services organizations, and people from the education community.

The Jail Diversion Committee met from FY 2006 through 2009 with the focus of keeping partner agencies in the loop on things happening in the adult and juvenile criminal justice services as well as problem solving issues related to continuity of care and service needs. As of June, 2009, several major activities took place in Harris County which changed the locus for determining Jail Diversion initiatives and activities in Harris County. Harris County Commissioner's Court authorized the Justice Management Institute to conduct a study of the criminal justice system in Harris County. The study began in February, 2009 and ended with a preliminary report on June 17, 2009 (see attachment A) which provided 28 recommendations to be implemented. Following the study, Harris County Commissioner's Court created the **Criminal Justice Coordinating Council** through whom all diversion activities in Harris County are to be coordinated and through whom review and implementation of the 28 recommendations are to occur. Thus, the MHMRA Jail Diversion meetings were terminated as these meetings were viewed by the Council and participants as being a duplication of effort. Copies of the Coordinating Council meetings minutes can be provided, if requested. MHMRA is at the table serving on one of the sub-committees for jail over crowding.

In addition to the establishment of the Criminal Justice Coordinating Council, several sub-committees were formed. The Harris County Sheriff serves as co-chair of the Jail Population Committee of the Criminal Justice Coordination Council and he created a task force designed to look at jail over crowding and what type of community collaborations could improve the diversion of people from the jail and deter the quick re-cycling back into the jail. MHMRA has representation on this task force in the form its Executive Director, Steven B. Schnee, PhD.

To ensure continuity of services to persons discharged from the jail, Dr. Schnee's directive to MHMRA staff is that persons referred from the Harris County Jail who meet the DSHS eligibility criteria would be considered as continuity of care referrals and would have the same priority admission status as a discharge from Harris County Psychiatric Hospital, Rusk State Hospital, and the Neuro Psychiatric Center.

In short, the jail diversion plans and discussions are actively occurring within Harris County with MHMRA at the table; but these activities are not under the purview of MHMRA of Harris County. Therefore, the remaining part of this report will clarify MHMRA service activities focused upon education of the community, coordination of care, and new and existing diversion activities focused around offenders.

Training:

MHMRA has used some of its Crisis Re-Design dollars to hire staff to provide the Mental Health First Aid training sponsored by the National Council on Behavioral Health. This course has received great reception from the community as it assists people in learning how to recognize and help people obtain appropriate help when in crisis. See Attachment B for trainings. In addition, MHMRA partnered with the City Health Department in creating literature for the community to teach when and how to access 9-1-1. Please see the Crisis Services Plan for more information.

Strategies to Maximize Funding:

MHMRA applied for and received SSBG dollars from Houston Galveston Area Council (HGAC) which are being used to provide programs which relate to providing supports to persons released from jail in the form 90-days of case management, assistance with benefits acquisition, temporary housing, and medication management focused on engagement and transitioning into mental health services. These dollars are available until September 30, 2010 unless Harris County is granted an extension in the use of these dollars. The City of Houston Environment and Health Department has applied for a re-entry grant in the hopes of sustaining this program model for another 2 years. It is hoped that Houston will receive the award.

Strategies of Diversion:

There are several diversion efforts in Houston/Harris County to manage the flow into and out of the Harris County Jail, please see the descriptions of these programs below. Please see Crisis Plan for a complete listing of services which may also impact the flow of persons into the Jail:

HPD Circular: Houston Police Department has an operations guideline (circular) which permits an officer to take an individual to the NPC if, in the officer's judgment, the person is having a mental health crisis. In addition, all officers are required to have mental health training as a part of their officer certification. Some 600 individuals per month are seen by the NPC for evaluation. If there is a mental health condition which requires treatment, the person is detained; if not, the officer proceeds to the jail.

CIT Officers: When a call comes in the dispatch office, the caller is questioned whether or not this call involves a mental health need. If necessary and available, a specially trained CIT officer is dispatched to the scene. Close coordination of services occurs between the NPC and the CIT administrative office located at the NPC.

JETT Team: The Jail Engagement Transition Team, a case management team was created with DSHS Rider 65 funding to provide 90 days of case management to engage persons discharged from the Harris County Jail with the goal of transitioning them into permanent care and to begin benefits acquisition. These case managers have available dollars for 90 days of residential care and help to navigate the person through the mental health system.

CETT Team: The Community Engagement Transition Team, a case management team also created with DSHS Rider 65 funding to provide 90 days of case management to engage persons who have had a booking into the county jail in the past year and who are recently discharged from the community psychiatric hospital, HCPC. The intent of the service is the same as the Jett team.

HGAC Team: A case management team working within the Harris County Jail to identify persons who need the additional supports within the community to engage in services. Funding for housing, medical services, substance abuse residential treatment and benefits acquisition for 90-days is available. These are SSBG dollars received from Houston Galveston Area Council and are available until September 30, 2010.

FACT: The Forensic Community Treatment team was expanded with DSHS Rider 65 dollars to provide services to consumers released from jail who require DSHS level SP4 services. This team works directly with the courts and receives their referrals from the Forensic Single Portal Authority.

Forensic Single Portal: MHMRA provides the psychiatric services for the Harris County Jail. The Forensic Single Portal was established to provide a single place where all referrals/requests from the courts, the DA's Office, the probation officers assigned to the courts, and the court coordinators could seek information and arrange for an individual's care within the jail and connection to MHMRA services when released. This effort curbed the need "shop around" for services when the linkage would occur through a person knowledgeable about MHMRA services.

Substance Abuse Screening/Linkage: Social Security Block Grant (SSBG) dollars were secured from both HGAC and DSHS to provide substance abuse screening and linkage to services for the single and dually diagnosed person being released from the Harris County Jail. While case management is not a part of this program, the person may be referred to the JETT , CETT, or HGAC case management teams for engagement into MHMRA services when their residential treatment has been completed.

Impact on the State Hospital Forensic Wait List: Harris County has made significant impact upon the size of the Forensic State Hospital Waiting List. Several initiatives were either enhanced or implemented to reduce the number of referrals to the State Hospital Forensic Wait List and to decrease the time spent on the Wait List. Please see a description of these initiatives as follows:

- **21-Day Diversion Program:** The existing 21-day Diversion program was enhanced to provide a dedicated physician, 2 case workers, and a clerical support to focus efforts toward aggressive stabilization of persons who were court ordered into the program. The case workers keep close tabs on the persons participating in the program to ensure their medications were dispensed; to report on their condition daily to the psychiatrist; and to request extends from the court if stabilization has not occurred but is imminent. Once stabilized, a court date is requested and the case proceeds toward adjudication. If stabilization does not occur, the court orders a competency evaluation. These enhancement funds were provided via SSBG funds from HGAC and will end on September 30, 2010. From January, 2010, a total of 902 court referrals have been made to the 21-day diversion program of that number: 621 have been diverted from the Wait list: 41 have been transferred for competency restoration; and 240 cases are pending adjudication.
- **Review of the Wait List:** In January, 2010, a Licensed Professional of the Healing Arts was hired to review all cases of people on the wait list. If the person appears to be stable, the LPHA petitions the court to order another competency evaluation to see if the person is competent to stand trial. If the person, while on the wait list refuses to take the medications, the LPHA petitions the civil court for an order to force medications if refused. In January, 2010, approximately 97 people were on the Forensic State Hospital Waiting List. From January through July, total of 23 requests for re-evaluation were sent to the court.
- **Inpatient Competency Restoration Services:** MHMRA contracted with Intracare Medical Center, a local private psychiatric hospital for a specific bed day rate which included: medications, food, housing, labs, attending physician, nursing, psychiatric technicians, and staff to provide the competency training (uses a curriculum from Florida with videos and workbooks in English and in Spanish). All persons transferred from the Jail to Intracare were on the Forensic

State Hospital Waiting List awaiting transfer to Rusk State Hospital. Forensically certified psychologist, not involved in the treatment, were hired, through contract with MHMRA to perform the competency evaluations. Since May, 2010, 91 people were on the Wait List and a total of 31 are on the list as of July 22, 2010.

- Funds for this project were provided by DSHS SSBG funding to end September 30, 2010. Because the utilization of these funds is expected to exceed the DSHS allocation, MHMRA requested and received permission to use lapsed funds from the SSBG dollars provided by HGAC to cover the costs of the program.

For those found incompetent to stand trial, MHMRA is working with the Harris County District Attorney's office to develop specific treatment plans which may include recommendations for civil outpatient commitment. The FACT team is available to accept these referrals from the courts.

- **Diversion Center??:** There are discussions between Harris County and the City of Houston about the feasibility of building a center where (1) people who violate the law a brought and processed for detention or diversion; and, (2) where persons released from the jail may be stepped down at some point near the end of their sentence to be connected with mental health services. If this occurs, this will be the first joint effort of diversion between the city and county. These discussions are occurring in many meeting of the Criminal Justice Coordinating Council.
- **Juvenile Services:** MHMRA partners with the Harris County Juvenile Probation Department to provide services in the Juvenile facilities and to coordinate services into the MHMRA service system. Over 600 juvenile offenders are seen monthly by MHMRA staff.

In summary, MHMRA of Harris County has primarily focused its energy on the highest priority as determined by Commissioner's Court; decreasing the overcrowding of the Harris County Jail. The costs of these additional services have been funded with the additional combined allocation of \$4.2 million dollars from DSHS and HGAC funding. With the loss of these funds, the current wait list for services (1000) will continue to grow and the first people to access services will be those priority admissions from the jail, HCPC, state hospitals, and NPC. Others will potentially only access services through the crisis door.

Please direct comments to: rose.childs@mhmraharris.org

MHMRA of Harris County

Local Network

Development

Plan

(See Attachment C)