Bexar County Mental Health Systems Assessment

Final Report | September 2016

TEXAS STATE of MIND

THE MEADOWS MENTAL HEALTH POLICY INSTITUTE

Methodist Healthcare Ministries OF SOUTH TEXAS, INC.

"Serving Humanity to Honor God"

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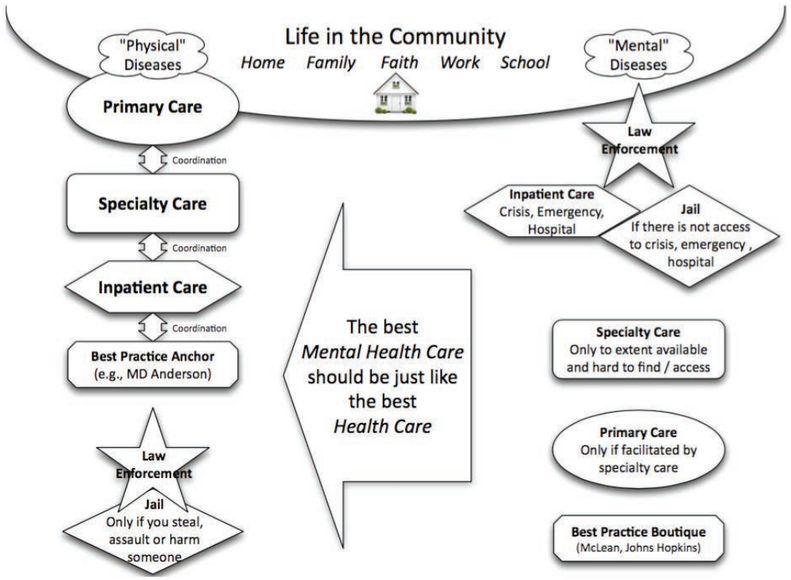
Executive Overview

In the summer of 2015, Methodist Healthcare Ministries of South Texas, Inc. engaged the Meadows Mental Health Policy Institute (MMHPI) to review the performance of Bexar County behavioral health systems. These findings are based on reviews conducted in the fall of 2015 and early 2016.

Bexar County is a large and diverse metropolitan area with nearly 2 million residents. While between one in five and one in three Texans suffer from some level of mental health need (best estimate for Bexar County is just under 500,000 people), the primary focus of this assessment was on the most severe needs: adults with serious mental illness (just over 60,000) and children with serious emotional disorders (just over 37,500). This report primarily focuses on the over 56,000 people (nearly 35,000 adults and nearly 21,500 children) in poverty (under 200% FPL) that serves as the benchmark of need to be met by the overall public mental health system. There are also smaller subsets of the people with specialized needs, including:

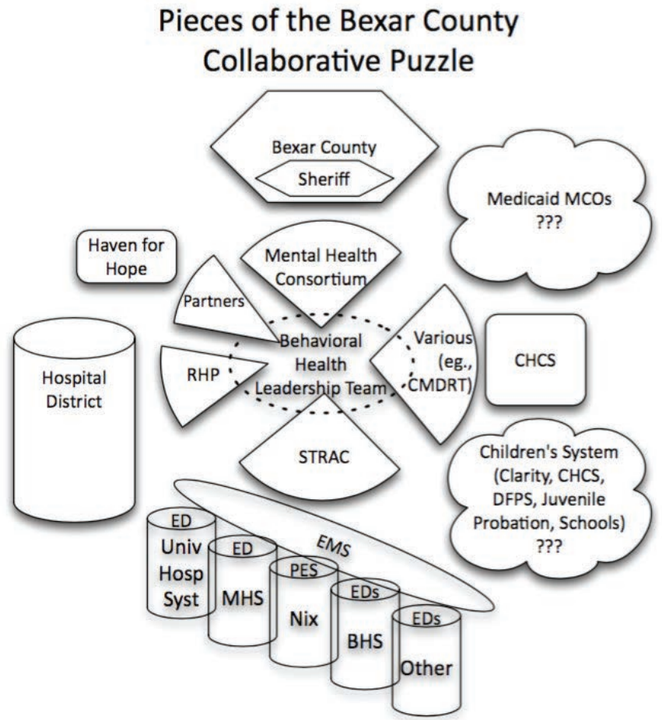
- The 2,600 cases each year of "super-utilizers" (most with co-morbid substance use disorders) in poverty at highest risk of using jails, hospitals, emergency rooms, or homeless services;
- About 300 new cases each year of psychosis (including schizophrenia) among older adolescents / young adults at high risk to become "super-utilizers" if not treated early; and
- Approximately 2,200 children and adolescents in need of time-limited, intensive home and community-based supports to avoid or reduce risk of out-of-home or out-of-school placement, including many in or at risk of the child welfare and juvenile justice systems.



Over 80% of adults in poverty with severe needs (about 27,500) are served by the Center for Health Care Services (CHCS), University Health System, Medicaid providers, the University of Texas Health Science Center at San Antonio (UTHSC-SA), and Haven for Hope. However, very few people with the most severe needs receive the intensity and level of care necessary. The system has capacity to serve less than one in five non-forensic super-utilizers and no dedicated capacity for forensic super-utilizers. Access to inpatient care was substantially improved by development of additional capacity at Nix Health and is limited less by a lack of local bed capacity than by insufficient funding for uninsured patients in the community, forensic back-ups, and a lack of systemic coordination across crisis / emergency providers.

Just over one-fifth of children in poverty with severe needs (about 4,800) are served by the two leading child providers, Clarity Child Guidance Center (primary inpatient and psychiatric care provider) and CHCS (primary intensive community-based support provider). While a very low level of service overall, even fewer children receive the intensity and level of care necessary (fewer than 3% of the 2,200 in need of intensive, community-based supports), leading to an over-reliance on juvenile justice, child welfare, and specialty school placements.

Bexar County is home to many high quality programs, providers, and pockets of excellence detailed in the full report. The primary challenge facing Bexar County is the need to transform from a set of discrete programs into a high performing behavioral health (BH) system of care that is managed effectively and efficiently by a collaborative of elected officials, local funders, and key providers. Local leaders must develop a locally driven, empowered behavioral health leadership team to lead collaborative efforts and efficiently direct system improvement efforts, building on leadership development efforts across the system, including the County Mental Health Consortium, Haven for Hope, the 1115 Waiver Regional Health Partnership (RHP), Southwest Texas Regional Advisory Council (STRAC), and multiple CHCS forums. This will require both a deeper commitment of key local leaders and an aligned and efficient operational infrastructure to develop a trusted and effective forum for local system planning and coordination.



Key programmatic gaps to address include:

- A top priority should be to develop a comprehensive, integrated crisis system across all major public payers, hospital providers, and behavioral health providers.
- A second major priority should be a cross-payer effort to develop assertive and intensive ongoing services for the 2,600 highest utilizers of jail, homeless, crisis, emergency response system, ER, and inpatient care, including both housing and co-occurring substance abuse services for most. Currently, a fraction of these adults is engaged in long-term care sufficiently intensive to prevent overuse of jails, ERs, crisis, and inpatient care.
- For more routine care, primary health/behavioral health integration offers the only path to meeting the need; current initiatives are effective and can serve as a base for scaling up.
- For children, there is a need to:
  - Develop a unified, system-wide planning process within the broader system planning effort, involving all child and family serving providers and working with all major payers and providers, including the Department of Family Protective Services and juvenile probation,
  - Expand access to intensive, time-limited home- and community-based supports for the 2,200 at highest risk of out-of-home placement, and
  - Expand early intervention services for severe mental illness manifesting in adolescence, including best practice First Episode Psychosis services and school-based and school-linked services to begin to address the "school to prison pipeline."

Findings and recommendations for each major behavioral health provider were also identified, including Clarity, CHCS, Haven for Hope, Nix Health, University Health System, UTHSC-SA, and primary health / behavioral health integration initiatives through CentroMed, CommuniCare, Methodist Healthcare Ministries' Wesley Health & Wellness Center, and CHCS.

Executive Summary

Methodist Healthcare Ministries engaged the Meadows Mental Health Policy Institute (MMHPI) to review the performance of Bexar County behavioral health systems. These findings are based on reviews conducted in the fall of 2015 and early 2016.

Severe Mental Health Needs and Capacity (N) in Bexar County

- **N-1**: Bexar County is a large and diverse metropolitan area with nearly 2 million residents, trailing only Dallas, Harris, and Tarrant counties in total population. Among all 254 Texas counties in the most recent year for which statistics are available (2013), Bexar County had the fourth highest prevalence of both adults with serious mental illness (just over 60,000) and children with serious emotional conditions (just over 37,500). This report primarily focuses on the over 56,000 people (nearly 35,000 adults and nearly 21,500 children) in poverty (under 200% FPL) that serves as the benchmark of need to be met by the overall public mental health system.

Twelve-Month Prevalence of Adults with SMI and Children with SED Living at or below 200% Federal Poverty Level (FPL) Relative to Population in Large Texas Counties

County	Total 2015 Population	Adults with SMI (2013)	Adults with SMI Under 200% FPL	Children with SED (2013)	Children with SED Under 200% FPL
Bexar	**1,882,834**	**60,034**	**34,871**	**37,523**	**21,438**
Dallas	2,496,859	88,279	54,112	53,222	35,365
Harris	4,471,427	142,930	87,283	91,414	56,044
Tarrant	1,959,449	64,191	35,873	39,006	21,569
Travis	1,144,887	38,253	21,673	19,965	10,703

Within this larger group, there are smaller subsets of the population in need that may benefit from more targeted interventions, including:

- The approximately 300 new cases of schizophrenia and other psychoses that emerge every year among older adolescents and young adults that are more responsive to treatment if addressed in the first 17 months;
- The 2,600 cases each year of "super-utilizers" who are at highest risk of using jails, emergency rooms, hospitals, or homeless services; and
- The approximately 2,200 children and adolescents in need of time-limited, intensive home and community-based supports to avoid or reduce risk of out-of-home or out-of-school placement.

- **N-2**: For adults in poverty (incomes below 200% FPL) with severe needs, the core capacity for outpatient services is comprised of the Center for Health Care Services (CHCS), University Health System, Medicaid providers, the University of Texas Health Science Center at San Antonio (UTHSC-SA), and the Haven for Hope. Collectively they currently serve over 80% (27,564) of adults in poverty with severe needs (34,871). However, relatively few people with the most severe needs receive the intensity and level of care necessary. While CHCS provides intensive services to a relatively higher proportion of people with complex needs than other leading Texas local mental health authorities, the overall capacity for both ongoing and intensive services across all safety net providers is insufficient for the identified need, resulting in an overreliance on crisis, emergency, and criminal justice services. While service availability is better than in comparison Texas communities, the system has capacity to serve less than one in five non-forensic super-utilizers and no dedicated capacity for forensic super-utilizers. Supported housing capacity is a relative strength, but also is substantially lower than the need.

- **N-3**: For children in poverty (family incomes below 200% FPL) with severe needs, the core capacity for outpatient services is comprised of Clarity Child Guidance Center as the leading children's psychiatric provider and the Center for Health Care Services (CHCS) as the leading provider of intensive community based supports. Collectively, these two providers currently see just over one-fifth (4,796 or 22.3%) of children in poverty with severe needs (21,483), and the number is in fact even lower given that some children receive services from both providers. While a very low level of service overall, of equal concern is the fact that relatively few children receive the intensity and level of care necessary. Currently, less than 5% of children in need of intensive, community-based supports able to receive such care through CHCS or community providers, leading to an over-reliance on juvenile justice, child welfare, and specialty school placements.
- **N-4**: Access to inpatient care for adults in Bexar County is limited less by a lack of bed capacity than by insufficient funding for uninsured patients in the community, back-ups related to high forensic use of San Antonio State Hospital, and a lack of systemic coordination across crisis program and emergency providers. Access to inpatient care for children is better given capacity development by Clarity and broader Medicaid coverage, but access is challenging for adolescents with co-occurring needs and the crisis response system is under-developed.
- **N-5**: Public funds available for behavioral health care: Expenditures of over $220 million for behavioral health services were made in FY 2014, including estimated jail and emergency room costs, and not including funding through Clarity, University Health System internal spending, Medicaid funding (outside of CHCS), or expenditures by several other providers. Coordinated planning across the major payers for public mental health – state general revenue, Medicaid, Delivery System Reform Incentive Payment (DSRIP), county expenditures, and local private funders (both foundations and contributors to uncompensated care) – is both lacking and essential to making best use of these considerable, but nonetheless limited, resources.
- **N-6**: State-level policy barriers: State-level policy serves to reinforce segregation of funding streams, fragmentation of planning processes, unaligned accountability measures, and a lack of incentives for collaboration across payers. This hampers local control and tremendously complicates local efforts to plan and act on plans to leverage resources and maximize efficient and effective use of limited public funds in pursuit of system improvement and population health goals.

Major System Level Findings and Recommendations

MMHPI identified numerous high quality programs, providers, and pockets of excellence detailed throughout the full report. Bexar County also deserves recognition for being the only county in Texas to establish a County Mental Health Department. However, despite these excellent programs and leadership efforts, the primary challenge facing Bexar County is the need to transform the existing Bexar County behavioral health (BH) service array from a set of discrete programs and special projects into a high performing system of care that is effectively and efficiently managed by a collaborative of elected officials, local funders, and leading providers.

Major System Findings (SF)

- **SF-1**: The current leadership structure at the system level for the county has made steady progress through multiple, often parallel, planning efforts. Additional progress will require both the commitment of key local leaders to fully aligned planning and the support of an efficient operational infrastructure to develop a trusted and effective forum for local system-level behavioral health service planning and coordination. The emphasis will be on shared metrics and accountability across providers.

- **SF-2**: Cross-payer and cross-agency collaboration is hampered by discrete collaborative planning efforts within separate funding streams, including: state general funds (CHCS, through multiple forums, including the Community Medical Directors Round Table [CMDRT]), county funding (through the Behavioral Health [BH] Consortium), hospitals (e.g., emergency medical system [EMS] response through the Southwest Texas Regional Advisory Council [STRAC]), DSRIP (primarily through the Regional Health Partnership [RHP]), and Medicaid (discrete efforts by each of the multiple Medicaid MCOs).The lead agencies for each major public funding source lack a trusted forum for coordinated behavioral health planning and system-level efforts (e.g., a "behavioral health leadership team"). See the figure that follows.
- **SF-3**: Bexar County faces a significant public health challenge with its current BH services gaps that must be addressed by local leadership. The current capacity, while delivering some impressive examples of high quality service, simply does not meet demand, and access is limited throughout Bexar County, particularly for those most in need and using services across systems.
- **SF-4**: Bexar County needs to take its programs to scale systematically over time. Many excellent programs could serve as a model for scaling, but this will require both system-wide commitments (rather than discrete individual agency efforts) and a multi-year development plan prioritizing newly available funds toward system-wide priorities.
- **SF-5**: There are some excellent crisis services, but these are not connected into a crisis system of care. As a result, the success of any given program ranges over time and is dependent on individual agency actions, rather than coordinated action across agencies.
- **SF-6**: A primary barrier to developing a crisis system of care is a lack of consensus regarding consistent county-wide policies, procedures, and metrics for adults who present in psychiatric crisis and require admission to psychiatric crisis facilities or hospital beds. Such consensus would be a first step toward developing system-wide quality improvement efforts to address both quantitative and qualitative gaps in care.
- **SF-7**: A second primary barrier to an effective crisis system is the lack of sufficient capacity to provide ongoing care for high utilizers of crisis, jail, emergency room, inpatient, and homeless services. Resources for case management and intensive case management are lacking across the board, but a key gap is the lack of capacity for what we have termed "super-utilizers," those adults repeatedly cycling through inpatient, jail, and crisis services, particularly the 2,600 forensic and non-forensic "super-utilizers" with incomes under 200% of FPL.
- **SF-8**: Current primary health/behavioral health integration initiatives are effective and could serve as a base for scaling up broader access for those with more routine needs.
- **SF-9**: Efforts to develop a Children's System of Care (CSOC) have a positive history of a strong CSOC collaboration among some key providers, but there is not a system-wide approach.

Major System Level Recommendations (SR)

- **SR-1**: Local leaders should develop a locally driven, empowered BH leadership team to lead collaborative efforts and efficiently direct system improvement efforts. This initiative should build on emerging leadership development efforts across the system (e.g., County Behavioral Health Consortium, RHP, STRAC, various CHCS efforts), but it will require both a deeper commitment of key local leaders and an aligned and efficient operational infrastructure to transform itself into a trusted and effective forum for local system planning and coordination.
- **SR-2**: Bexar County can and should develop and articulate a vision for what the BH system should look like if it were taken to scale. The results of this assessment should inform that vision, however the vision cannot be established by an external review – it must be developed collaboratively by the local BH leadership team.
- **SR-3**: Once the vision is established, the local BH leadership team should establish a prioritized timeline for incremental development to address system gaps over a multi-year period (e.g., five years). Based on the findings of this report, the following system development priorities are recommended for consideration within this multi-year plan:
  - **SR-4**: A top priority should be the need to develop a comprehensive, integrated crisis system across all major public payers, hospital providers, and behavioral health providers. Protocols and procedures for access and diversion should be consensus-based and transparent, and the system should provide access to a range of crisis services including crisis diversion. Development of additional inpatient capacity should occur in the context of this system. It should be anticipated that inpatient capacity will continue to be constricted for the near to medium term, so maximizing coordination of the broader crisis continuum is of paramount importance.
  - **SR-5**: A second major priority should be to develop a cross-payer effort to provide ongoing services for the 2,600 highest utilizers of jail, homeless, crisis, emergency response system, ER, and inpatient care. Currently, a fraction of these adults are engaged in sufficiently intensive ongoing services to prevent overuse of jails, crisis, and inpatient care. Intensive services at this level of care appear to be more readily scalable than additional inpatient or crisis care.
  - **SR-6**: Grow the development of BH capacity integrated with primary health services on a larger scale. Given workforce limitations and the breadth of service needs, as well as the clear evidence of the degree to which physical health needs of adults with SMI contribute to morbidity and mortality (and associated costs), primary care based delivery strategies for behavioral health should be a major system development priority.
  - **SR-7**: Develop a system-wide CSOC planning process within the broader system planning effort, involving all child and family serving providers and working with all major payers and providers. A key priority within this planning process should be to expand implementation of intensive home- and community-based supports for those at highest risk of out-of-home placement, wraparound planning that fully leverages YES Waiver funding, early intervention services for severe mental illness manifesting in adolescence (including best practice First Episode Psychosis services), and school-based and school-linked services to maximize access and begin to address the "school to prison pipeline."
- **SR-8**: Emphasize cross-payer collaboration across all of these initiatives to maximize system efficiency and impact, using the BH leadership structure to bring together major payers into an enduring cross-payer collaboration to design and develop the BH system that Bexar County needs and deserves. This should include continued work with payers/health plans to develop value-based purchasing strategies that promote flexibility, especially for crisis services and services to super-utilizers.
- **SR-9**: Implement strategies to facilitate information exchange within the existing health information exchange system.

Major Mental Health Provider Findings and Recommendations

Findings and recommendations for each major BH provider identified by Methodist Healthcare Ministries are included in this section, including CHCS, Clarity, Haven for Hope, Nix, University Health System, and UTHSC-SA.

Center for Health Care Services

The mission of the Center for Health Care Services (CHCS) is to improve the lives of people with mental health disorders, substance use challenges, and developmental disabilities. As the state-designated local mental health authority, CHCS is responsible for all MH services funded by state general revenue (GR) and offers a wide range of crisis, outpatient, and specialty services for adults and children with a range of needs, primarily those with more severe needs.

CHCS Major Findings (CHCS F)

CHCS has developed some superb programs that reflect national best practices and evidence-based programs, and their array of services is impressive among Texas community mental health providers, as well as nationally in several cases.

However, like community mental health agencies across Texas and the nation, CHCS faces multiple organizational and program improvement challenges. It is well positioned to take these challenges on with its emerging quality improvement programming, however many will require improved collaboration both within the organization and with key partners. Major findings related to improvement opportunities are noted below:

- **CHCS F-1**: There is a need to improve collaboration and teamwork across discrete program areas within the organization.
- **CHCS F-2**: Internal teamwork at the leadership level lacks an overarching set of organization-level goals and structure to align programs across senior managers. Our observation is that each senior manager operates well within his or her separate domain, but there is a lack of unifying programmatic goals to bring discrete programs together.
- **CHCS F-3**: There is a need to reorient current Lean quality improvement (QI) programming (which is a major organizational strength) to focus less on program-level compliance and more on organization-wide performance and clinical quality improvement, particularly those noted in findings CHCS F-1 and CHCS F-2 above.
- **CHCS F-4**: Relationships with external agencies vary based on the program and are generally more positive for programs with the capacity to provide follow-up, outreach, and engagement. A primary driver of negative perceptions is the lack of a system-wide planning function, rooted to some degree in outdated views that system-wide planning is not necessary given the role of CHCS as the "local mental health authority."
- **CHCS F-5**: Child Behavioral Health Services needs to expand its clinical consultation role and the development of a broader system of care for children, youth and their families to improve collaboration with schools and other child serving systems.
- **CHCS F-6**: Access to care at CHCS is reported as most efficient through crisis services, but general access was reported by stakeholders to have lengthy wait times. It should be noted that there are currently major challenges in the recruitment of psychiatrists, pharmacists, and all other licensed clinicians and counselors, challenges that affect every Texas community and all other Bexar County providers.

Additional specific programmatic findings were also identified and provided to CHCS for review, in addition to those in this report.

CHCS Major Recommendations (CHCS R)

Major recommendations related to the above findings include the following:

- **CHCS R-1**: CHCS improvement efforts should focus on improving teamwork and collaboration at the senior management level through examination of strategies and/or staff positions that would foster development and implementation of organization-wide population management goals.
- **CHCS R-2**: CHCS should enhance continuous quality improvement (QI) approaches within and across programs and consider the following specific organization-wide QI activities:
  - **CHCS R-3**: CHCS should initiate an organization-wide QI activity to improve internal collaboration between programs, focused on movement between and coordination among programs.
  - **CHCS R-4**: CHCS should initiate an organization-wide QI activity to improve collaboration as an organization – both as a whole and for individual programs – with the broader array of providers and services across Bexar County.
  - **CHCS R-5**: CHCS should initiate an organization-wide QI activity to improve access to care across system boundaries, particularly for complex cases.
  - **CHCS R-6:** The Child Behavioral Health Services should initiate QI activities with key partners (e.g., Clarity, local ISDs, child serving systems) to coordinate access and ongoing care for children served by both CHCS and these partners.

Additional specific programmatic recommendations were also identified and provided to CHCS for review.

Clarity Child Guidance Center

Clarity Child Guidance Center (Clarity) is a private, not-for-profit mental health organization providing mental health programs tailored to the needs of families, individuals, and the community. Founded in 1886, Clarity has been very involved in Bexar County and the broader community for decades, and now focuses on serving the needs of children and adolescents ages 3 to 17 and their families. Its mission is to enable individuals and their families to create meaning and purpose from life's challenges and to restore hope and motivation to more effectively manage those challenges.

Clarity Major Findings (Clarity F)

The quality of the Clarity services at all levels is excellent in its specialized services to children with acute behavioral health disorders. Clarity addresses an important need for inpatient care for children and youth in Bexar County, anchoring the acute and subacute care system. Since 2010, Clarity has more than doubled its outpatient services funding, and expanded services include a clinic, a new crisis center, and a larger partial hospital program. A three-story outpatient building is under development. Within this context, major findings include:

- **Clarity F-1**: Clarity has numerous strengths and could potentially address some of the key gaps that exist in the broader system of care in Bexar County for children with severe needs noted in the system-level findings. This would need to occur within the context of the considerable growth in outpatient care that Clarity has already taken on, and it should only occur if Clarity can be confident that it can maintain program quality as it expands.
- **Clarity F-2**: There is limited co-occurring mental health (MH) and substance use disorder (SUD) practice available within Clarity (and throughout Bexar County). This is both a capacity gap and a barrier to serving the most complex adolescent cases, many of which involve co-morbid substance use.
- **Clarity F-3**: Community stakeholders want Clarity to expand further to address system gaps in home-, community- and family-based services and co-occurring services, which is a testament to its strong reputation.
- **Clarity F-4**: Clarity does not have formal partnership agreements with major children's services providers and funders, most notably Children's Protective Services (CPS) and county and state juvenile justice (JJ) agencies. Such formal partnership arrangements could be a key enabler to broader, system-wide children's system of care planning. Clarity enjoys strong existing relationships with these agencies that could serve as a basis for such agreements.

Additional specific programmatic findings were also identified and provided to Clarity for review.

Clarity Major Recommendations (Clarity R)

- **Clarity R-1**: Clarity will need to decide on the degree to which it can expand its service array and capacity to fill the system gaps noted above for children and families, especially given the extensive expansion that has occurred to date in its outpatient facility settings.
- **Clarity R-2**: If Clarity decides to expand its service models to address system level gaps, we recommend that it consider two priorities: (1) establishing a co-occurring MH/SUD practice model within Clarity's current programs and (2) developing intensive home-, community-, and family-based models of care.
- **Clarity R-3**: Clarity should increase it system-leadership role in helping to define an overarching system of care for children and youth. Clarity has many current partnerships with individual agencies and payers, but the system-level recommendations noted above will require greater leadership in forming a partnership framework. Clarity is well positioned to work alongside CHCS and other child and family providers in such an effort.
- **Clarity R-4**: Clarity and CHCS Children's Program should establish routine program manager / clinical manager meetings to improve coordination of care for children and families served by both agencies.

Additional specific programmatic recommendations were also identified and provided to Clarity for review.

Haven for Hope

Haven for Hope offers a best practice array of programs and services to support people who are homeless. It aligns the participation of community organizations to address various aspects of homelessness with 92 current partners. It is a highly successful example of private and public collaboration addressing the complexity of needs required within system of care for individuals with complex BH needs.

Haven for Hope Major Findings (H4H F)

- **H4H F-1**: The strong emphasis on a recovery-oriented system of care (ROSC) framework and incorporation of peer providers (people with lived experience of mental health, substance use, and/or homelessness) working in a variety of roles is a positive example for the larger system of care and a model to emulate more broadly.
- **H4H F-2**: The Intake Center, the key entry point for services at H4H, is a model for screening, assessment, referral, and triaging of those most in need.
- **H4H F-3**: Haven for Hope has been operating at and above capacity within the Courtyard for the last two to three years serving approximately 700 individuals with complex needs (200-300 over capacity).
- **H4H F-4**: Recognizing that demand is greater than the services available, H4H is expanding through the acquisition of a new building adjacent to the existing campus.
- **H4H F-5**: CHCS is the partner with the most services on the H4H campus. Overall, these tend to be model services, but need exceeds current capacity.
- **H4H F-6**: The scope and complexity of homelessness contributes to the perception by the community and the city government that Haven for Hope has not "solved" the homeless problem. While it can serve a key role for the most complex cases of homelessness, a single program – even one with the impressive service array provided through H4H and its providers – cannot address the lack of affordable housing for Bexar County residents.
- **H4H F-7**: Access to affordable health care is an ongoing challenge, in part due to funding and regulatory requirements.
- **H4H F-8**: Required data systems for the various funders require redundant data input into multiple systems in order to maintain compliance for the same client when multiple needs are served.

Additional specific programmatic findings were also identified and provided to Haven for Hope for review.

Haven for Hope Major Recommendations (H4H R)

- **H4H R-1**: Continue to build on the ROSC framework, including expanding use of motivational interviewing and training on trauma-informed services for all health and human services providers, as well as expanding the peer workforce.
- **H4H R-2**: Taking programs to scale is necessary to address the health and social needs of homeless individuals. Prioritizing the resources and cross-agency efforts to accomplish this will need to be addressed by the county-wide BH leadership process described above – Haven for Hope cannot achieve this on its own.
- **H4H R-3**: Adopting a county-wide policy that promotes access to affordable housing is a critical step towards moving people from the streets to recovery. National best practices and evidence tend to favor "housing first" approaches that rapidly establish individuals in permanent housing, with necessary supports.
- **H4H R-4**: Haven for Hope should seek agreements to further connect integrated primary and behavioral health care services, create health homes for people with complex needs, and take fuller advantage of resources to fund indigent care, particularly for access to specialists, vaccines, and affordable medications.
- **H4H R-5**: Work with HHSC, the health information exchange (HIE), and local providers to streamline reporting on individuals and programs, improve efficiency and allow better reporting approaches to population management. This will specifically require work with HHSC and its agencies to streamline DSRIP and other state reporting requirements.

Additional specific programmatic recommendations were also identified and provided to Haven for Hope for review.

Nix Health

Nix Health offers an array of behavioral health (BH) inpatient and crisis intervention services and has expanded its array of services over the course of the past year. Nix is becoming an increasingly important partner in the public BH system of Bexar County, operating acute psychiatric beds for children, adolescents and adults, as well as a specialized geriatric psychiatric inpatient program, a 16-bed Crisis Intervention Unit (CIU) that accepts voluntary patients, and a 16-bed Psychiatric Emergency Services (PES) that accepts voluntary and involuntary patients and provides complete psychiatric needs assessments, 24 hours a day, seven days a week. Nix also offers an Intensive Outpatient Program (IOP) and a large Mobile Assessment Team that covers not only Bexar County but also other facilities and programs in central and southern Texas.

At the time of the initial site visit to Nix in July 2015, the Nix Psychiatric Emergency Services (PES) and Crisis Intervention Unit (CIU) were underutilized. However, changes initiated in November 2015 have led to increased utilization of these important services in early 2016. Nix has an excellent crisis continuum service array, the elements of which represent most of the components of a crisis hub that can respond appropriately to any level of crisis and manage individuals through the continuum as needed, including provision of medical clearance.

Nix has recently appointed new administrative and medical leadership and, as a result, their potential to partner in an ongoing way with the larger system has substantially increased.

Nix Major Findings (Nix F)

- **Nix F-1**: Nix operates a nearly complete array of crisis services that represents a model for a crisis continuum, which can serve as a blueprint for a county-wide crisis system. Strategies in place for medical clearance and mobile crisis, as well as the strong efforts to coordinate care, represent strengths to build on, both for Nix and

the broader Bexar County system.

- **Nix F-2**: Nix's crisis continuum is welcoming to challenging patients, particularly the PES site, given its non-institutional design. While Nix utilization has increased, there is no consistent plan in the community for how people flow through the PES/crisis system and, subsequently, no county-wide coordination of response to crisis, either for individuals, families, or ERs.

Additional specific programmatic findings were also identified and provided to Nix for review.

Nix Major Recommendations (Nix R)

- **Nix R-1**: Work with other crisis and emergency room providers in Bexar County to develop a system-wide strategy and plan for delivery of crisis services that better define the role of the Nix continuum.
- **Nix R-2**: As part of the work designing the crisis system, collaborate with the BH leadership planning effort to develop consensus for consistent county-wide policies, procedures, and protocols for adults who present in psychiatric crisis, including patients who are intoxicated and require admission to psychiatric crisis facilities or hospital beds.

Additional specific programmatic recommendations were also identified and provided to Nix for review

University Health System

University Health System is the hospital district for Bexar County, and as such is a separate political subdivision of the state of Texas owned by the people of Bexar County. University Health System employs 6,000 staff, including 1,000 physicians. As the primary teaching partner of the University of Texas Health Science Center at San Antonio, University Health System also employs 700 resident physicians. University Health System operates University Hospital, a 496 bed acute care hospital (including a Level 1 Trauma Center) and a county-wide array of 19 outpatient health centers that provides preventive, primary, and specialty health services, primarily to uninsured and Medicaid/Medicare populations. University Health System also provides the medical and behavioral health care for the Bexar County Adult Detention Center and Juvenile Detention Center.

- University Health System, as the hospital district, is an important and critical partner in establishing a BH leadership structure for the overall county BH system and through collaborative partnerships addressing health outcomes across the population served. Strong strategic leadership collaborations have already been established.
- The Health System has hired an effective BH leadership team as a foundation on which to build and improve BH services system-wide.
- An initial review of the prevalence of BH conditions among the current University Health System patient population found that a high percentage of people and families served have BH conditions. University Health System continues to look for ways to expand integrated behavioral health services into primary care settings.
- Lessons learned from collaboration between University Health System and Nix to establish a Psychiatric Emergency Service and a Crisis Intervention Unit have helped build the foundation for establishing a system-wide crisis response system that facilitates access and manages utilization of these important resources. The Health System is in an excellent position to contribute in the design of a system-wide crisis system.
- University Health System utilizes Lean quality improvement methodology, which can be useful in moving toward both improvement and expansion of integrated physical health (PH) and BH care, as well as towards improving coordination and collaboration with system partners.

University Health System Major Findings (F)

- **University Health System F-1**: University Hospital's Psychiatric Inpatient Service is well suited to the highest acuity patients, but also somewhat constrained by factors related to the care of these high acuity cases. The unit is reasonably well configured physically, patient acuity is well managed, and the unit is able to accept individuals with all levels of acuity treatable in the community and with all levels of co-occurring substance use. However, capacity is at times limited because the high acuity of patients (along with a shift in the past several years to a mostly involuntary unit) restricts them at times to single rooms, which then limits the use of the full 20 bed capacity (some payer limitations, such as assertive carve outs, also limit capacity). University Health System has added an additional six bed medical unit proximal to the psychiatric inpatient unit, which provides for more collaborative management of patients needing the level of care of a medical bed, but who have comorbid behavioral health conditions requiring closer psychiatric consultation.
- **University Health System F-2**: The University Hospital Emergency Department serves a growing number of people and continues to see the highest proportion of persons detained by law enforcement. The Emergency Department has been recently renovated to be a much larger (approximately 10,000 square feet) and more modern facility. The area designated for patients with behavioral health comorbidities is strategically located for ease of access by law enforcement to bring individuals who are under emergency detention or detained under mental health warrants as well as for those being brought for medical emergency services from the jail who do not need the level of care of the resuscitation area. The jail and psychiatric patients are treated in separate pods with a shared nursing station. Multiple recent quality improvement initiatives using Lean methodology have led to improved movement of patients out of the Emergency Department to appropriate care settings, addressing care transitions, transfers, policies, clinical management and treatment of psychiatric conditions, and training of nursing staff. University Health System has been tracking the new PES and CIU programs at Nix to determine if these programs are reducing utilization of its Emergency Department. The data shared show mixed success through 2015, but length of stay went down from 11.4 hours to 9.3 hours for discharged patients, and from 15.4 hours to 11.9 hours for transferred patients. The reduction in length of stay for those transferred is due to the availability of the Nix PES. Evaluating how patients move through the emergency/crisis system might uncover opportunities for efficiencies and referral patterns that better serve patients at the right location, in addition to targeting high utilizers in a community-wide, organized strategic plan.
- **University Health System F-3**: Services through the Health System's Outpatient Clinics have expanded primary health/behavioral health integrated (PHBHI) services, and capacity should continue to be developed to align with needs. University Health System has an extensive network of outpatient (OP) primary care and specialty services for the medically needy populations of Bexar County. University Health System has begun to expand and integrate behavioral health services, and continues to evaluate strategic opportunities for expansion. Collaborative efforts with the Center for Health Care Services (CHCS) are ongoing in order to define and offer the right level of care at the right location.
- **University Health System F-4**: Care coordination is key for improving cross-system care transitions. Over the past several years, University Health System has expanded its Care Coordination Department, and utilizes social workers, nurses, and psychiatric social workers to facilitate discharge planning and transitions of care. Treatment resource limitations continue to be a challenge; however, ongoing robust efforts are being made to identify next appropriate levels of care and improve processes to access them.
- **University Health System F-5**: The Health System's BH leadership is involved in and dedicated to system-level collaboration. University Health System leadership regularly participates in community-wide system collaboration activities, most notably in its lead role on DSRIP through the Regional Health Partnership. The Health System has also been an important partner for jail-based services in the current Council of State Governments/MMHPI project to increase Central Magistration Unit (CMAG) diversion. Two other major areas of collaboration have involved the County's Behavioral Health Consortium and the Community Medical Director's Round Table (CMDRT). With the creation of the Bexar County Mental Health Department, there is a great opportunity for ongoing gap analysis activities and, with University Health System as an important collaborative partner, to address gaps as a community.

Additional specific programmatic findings were also identified and provided to University Health System for review.

University Health System Major Recommendations (R)

- **University Health System R-1**: The Health System's leadership should continue to help lead the overall county BH system, and may require expanded involvement to help the system move to the next level. University Health System, as the hospital district, is a critical and influential partner in establishing a more comprehensive and effective BH leadership structure for the overall county BH system, with capacity for sharing responsibility for BH outcomes across the population served.
- **University Health System R-2**: Continue to commit to a vision to expand integration of behavioral health into the Health System's total business of providing health care and to incorporate behavioral health into the Health System's overall strategic plan. University Health System is deeply involved in both the direct delivery of the BH services described above and the delivery of health care services to people and families who suffer from comorbid BH conditions. As University Health System continues to articulate this vision over time, partnerships with other agencies will also need to be part of the strategic vision, allowing University Health System to leverage the full array of needed services while defining which services are best provided internally.
- **University Health System R-3**: Continue to refine data collection on the current baseline of BH needs across the entire University Health System patient population. This move will potentially allow for better data-driven planning. An important aspect of this effort will be to evaluate the cost of high utilizer / high cost / poor outcome populations, as well as the cost impact to the system of unmet / under-met BH needs in the form of medical ER visits, medical hospitalizations, readmissions, and other costs.
- **University Health System R-4**: University Health System should view itself as a full partner in designing and implementing a county-wide psychiatric crisis system. Bexar County is in a public health emergency regarding the unmet need of individuals and families in psychiatric crisis. University Health System is a natural leader in helping to convene all partners to have a high level public health response that would parallel what is starting to happen in the criminal justice system and the homeless system (via Haven for Hope). Key to this will be continuing engagement with the STRAC's planning process in managing regional emergency response capacity.

Additional specific programmatic recommendations were also identified and provided to University Health System for review.

University of Texas Health Science Center – San Antonio

The University of Texas Health Science Center at San Antonio (UTHSC-SA), Department of Psychiatry, provides significant psychiatric services throughout the region, both directly and through contracts with other providers, through its staff and psychiatric residency program:

- The Transitional Care Clinic, a short-term clinic that helps individuals transition from hospitals to community care;
- Medical staff and/or residents for key providers, including University Health System, Clarity, Laurel Ridge Hospital, San Antonio State Hospital (SASH), Cindy Krier Juvenile Correctional Treatment Center, the Kerrville Veteran's Administration, San Antonio Military Medical Center, the UT Student Counseling Center, and many other community sites;
- Model integrated behavioral health services;
- Expanding addiction and co-occurring MH / SUD services; and
- Telehealth linkages to other parts of South Texas.

UTHSC-SA Major Findings (UTHSC-SA F)

- **UTHSC-SA F-1**: The Medical Drive Clinic for Physical Health Behavioral Health Integration (PHBHI) is modeling implementation of integrated care for the UTHSC-SA clinic system and the broader community. While limited in scope, it offers many best practices.
- **UTHSC-SA F-2**: The Transitional Care Clinic is another program that can inform design of programs more broadly across the community. While limited in its community reach, many of its clinical practices are exemplary.

Additional specific programmatic findings were also identified and provided to UTHSC-SA for review.

UTHSC-SA Major Recommendations (UTHSC-SA R)

- **UTHSC-SA R-1**: UTHSC-SA should become more engaged as a major partner in system design and implementation at the system level. Expanding its residency and training programs is essential to addressing local (and regional) workforce gaps, and that expansion should ideally combine best practice community psychiatry, relevant applied research, and expanded capacity to address priority gaps in the local system of care.
- **UTHSC-SA R-2**: As it expands, UTHSC-SA should prioritize major system gaps identified by the BH leadership team, including the potential to increase training opportunities in community-based and integrated service settings, as well as additional emphasis on integrated MH/SUD service delivery across the continuum.
- **UTHSC-SA R-3**: UTHSC-SA should expand the reach of its TCC and PHBHI programs through community partnerships to increase both the scope and relevance of these programs within the community.

Additional specific programmatic recommendations were also identified and provided to UTHSC-SA for review.

Primary Health and Behavioral Health Care Integration (PHBHI) Provider Findings

Four Bexar County outpatient providers offering Primary Health/Behavioral Health Integration services were also reviewed in depth, including two federally qualified health centers (CentroMed and CommuniCare), the Wesley Health & Wellness Center, and CHCS. All four providers embed behavioral specialists within the primary services they offer, and PH/BH staff work closely and collaboratively in planning and delivering care. The FQHCs offer PHBHI in several clinic locations to children, adolescents and adults. In fact, CommuniCare has several child psychiatrists and an even greater capacity to provide PHBHI to children and youth. The Wesley Health & Wellness Center also serves children, adolescents and adults, focusing primarily on mild to moderate levels of need. CHCS offers PHBHI to adults with SMI at its Northwest Clinic.

PHBHI Major Finding (PHBHI F)

- **PHBHI F-1**: PHBHI is a precious resource in Bexar County, as these four providers meet much less than 10% of the PHBHI need among lower income residents and an even smaller fraction of the need among adults with SMI.
- **PHBHI F-2**: Despite the need to increase its scale, these four providers model various best and emerging best practices and offer a strong base on which to build a broader array of supports system wide. Brief summaries of the capacity of each provider and the major site visit findings are included in Appendix B, C, D and E.

PHBHI Major Recommendation (PHBHI R)

- **PHBHI R-1**: Safety net providers in Bexar County, higher education training programs, advocates, families, consumers, and payers/funders need to work together to develop a formal, strategic plan for increasing access to PHBHI in Bexar County.
- **PHBHI R-2 to R-5**: The plan should delineate the following: specific residency and training mechanisms whereby more clinicians will be trained in PHBHI; prioritization of the PH/BH conditions and severity levels that will be the focus of capacity expansion; the collaboration, co-location and referral mechanisms and inter-agency agreements that need to be established; and the financing mechanisms that can be used to sustain PHBHI.

Other System Partner Findings and Recommendations

Other system partners reviewed for this report include health plans and payers, other leading hospitals and acute care / crisis providers in the county, county and other social services and human services systems, existing system / stakeholder collaboratives, Medicaid and Medicare health plans doing business in Bexar County, the justice system, family members, consumers, advocates, and other stakeholders. Many of these stakeholders either facilitate or participate in system coordination functions, such as NAMI, the San Antonio Council on Alcohol and Drug Abuse (SACADA), and the Southwest Texas Regional Advisory Council (STRAC). Health plans and payers are also trying to fund systems of care for their specific populations. Providers are trying to coordinate care across a range of conditions and populations. Other stakeholders reported multiple themes related to the goal of having a system that responds to needs in a more coordinated and person-centered way.

Other System Partners Major Findings (SP F)

- **SP F-1**: There is tremendous interest and energy already expended in an array of collaborative forums where agencies and leaders at multiple levels come together to attempt to better manage services across providers and systems. However, as noted in the system level section, these forums lack the necessary scope and operational infrastructure to address major system needs.
- **SP F-2**: Other system partners also universally expressed interest in a stronger planning approach that focuses on coordination and development across (rather than within) silos.
- **SP F-3**: There is interest among current providers and payers to expand capacity to address system needs, especially better coordination of crisis services (SP F-4) and services for individuals with SUD and co-occurring substance use and mental health conditions (SP F-5).
- **SP F-4**: All major inpatient providers in the community, including University Health System, Nix, Baptist Hospital, Methodist hospital, and San Antonio Behavioral Health, are affected in their emergency room, behavioral health, and broader service delivery by unmet BH needs, particularly by "super-utilizers." Emergency medical system coordination through the STRAC has begun to address better coordination for individuals with BH needs served at Haven for Hope, involving multiple community providers, including both CentroMed and CHCS.

Other System Partners Major Recommendations (SP R)

- **SP R-1**: A broad set of stakeholders should be involved in system of care planning the Bexar.
- **SP R-2**: It is important to include diverse members representing the major cultural, ethnic and linguistic minorities to build alliances and understanding, as well as to engage these community leaders in the planning to develop the quality and capacity of services that address diverse populations.
- **SP R-3**: Efforts to broaden BH system planning should incorporate the planning in the STRAC related to Haven for Hope and potentially expand that planning to include a broader system-wide EMS response to "super-utilizers."

Background and Methods

Methodist Healthcare Ministries of South Texas, Inc., commissioned the Meadows Mental Health Policy Institute (MMHPI) to assess the behavioral health (BH) systems of Bexar County. These findings are based on reviews conducted in the fall of 2015 and early 2016.

The objective of the assessment was to evaluate current capacity – service delivery capacity, system development capacity, and population health management capacity – to determine viable strategies that build on existing strengths to further develop the system of care, in alignment with the following goals:

- Be more responsive, accountable, vision-driven, recovery-oriented, and integrated;
- Increase the quality and effectiveness of service delivery for populations with more complex needs;
- Improve the efficiency of system operations, resource allocations, and revenue generation across available federal, state, and local funding streams; and
- Continue to ensure compliance with changing and complex state and federal regulatory requirements.

Key providers of behavioral health services identified by Methodist Healthcare Ministries were the primary focus of the review including the Center for Health Care Services (CHCS), Clarity Child Guidance Center, Haven for Hope, Nix Health, the University Health System, and the University of Texas Health Science Center (UTHSC-SA). MMHPI also conducted reviews of Physical Health/Behavioral Health Integration (PHBHI) providers including CentroMed Federally Qualified Health Center (FQHC), the Northwest Clinic PHBHI program located at CHCS, CommuniCare FQHC, and the Wesley Health & Wellness Center. Other system partners that offer mental health and support services were also interviewed: health plans and payers, social services and human services systems, family members, consumers, advocates and other stakeholders, and the justice system.

MMHPI would like to thank Methodist Healthcare Ministries, Bexar County, and all participants for their collaboration in the system review and for providing information. Their collaboration is the basis for system improvements going forward.

MMHPI initiated this review in June 2015 with meetings with Methodist Healthcare Ministries' leadership and key contacts they identified from the broader service delivery system to engage them in the review and request system-wide data that would help us to understand the key system providers and services. MMHPI held an initial meeting with Methodist Healthcare Ministries and sent a detailed information request inclusive of program descriptions, policies and procedures, organization charts, benchmark data and reports, and financial information to the specific behavioral health providers listed previously. MMHPI also began to collect data from other sources (e.g., Department of State Health Services, Texas Department of Criminal Justice) to assist us with a comparison of Bexar County to other Texas counties and other states, as well as a comparison of the Center for Health Care Services (CHCS) to other local mental health authorities.

From July through November 2015, the MMHPI team – consisting of a psychiatrist, psychologist, two social workers, an operations consultant, and an information system expert – conducted telephone and in-person interviews with staff from a wide array of service delivery sites. Visits to a range of system partners complemented the on-site review of behavioral health providers. A full list of all participants is included in Appendix A.

In addition to reviews of Physical Health Behavioral Health Integration (PHBHI) programs operated by CHCS (Northwest Clinic) and UTSCH-SA, MMHPI reviewers conducted day-long site visits with three additional PHBHI providers in Bexar County: CentroMed FQHC, CommuniCare FQHC, and the Wesley Health & Wellness Center. Our review of the programs' current capacities for PHBHI primarily consisted of extensive interviews with administrative and clinical leaders, as well as reviews of electronic health records, agencies' vision and mission statements and other important documents.

Preliminary draft reports were shared with each of the providers visited by the MMHPI team to obtain feedback on our initial findings and recommendations on the system as a whole and on the participating providers' roles within it. The preliminary reports were reviewed in detail, additional interviews were carried out, and supplemental data were requested and received. Feedback from all parties was incorporated to improve the accuracy and clarity of report findings and to inform further development of the recommendations.

This initial draft of the full report was completed in December 2015. Upon review of the report by Methodist Healthcare Ministries and key providers, additional edits and content will be integrated during January 2016, and the full revised report is anticipated to be completed in February 2016. However, in coordination with Methodist Healthcare Ministries, the timing of the final revised report may change in order to accommodate sufficient review and input by stakeholders.

The report is divided into the following sections:

- Needs: Findings related to severe mental health needs in Bexar County;
- System-Level Findings and Recommendations: Findings and recommendations related to how well providers, payers, and their partner agencies work together in Bexar County to function as a system of care and the major overall recommendations for improving system-level performance and outcomes; and
- Provider Findings and Recommendations: Agency-specific findings and recommendations related to the five major mental health providers, the additional PHBHI providers, and the input of other payers, providers, and stakeholders.

Severe Mental Health Needs and Capacity in Bexar County

Finding N-1: People with the Most Severe Needs of Mental Health Services

Bexar County is a large and diverse metropolitan area with nearly two million residents. Within Texas it trails only Dallas, Harris, and Tarrant counties in total population. When looking at mental health needs, many people are familiar with the broad estimates that between one in five and one in three Texans (depending on the source cited) suffer from some level of mental health need. However, the primary focus of this report is on severe needs, and far fewer Texans suffer from these. Among all 254 Texas counties in the most recent year for which statistics are available (2013), Bexar County had the fourth highest prevalence of people with the most severe needs: adults with serious mental illnesses (just over 60,000 or 4.5% of the overall adult population) and children with serious emotional disorders (just over 37,500, 7.8% of the overall population under age 18).[1]

To estimate prevalence of mental health disorders, MMHPI used an epidemiological methodology developed by Dr. Charles Holzer. Dr. Holzer uses findings from the most widely accepted national epidemiological studies, particularly the 2004 National Comorbidity Study Replication (NCS-R). Holzer draws on the NCS-R findings of the correlations between demographic variables (e.g. race/ethnicity, age, sex and income) and mental health disorders, as well as on the latest demographic data from the American Community Survey and the national census, to develop algorithms that provide the most precise estimates available of the rate of mental illness in the population. The data are usefully broken out by multiple factors, including race/ethnicity, age, and income (200% federal poverty level), and are therefore more helpful for planning purposes by mental health authorities and advocates.

In estimating the prevalence of mental health disorders, the NCS-R is much more thorough than other sources that are often cited, such as the National Survey on Drug Use and Health (NSDUH), and more inclusive than older estimates, such as the 1999 Federal Register definition used by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Dr. Holzer and colleagues' 2013 estimates were commissioned specifically by MMHPI for use in Texas and are the most recently available. The following table breaks out levels of severe need for adult and child populations across Bexar and the comparison counties.

Table 1: Twelve-Month Prevalence of Adults with SMI and Children with SED Living at or below 200% Federal Poverty Level (FPL) Relative to Population in Large Texas Counties[2]

County	Total Population	Adults with SMI	Adults with SMI Under 200% FPL	Children with SED	Children with SED Under 200% FPL
Bexar	**1,882,834**	**60,034**	**34,871**	**37,523**	**21,438**
Dallas	2,496,859	88,279	54,112	53,222	35,365
Harris	4,471,427	142,930	87,283	91,414	56,044
Tarrant	1,959,449	64,191	35,873	39,006	21,569
Travis	1,144,887	38,253	21,673	19,965	10,703

Given the charitable interests of Methodist Healthcare Ministries, this assessment focuses on the needs and level of services available to people with incomes under 200% FPL, which includes just under 35,000 adults with SMI (2.6% of the total adult population of over 1.3 million) and just under 21,500 children with SED (4.5% of the total child population of just over 480,000).

We can also break this population of people with severe needs down in two further ways: primary diagnosis and recency of onset. MMHPI believes that one barrier to better treatment of mental illness is our tendency to group a range of diverse needs into a single, large group of "people with major mental illness" or "adults with serious mental illness." We do not do this for other severe medical conditions. For example, the most recent Texas Cancer Plan[3] does not even note the total number of people in Texas with cancer (which is just over 500,000[4]), nor does it break out the number of severe cases (e.g., "Stage Four" cases). Instead the plan focuses on specific cancer conditions (e.g., breast cancer, prostate cancer) and the number of new cases that emerge each year (otherwise known as incidence). Table 2a breaks out the incidence rates for the one of the major diagnostic groups that makes up the group of adults with SMI, people with schizophrenia. Note that the number of people that develop schizophrenia is a subset of the people for whom an initial psychosis emerges. While approximately 300 adolescents and adults each year (125 of whom are in poverty) will manifest a first episode of psychosis,[5] not all develop schizophrenia. Studies suggest that essentially all of the people who develop schizophrenia will meet functional criteria for SMI, as opposed to only 80% of those with bipolar disorder[6] and just under 20% of those with major depression.[7]

1 Serious mental illness (SMI) refers to adults and older adults with schizophrenia, severe bipolar disorder, severe depression, and severe post-traumatic stress, all of which are conditions that require comprehensive and intensive treatment and support. A subgroup of these people is defined as having a Serious and Persistent Mental Illness (SPMI) that more severely impairs their ability to work and live independently and that has either persisted for more than a year or resulted in psychiatric hospitalizations. Severe Emotional Disturbance (SED) refers to children and youth through age 17 with emotional or mental health problems so serious that their ability to function is significantly impaired, or their ability to stay in their natural homes may be in jeopardy.

2 Holzer, C., Nguyen, H., & Holzer, J. (2015). *Texas county-level estimates of the prevalence of severe mental health need in 2013*. Dallas, TX: Meadows Mental Health Policy Institute. Compared to the overall population, these numbers tend to underestimate the need, as they are based on 2013 population levels.

3 Cancer Prevention and Research Institute of Texas. (2012). Texas Cancer Plan, 2012. Retrieved at: http://www.cprit.state.tx.us/images/uploads/tcp2012_web_v2a.pdf.

4 Texas Department of State Health Services (DSHS). (2015). Calculated Cancer Prevalence of Cancer in Texas, 1/1/2012. Retrieved at: https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590004026.

5 Kirkbride, J.B., Jackson, D., et al. (2013). A population-level prediction tool for the incidence of first-episode psychosis: Translational epidemiology based on cross-sectional data. BMJ Open, 3(2), 1-12.

6 Merikangas, K.R., et al. (2007). Lifetime and 12-month prevalence of bipolar spectrum disorder in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *64*, 543-552.

7 Kessler, R.C., et al. (2003). The epidemiology of major depressive disorder: Results from the national comorbidity survey replication (NCS-R). *JAMA*, 289(23), 3095-3105.

Table 2a: SMI Prevalence Rates Versus Prevalence and Incidence of Schizophrenia in Bexar County

Population Subgroups	Bexar County Adult Population	% of All Adults	Bexar County Adult Population (Under 200% FPL)	% of Adults
Total Population	1,331,121	100.00%	455,824	34.20%
Serious Mental Illness – Prevalence over 12 Months (ALL cases in one year)	60,034	4.51%	34,871	2.62%
Schizophrenia – Prevalence over 12 Months (ALL cases in one year)[8]	4,400	0.33%	1,500	0.11%
Schizophrenia – Incidence over 12 Months (NEW cases in one year)[9]	250	0.02%	90	0.01%
First Episode Psychosis – Incidence over 12 months (NEW cases in one year)[10]	300	0.02%	125	0.01%

While the number of people with serious mental illness in Bexar County is relatively large (nearly 1 in 20 adults), the numbers go down as we look with more specificity. A much smaller proportion (1 in 300) have schizophrenia in a given year, and even fewer new cases of schizophrenia emerge each year among adolescents and young adults (fewer than 1 in 5000). We are learning that treatment outcomes for schizophrenia and other psychotic illness improve dramatically if treated within the first year or so of emergence.[11] Similar to how cancer survival rates have improved as treatment moved from later stages (e.g., Stage Four, after metastasis) to earlier intervention (e.g., Stage 1, when the condition is more contained), emerging research shows the promise of more effectively treating major mental health disorders such as schizophrenia early on in order to prevent the functional impairments that characterize SMI.[12]

Another way to look at needs involves a public health framework that seeks to prevent major adverse outcomes of SMI, such as homelessness, jail use, and emergency room use. The Bexar County Mental Health (MH) Consortium has recently begun to prioritize subgroups of need in the community using a public health color coding of "red" (current / high risk of adverse outcomes, tertiary prevention), "yellow" (moderate risk of adverse outcomes, secondary prevention), and "green" (low risk of adverse outcomes, primary prevention).

Focusing on the "red" risk group that at any one time needs to use a jail or hospital bed or that is homeless or otherwise at high risk for jail, emergency room, or hospital use, MMHPI has used various sources to estimate the relative need among adults with SMI of the following levels of care:

- Need for beds in the Bexar County Jail: Unfortunately, not all of the estimated 24% of adults in the Bexar County jail with mental illness can be diverted. Using data from the Council of State Governments (CSG) Justice Center's most recent in-depth analysis of diversion opportunities in the Bexar County Jail,[13] of the 59,191 people booked into the jail in 2014, more than half (31,520 or 53%) were only there for a relatively short time anyway (e.g., less than three days) so the window for diversion is too short to meaningfully affect.

8 Estimated by MMHPI based on: McGrath, J., Saha, S., Chant, D., & Welham. (2008). Schizophrenia: A concise overview of incidence, prevalence, and mortality. *Epidemiological Reviews, 30*, 67-76.

9 Estimated by MMHPI based on: McGrath, J., Saha, S., Chant, D., & Welham. (2008).

10 Estimated by MMHPI based on: Kirkbride, J.B., Jackson, D., et al. (2013). A population-level prediction tool for the incidence of first-episode psychosis: Translational epidemiology based on cross-sectional data. *BMJ Open, 3*(2), 1-12. Estimated upwards to account for urban effect noted by McGrath et al.

11 Kane, J.M., et al. (October 20, 2015). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. American Journal of Psychiatry. Retrieved from: http://dx.doi.org/10.1176/appi.ajp.2015.15050632.

12 Insel, T.R. (October 20, 2015). RAISE-ing our expectations for first-episode psychosis. American Journal of Psychiatry. Retrieved from: http://dx.doi.org/10.1176/appi.ajp.2015.15091204.

13 CSG Justice Center. (2015). Stepping Up case study: Bexar County Jail Prevalence, Match to Services, Flow and Hypothetical Scenario about Impact on Prevalence and Review of a Local Mental Health System.

Of the remaining 47% (27,671 people, whose stays are much longer and who therefore comprise over 99% of jail use: 3,738 out of the 3,764 bed average daily population or ADP), nearly two-thirds (17,841) cannot be diverted because the nature of their offense requires them to stay until sentenced or transferred to a state or federal facility. CSG's analysis of the remaining third (9,830) of those who stay more than three days suggests that only 1,250 people, using an average of 159 beds a day per year (4.2% of total ADP), can be diverted. That means that on any given day, the jail must house approximately 690 people with mental illness who will stay more than three days (5,400 per year), even if aggressive diversion practices can be implemented. While a comprehensive diversion program may exceed that, it is safe to assume that currently non-divertible legal involvement will necessitate approximately 690 jail beds per day.

- Need for inpatient beds: In January 2015, two important reports were released attempting to define the need for inpatient "beds" in the state of Texas, which yield estimates for Bexar County of between 350 and 400 publicly and privately funded beds:
  - Rider 83 State Hospital Long Term Plan: This Department of State Health Services (DSHS) report drew a great deal from the November 2014 consulting report by CannonDesign.[14] CannonDesign recommended development of 570 beds in the near term (and an additional 607 beds to keep pace with population growth through 2024), for an overall 5,424 publicly and privately funded beds in 2014. Based on the proportion of Texas adults with SMI living in Bexar County, this suggests a need for 348 psychiatric beds.
  - HB 3793 Report: This DSHS report (Allocation of Outpatient Mental Health Services and Beds in State Hospitals) originated from the 83rd Legislature (HB 3793), which required a plan to identify needs for inpatient and outpatient services for both forensic and non-forensic groups. A diverse stakeholder group was identified in the legislation to advise DSHS in determining the need and developing a plan to address it. The Task Force recommended a higher level of need for additional state funded beds (1,500, versus 607 by CannonDesign). Using this estimate yields an overall need of 6,325 publicly and privately funded beds in 2014. Based on the proportion of Texas adults with SMI in Bexar County, this suggests a need for 407 psychiatric beds.
- Super-utilizers: While discussion often focuses on the need for inpatient beds or overuse of jails, the reality is that people with severe needs do not stay very long in these settings. Most adult inpatient stays are for less than a week and the vast majority of those who stay longer at state hospitals are in care for weeks or months, rather than years. The average length of stay for an adult with SMI in the Bexar County Jail is 46.5 days. As a result, the vast majority of people in need are in the community. However, not all of the 54,000 adults in Bexar County with SMI (or the 37,000 adults in poverty with SMI) are at equal risk of jail use. Two careful studies of the proportion of adults with SMI at high risk of homelessness, emergency room use, and inpatient use each year[15] and those at risk of repeat forensic involvement[16] suggest that the number of adults at highest risk – a group that we term "super-utilizers" – totals 4,217 people a year, of whom most (58%) are in poverty (about 2,600). Of these 2,600 individuals, about 1,200 need non-forensic intensive treatment, about 1,000 need forensic intensive treatment, and about 400 could benefit from either.

Table 2b summarizes the "red" level of need within Bexar County, both overall and among people in poverty (under 200% FPL), compared to total levels of adults in each group with SMI. While the focus of this report is primarily on people in poverty without resources of their own to seek care, given the public health burden of the "super-utilizers" (SU), both groups are presented in the table.

14 CannonDesign et al. (2014). Analysis for the Ten-Year Plan for the Provision of Services to Persons Served by State Psychiatric Hospitals: Consulting Services Regarding DSHS Rider 83 RFP Final Report. Retrieved from http://www.google.com/url?sa=t&rct=-j&q=&esrc=s&source=web&cd=1&ved=0CB8QFjAA&url=http%3A%2F%2Fwww.dshs.state.tx.us%2Fmhsa%2Freports%2FSPH-Report-2014.pdf&ei=XacBVfuqGZCTyATf7oCYBA&usg=AFQjCNFXiZEIWILKJIVFJ1mIsWzicdYpMw&bvm=bv.87920726,d.aWw

15 Cuddeback, G.S., Morrissey, J.P., & Meyer, P.S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806.

16 Cuddeback, G.S., Morrissey, J.P., & Cusack, K.J. (2008). How many forensic assertive community treatment teams do we need? *Psychiatric Services, 59*, 205-208.

Table 2b: SMI Prevalence Rates Versus "Red" Risk Needs in Bexar County

Diagnosis	Adult Population	Total SMI	Jail Need	Inpatient Need	Non-Forensic SU	Forensic SU	Either Group SU
All SMI	1,331,121	60,034 (4.5%)	690 Beds	350 to 400 Beds	2,223 (0.17%)	1,408 (0.11%)	586 (0.04%)
SMI in Poverty		34,871 (2.6%)			1,291 (0.10%)	818 (0.06%)	340 (0.03%)

Note that only a relatively small number of people (less than one-third of one percent) are driving the majority of use of jails, ERs, and inpatient beds, and even fewer (less than one-fifth of one percent). In addition to occasional hospitalization and intensive mental health services in the community (e.g., assertive community treatment / forensic assertive community treatment or other intensive modalities of care), these individuals tend often to need additional supports to recover, including supported housing, supported employment, and peer services. The degree to which services in Bexar County are available to meet the needs of this group, as well as the broader population of individuals with severe mental health needs, is described in the following subsections.

Intensive service needs for children and families are more difficult to estimate. Based on our work in multiple states that have developed community-based service arrays in response to system assessments and EPSDT legal settlements (WA, MA, CT, NE, and PA), the MMHPI team estimates that one in 10 children with SED at any one time (approximately 2,200) would require time-limited, intensive home and community-based services to avoid or reduce risk of out-of-home or out-of-school placement. Of these, a subset of approximately 800 to 1,200 would require intensive wraparound service coordination and supports to function adequately in the community.

Finding N-2: Core Public Outpatient System Capacity for Adults With Severe Needs

For adults in poverty (incomes below 200% FPL) with severe needs, the core capacity for outpatient services is comprised of the Center for Health Care Services (CHCS), University Health System, Medicaid providers, the University of Texas Health Science Center at San Antonio (UTHSC-SA), and the Haven for Hope. Collectively they currently serve over 80% (27,564) of adults in poverty with severe needs (34,871). However, relatively few people receive the intensity and level of care necessary. While CHCS serves a relative higher proportion of people with complex needs with intensive services that other leading Texas LMHAs, the overall capacity for both ongoing and intensive services across all safety net providers is insufficient for the identified need resulting in an overreliance on crisis, emergency, and criminal justice services.

Determining the overall capacity of the outpatient public mental health system to serve those with severe needs is complex. To compute our estimate, MMHPI took the following steps:

- Defining the core public mental health outpatient system. The first step was to determine the primary system components. Our analysis focused on the following:
  - CHCS, the local mental health authority for the county;
  - University Health System, the local hospital district (focusing on their outpatient services – inpatient and emergency services are discussed later in this report); and
  - Medicaid fee-for-service (FFS) – primarily those delivered by the federally qualified health centers (FQHCs) in Bexar County – and managed care organizations (MCOs), which are responsible for the behavioral health care of people with Medicaid, including services delivered by CHCS.
- Determining the proportion of adults served with SMI in poverty by each system component. MMHPI obtained data from the Texas Department of State Health Services (DSHS) on the unduplicated number of adults receiving services through CHCS and verified the numbers with CHCS. To determine the level of Medicaid services, we drew on a Meadows Foundation commissioned study from 2015 by researchers from the University of Texas School of Public Health in Houston analyzing the number of Texans with SMI served by the Medicaid system.[17] The data are for calendar year 2012, so should be viewed as a conservative estimate given population growth.

The following table summarizes the overall adult service capacity across major outpatient public mental health service systems in Bexar County. Our calculation of the number of unduplicated individuals served in outpatient settings indicates that there is capacity among the three major components of the system – CHCS, University Health System, and the Medicaid providers – to serve over 80% of those in need and in poverty, at some level of care. The critical question remains, however, whether the right type and intensity of care is available.

Table 3: Adults Served by Core Public Providers vs. Adults in Need of Care, FY 2014

Adults Served	Bexar	Harris	Comments
Need: Adults in Poverty with Severe Needs (SMI 200% FPL Population)	**35,000**	**87,000**	Rounded to nearest thousand for ease of comparison.
Received Public Mental Health Outpatient Services at Any Level	**27,564**	**65,000**	Estimate of unduplicated cases served by core system. Does not include University Health System.
Local Mental Health Authority (CHCS in Bexar, MHMRA in Harris)	9,708	16,359	Total served in ongoing levels of care.
Health District (University Health System in Bexar, Harris Health in Harris)	Not Provided	34,917	Only adults with severe needs (e.g., SMI).
Medicaid FFS and HMO[18]	17,856	28,717	This is the unduplicated number of adults with SMI served in 2012; level of care received is not clear.
Percent of Severe Need in Poverty Served by Core Public Providers	**79.3%**	**74.5%**	Not necessarily served at right level of care. Does not include University Health System.

While it appears that the system has sufficient capacity to provide some level of care to nearly 4 out of 5 people in poverty with severe needs, it is critical to keep in mind that access to care in general is not the same as access to the right level of care. Medicaid MCOs and FQHCs provide routine outpatient care and, through the MCOs, higher levels of care such as inpatient.

But those MCO networks have generally only been building intermediary levels of care[19] since they began managing the rehabilitative services that, prior to September 2014, had been only available through LMHAs. While Bexar County MCOs are developing additional treatment options, CHCS is still the primary infrastructure for those with intensive needs at risk of using hospitals, emergency departments, and jails.

17 Rowan, P.J., Begley, C., Morgan, R., Fu, S., & Zhao, B. (2014, September). Serious and Persistent Mental Illness in Texas: County-Level Enrollee Characteristics of Medicaid-Supported SMI Care, Texas, 2012.
18 Rowan, P.J., Begley, C., Morgan, R., Fu, S., & Zhao, B. (2014, September).
19 Rowan, P.J., Begley, C., Morgan, R., Fu, S., & Zhao, B. (2015, February). Serious and Persistent Mental Illness in Texas Medicaid: Descriptive Analysis and Policy Options Final Report. Study Prepared for The Texas Institute on Healthcare Quality and Efficiency and The Meadows Foundation.

This scenario is similar to what is seen in communities across Texas, where LMHAs such as CHCS generally fill the space in between, offering a continuum ranging from crisis alternatives to intensive outpatient services – such as assertive community treatment (ACT) – to skills building treatment, case management, and medication management. As discussed further under finding N-6, the state-funded service array in Texas does not include some important levels of care (including an array of crisis alternatives and step-downs), but LMHAs such as CHCS nevertheless form the primary source for more intensive mental health services (that is, care for cases too complex to be seen in primary or routine specialty care settings) in most Texas communities.

We examined the number of adults and children served by LMHAs across the Texas Resilience and Recovery (TRR) levels of ongoing care, relative to the estimated number of lower income persons in need during a 12-month period that were presented in the section above. In fiscal year 2014, CHCS served a significantly higher percentage of adults with SMI in the county than did the LMHA in Harris, but slightly fewer than in Tarrant County and significantly fewer than in Travis County. CHCS served just over one-fourth of the total estimated number of people with SMI.

Table 4: Unduplicated Number of Adults Who Received Services by LMHA, FY 2014

Adults	Bexar	Harris	Tarrant	Travis
SMI 200% FPL	**34,817**	87,283	35,873	21,673
LOCs Served	**9,708**	16,359	10,912	7,968
Percent in Need	***27.8%***	***18.7%***	***30.4%***	***36.7%***

To better understand these dynamics, data was also obtained and analyzed regarding the distribution of care provided by LMHAs at different levels of care. DSHS contracts with local mental health authorities (LMHAs) to provide defined levels of care (LOCs) referred to as Texas Resiliency and Recovery (TRR) levels of care. The LOCs are broken into graduated levels of intensity to meet the various levels of service needs of children and adults entering the public mental health system.

There are five adult LOCs for ongoing mental health services:

- Medication Management (A1M): This is the lowest level of service, typically involving less than an hour of care per month, generally for people who are stable and in a maintenance phase needing only medication. LMHAs rarely deliver this level of care.
- Skills Training (A1S): This also involves a low level of service, adding an hour or two of psychosocial rehabilitation and minimal case management to medication. This is the more typical level of care delivered to people who are in a stable phase of treatment needing only minimal support.
- Medication and Therapy (A2): This adds two to three hours of evidence-based counseling to the mix. This is for people primarily in need of therapy for depression or anxiety (including severe anxiety, such as post-traumatic stress), in addition to medication and minimal support.
- Team Based Treatment (A3): This is a more intense level of care for people in need of active treatment and psychosocial skills training and who have severe needs and significant gaps in functioning. Most people with serious mental illness who are not stable would need this level of care.
- Assertive Community Treatment (ACT) (A4): This is the highest level of service intensity, emphasizing prevention of repeated psychiatric hospitalizations and coordinating an array of services to meet other intensive and complex needs (housing stability, ongoing justice system involvement, co-occurring substance use). ACT is designed for non-forensic "super-utilizer" group of people with serious mental illness noted above in the needs section.[20]

20 Cuddeback, G.S., Morrissey, J.P., & Meyer, P.S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806.

In addition to these five ongoing treatment levels, LMHAs also provide two levels of crisis support:

- Crisis Response: This is the initial response to a crisis, either through mobile crisis or services at a facility, and can involve up to six days of follow-up.
- Transitional: This involves up to 90 days of additional transition services until the situation is resolved.

The following table summarizes the distribution of care provided by LMHAs at different levels of care. When the distribution of adults served across TRRs is examined, CHCS is found to provide much more team-based care (LOCs A3 and A4 combined) relative to the other large LMHAs examined. This is very important, given that adults with SMI whose symptoms are not stable generally need these more intensive levels of care (as opposed to the lower level LOCs). Exactly one-third of people in Bexar County served through CHCS receive care through the more intensive team-based LOCs, whereas, in other LMHAs typically about one in five people served receive ongoing care in LOCs A3 and A4. This represents a striking difference and a strong base for the community to build on.

Table 5: Adult Levels of Care Analysis

LMHA	Crisis Continuum		Ongoing Treatment Levels					
Level of Care[21]	Crisis Response	Crisis Transition	Medication Management	Skills Training	Medications & Therapy	Team Based	ACT	Total Non-Crisis
Bexar	2,965	267	0	5,979	525	2,949	255	**9,708**
% of LOCs			0%	62%	5%	30%	3%	
Harris	5,814	392	206	12,010	1,724	2,138	281	**16,359**
% of LOCs			1%	73%	11%	13%	2%	
Tarrant	382	581	2	8,386	386	2,037	101	**10,912**
% of LOCs			0%	77%	4%	19%	1%	
Travis	2,738	660	63	6,164	186	1,326	229	**7,968**
% of LOCs			1%	77%	2%	17%	3%	
Total	**12,078**	**2,148**	**287**	**34,541**	**2,856**	**8,800**	**934**	**47,418**
% of LOCs			***1%***	***73%***	***6%***	***19%***	***2%***	

In addition to CHCS, UTHSC-SA operates two important programs for adults with serious mental illness:

- UTHSC-SA operates a small First Episode Psychosis (FEP) team at which serves about 25 people in a year (approximately 1/12th of the people in need of such care annually. As noted in the needs section, FEP services have the potential to dramatically improve outcomes for individuals with emerging schizophrenia and other psychotic disorders.
- UTHSC-SA also operates a Transition Care Clinic that serves 900 people a year to help people bridge from crisis situations into ongoing care. This provide a potential tertiary prevention role.

To better understand the service delivery dynamics related to this lack of capacity for functionally-focused treatment for adults with SMI, additional data was examined for four essential sub-components of active treatment for SMI: the most intensive level of ongoing care (Assertive Community Treatment or ACT), Supported Housing, Supported Employment, and peer support.

21 The "% of LOCs" exclude crisis and crisis follow-up.

Various data were available from CHCS, DSHS, comparison counties, and other communities around the country on three evidenced-based practices for adults with serious mental illness: Supported Housing, Supported Employment, and Assertive Community Treatment (ACT). The comparative data include benchmarks to other Texas counties and best practice regions of the United States that place the data from CHCS and Bexar County in context. CHCS provides all three of these evidence-practices.

Besides examining available data from other large systems in Texas, MMHPI used data on evidence-based practice (EBP) utilization from other systems around the country that were publicly available either through published and non-published sources. These include:

- Maricopa County (Phoenix) and Arizona were chosen because Phoenix is a large city (adult population of Maricopa County is just under 3 million) and because it provides "best practice" benchmarks in the areas of ACT.
- Because data were readily available from the California, New York State, and New York City, we also obtained EBP utilization data from that very large city. These states and New York City represent typical national benchmarks (not necessarily best practice benchmarks).
- Finally, Denver, while not a large city, enjoys some of the highest utilization of EBPs nationally, including ACT, Supported Housing, and Supported Employment, and in many ways it provides the broadest "best practice" level of benchmarking we are aware of for these three EBPs. The MMHPI team was able to obtain local (Denver) and state (Colorado) data through key informant contacts at the Mental Health Center of Denver, the LMHA equivalent for the City and County of Denver, Colorado.

Collectively, these comparison communities allowed MMHPI to place EBP utilization in Bexar County into a broader context. The best practice benchmarks available from Maricopa County (ACT and Peer Support) and Denver (ACT, Supported Employment, Supported Housing) provide a level of investment in EBPs to which Texas as a whole and Bexar County in particular might aspire over the longer term. Examination of more typical levels of EBP utilization, based on findings from other Texas communities and New York, also help put Bexar County EBP utilization in context.

Assertive Community Treatment (ACT). We noted above that, compared to other LMHAs, CHCS serves a high percentage of its population in more intensive levels of care. However, in general, large counties in Texas do not have adequate resources in the area of intensive community treatment for people with SMI and co-occurring substance use or criminal justice system involvement. In particular, the highest levels of evidence-based intensive community treatment – Assertive Community Treatment and Forensic Assertive Community Treatment – are not widely available, including in Bexar County.

In Table 6, we show the number of people receiving ACT relative to the estimated number in need in Bexar County and other regions inside and outside of Texas. As can be seen in the table, it is rare for any region to provide the number of ACT teams necessary to meet the need for intensive community treatment. It should be noted that the CHCS High Utilizer Team (which overlaps some with its ACT services) is not included in the table, but does represent an additional community resource in Bexar County to serve an additional 175 people at any one time (300 per year).[22]

22 According to personal communication with Josie Alcala, Director of the CHCS Northwest Clinic, there is some overlap between the ACT team and the High Utilizers Team.

Table 6: Adults with SMI (200% FPL) Known to Have Received Assertive Community Treatment (ACT)

Region	200% FPL SMI Population[23]	Need ACT[24]	Received ACT[25]	Percent in Need Received ACT
United States	7,495,538	322,308	63,445	20%
Arizona	116,710	5,019	8,683	173%
Maricopa Co. (Phoenix, AZ)	72,217	3,105	1,361	44%
California	552,096	23,740	5,227	22%
Colorado	123,567	5,313	3,182	60%
Denver	14,699	632	800	127%
New York	459,945	19,778	6,189	31%
New York City	196,743	8,460	1,500	18%
Texas	531,573	22,858	3,335	15%
Bexar County	**34,817**	**1,499**	**255**	**17%**
Dallas County	54,112	2,327	525	23%
Harris County	87,283	3,753	427	11%
Tarrant County	35,873	1,543	101	7%
Travis County	21,673	932	229	25%

However, the quality of ACT services delivered is also important. Best practice ACT services – including those in Texas – seek to systematically promote consistent outcomes across programs over time through a comprehensive process of interactive, qualitative fidelity monitoring using best practice measures. Such an approach is particularly critical because high fidelity implementation of programs like ACT is a predictor of good outcomes[26] and of system-wide cost savings.[27] Rigorous fidelity assessment also provides a basis for needed service delivery enhancements within a continuous quality improvement (CQI) process. In effect, qualitative clinical services monitoring will help ensure fidelity to the ACT model, evaluate whether settlement stipulations are being met, and contribute to a continuous quality improvement process. MHMRA performs well on these audits, indicating that its teams – both its regular ACT team and its forensic ACT team – deliver high quality services according to Texas standards.

However, Texas uses the Dartmouth Assertive Community Treatment Scale (DACTS) developed in the late 1990s, rather than the current state of the art Tool for Measurement of Assertive Community Treatment (TMACT).[28] The TMACT is the current standard in the field and represents the best currently known way to

23 SMI population estimates: Texas estimates are based on Dr. Holzer's refined SMI prevalence estimation methodology. California: state-level estimates are based on applying SAHMSA's 2012-2013 model-based prevalence estimates for serious mental illness among adults 18 years or older (based on the National Survey on Drug Use and Health – NSDUH) to each respective state's 2013 federal census population (adults 18 years or older).

24 Based on an analysis by Cuddeback, G.S., Morrissey, J.P., & Meyer, P.S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806. The Cuddeback et al. estimate was applied to people with SMI, regardless of income level.

25 State-level figures are based on state authorized mental health services, including Medicaid enrollees, reported in the SAMHSA's NOMS system in 2012, retrieved from http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx.http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx

26 Teague & Monroe-DeVita (in press). Not by outcomes alone: Using peer evaluation to ensure fidelity to evidence-based Assertive Community Treatment (ACT) practice. In J. L. Magnabosco & R. W. Manderscheid (Eds.), *Outcomes measurement in the human services: Cross-cutting issues and methods* (2nd ed.). Washington, DC: National Association of Social Workers Press.

27 See for example, Latimer, E. (1999). Economic impacts of assertive community treatment: A review of the literature. *Canadian Journal of Psychiatry, 44*, 443-454.

28 Monroe-DeVita, M., Teague, G.B., & Moser, L.L. (2011). The TMACT: A new tool for measuring fidelity to assertive community treatment. *Journal of the American Psychiatric Nurses Association, 17*(1), 17-29.

promote high quality ACT services.[29] Key advantages of the TMACT model include:

- More specialized requirements for staffing and role functioning for peer, housing, and substance abuse specialists on the team.
- Dynamic caseload modeling that allows caseloads to flex up or down depending on levels of staffing. This allows more flexible service delivery than the Texas standards, as caseloads for a standard team of 100 could maintain full fidelity and range as high as 125 (thus allowing for more capacity, alongside the enhanced staffing requirements).
- TMACT also emphasizes movement on and off teams:
  - It requires teams operating below full capacity (TMACT Standard OS7) to "actively recruit[s] new consumers who could benefit from ACT, including assertive outreach to referral sites . . . [and] common referral sources and sites outside of usual community mental health settings (e.g., state and community hospitals, ERs, prisons/jails, shelters, street outreach)."
  - It also requires teams to work to graduate consumers to lower levels of care through "regular assessment of need for ACT services [for current team members]," "explicit criteria or markers for need to transfer to less intensive service option," and "gradual and individualized" transition "with assured continuity of care" and monitoring following transition, with "an option to return to team as needed" (TMACT Standard OS9).

Supported Housing (SH). Supported Housing (SH) (sometimes called Supportive Housing outside of Texas), involves a wide range of approaches and implementation strategies to effectively meet the housing needs of people with SMI. Supported Housing may include supervised apartment programs, scattered site rental assistance, and other residential options. The overall goal of Supported Housing is to help people find permanent housing that is integrated socially, reflects their personal preferences, and encourages empowerment and skills development. Program staff provide an individualized, flexible, and responsive array of services, supports, and linkages to community resources, which may include such services as employment support, educational opportunities, integrated treatment for co-occurring disorders, recovery planning, and assistance in building living skills. The level of support is expected to fluctuate over time.

DSHS defines Supported Housing as: "Activities to assist individuals in choosing, obtaining, and maintaining regular, integrated housing. Services consist of individualized assistance in finding and moving into habitable, regular, integrated (i.e., no more than 50% of the units may be occupied by individuals with serious mental illness), and affordable housing." The two main components of Supported Housing are:

- Funds for rental assistance as part of a transition to Section 8, public housing, or a plan to increase individual income so housing will become affordable without assistance.
- Services and supports to assist with locating, moving into, and maintaining regular integrated housing.

One major barrier to delivery of Supported Housing in Texas is that these services and supports cannot be billed as rehabilitative services, though concurrent rehabilitative training can be provided. As a result, there is a financial disincentive to deliver this service in Texas.

Supported Housing is a critical service for adults in poverty with SMI. A significant body of research demonstrates that people in Supported Housing experience reduced homelessness, increased residential stability, reduced recidivism to hospitalization and shorter lengths of stay, and reduced time spent incarcerated.[30] In Texas, Supported Housing is not a billable service in and of itself, either for Medicaid or for state funds. Instead, the services that support someone being successful in housing of their choice are often billable under rehabilitation as skills training or psychosocial rehabilitation. In addition, Targeted Case Management is billable and includes components of services that can be billed that help someone obtain or maintain housing.

29 The TMACT is currently the standard used in numerous states for statewide ACT implementation (e.g., Delaware, Indiana, North Carolina, Pennsylvania, and Washington).

30 See: Ridgeway, P. and Marzilli, A. (2006). Supported Housing and Psychiatric Disability: A Literature Review and Synthesis: Prepared for the Development of an Implementation Toolkit.

Data from Haven for Hope and CHCS indicate that in the most recent 12-month period for which data were available, nearly 2,000 people received supported housing in Bexar County. This level of development stands out as a best practice nationally, a higher level than any other major Texas community and comparable to best practice communities like Denver. While serving less than 10% of all people with SMI (and certainly less than current need), it is nonetheless a strong base to build upon.

Table 7: Adults with SMI (200% FPL) Known to Have Received Supported Housing (SH)

Region	Adult Need Under 200% FPL[31]	SH Service Units Delivered	Adults Receiving SH[32]	Percent of Need Receiving SH
United States	7,495,538	n/a	75,875	1.0%
Arizona	116,710	n/a	2,383	2.0%
Denver County	14,699	n/a	1,650	11.2%
New York State	459,945	n/a	4,983	1.1%
New York City	196,743	n/a	2,351	1.2%
Texas	531,573	n/a	7,826	1.5%
Bexar County	**34,817**	**1,607**	**1,982**	**9.8%**
Harris County	87,283	1,019	823	0.9%
Tarrant County	35,873	3,654	2,951 (est.)	8.2%
Travis County	21,673	301	243 (est.)	1.1%

Supported Employment (SE). Supported Employment promotes rehabilitation and a return to mainstream employment for people with SMI. Supported Employment programs integrate employment specialists with other members of the treatment team to ensure that employment is an integral part of the treatment plan. DSHS defines Supported Employment as: "Intensive services designed to result in employment stability and to provide individualized assistance to individuals in choosing and obtaining employment in integrated work sites in regular community jobs.

This includes activities such as assisting the individual in finding a job, helping the individual complete job applications, advocating with potential employers, assisting with learning job-specific skills, and employer negotiations."

A considerable body of research indicates that specific Supported Employment models, such as Independent Placement and Support (IPS), are successful in increasing competitive employment among adults with SMI.[33] In addition, the research consistently shows that Supported Employment is effective across a broad range of individual factors, such as diagnosis, age, gender, disability status, prior hospitalization, co-occurring substance use disorder, and education.[34]

31 When we have benchmarks for EBPs outside of Texas, we use the total estimated number of people with SMI in each region, applying a 58% factor based on Texas data to estimate the number who are living at/below 200% FPL, in order to better facilitate comparisons to the communities outside of Texas.

32 Generally, state-level figures are based on state authorized mental health services, including Medicaid enrollees, reported in the SAMHSA's NOMS system in 2012. Retrieved from http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx. New York State and New York City "Received SH" data were estimated based on average lengths of stay and quarterly capacity and occupancy data.

33 Drake, R.E., Becker, D.R., Clark, R.E. & Mueser, K.T. (1999). Research on the individual placement and support model of supported employment. Psychiatric Quarterly, 70, 289-301.

34 Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Co-Occurring Disorders: Supported Employment Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (Supported Employment Resource Kit).

As a result, best practices recommend providing Supported Employment to all individuals with mental illnesses and/or co-occurring disorders who want to work, regardless of prior work history, housing status, or other population characteristics.[35]

A review of three randomized controlled trials found that, in general, 60-80% of people served by a Supported Employment model obtain at least one competitive job.[36] Research suggests that about half of adults with SMI want to work.

In Texas, Supported Employment is not a billable service in and of itself, either for Medicaid (FFS or MCO) or for state funds. Instead, many services that support someone getting and keeping employment can be billable under rehabilitation as skills training or psychosocial rehabilitation, and formal vocational rehabilitation (VR) services must be coordinated with the Department of Assistive and Rehabilitative Services (DARS). One coordination issue involves the DARS intake and eligibility process, which often involves substantial delays and works optimally only where there are strong relationships between the mental health clinician and the DARS VR counselor. In a large system, this is particularly challenging. In addition, Targeted Case Management is billable and includes components of services that can be billed that help someone obtain or maintain housing. Under the new Medicaid 1915i State Plan Amendment that Texas had approved in late 2015, a more comprehensive and formal Supported Employment benefit will be available for eligible individuals.[37]

While the majority of people with serious mental illness are unemployed, and while a majority of them, when properly educated about their options, wish to be employed, fewer than 1,000 out of an estimated more than 15,000 in need of SE in Bexar County currently receive it.[38] As in other areas, Bexar County leads the other major urban communities of Texas in the amount of SE provided. Nevertheless, Bexar System Levels are not as high as those of some benchmark communities outside of Texas, such as Denver and Maricopa County (Phoenix).

Table 8: Adults with SMI (200% FPL) Known to Have Received Supported Employment (SE)[39]

Region	Adult Population Under 200% FPL	Adults Needing SE[40]	Adults Receiving SE[41]	Percent in Need Receiving SE
United States	7,495,538	3,364,000	54,190	1.6%
Arizona	116,710	54,333	12,137	22.3%
Maricopa Co. (Phoenix, AZ)	72,217	32,615	7,366	22.6%
California	552,096	249,340	893	0.4%
Colorado	123,567	55,806	1,380	2.5%
Denver County	14,699	6,639	680	10.2%
New York (state)	459,945	207,722	1,634	0.8%
Texas	531,573	240,071	4,525	1.9%

35 North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Mental Health Systems Transformation: Supported Employment Toolkit. Retrieved from http://www.governorsinstitute.org/index.php?option=com_content&task=view&id=32&Itemid=61&PHPSESSID=c0381139b8ae1fb19764f80bd8d57992.

36 New Freedom Commission on Mental Health (2003). Achieving the Promise: Transforming Mental Health Care in America. Final Report. Rockville, MD: DHHS Pub. No. SMA-03-3832 at 41, citing Drake, R.E., Becker, D.R., Clark, R.E., and Mueser, K.T. (1999). Research on the individual placement and support model of supported employment. Psychiatric Quarterly, 70, 289-301.

37 Texas Department of State Health Services (n.d.). Home and Community-Based Services – Adult Mental Health Billing Guidelines, pp. 41-46. Retrieved from https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589993416 on May 15, 2015.

38 The unemployment rate for people with SMI served in publicly funded mental health systems is approximately 90%, but research shows about 50% of people with SMI want vocational help. These rates were applied to SMI prevalence (using the 200% FPL) to determine estimated need for SE.

39 FY14 data for LMHAs received through personal communication with DSHS on January 15, 2015. Texas data are from FY2014. Data for communities outside of Texas are from 2013 from Arizona, Colorado, and for New York and California are from 2012 for population data and 2013 for the number of people receiving Supported Employment.

Region	Adult Population Under 200% FPL	Adults Needing SE[40]	Adults Receiving SE[41]	Percent in Need Receiving SE
Bexar County	**34,817**	**15,414**	**982**	**6.4%**
Harris County	87,283	37,305	1,287	3.4%
Tarrant County	35,873	16,754	784	4.7%
Travis County	21,673	9,984	270	2.7%

Peer Support. A key best practice in service delivery is the use of peer support through certified peer specialists and family partners. Certified peer specialists are individuals who have lived the experience of dealing with a serious mental illness and receiving treatment. In the case of family partners, these individuals have parented a child with SED. In both cases, they have received training and certification to use their experience to help others feel a sense of hope and assist with practical support as the people they serve go through a similar experience.

Peer Support has been designated as an evidence-based model since 2007 by the federal Centers for Medicare and Medicaid Services,[42] and there is good evidence of its effectiveness[43] and emerging evidence of its cost-effectiveness.[44] However, Texas has relatively few peer providers compared to other states. According to the HB 1023 report, as of January 2014, Texas had 333 certified peer specialists, 99 certified family partners, and "over 300" recovery coaches, for a total of just over 700 peer providers (2.75 per 100,000 Texans). By comparison, Pennsylvania has over 9.0 peers per 100,000 population.

Table 9 shows the number of certified peer specialists who have been trained in each county, which is different than the number employed by the LMHA. Note that Bexar County falls into the mid-range in terms of the number of certified peer specialists per 100,000 people in need, compared to other Texas communities. Together, CHCS and Haven for Hope provided Peer Support to 2,346 people. It is hard to draw comparison to other communities, as the only data reported across LMHAs is the number of Peer Support Service Units provided and it is not consistently tracked. Based on our review, like in most communities across the nation, there is an opportunity to expand the peer work force further and there is also a broader opportunity to integrate peer service delivery into clinical operations more comprehensively.

40 The unemployment rate for people with SMI served in publicly funded mental health systems is approximately 90%, but research shows about 50% of people with SMI want vocational help. These rates were applied to SMI prevalence of each region to determine estimated need for supported employment.

41 State-level figures are based on state authorized mental health services, including Medicaid enrollees, reported in the SAMHSA's NOMS system in 2012. Retrieved from http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx.http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx.

42 See State Medicaid Director Letter #07-011 at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf.

43 Hogg Foundation for Mental Health (2014, October). Peer Support Services Outcomes.
Davidson L, Bellamy C, Guy K, Miller R. Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry,* Jun 2012;11(2):123-128.
Sledge, W., Lawless, M., Sells, D., Wieland, M., O'Connell, M., & Davidson, L. (2011.) Effectiveness of peer support in reducing readmission of persons with multiple psychiatric hospitalizations. *Psychiatric Services*, (62)5, 541-544.

44 Trachtenberg, M., Parsonage, M., Shepherd, G., Boardman, J. (2014.) Peer support in mental health care: Is it good value for money? Centre for Mental Health. Retrieved from http://www.centreformentalhealth.org.uk/pdfs/peer_support_value_for_money_2013.pdf.
Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S.E., Ryan, R., Berends, L. (2013.) Consumer-providers of care for adult clients of statutory mental health services. Cochrane Database Syst Rev. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23203360.

Table 9: Peer Support Services Units Delivered by LMHAs to Adults, FY 2014

Region / County	Adult Need Under 200% FPL	Trained Peer Specialists[45]	Specialists per 100,000 in Need
Texas	**531,573**	**333**	62.6
Bexar County	**34,817**	**45**	**128.9**
Harris County	87,283	68	77.9
Tarrant County	35,873	62	172.8
Travis County	21,673	60	276.8

Finding N-3: Core Public Outpatient System Capacity for Children With Severe Needs

For children in poverty (family incomes below 200% FPL) with severe needs, the core capacity for outpatient services is comprised of Clarity Child Guidance Center as the leading children's psychiatric provider and the Center for Health Care Services (CHCS) as the leading provider of intensive community based supports. While Medicaid providers also undoubtedly serve many additional children in poverty with mental health needs, data were not available, so our primary focus was on these two providers. Collectively, these two providers currently see just over one-fifth (4,796 or 22.3%) of children in poverty with severe needs (21,483), and the number is in fact even lower given that some children receive services from both providers. While a very low level of service overall, of equal concern is the fact that relatively few children receive the intensity and level of care necessary in the community, with less than 5% of children in need of intensive, community-based supports able to receive such care through CHCS or community providers, leading to an overreliance on juvenile justice, child welfare, and specialty school placements.

Below we have summarized the estimated number of people in need served in outpatient care. We have compared Bexar County and Harris County because we have data our comprehensive assessments in both counties. All Harris County data are taken from the MMHPI report, Review of Harris County Mental Health Systems Performance: Final Report, May 2015.

Table 10: Children Served by Core Public Providers vs. Children in Need of Care, FY 2014

Adults Served	Bexar	Harris	Comments
Need: Children in Poverty with Severe Needs (SED 200% FPL Population)	**21,483**	**56,044**	Rounded to nearest thousand for ease of comparison.
Received Public Mental Health Outpatient Services at Any Level	**4,796**	**12,168**	Estimate of unduplicated cases served by core system. Does not include University Health System
Clarity Child Guidance Center	2,878	n/a	Total served in outpatient care.
Local Mental Health Authority (CHCS in Bexar, MHMRA in Harris)	1,918	3,947	Total served in ongoing levels of care.
Health District (University Health System in Bexar, Harris Health in Harris)	Not Provided	8,221	Only children with severe needs (e.g., SED). Does not include University Health System.
Percent of Severe Need in Poverty Served by Core Public Providers	**22.3%**	**21.7%**	Not necessarily served at right level of care. Does not include University Health System

45 Number of FY14 trained peer support specialists by county (not LMHAs). Data obtained on February 13, 2015 via personal communication with Dr. Stacey Manser, University of Texas. Number of Peer Specialists at the LMHA is different.

We also looked more specifically at the levels of care provided to children in both systems. While Clarity serves more children, it is organized primarily to provide office-based outpatient and facility-based intensive services (e.g., partial hospitalization and inpatient care). As a result, CHCS still provides much of the community-based capacity for children with intensive needs at risk of out-of-home placement, similar to other communities across Texas.

As a point of comparison, the following tables provide a comparison of services provided by CHCS and three other urban Texas Counties: Harris, Tarrant and Travis. MMHPI obtained FY 2014 data on these services from DSHS for CHCS and comparison LMHAs, and this is summarized in the following tables. Unlike the case with adult services, Bexar County ranks on the lower end of the continuum among large counties in Texas. Similar to two of the other comparison counties, CHCS meets under 10% of the estimated need, while Travis County sets the bar on the higher side of met need.

Table 11: Unduplicated Number of Children with SED in Poverty Served by LMHA, FY 2013-14

County	Child Population Under 200% FPL	Children with SED Under 200% FPL	Children Served in Ongoing Treatment	Percent	Percent Medicaid
Bexar	**238,470**	**21,483**	**1,918**	**9%**	**75%**
Harris	619,683	56,044	3,947	7%	74%
Tarrant	39,006	21,568	2,060	10%	82%
Travis	240,450	10,703	1,657	15%	67%

As with adults, all LMHAs in Texas provide defined Texas Resiliency and Recovery (TRR) levels of care (LOCs) to children. The LOCs are broken into graduated levels of intensity to meet the various levels of service needs of children and adults entering the public mental health system. There are four primary child LOCs for ongoing mental health services:

- Medication Management (C1): This is the lowest level of service, typically involving less than an hour of care per month, generally for children who are stable and in a maintenance phase needing only medication or low levels of psychosocial or case management supports. A child with SED would need to be relatively stable to receive this LOC.
- Targeted (C2): This adds two to three hours of family / individual counseling or skills training to the mix. This is for children primarily in need of treatment with low levels of functional impairment. As with Medication Management, a child with SED would need to be relatively stable functionally to receive this LOC.
- Complex (C3): This is a more intense level of care for children with functional impairments in need of active treatment and psychosocial skills interventions aimed at preventing juvenile justice involvement, expulsion from school, displacement from home, or worsening of symptoms or behaviors. Most children with SED who are not stable would need this level of care.
- Intensive Family Services (C4): This is the highest level of service intensity for children, generally for children with significant involvement with multiple child serving systems. It involves intensive family-focused treatment (target of two or more hours per week on average), generally delivered in the home or community. The level of functional impairment must be high, resulting in (or at least likely to result in) juvenile justice involvement, expulsion from school, out-of-home placement, hospitalization, residential treatment, serious injury to self or others, or death.

Children and families also have access through LMHAs to two specialized levels of care:

- Young Child Services (YC): These are services for children ages three to five with a particular focus on the relationship between the parent and child.

- Youth Empowerment Services (YES) Waiver (YES): In a growing number of Texas counties, including Bexar County, YES Waiver services are available. LMHAs coordinate the care and provide high-fidelity wraparound planning and service coordination, but the additional supports are provided by non-LMHA providers. YES Waiver home and community-based supports are only available for Medicaid recipients. In addition to regular Medicaid services, waiver participants are eligible for other services as needed, including respite care, adaptive aids and supports, community living supports, family supports, minor home modifications, non-medical transportation, paraprofessional services, professional services, supportive employment services, supportive family-based alternatives, and transitional services.

In addition to these ongoing treatment levels, LMHAs also provide:

- Crisis Response: This is the initial response to a crisis, either through mobile crisis or services at a facility and can involve up to six days of follow-up.
- Transitional: This involves up to 90 days of additional transition services until the situation is resolved.

Looking at the distribution of children and youth served across the TRR ongoing levels of care we find that, just as with adults, CHCS tends to serve children and their families in higher levels of care – 27% are served in the two most intensive LOCs (Complex Services and Intensive Family). Tarrant County's LMHA provides intensive services at about the same level as does CHCS, but Harris and Travis tend to serve far fewer at the more intensive levels.

Table 12: LMHA Child and Youth Levels of Care Analysis

LMHA	Crisis Continuum		Ongoing TRR Treatment Levels				Specialized	
Level of Care[46]	Crisis	Transition	Medication Management	Targeted Services	Complex Services	Intensive Family	YES Waiver	Young Child
Bexar	448	16	487	1,258	601	54	104	136
% of LOCs			20%	52%	25%	2%		
Harris	638	61	707	3,303	668	33	171	228
% of LOCs			15%	70%	14%	1%		
Tarrant	56	19	1,285	981	363	52	163	139
% of LOCs			48%	37%	14%	2%		
Travis	254	133	670	890	352	90	132	81
% of LOCs			33%	44%	18%	5%		
Total	**1,396**	**229**	**3,149**	**6,432**	**1,984**	**229**	**570**	**584**
% of LOCs			*27%*	*55%*	*17%*	*2%*		

However, relatively few children served by any LMHA receive the kind of intensive family-based services research has found are necessary to avoid out-of-home treatment. Based on our work in multiple states (WA, MA, CT, NE, and PA) that implement intensive services for those children with SED most at risk for out-of-home placement, the MMHPI team estimates that one in 10 children with SED at any one time (approximately 2,200) would require intensive services (LOC C4) and YES Waiver services. As noted in Table 12, CHCS served only 54 children at the C4 (Intensive Family) level of care in 2014. To the extent that CHCS is the only provider of such intensive community-based services (and our interviews suggest that it is), this represents a dramatic gap, with only one in 40 children with such severe needs receiving care.

46 The "% of LOCs" include all LOCs that provide ongoing outpatient care for children.

Similarly, only 48 children to date have received YES Waiver services, which provide the kinds of wraparound coordination and non-clinical supports necessary to prevent out-of-home placement. Based on our work in those same other states (WA, MA, CT, NE, and PA), it is likely that – among the 2,200 in need of intensive supports – somewhere between 800 to 1,200 of the most functionally impaired children and their families in Bexar County would need wraparound and the broader YES Waiver service array, which are only available through CHCS (CHCS is the coordinating entity and wraparound provider and works with a network of providers). Since this is a Medicaid benefit, funding theoretically should be available to serve every one of these children. However, capacity would need to increase many times over to meet the demand estimated by MMHPI

The YES Waiver array includes delivery of fidelity-based Wraparound Service Coordination (based on the standards of the National Wraparound Initiative). This support is delivered by CHCS and involves an integrated care coordination approach for children involved with multiple systems and at the highest risk for out-of-home placement.[47] Wraparound is not a treatment per se. Instead, wraparound facilitation is a care coordination approach that can fundamentally change the way in which individualized care is planned and managed across systems.

The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, compared to traditional treatment planning, has been shown to result in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network. The wraparound process also centers on intensive care coordination by a child and family team (CFT) coordinated by a wraparound facilitator. The family, the youth, and the family support network comprise the core of the CFT members, joined by parent and youth support staff, providers involved in the care of the family, representatives of agencies with which the family is involved, and natural supports chosen by the family. The CFT is the primary point of responsibility for coordinating the many services and supports involved, with the family and youth ultimately driving the process. The wraparound process involves multiple phases over which responsibility for care coordination increasingly shifts from the wraparound facilitator and the CFT to the family.[48]

Family Partner Services (Peer Support). Additional analysis of levels of care for children includes data on family partner services, a subset of peer support provided to and delivered by family members of children with SED. Increasingly, collaboration and partnership between families, youth and service providers have been recognized as the threads that link successful programs, policies, and practices. A recent literature review sponsored by the University of South Florida Research and Training Center for Children's Mental Health provides synthesis of available evidence for the approach.[49] MMHPI was able to obtain data from the University of Texas on the number of certified family partners (CFPs) and data from DSHS on CFP Service Units, which are summarized in the table that follows. At the time of this report, data from CHCS was unavailable for the number of unique families that received a CFP service, so we used the proportion of units to people for Harris County to estimate the number of people receiving CFP in other Texas counties. It is evident that CHCS is actively pursuing the use of CFPs and has historically been a state leader alongside other large urban LMHAs in hiring and deploying CFPs.

47 Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004). Ten principles of the wraparound process. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.
Aos, S., Phipps, P. Barnoski, R., & Lieb, R. (2001). The Comparative Costs and Benefits of Programs to Reduce Crime. Olympia: Washington State Institute for Public Policy.
Hoagwood, K., Burns, B., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52:9, 1179-1189.

48 For additional information on the phases of the wraparound process, see information at http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf

49 Robbins, V., Johnston, J., Barnett, H., Hobstetter, W., Kutash, K., Duchnowski, A. J., & Annis, S. (2008). Parent to parent: A synthesis of the emerging literature. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies.

Table 13: Family Partner Services Units Delivered by LMHAs in FY 2013-14

Region / LMHA	Child Need in Poverty	CFPs FY13[50]	CFPs FY14[51]	# Receiving CFP	% of Need Receiving CFP	CFP Units[52]
Bexar County	**21,483**	**7**	**8**	***227 (est.)***	***1.0% (est.)***	**817**
Harris County	56,044	4	9	1,376[53]	2.5% (actual)	4,954
Tarrant County	21,568	3	4	*388 (est.)*	*1.8% (est.)*	1,398
Travis County	10,703	3	1	*82 (est.)*	*0.8% (est.)*	296

Finding N-4: Public Inpatient and Crisis System Capacity

One consistent report across stakeholders is that Bexar County lacks sufficient inpatient capacity to serve the demand of its population base. Our analysis suggests that this is less a function of insufficient inpatient programming, but rather due to two factors: (1) a lack of resources for inpatient care for people without insurance and (2) a lack of coordination among inpatient, crisis, and emergency room providers at a system level.

While Bexar County has made a concerted effort over the past decade to develop its behavioral health crisis services and create alternatives to incarceration and psychiatric hospitalization, crisis diversion programs tend to be facility specific, focusing on the diversion needs of a given provider or subset of providers, rather than the community as a whole. As a result, the array of crisis services does not function as a system with defined pathways, which leads to redundant backups that prevent people from getting the right service at the right time, including at times psychiatric hospitalization. Development of a coordinated crisis response system across all payers, including Medicaid managed care organizations (MCOs), is essential to make best use of limited inpatient and other high cost resources. Note that the crisis array should ideally be jointly funded across all payers (e.g., state, Medicaid, local, private) in order to optimize efficiencies and economies of scale, rather than each funding stream supporting a separate crisis care continuum. The HHSC Sunset Commission report in Recommendation 6.1 for Issue 6 prioritized such cross-payer crisis coordination.[54]

Adult Inpatient Care. As noted previously in the needs section of the report, lack of access to inpatient beds is a problem across the state that has been studied in depth. The state reports reviewed in that section suggest that Bexar County needs between 350 and 400 publicly and privately funded beds. Current public and private inpatient capacity is summarized in Table 14 below, describing capacity of over 500 inpatient beds in the community. While on first glance this appears to be sufficient, it is not so given multiple complicating factors.

50 Number of certified family partners by LMHA. Data obtained on February 13, 2015, personal communication with Dr. Stacey Manser, University of Texas.

51 Number of certified family partners by LMHA. Data obtained on February 13, 2015, personal communication with Dr. Stacey Manser, University of Texas. According to DSHS data, MHMRA of Harris County had no turnover in CFPs from FY13 to FY14. MHMRA also reported nine CFPs on staff in December, 2014.

52 Data are number of children's services delivered, by LMHA, that were coded as "Family Partner" in FY 2014. Data received from DSHS on February 20, 2015. Service provided by CFPs may in many instances be coded as something other than "Consumer Peer Support."

53 Data received from MHMRA of Harris County in December, 2014.

54 Sunset Advisory Commission (2015, February). Report to the 84th Legislature (see page 15). Retrieved from https://www.sunset.texas.gov/public/uploads/u64/Report%20to%20the%2084th%20Legislature.pdf

Table 14: Capacity Among Adult Inpatient Providers in Bexar County

Adults Inpatient Providers and Facilities[55]	Psychiatric Beds	SUD Inpatient Beds
San Antonio State Hospital[55]	163.6	n/a
Nix Health System[57]		n/a
Adult – Moderate Acuity (Nix Behavioral Health Center)[58]	42	n/a
Adult – High Acuity[59] (Nix Specialty Health Center)	74	n/a
Geriatric (Nix Specialty Health Center)	18	n/a
Geriatric (Nix Medical Center – Downtown)	15	n/a
University Hospital System[60]	20	n/a
Southwest General Hospital[61]	48	n/a
Baptist Medical Center[62]		n/a
Adult	23	n/a
Geriatric	11	n/a
Methodist Hospital (Adult and Geriatric)[63]	60	14
Laurel Ridge Treatment Center (Adult and Chemical Dependency)[64]	16	16
San Antonio Behavioral Healthcare Hospital (Adult and Chemical Dependency)[65]	32	18

First among the complicating factors, Bexar County is part of a broader region and people from surrounding counties regular access these services. Second, and more critically, a high proportion of emergency room and inpatient need falls among people without insurance, and state-funded inpatient capacity is just under 183 beds currently (state-funded contract beds through CHCS were increased by five for FY 2016). Third, both the CannonDesign and the HB 3793 Task Force reports documented the challenges of forensic use of civil beds, with most of the 152.7 San Antonio State Hospital beds filled on any given day by court ordered and forensic cases. This court involvement considerably complicates discharge planning and timely access to community step-down development. Finally, Bexar County's population continues to grow and the challenge of efficiently using current inpatient capacity will grow commensurately.

55 Source: Unless otherwise noted, capacity data comes from the DSHS 2014 Hospital Survey.

56 Sources: Texas DSHS. (2015). *2014 DSHS/AHA/THA Annual Survey of Hospitals*. Published at http://www.dshs.state.tx.us/chs/hosp/hosp2.aspx; DSHS and CHCS report of current allocation; Note: San Antonio State Hospital operates just over 300 beds, but just under 153 beds on average are allocated for the use of Bexar County.

57 Source: Nix Health

58 16 of these beds are in the psychiatric emergency services unit.

59 Source: CHCS; Notes: In FY 2015, this included 25 beds purchased by CHCS using state funds; in FY 2016, the number of beds increased to 30, but are now purchased at Nix Health and Southwest General.

60 Source: University Health System documentation

61 Note: Beginning in FY 2016 with the expansion of beds purchased by CHCS using state funds from 25 to 30, CHCS began to also purchase beds within the 30-bed total from Southwest General in addition to Nix Health.

62 Source: Interview with CEO Jonathon Turton, November 4, 2015.

63 Source: Texas DSHS. (2015). *2014 DSHS/AHA/THA Annual Survey of Hospitals*. Published at http://www.dshs.state.tx.us/chs/hosp/hosp2.aspx; data confirmed with facility.

64 Source: Texas DSHS. (2015). *2014 DSHS/AHA/THA Annual Survey of Hospitals*. Published at http://www.dshs.state.tx.us/chs/hosp/hosp2.aspx; data not able to be confirmed with facility.

65 Source: Texas DSHS. (2015). *2014 DSHS/AHA/THA Annual Survey of Hospitals*. Published at http://www.dshs.state.tx.us/chs/hosp/hosp2.aspx; data confirmed with facility and updated, as they differed from the survey data.

One result of this is inefficient use of current resources. Data from DSHS on the use of state operated and purchased psychiatric facilities by the state's five largest counties. Based on this comparison, Bexar County relies to a much larger degree on state-funded hospital capacity per person in need than the comparison counties, with the exception of Dallas's NorthSTAR program. This suggests both a lack of access to non-state operated facilities and barriers to discharge among those using San Antonio State Hospital. It should also be noted that the data below pre-date the development of the Nix Health resources. However, our analysis of current utilization of Nix Health suggests that those resources continue to be under-utilized.

Table 15: State-Operated Psychiatric Hospital Days by Age, FY 2014[66]

Age Group	Bexar	Harris	Dallas (NorthSTAR)	Tarrant	Travis
Adult	**47,481**	**69,390**	**109,760**	**41,820**	**32,490**
Days per 1000 per SMI in Need	1,360.0	795.0	2,028.4	1,165.8	1,499.1
SMI <200% FPL	34,817	87,283	54,112	35,873	21,673
Geriatric	**14,040**	**7,975**	**9,504**	**2,592**	**3,792**
Days per 1000 per SMI in Need	402.1	91.4	175.6	72.3	175.0
SMI <200% FPL	34,817	87,283	54,112	35,873	21,673

However, as noted above, the availability of intensive treatment and crisis services can mitigate this need. The data under Finding N-2 above underscored the dramatic lack of intensive treatment capacity for adults, particularly for "super-utilizers" of crisis, emergency room, and inpatient care. It is likely that more capacity in this area (both intensive treatment and housing supports), targeted toward those with the highest needs using inpatient care, could reduce pressure on inpatient facilities, as well as the flow of people with SMI into the Bexar County Jail.

Another major indicator showing system needs involves lengths of stay in inpatient facilities. Comparison data, as summarized in the table below, shows that Bexar County adult and geriatric patients have relatively longer lengths of stay (with the exception of Harris County) than those in other large Texas communities This could be due in part to higher needs and greater complexity. It is also likely related to the lack of intensive treatment capacity and other supports in the community.

Table 16: State-Operated Psychiatric Hospital Average Lengths of Stay (Days) by Age Group, FY 2014[67]

Age Group	Bexar	Harris	NSTAR	Tarrant	Travis
Adult	**119**	257	64	123	57
Geriatric	**936**	1,595	352	144	316

Adult Crisis Services. Insufficient inpatient capacity, much of which is filled with forensic commitments, combined with the shortage of intensive outpatient services contributes to crisis services being backed up at times and people not receiving the right care at the right time. Long waits and backups in emergency room settings were reported by all inpatient systems, though each also has developed system-specific strategies to expedite assessment of behavioral cases in an effort to reduce time spent in the emergency room.

66 Data received through personal communication with DSHS on February 13, 2015. Data are for LMHAs and for NorthSTAR. Data were calculated by multiplying the number of admissions in FY14 by the Average Length of Stay.

67 Data received through personal communication with DSHS on February 13, 2015. Data are for LMHAs and for NorthSTAR.

While it is clear that Bexar County crisis services have received considerable attention and resources over the past decade, it was equally clear that the crisis services do not operate as a coordinated system. Every hospital provider reported continued back-ups in emergency rooms, and they are generally addressing this by focusing on their own diversion needs, rather than the community as a whole. Medicaid MCOs reported that members are frequently being admitted to multiple inpatient units prior to notification of the MCO, resulting in lost opportunities to divert members into intensive outpatient settings (or to identify needs for additional diversion capacity). A lack of timely data and data sharing across hospital systems limits the ability of any given provider to know what settings are available to receive individuals based on the level of acuity. A common framework and guideline for obtaining or performing medical clearance is currently not evident across all service providers (a topic which is further described in this report).

One additional complicating factor is the lack of geographic access to services. Like many communities, Bexar crisis facilities are not well dispersed geographically for a county of 1240 square miles, making access dependent on transport primarily by law enforcement and other emergency responders. This is in contrast to emergency response systems like Police, EMS and the Fire Department where there are multiple stations dispersed throughout the county. Analysis of emergency room utilization in FY2013 for the five largest Texas counties suggests that Bexar County has similar emergency room use as comparison counties, as seen in the following table. Bexar County falls just below the middle of the range, but visits are high.

Table 17: Estimated ED Visits for Mental Health Crisis, Relative to Estimated Prevalence of Adults with SMI[68]

Population	Bexar	Dallas	Harris	Tarrant	Travis
Visits	**22,087**	41,623	37,881	38,126	12,483
Adults with SMI – 200% FPL	**34,817**	54,112	87,283	35,873	21,673
Visit per 1000 Adults in Need	**634.4**	769.2	434.0	1062.8	576.0

As noted in Table 18, Bexar County has developed a broad array of crisis services, including crisis stabilization programs, detoxification programs, mobile crisis units, and transition services, summarized in the following table.

68 Emergency Department (ED) data for both mental health and substance abuse are from: Meadows Mental Health Policy Institute and Texas Conference of Urban Counties. (2015). *Survey of County Behavioral Health Utilization.* Unpublished Document. Dallas, TX: Meadows Mental Health Policy Institute.

Table 18: Adult Crisis Services in Bexar County

Adult Crisis Services	Number of Beds/Slots	Number Served Per Year	Provider
Jail/Prison/Juvenile Detention-based Services[69]	n/a	11,250 (6,750 with SMI)	University Health System
Emergency Detentions	n/a	2,706[70]	University Health System
Mobile Assessment Team	n/a	n/a	Nix
Admission Unit[71]	n/a	n/a	Nix
Psychiatric Emergency Services	16 beds	1,081 patients	Nix
Crisis Inpatient Unit (CIU)	16 beds	315 visits	Nix
Restoration Center: Psychiatric Emergency Room Services[72]	25 beds	4,212	CHCS
State Bed Authorizations		3,613	CHCS
Emergency Detentions Brought In		1,435	CHCS
Voluntary to Involuntary Emergency Detentions Brought In		88	CHCS
Mental Health Warrants (Law Enforcement Brought In)		5	CHCS
San Antonio State Hospital	28 beds	2,260 admissions	CHCS
Restoration Center: Detox Services RC[73]	28 "beds"	7,120 admissions	CHCS
Restoration Center: Substance Abuse Public Sobering Unit- RC[74]	n/a	2,440[75]	CHCS
Crisis Stabilization Unit/MCOT			CHCS
Transitional Crisis Units[76]			CHCS
Josephine Recovery Center	16 beds	558	CHCS
Cloudhaven	16 beds	81	CHCS
Crisis Line[77]		13,334	CHCS
Crisis Services - Total Placed Under Observation[78]		3,108	CHCS
Crisis Stabilization	260 beds	n/a	Haven for Hope
Homeless Services and Outreach	4,000 beds	3,687	Haven for Hope

69 University Health System. (August, 2015). Presentation for Senator John Cornyn Mental Health Roundtable. FILE: University Health System Meadows.pdf (page 21). Note: Based on presentation, 60% have SMI.
70 University Health System. (August, 2015). Presentation for Senator John Cornyn Mental Health Roundtable. FILE: University Health System Meadows.pdf (page 21).
71 Interview notes: admissions unit has capacity to provide mobile crisis assessment 24/7, all over the County.
72 Data provided by Restoration Center (Sylvia Soriano). Reporting period includes September 2014 through August 2015.
73 Data provided by Restoration Center (Sylvia Soriano). Reporting period includes September 2014 through August 2015.
74 Data provided by Josie Alcala, Northwest Clinic Administrator, September 15, 2015. The sobering unit "beds" include 13 beds, 3 mats, 3 sleeper chairs and 9 chairs for a total of 28 slots – data provided from correspondence with the Restoration Center (Sylvia Soriano).
75 Data provided by Restoration Center (Sylvia Soriano). Reporting period includes September 2014 through August 2015.
76 Smith, A. (2015). Mental Health Consortium Meeting Invitation. FILE: CMDRTReportsSeptember22,2015.pdf
77 Total calls (28,029) minus non-assessment/information only calls (14,695) FILE: CMDRTReportsSeptember22,2015.pdf
78 Smith, A. (2015). Mental Health Consortium Meeting Invitation. FILE: CMDRTReportsSeptember22,2015.pdf

Child and Adolescent Inpatient and Crisis Services. Unlike adult inpatient capacity, there have not been recent state or local analyses to determine a benchmark for sufficient local resources. Bexar County is fortunately to have a large, highly respected child provider such as Clarity in the community, and multiple other hospitals also provide child and adolescent inpatient capacity, as summarized in the table below.

Table 19: Capacity Among Child and Adolescent Inpatient Providers in Bexar County

Adults Inpatient Providers and Facilities[79]	Psychiatric Beds
Clarity Child Guidance Center[80]	
Acute Psychiatric	87
Residential / Subacute[81]	5
San Antonio State Hospital (Adolescent[82])	30
Nix Health (Child and Adolescent)	31
Laurel Ridge Treatment Center (Child and Adolescent, Acute and Residential)[83]	160
San Antonio Behavioral Healthcare Hospital (Adolescent)[84]	46

However, despite this considerable capacity, Bexar County continues to rely on state-operated facilities more than all but one comparison community, as summarized in the table below.

Table 20: State-Operated Psychiatric Hospital Days for Children and Adolescents, FY 2014[85]

Age Group	Bexar	Harris	Dallas (NorthSTAR)	Tarrant	Travis
Child/Adolescent	**5,184**	**1,900**	**13,572**	**4,160**	**1,288**
Days per 1000 per SED in Need	238.0	33.9	383.8	192.9	120.3
SED <200% FPL	21,483	56,044	35,365	21,568	10,703

On the positive side, the table below shows that children and adolescents at the state-operated facility for Bexar County have significantly shorter lengths of stay. The shorter lengths of stay in state-funded inpatient settings may be due to alternative inpatient beds such as those provided by Clarity.

79 Source: Unless otherwise noted, capacity data comes from the DSHS 2014 Hospital Survey
80 Source: Clarity Child Guidance Center
81 Clarity does not have designated "acute" and "sub-acute" beds. However, approximately 90% of the patients are considered "acute."
82 Source: DSHS report; Note: San Antonio State Hospital operates 30 adolescent beds; these are managed separately from the overall allocation and none are "set aside" for Bexar County (all state hospital child and adolescent beds are available to anyone in need statewide).
83 Source: Texas DSHS. (2015). 2014 DSHS/AHA/THA Annual Survey of Hospitals. Published at http://www.dshs.state.tx.us/chs/hosp/hosp2.aspx; data not able to be confirmed with facility.
84 Source: Texas DSHS. (2015). 2014 DSHS/AHA/THA Annual Survey of Hospitals. Published at http://www.dshs.state.tx.us/chs/hosp/hosp2.aspx; data confirmed with facility and updated, as they differed from the survey data.
85 Data received through personal communication with DSHS on February 13, 2015. Data are for LMHAs and for NorthSTAR. Data were calculated by multiplying the number of admissions in FY14 by the Average Length of Stay.

Table 21: State-Operated Psychiatric Hospital Average Lengths of Stay (Days), FY 2014[86]

Age Group	Bexar	Harris	NSTAR	Tarrant	Travis
Child/Adolescent	32	100	116	130	46

A partial continuum of crisis and step-down services for children, youth and families is available. Clarity operates partial hospital services that can serve as both a step-down and alternative to inpatient care. CHCS provides crisis respite and response, but only a relatively small number of children are served over a 12-month period.

Table 22: Child Crisis Services

Child Crisis Services	Number Served Per Year	Provider
Partial Hospital[87]	293[88]	Clarity
Crisis Respite Residential Center[89]	133	CHCS
Crisis Response Program/Hotline[90]	974	CHCS

Best practice communities outside of Texas (e.g., Milwaukee, WI) operate a much fuller continuum of crisis response, inclusive of multi-agency mobile supports and short- to intermediateterm, local out-of-home options, including respite, psychosocial and behavioral health interventions for youth and their families should include:

- A multi-agency mobile crisis team for children and families, with the capacity to provide limited ongoing in-home supports, case management and direct access to out-of-home crisis supports for children involved in any child-serving system, including mental health, child welfare and juvenile justice (Wraparound Milwaukee's Mobile Urgent Treatment Team / MUTT offers a best practice example[91], but it has been rarely replicated nationally).
- An array of crisis supports tailored to the needs and resources of the local system of care, including an array of options such as:
  - Crisis foster care (a few days up to 30 days),
  - Crisis group home (up to 14 days),
  - Crisis respite (up to three days),
  - Crisis runaway shelter (15 days),
  - Crisis stabilization (30 – 90 days) with capacity for 1:1 mental health crisis intervention,
  - Crisis supervision (30 – 90 days) to maintain safety in the community,
  - Placement stabilization center, providing out-of-home respite,
  - Acute inpatient care, and
  - Linkages to a full continuum of empirically supported practices.

86 Data received through personal communication with DSHS on February 13, 2015. Data are for LMHAs and for NorthSTAR.
87 Partial hospital program is provided at two (2) different Clarity locations.
88 Unduplicated count. There were 316 total admissions.
89 CHCS. (n.d.) (Poster Presentation). Crisis-Respite Residential Center. Projected total 12-month served). FILE: CBH (Crisis Respite Residential Center) 2015 07-13-15.pdf
90 Restoration Center. (May, 2015). Restoration Center Report: Community Medical Directors. (Annualized estimates for Crisis Helpline calls for children with mental health needs). FILE: CMDRT slides May 2015 data Final. Slide 9
91 For more information, see: http://wraparoundmke.com/programs/mutt/. While the MUTT model has not been demonstrated at the level of an EBP, it is widely cited as a best practice and has been the basis of EPSDT settlements in Massachusetts (Rosie D.) and many other positive systems reforms for children's systems of care nationally.

Finding N-5: Public Funds Available for Behavioral Health Services

Expenditures of over $220 million for behavioral health services were made in FY 2014, including estimates of jail and ER costs and not including Medicaid funding outside of CHCS, Clarity, University Health System internal spending, or expenditures by several other providers. Most notably lacking was coordinated planning across the major payers for public mental health – state general revenue, Medicaid, Delivery System Reform Incentive Payment (DSRIP), county expenditures, and local private funders (both foundations and contributors to uncompensated care). Such planning is essential to making best use of these considerable, but nonetheless limited, resources.

Funding for mental health services is difficult to determine due to the variety of funding streams and the ability to access the information, and only CHCS, Clarity, and University Health System provided data on expenditures (and University Health System data was only for external contracts). However, even these partial reports show that substantial amounts are being spent currently on mental health and substance abuse services in Bexar County.

The following table summarizes all CHCS spending, Clarity, University Health System external spending, and DSRIP spending, totaling just under $105 million a year in FY 2014.

Table 23: Partial Data on FY 2013/2014 on Annual Behavioral Health Funding in Bexar County

Funding Source	Expenditures / Valuation[92]	Comment
CHCS	$80,597,569	All FY 2014 funding and revenue sources reported through DSHS, including IDD and non-mental health services. See the next table for details.
Clarity	$19 million	This came from Clarity's 2014 annual report (2013 data)
University Health System		
Programs	Not Available	This is the cost of inpatient, emergency and outpatient programs operated by University Health System.
Carelink Contract	$500,000	Estimated portion for FY2014 from overall $1,034,726 in funding since 2011. Includes base agreement for detox and SUD services, plus fee-for-service component.
CHCS Local Match	$1,758,274	This is also included above in the CHCS line as a revenue source, but was not double counted in total.
Other CHCS	$657,885	Includes Mommies Program (methadone program) and methadone pharmacotherapy costs (also included in CHCS line).
1115 Waiver DSRIP Projects[93]	$23,809,665	Valuation of all behavioral health projects in DY 4 (October 2014 to September 2015). This includes $17 million from CHCS to Nix for their PES and CIU programs.
Total	**$123,907,234**	University Health System funds included in the CHCS line as a revenue source were not double counted in total.

A detailed breakout of the FY14 CHCS expenditures and revenue sources is in Table 24. MMHPI compared CHCS expenditure data to that of other large urban LMHAs and CHCS spending on administration and spending per case was comparable to the other urban areas.

92 All data from FY 2014 unless otherwise noted.
93 Lopez, M., & Stevens-Manser, S. (2014, September). Texas 1115 Medicaid Demonstration Waiver: *Review of 4-year behavioral health projects.* Austin, TX: Texas Institute for Excellence in Mental Health.

Table 24: Sources of Mental Health Funding and Mental Health Expenditures

Funding Sources	Adult Services	Child Services	Crisis Services	Hospital (HCPC)	Total Priority Mental Health	Other Services (IDD and others)	Totals
DSHS Allocated Funding (State and Federal)	**$16,547,351**	**$2,924,202**	**$4,765,599**	**$5,520,627**	**$29,757,779**		**$29,757,779**
Other State	**$2,279,960**	**$857,675**	**0**	**0**	**$3,137,635**	**$6,486,897**	**$9,624,532**
TCOOMMI	$1,579,578	$394,456	0	0	$1,974,034	0	
Other – MH	$700,382	$463,219	0	0	$1,163,601	0	
Other – IDD/other non-priority pop						$6,486,897	
Medicaid IDD						**$5,192,855**	**$5,192,855**
MH Federal	**$5,912,891**	**$1,748,238**	**0**	**0**	**$7,661,129**	**$15,600,477**	**$23,261,606**
Medicaid - MH	$5,912,891	$1,419,673	0	0	$7,332,564		
Medicaid - Other	0	0	0	0	0	0	
1115 Waiver	0	$328,565	0	0	$328,565	$8,221,142	$8,549,707
Local Funds	**$1,649,382**	**$1,431,768**	**$750,295**	**$316,511**	**$4,147,956**	**$8,612,841**	**$12,760,797**
Required Match	$1,139,229	$261,379	$324,893	0	$1,725,501	0	$1,725,501
Local – Other	510,153	1,170,389	425,402	0	2,422,455	8,612,841	
Totals	**$26,389,584**	**$6,961,883**	**$5,515,894**	**$5,837,138**	**$44,704,499**	**$8,612,841**	**$80,597,569**

In addition, MMHPI was also able to estimate costs reported serving people with mental health disorders in the Bexar County Jail and local hospital emergency departments. These estimates are presented in the following table, totaling nearly $83 million annually.

Table 25: Other Costs Related to Mental Health Needs

Source of Costs	FY 2014 Costs	Comment
Bexar County Jail Costs[94]	$17,682,607	Includes housing and booking ($15,898,358) and estimated medication and treatment costs ($1,784,249).
MH Emergency Room Costs	$64,954,534	Estimates by MMHPI based on 2013 data.[95]
Total	**$82,637,141**	

94 Meadows Mental Health Policy Institute and Texas Conference of Urban Counties. (2015). Survey of County Behavioral Health Utilization. Unpublished Document. Dallas, TX: Meadows Mental Health Policy Institute. Data was provided directly by Harris County.

95 Meadows Mental Health Policy Institute and Texas Conference of Urban Counties. (2015). Survey of County Behavioral Health Utilization. Unpublished Document. Dallas, TX: Meadows Mental Health Policy Institute. Estimates were based on a 2012 Texas Health Care Information Collection hospital survey of 580 hospitals and costs from a 2013 Dallas Fort Worth Hospital Council Foundation report.

Viewed in total, it is reasonable to conclude that well over $200 million went to caring for people with SMI and SED. While only a partial accounting, these are considerable sums. A key lack that impedes potential best use of funds across agencies is the lack of coordinated planning across the major payers for public behavioral health noted above.

Finding N-6: State-Level Policy and Local System Development

State-level policy serves to reinforce segregation of funding streams, fragmentation of planning processes, unaligned accountability measures, and a lack of incentives for collaboration across payers hampers local control and tremendously complicates local efforts to plan and act on plans to leverage resources and maximize efficient and effective use of limited public funds in pursuit of system improvement and population health goals.

While there is a notable exception in the legislatively-directed Community Collaborative initiatives for expanded homeless services, most state funds are siloed according to the agencies distributing funds. In an effort to be accountable for funds each agency has set its own accountability systems up for the funds they distribute. These state mandates complicate the task of local systems as they work to address the needs that present at the community level and prioritize expenditure of funds accordingly.

In an effort to be equitable and fair, DSHS has established statewide performance standards that do not take into account many of the unique factors in a county or community that impact access, cost and quality. Differences in acuity levels and service intensity of the people needing service get lost in a statewide system. Additionally, Medicaid (the largest payer for mental health care) services are purchased through a different agency (HHSC) than DSHS using different guidelines and monitoring mechanisms. The 1115 DSRIP projects have provided a substantial influx of funding and a more common use of metrics, however, in meeting those measures it has further segregated care in order to ensure project targets are met.

The segregated funding and accountability measures are not driven by the agencies alone. Each agency has to report on the expenditure of funds to the legislature and its Legislative Budget Board. To incentivize cross-systems collaboration, it will likely require additional legislative guidance to the agencies that receive state funds

The state context also creates multiple additional challenges that complicate service delivery in Bexar County and every other Texas county, to one degree or another:[96]

- Texas has the highest rate of uninsured people in the United States at 19%, and approximately 17% of Texans live in poverty.
- Texas has shortages of virtually all health care providers, including primary care physicians, psychiatrists and other mental health professionals, and advanced practice nurses, with rural areas lacking disproportionately. Studies of the local market have documented similar shortages in Bexar County. For example, a 2010 Capital Healthcare Planning report projected a need for over 100 additional psychiatrists in the county by 2019.
- State funding increases since 2013 have disproportionately focused on eliminating waitlists, yet, historically, a lack of waitlists for CHCS resulted in less state funding for Bexar County than it might have received if CHCS had a waitlist.

96 Information on Texas contextual challenges provided by University Health System and included based on their request. All data were obtained on February 12, 2016 via personal communication with Dr. Sally Taylor, University Health System and have not been verified, unless otherwise noted.

Major System Level Findings and Recommendations

In our assessment of Bexar County mental health systems, we identified numerous high quality programs, providers, and pockets of excellence. These will be discussed in greater detail in the following sections of the report. Bexar County also deserves recognition for being the only county in Texas to establish a County MH Department. In the past eighteen months, the Department has made steady progress to galvanize and better organize efforts at system-wide collaboration. Despite these excellent programs and leadership efforts, the primary challenge facing Bexar County is the need to transform the existing Bexar County behavioral health (BH) service array from a set of discrete programs and special projects into a high performing system of care that is effectively and efficiently managed by a collaborative of elected officials, local funders, and leading providers. There remains much work to be done to transform Bexar County's BH service array to a high performing system of care, rather than an array of programs and projects. Bexar County will need to more fully leverage the current array of services and resources, improving linkages and collaboration to address the magnitude of BH need for all residents (insured and uninsured).

We found that Bexar County's BH services are operating well beyond their current capacity. Emergency rooms, public safety personnel, Emergency Medical Services (EMS), jails, CHCS, University Health System, Haven for Hope and other settings are overwhelmed with the growing volume of individuals (primarily adults) with severe mental health and substance use conditions who present in crisis throughout the county. There are multiple programs that are designed to intervene in order to prevent and divert crises and to promote recovery, but the capacity of these programs is small compared to the volume of need. While the strong efforts to develop a responsive crisis system are apparent, there is tremendous difficulty with access to help soon enough to prevent crises, as well as access to continuing services that would maintain community stabilization. As a result, there is a small but significant number of individuals who cycle through crisis response settings repeatedly, incurring high costs, adding disproportionately to the volume of need, and continuing to have poor outcomes. The situation for children and adolescents is less dramatically obvious, but nevertheless a challenge. Again there are some excellent programs and collaborations (as shall be described), but there is still evidence of a significant lack of adequate service capacity for those individuals and families with the most severe needs, who might best benefit from ongoing best practice in-home wraparound interventions to prevent hospitalizations and residential placements.

The good news is that there is much that can be done to alleviate the current burden on the system and turn the tide. Further, although more resources are certainly needed, much can be accomplished if the current resources are leveraged more effectively to respond to the overwhelming demand for services. This will require appropriately designed system-wide improvement strategies within a broad county-wide strategic collaboration for change.

In the following section of the report outlining findings and recommendations, the elements of this system strategy will be identified, and the capacity to build on existing strengths and efforts in the system to make progress will be illustrated briefly. The point of this framework is to develop a basic template for the Bexar County BH system to move from a reactive approach that responds to individuals in severe crises, to a more proactively engaged public health response across the system that can both manage populations as well as assist individuals.

Major System Level Findings

This section of the report outlines findings related to important system design elements.

System Level Finding SF-1: The current leadership structure at the system level for the county has made steady progress but requires both the commitment of key local leaders and an aligned and efficient operational infrastructure to transform itself into a trusted and effective forum for local system planning and coordination. The formation of the Bexar County Mental Health (MH) Department, as well as a range of other more focused collaborative efforts, is apparent. However, the Department is under-resourced and under-positioned to be managing an adequate systemic response for a county of nearly two million people, while other bodies (such as the Southwest Texas Regional Advisory Council [STRAC]) engage leaders in effective collaboration regarding related system components (such as emergency room capacity management), but their scope is too narrow.

System Level Finding SF-2: Cross-payer collaboration is hampered by planning within separate silos, as the lead agencies for each major public funding source – state general funds (CHCS), county health funds (University Health System), Medicaid (the multiple Medicaid MCOs), DSRIP (CHCS and University Health System) – lack a trusted forum for coordinated planning and system-level effort. Within the current efforts to address Bexar County's BH system needs, it is clear that each set of payers is proceeding in separate silos to serve its defined population, with separate planning for uninsured MH, uninsured SUD, the hospital district health plan, each Medicaid MCO, Medicare initiatives, and various private insurers.

System Level Finding SF-3: Bexar County faces a significant public health challenge with its current BH services that must be addressed by local leadership. The current capacity, while delivering some impressive examples of high quality service, simply does meet demand, and access is limited throughout the Bexar County. However, what we contend that is holding Bexar County back is the pervasive sense that the BH challenge is "not really our problem … it belongs to the State (San Antonio State Hospital and CHCS)." It is unlikely that Bexar County will be successful waiting for the State to solve the problems for all its residents. State resources are helpful, but the public health challenge affects all the partners and needs to be responded to by all the partners in Bexar County.

System Level Finding SF-4: Bexar County needs to take its programs to scale. Many excellent programs could serve as a model for scaling, but this will require both system-wide (rather than discrete individual agency) commitments and a multi-year development plan prioritizing new funds that become available toward system-wide priorities. A key issue for Bexar County is to recognize that it needs to move from the perspective of "we have excellent programs" to one that builds a systemic programmatic response and brings services to scale for a geographically spread county approaching two million residents.

System Level Finding SF-5: There are some excellent crisis services, but these are not connected into a crisis system of care. The need to track use of crisis services, ERs and inpatient psychiatric and detox beds across the system is critical to develop a crisis system, population based approaches to crisis care, and individualized care planning. While there are some instances where this data is tracked by unique programs, the information is not uniformly available to those who need it in real time crisis situations. Past efforts to track this data have not gained traction.

System Level Finding SF-6: A primary barrier to developing a crisis system of care is a lack of consensus regarding consistent county-wide policies, procedures, and protocols for medical screening ("medical clearance") for adults who present in psychiatric crisis and require admission to psychiatric crisis facilities or hospital beds. Other county and regional systems in Texas either have developed such consensus (e.g., Midland County, East Texas Multi County collaborative) or are working on it (Smith County). Without such consensus, there will continue to be a lack of consistent and clear guidelines for law enforcement regarding when to bring individuals to an Emergency Department or when to bring individuals to a crisis facility (Crisis Care Center, Nix PES), particularly when different facilities may have different rules. Further, some providers indicated their "understanding" that ER based medical clearance is "required" by licensure; this is simply not true, as many facilities in Texas carry out direct admissions and perform medical screening as part of routine nursing admission, with diversion to ER only when warranted. The application of this type of "rule" can result in overutilization of ER for medical screening, when direct admission to inpatient or crisis beds could be both quicker for the person receiving services as well as less burdensome on the system.

System Level Finding SF-7: A second primary barrier to an effective crisis system is the lack of sufficient capacity to provide ongoing care for high utilizers of crisis of jail, emergency room, inpatient, and homeless services. Resources for intensive case management and case management are lacking across the board, but a key gap is the lack of ongoing care for what we have termed "super-utilizers," those adults repeatedly transitioning

from inpatient and crisis services, particularly the 2,600 forensic and non-forensic "super-utilizers" with incomes under 200% of FPL. Access to medication management, wraparound services, housing, intensive outpatient treatment and partial hospitalization, and other treatment services during post discharge as well as resources for ongoing care were noted as significant challenges and contributing to revolving use of ERs and inpatient beds.

System Level Finding SF-8: Current primary health/behavioral health integration initiatives are effective and could serve as a base for scaling up broader access for those with more routine needs. There is an opportunity for system growth in the development of BH capacity integrated within primary health services on a large scale. It is clear that this is an important issue for both Texas[97] and the nation. High medical cost and utilization among complex populations is directly connected to under-met health and BH needs, not just those with SMI, but the full range of needs, including SUD, associated with chronic health conditions. What is striking in the assessment is that there are many large health systems in Bexar County, including the hospital district, with a significant amount of resources addressing individuals with chronic health conditions. However, the BH investment is focused on a few inpatient units and ER response, rather than any of these entities having articulated a large-scale strategy to develop integrated BH capacity to produce value within its larger community health delivery system.

System Level Finding SF-9: Efforts to develop a Children's System of Care (CSOC) have a positive history of a strong CSOC collaboration among some key providers, but there is not a system-wide approach. The current CSOC involves CHCS, Child Protective Services (CPS), Juvenile Justice (JJ), and some independent School Districts. This CSOC collaboration has been recently fueled by a federal grant provided to the City of San Antonio. However, the current CSOC collaboration is focused on using the funding for gap programming, rather than elevating the conversation to develop a true CSOC philosophy for all child serving providers and working with all payers and providers to expand implementation of wraparound principles in all services. There is a need to shift from more medical and deficit centered care to best practice CSOC home-based approaches across the system.

Major System Level Recommendations

System Level Recommendation SR-1: Local leaders should develop a locally driven, empowered BH leadership team to lead collaborative efforts and efficiently direct system improvement efforts. This effort should build on Bexar County's emerging leadership development efforts, but will require both a deeper commitment of key local leaders and an aligned and efficient operational infrastructure to transform itself into a trusted and effective forum for local system planning and coordination. The BH leadership team should include key political leaders to make the BH response a priority, and the key partners would need to commit to establishing an ongoing BH Leadership Team. The Department also needs the resources and expertise to build on a systemic assessment with a data driven strategic plan for the whole system. Further, Bexar County and its key partners, including CHCS and the University Health System, cannot do this alone. This is a problem that impacts every aspect of the county and city: public safety, public health, health providers and payers, businesses, schools, housing, and the criminal justice system and requires their participation.

System Level Recommendation SR-2: Bexar County can and should develop a vision for what the BH system should look like if it were taken to scale. The results of this assessment should inform that vision, however the vision cannot be established by an external review – it must be developed collaboratively by the local BH leadership team.

System Level Recommendation SR-3: Once the vision is established, the local BH leadership team should establish a prioritized timeline for incremental development to address system gaps over a multiyear period (e.g., five years). Based on the findings of this report, the following system development priorities are recommended for consideration within this multiyear plan:

97 Senate Bill 58 of the 83rd Legislative Session focused on the integration of behavioral and physical health services within Medicaid managed care, including mental health targeted case management and mental health rehabilitative services. It also requires the selection of two health home pilot programs in two health service areas of the State.

- **System Level Recommendation SR-4**: A top priority should be the need to develop a comprehensive, integrated crisis system across all major public payers, hospital providers, and behavioral health providers. Protocols and procedures for access and diversion should be consensus-based and transparent, and the system should provide access to a range of crisis services including crisis diversion. Development of additional inpatient capacity should occur in the context of this system. It should be anticipated that inpatient capacity will continue to be constricted for the near to medium term (e.g., five years), so maximizing coordination of the broader crisis continuum is of paramount importance.

- **System Level Recommendation SR-5**: A second major priority should be to develop a cross-payer effort to provide ongoing services for the approximately 2,600 highest utilizers of jail, homeless, crisis, emergency response system, ER, and inpatient care. Currently, a fraction of these adults are engaged in sufficiently intensive ongoing services to prevent overuse of jails, crisis, and inpatient care. Intensive services at this level of care appear to be more readily scalable than additional inpatient or crisis care.

- **System Level Recommendation SR-6**: Grow the development of BH capacity integrated with primary health services on a larger scale. Given workforce limitations and the breadth of service needs, as well as the clear evidence of the degree to which physical health needs of adults with SMI contribute more to morbidity and mortality (and associated costs), primary care based delivery strategies for behavioral health should be a major system development priority.

- **System Level Recommendation SR-7**: Develop a system-wide CSOC planning process within the broader system planning effort, involving all child and family serving providers and working with all major payers and providers. A key priority within this planning process should be to expand implementation of intensive home and community based supports for those at highest risk of out-of-home placement, wraparound planning that fully leverages YES Waiver funding, early intervention services for severe mental illness manifesting in adolescence (including best practice First Episode Psychosis services), and school-based and school-linked services to maximize access and begin to address the "school to prison pipeline."

System Level Recommendation SR-8: Emphasize cross-payer collaboration across all of these initiatives to maximize system efficiency and impact, using the BH leadership structure to bring together major payers into an enduring cross-payer collaboration to design and develop the BH system that Bexar County needs and deserves. To address the public health challenge with BH Services, Bexar County will need to develop coordination strategies that can more effectively leverage existing resources. In our assessment, there was surprising willingness for this to happen, but no clarity as to how it would take place. Utilizing a county-empowered BH leadership collaborative would enable system partners to participate in a planning effort. As new funding becomes available, effective planning can assist Bexar County to plan a systemic public health response. In order for Bexar County to be successful, it needs to engender political, payer, and provider commitment to respond to this challenge, building on the work of the Department and the Consortium. Bexar County's leaders (not just within County government, but all leaders) clearly have the ability to do this, as illustrated by the programs that have developed. This should include continued work with payers/health plans to develop Alternative Payment Methods (APAs) that promote flexibility, especially for crisis services and services to super-utilizers.

System Level Recommendation SR-9: Implement strategies to facilitate information exchange within the existing health information exchange system. One such strategy is the development of a universal release of information that allows multiple providers to share information on an individual's care based on the individual's approval. BH organizations also need an Electronic Health Record (EHR) and the ability to provide data to HealthCare Access San Antonio (HASA), the Health Information Exchange (HIE) for effective population management and care coordination. The RWJF proposal prepared by CHCS in July 2015, Data Across Sectors for Health: Empowering Communities Through Shared Data and Information (DASH), targeted a "connected information system to enable spontaneous, shared Community treatment of adults with severe mental illness" and is a very positive example of the data sharing approach that is needed. Bexar County and its providers need to obtain or upgrade their EHR and work with HASA for capturing, sharing and utilizing BH data.

Major Mental Health Provider Findings and Recommendations

Findings and recommendations for each major BH provider identified by Methodist Healthcare Ministries are included in this section, including CHCS, Clarity, Nix, University Health System, and UTHSC-SA.

Center for Health Care Services

The mission of the Center for Health Care Services (CHCS) is to improve the lives of people with mental health disorders, substance use challenges, and developmental disabilities. As the state-designated local mental health authority (LMHA), CHCS offers a wide range of crisis, outpatient, and specialty services for these individuals. The Center's fiscal year (FY) 2016 budget is approximately $100 million and CHCS employs over 1,250 staff.

Highlighted Agency Strengths

CHCS has developed some superb programs that reflect national best practices and evidence-based programs. The array of services is impressive among Texas community mental health providers, as well as nationally in several cases. Below we review major strengths. Many of these programs are also reviewed in the findings and recommendations section.

- The commitment to excellence in each of the programs is very strong and there are common tasks identified among the program managers. For example, peer workforce integration is a key function for multiple programs, including Community and Transformational Services, Restoration Services, and Adult Behavioral Health Services. The use of Family Partners under Child Behavioral Health Services is also noted. This demonstrates an agency-wide commitment to the use of individuals with lived experience.
- The implementation of Lean quality improvement methodology is a key strength and now serves as a foundational element to the Quality Improvement program and tracking metrics essential to drawing down funding from the 1115 Waiver.
- CHCS human resource management is very professional and focused on both short-term needs and long-term strategies to recruit, develop, and maintain the workforce. It should be noted that there are currently major challenges in the recruitment of psychiatrists and pharmacists, challenges that affect every Texas community and other Bexar County providers.
- The CHCS External Relations efforts to improve public information, enhance community relations, conduct outreach, and educate the community are strong.
- The Community and Transformational Services program efforts are thoughtful and well-informed approaches to serving homeless individuals and veterans. There are linkages with the Haven for Hope Transformational Campus and the Courtyard for provision of a wide range of services: counseling services, crisis care, the In-house Recovery Program (IHRP), the In-house Wellness Program (IHWP), the In-house Women's Wellness Program (IHWWP), and the Projects for Assistance in Transition from Homelessness (PATH) Program, Shelter Plus Care, the HOMES Project, and clinic services.
- CHCS has three primary care clinics in behavioral health settings, which represent a positive and substantial effort towards provision of integrated care, each operated by the divisions responsible for the specific populations served:
  - The Community and Transformational Services Division operates a primary care clinic at Haven for Hope where the Wellness Center is in the process of combining with the primary care clinic, a strategy that enhances care for homeless individuals.
  - The Restoration Center Integrated Care Clinic primarily serves people with substance use disorders (SUD) and HIV who participate in methadone services at that site, in part due to its location. However, all CHCS clients with SUD conditions are permitted to access primary care services at the Restoration Center. This program was established with 1115 Waiver DSRIP funding specifically for the SUD population. CHCS has set the goal of providing primary care for all CHCS clients and their families in an effort to address unmet health care needs, as well as to sustain the program by bringing in third party billings to support operations once DSRIP funds are no longer available.
  - The Adult Behavioral Health Services Division at the Northwest Clinic operates an integrated care program, a model program targeting individuals with complex behavioral health (BH) and physical health (PH) conditions who are served by a dedicated team of behavioral health and primary care clinicians. The program offers a progressive trauma-informed care (TIC) approach that incorporates research-based practices. A fuller assessment of this program is included in a separate section of this report focused on integrated care.
- CHCS's Restoration Center focuses on the provision of SUD services and has undergone several positive programmatic changes in the last two years. Programs have been relocated within the facility and the new wing has been expanded to accommodate offices, as well as the primary care clinic for individuals with SUD and HIV. Services provided include: four-hour crisis assessment and intervention; sobering and detoxification; psychological crisis training for law enforcement and jail/emergency room diversion; outpatient recovery counseling and support; integrated physical/mental health assessment, treatment and coordination; integrated psychological/addiction therapy; and post- acute sexual assault forensic exam follow-up/testing. The ability to provide crisis services, support for law enforcement, treatment for mental health and substance use conditions, and a wide array of services is impressive.
- Under Adult Behavioral Health Services, the Assertive Community Treatment (ACT) team and forensic services have made strides in identifying people who are clinically appropriate for ACT and in triaging appropriate clients into forensic diversion programs.
- Also under Adult Behavioral Health Services, the Money Follows the Person (MFP) Centers for Medicare and Medicaid (CMS) funded initiative with nursing homes provides services, support, and cash (for moving, rental costs, etc.) to help individuals move from nursing homes into the community. This program has had great success with nursing home clients, and all 30 individuals in the past year were moved into the community. Perhaps most notable was that none of the clients throughout the year returned to their previous nursing home residence. Unfortunately, MFP grant funds from CMS through the Home and Community Based Services (HCBS) waiver are scheduled to end for this program in 2016. At present, the census is capped at 50 individuals. While there is an organizational focus on trying to obtain funding through the Medicaid MCOs after the grant termination, it is not clear that resources will continue.
- Child Behavioral Health Services operates a 16 bed crisis residential center that accepts referrals from their internal crisis services program, as well as providing planned respite funded by the Youth Empowerment Services (YES) waiver. These beds can also be used as a step-down program from inpatient care. The program exceeded their target of serving over 100 youth, and would like to expand access across the child delivery system and increase utilization. A unique component of this program is that staff will drive youth to school to prevent school absence during respite stays. All staff are qualified mental health professionals (QMHPs) who are supervised by a licensed clinical professional.
- Collaboration between CHCS and Healthcare Access San Antonio (HASA), the local health information exchange (HIE), is underway with the goal of developing a connected information system with the capacity to organize, update, and disseminate an individualized, integrated community treatment plan that can direct the course of care for high risk, high utilizing behavioral health consumers.

- CHCS's goal of implementing Value-Based Purchasing (VBP) strategies with managed care organizations (MCOs) is a promising development. Refinement of the approach and metrics necessary to execute VBP contracts with the MCOs is the next step in this process.

CHCS Major Findings

CHCS is an excellent organization and has developed some superb programs that reflect national best practices and evidence-based programs, and their array of services is impressive among Texas community mental health providers, as well as nationally in several cases. However, like community mental health agencies across Texas and the nation, CHCS faces multiple organizational and program improvement challenges. It is well positioned to take these challenges on with its emerging quality improvement programming. Major findings related to improvement opportunities are noted below.

CHCS Major Finding 1: There is a need to improve collaboration and teamwork across discrete program areas within the organization. Improvement in collaboration and team work is needed at three levels: between programs within divisions; between programs that cross divisions; and between CHCS' continuum of services as a whole and other community partners (e.g., University Health System, inpatient psychiatric units, other providers, public safety, etc.). There is also a need to better integrate medical staff into most interdisciplinary teams.

CHCS Major Finding 2: Internal teamwork at the leadership level lacks an overarching set of organization-level goals and structure to align programs across senior managers. Our observation is that each senior manager operates well within his or her separate domain, but there is a lack of unifying programmatic goals to bring discrete programs together. Fortunately, the CHCS executive team recognizes the need for improvements in this area, which prompted the development of the Lean Initiative. Work is underway on actively framing and integrating disparate divisional goals and providing strategic alignment of the goals and the operational structure.

CHCS Major Finding 3: There is a need to reorient current Lean quality improvement (QI) programming (which is a major organizational strength) to focus less on program-level compliance and more on organization-wide performance and clinical quality improvement, particularly those noted in findings CHCS F-1 and CHCS F-2 above. There is evolving awareness of this need within CHCS and active use of the Lean Initiative to enhance clinical quality improvement, which is important to continue.

CHCS Major Finding 4: Relationships with external agencies vary based on the program and are generally more positive for programs with the capacity to provide follow-up, outreach, and engagement. A primary driver of negative perceptions is the lack of a system-wide planning function, rooted to some degree in outdated views that system-wide planning is not necessary given the role of CHCS as the "local mental health authority." Without a visible shift in county/region-wide planning to a platform that involves Bexar County and the full array of community and hospital service partners, the unrealistic expectations on CHCS will likely persist despite the organization's efforts.

CHCS Major Finding 5: Child Behavioral Health Services needs to expand its clinical consultation role and the development of a broader system of care for children, youth and their families to improve collaboration with schools and other child serving systems. While CHCS collaborates with other child-serving partners, there are challenges in connecting with schools systems and other community organizations. These issues are exacerbated by the limited availability of bilingual/bi-cultural staff, as well as the overall small size of the children's services delivery system within CHCS. This is a system-wide issue that needs to be address by a regional effort to promote improved coordination of services for children and their families.

CHCS Major Finding 6: Access to care at CHCS is reported as most efficient through crisis services, but general access was reported by stakeholders to have lengthy wait times. The perception is that while CHCS is able to provide access through their crisis program, it struggles to provide efficient access in many of its other non-crisis programs that provide ongoing care. Many external system partners report lengthy wait times for clients transitioning from inpatient and other services, including access to psychiatry, case management, and other outpatient services.

CHCS reports that the time from client request for services to prescribers is accomplished within seven (7) days and often within three (3) days. For hospital discharge, CHCS reports access to prescribers within seven (7) days. The different experiences and perspectives about access may be related to capacity issues, but must be further explored because limited access to an array of services, including case management was an important discussion among system partners.

Additional specific programmatic findings were also identified and provided to CHCS for review, in addition to those in this report.

CHCS Major Recommendations

Major recommendations related to the findings are noted below.

CHCS Major Recommendation 1: CHCS improvement efforts should focus on improving teamwork and collaboration at the senior management level through examination of strategies and/or staff positions that would foster development and implementation of organization-wide population management goals.

CHCS Major Recommendation 2: CHCS should enhance continuous quality improvement (QI) approaches within and across programs and consider the following specific organization-wide QI activities. An important starting point for internal teamwork at the leadership level is to prioritize improvement in transitions across the boundaries between programs. The organization's existing and robust Lean performance improvement methodology provides an excellent technology to employ as a team to make measurable progress in this area.

- **CHCS Major Recommendation 3**: CHCS should initiate an organization-wide QI activity to improve internal collaboration between programs, focused on movement between and coordination among programs. Restructuring QI to focus on the engagement of staff across programs and disciplines, in our view, is key to taking CHCS performance – which, as noted above, is in many ways exemplary among community mental health agencies in the state – to yet a higher level of excellence. The Medical Services division is a champion for the continuous QI effort.
- **CHCS Major Recommendation 4**: CHCS should initiate an organization-wide QI activity to improve collaboration as an organization – both as a whole and for individual programs – with the broader array of providers and services across Bexar County. CHCS is in many ways an excellent agency. However, being an excellent agency is not sufficient to achieve the most effective and efficient outcomes for individuals with complex needs within the context of a population-health framework. Fortunately, the same set of QI strategies that will promote internal collaboration and accountability for client transitions will similarly facilitate CHCS being more effective as a collaborator with other service providers in the county. But CHCS cannot do this alone – it will need to be part of an organized collaborative structure that brings together all levels of care within the county.
- **CHCS Major Recommendation 5**: CHCS should initiate an organization-wide QI activity to improve access to care across system boundaries for complex cases within CHCS needs to be elevated to a focused QI project focused on delivery of person-centered care to engage clients so they do not fall through the cracks. CHCS reports that this work is already under way, but continued effort must focus on both CHCS system boundaries to achieve the best care outcomes, while also focusing on external systems within the county, recognizing that there are limits to CHCS's ability to impact external partners without an organized collaborative structure.
- **CHCS Major Recommendation 6**: The Child Behavioral Health Services should initiate QI activities with key partners (e.g., Clarity, local ISDs, child serving systems) to coordinate access and ongoing care for children served by both CHCS and these partners.

Additional specific programmatic recommendations were also identified and provided to CHCS for review.

Clarity Child Guidance Center

Clarity Child Guidance Center (Clarity) is a private, not-for-profit mental health organization providing mental health programs tailored to the needs of families, individuals, and the community. Founded in 1886, Clarity has been very involved in Bexar County and the broader community for decades, and now focuses on serving the needs of children and adolescents ages 3 to 17 and their families. Its mission is to enable individuals and their families to create meaning and purpose from life's challenges and to restore hope and motivation to more effectively manage those challenges.

Clarity has three primary programs, two focused on intensive programming for children and adolescents to stabilize severe needs and one broader outpatient program providing specialty psychiatric and treatment services:

1. There are two levels of care within the inpatient program: the Acute Care Program that provides intensive inpatient mental health treatment for children and adolescents experiencing severe, acute psychiatric symptoms, and the Residential Treatment Program (RTP), a subacute component of the acute care program, that provides a medically supervised, interdisciplinary program of mental health treatment with milieu services provided on a 24-hour-per-day, seven-day-per-week basis,
2. The Partial Hospitalization Program (PHP) that provides a structured therapeutic milieu for children and adolescents who are experiencing a persistent psychiatric disorder that is pervasive and involves several major life areas, and
3. The Clarity Child Guidance Center (CCGC) Outpatient Clinic that offers outpatient diagnostic and treatment services for children, adolescents and their families.

Clarity's 2014 Annual Report[98] indicates an operating budget of approximately $19 million in 2014, with about $2.5 million available for capital investment. DSRIP funds contributed about $936,000 to their capital funds and foundations contributed the remaining $1.45 million. The majority of its income is from patient services, with other income from a Disproportionate Share Hospital payment due for FY 2013 at $1.137 million, and United Way contribution of about $1 million. The remaining funding is from contributions through corporations and individuals. Clarity reports an administrative rate of 13%.[99] Clarity takes Medicaid and other insurance and contracts with most major managed care organizations. It also contracts with other providers.

This section of the report focuses on highlights, findings and recommendations related to the organization and performance of Clarity Child Guidance Center as part of a larger system of care for children in Bexar County. The strengths and gaps identified and descriptions of some of the programs reviewed are below to highlight the themes we emphasize in our specific findings and recommendations discussed later in this section.

Highlighted Agency Strengths

Highlighted strengths from our findings include the following:

- Clarity is mission-driven and clearly aspires to excellence across their entire setting. Clarity has made extensive efforts with the One in Five Minds initiative to create a regional platform for ending stigma associated with mental health conditions.
- Clarity is accredited by the Joint Commission and maintains an active ongoing teaching and research affiliation with the UTHSC. More recently, a partnership has been initiated with the Baylor College of Medicine for first-year pediatric residents.

98 Big Plans, 2014 Annual Report. Clarify Child Guidance Center. Accessed August 25, 2015 at http://www.claritycgc.org/docs/default-source/reports-for-the-community/2014-clarity-cgc-annual-report-individual-pages.pdf?sfvrsn=2

99 Big Plans, 2014 Annual Report. Clarify Child Guidance Center. Accessed August 25, 2015 at http://www.claritycgc.org/docs/default-source/reports-for-the-community/2014-clarity-cgc-annual-report-individual-pages.pdf?sfvrsn=2

- Clarity is in its fourth year of directly offering provider education to the community at large. Over 350 attendees participated in these educational events last year. Clarity provides CEUs for its on campus education and also through its YouTube channel where 75,000 visitors viewed over 35,000 minutes in a year.
- Clarity has established a substantial base of highly trained child psychiatrists. This allows Clarity to provide a vital treatment foundation throughout the organization and is a critical resource for the broader community.
- The quality of the Clarity services at all levels is excellent as it is specialized and targets children with acute behavioral health disorders. Clarity addresses an important need for inpatient care for children and youth in Bexar County, anchoring the acute and subacute care system.
- Over the past three to four years, Clarity has expanded to include a clinic and a new crisis center. An expanded partial hospital program and a three-story Outpatient building is under development. Since 2010, Clarity has expanded its budget from about $10 million to about $20 million dollars. As a result, the administration is working to stabilize programs while undergoing immense expansion. While there is further capacity to expand, any expansion must be thoughtfully planned to promote stability of current services.

Clarity Major Findings

Clarity Major Finding 1: Clarity has numerous strengths and could potentially address some of the key gaps that exist in the broader system of care in Bexar County for children with severe needs noted in the system-level findings. This would need to occur within the context of the considerable growth in outpatient care that Clarity has already taken on, and should only occur if Clarity can be confident that it can maintain program quality as it expands. As is generally the case when providing inpatient care, Clarity's psychiatrists are facility bound rather than available in community settings. While Clarity has opened satellite outpatient offices in addition to its campuses, Clarity's overall organizational philosophy is anchored in a medically-based model of care. While best-practices are used, they are within the well-known therapy models which are typically predicated on in-office service. While the availability of inpatient care and access to child psychiatry are considerable strengths, the needs across Bexar County for home- and school-based interventions were discussed as significant service gaps by stakeholders that Clarity could potentially augment its programming to address. Clarity reported a policy restriction that prevents BH hospitals from providing outreach to schools directly. This policy must be clarified, including the source of the policy, and modified to allow Clarity to provide outreach for its outpatient services and any future family and home and community-based services.

Clarity Major Finding 2: There is limited co-occurring mental health (MH) and substance use disorder (SUD) practice available within Clarity (and throughout Bexar County). This is both a capacity gap and a barrier to serving the most complex adolescent cases, many of which involve co-morbid substance use. Clarity's current model is primarily focused on mental health treatment, which results in a high percentage of clients referred by the Emergency Departments rejected for admission secondary to more significant substance use disorders. This may adversely impact community relationships as it significantly limits the diversity of youth who can receive treatment from Clarity. The issue of medical clearance was raised by Clarity as a challenge as their programs do not have the infrastructure in place today to handle physical health issues, including overdoses. Clarity expressed interest in addressing non-medically related substance use treatment.

Clarity Major Finding 3: Community stakeholders want Clarity to expand further to address system gaps in home-, community- and family-based services and co-occurring services, which is a testament to its strong reputation. There is a desire for Clarity to (1) be able to leverage its psychiatry and other resources to meet community needs (for example, intensive outpatient needs of children served by other systems) and (2) to accommodate the needs of children with comorbid substance use disorders in its intensive treatment programs. Clarity does have interest in provision of Intensive Outpatient Treatment and non-medical substance use treatment, which presents opportunities for expansion and increased access to these services.

Clarity Major Finding 4: Clarity does not have formal partnership agreements with major children's services

providers and funders, most notably Children's Protective Services (CPS) and county and state juvenile justice (JJ) agencies. Such formal partnership arrangements could be a key enabler to broader, system-wide children's system of care planning. Clarity enjoys strong existing relationships with these agencies that could serve as a basis for such agreements. Protocols or memorandums of agreement that clearly define Clarity's mission and service delivery goals would be useful to improving system-wide service planning and development within the broader missions of these two critical child-serving agencies could be helpful, both to Clarity's positioning and to the broader community. Clarity is committed to addressing this finding and will work to address with the criminal justice system and CPS. Past challenges include the inadequacy of reimbursement for residential services.

Additional specific programmatic findings were also identified and provided to Clarity for review.

Clarity Major Recommendations

Clarity Major Recommendation 1: Clarity will need to decide on the degree to which it can expand its service array and capacity to fill the system gaps noted above for children and families, especially given the extensive expansion that has occurred to date in its outpatient facility settings. Clarity's current services are essential and well-delivered. Yet, there are system-wide needs for services in less restrictive levels of care. A regional system of care requires development of a broader set of home- and community-based models of care, including wraparound, hospital/crisis diversion and treatment for co-occurring conditions. Clarity will need to determine if it wants to fill any of these service gaps. If so, this will require an expanded and potentially revised clinical framework, as well as business models to support community-based services in addition to inpatient care. If Clarity does not expand, it will need to help the community develop referral sources that can address these needs, otherwise Clarity – as in many ways the leading child provider in San Antonio – will be seen by some key community stakeholders as failing to fill a critical gap that people perceive it to be (rightly or wrongly) as best positioned to fill. While Clarity has traditionally viewed CHCS, as the local mental health authority, responsible for community-based models of care, the need exceeds the capacity of all current agencies to serve children, youth and families. A broader regional planning effort, which is a key recommendation of this report, is needed to develop a coordinated system of care that offers improved access, and choice of providers. Under this regional approach, the goal of Clarity providing a broader array of coordinated community-based services is desirable.

Clarity Major Recommendation 2: If Clarity decides to expand its service models to address system level gaps, we recommend that it consider two priorities: (1) establishing a co-occurring MH/SUD practice model within Clarity's current programs and (2) developing intensive home and family based models of care. The overarching recommendation is to determine, through a focused regional planning effort, if Clarity wants to expand its continuum of care throughout Bexar County. If the decision is made to move toward a broader services array, Clarity would likely need a strategy that includes some or all of the following components:

- **Major Recommendation 2a**: Begin with establishing a co-occurring practice within Clarity's current programs. If Clarity were to develop clinical expertise in the delivery of co-occurring mental health and substance use conditions, this would partially, but significantly, address a large gap in treatment capacity for high need adolescents within Bexar County. Clarity is interested in addressing this need but requires assistance with medical clearance and treatment of overdoses.

- **Major Recommendation 2b**: Transition to a more Youth and Family Centered Practice. This model of treatment is significantly different from a physician-led model of care and creates development challenges for most professional organizations. Yet, Clarity's experience with engaging families provides a strong foundation on which to build. It will be important to involve families and youth as full partners in the design of the service delivery models. This is, however, far more complicated than simply hiring individuals with lived experience; instead it is ensuring consumer and family "voice" at all levels of system development, including continuous quality improvement. If Clarity desires, additional detail and sample protocols can be shared to inform decision-making in this area. As part of this, Clarity may want to consider establishing an internal system of care planning team, which includes a youth guided, family driven advisory committee. The purpose of this planning team would be to conduct a readiness assessment and develop subsequent logic model towards system transformation. It should be noted that Clarity's work on incorporating a voice of the consumer (VOC) process includes developing a satisfaction survey using local and national benchmarks. The VOC at Clarity was developed to be very similar to the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey, the first national, standardized, publicly reported survey of patients' perspectives of hospital care. This work is an important foundation on which to build the transition to youth and family centered practice.

- **Major Recommendation 2c**: The staffing pool will need to broaden. The current pool of staff are principally highly credentialed providers, such as licensed therapists and psychiatrists. Typically highly credentialed professionals are not well prepared to provide community-based care, given attitudes toward other child and family systems (e.g., CPS, JJ), the role of families (as co-leaders in care vs. patient collaterals), and the role of youth (as co-leaders in care vs. patients). Within this context there may need to be significant technical assistance for existing staff, including a focus on attitudes and practice in relation to systems of care. As part of this, working with staff at all levels around the concept of collaborative decision making within a multidisciplinary team concept (including Youth Peers and Family members in paid roles) will require emphasis within the training and consultation process. Clarity's Collaborative Problem Solving model called ClarityCare is demonstration of the capacity to broaden its approach and staffing pool. This model, developed under the guidance of Dr. Ross W. Greene, PhD, originator of the empirically supported Collaborative & Proactive Solutions (CPS) approach and author of the influential books *The Explosive Child* and *Lost at School* relies on peer-based roles to engage youth in treatment. This is a positive strategy that can be used as a base to broaden the staffing pool and engage family partners and youth peers.

- **Major Recommendation 2d**: New resources will be needed to change service models. High need services for children and youth that Clarity may be particularly capable to provide, potentially in partnership with others, include mobile crisis, short-term crisis/respite beds, and early intervention consultation. New resources would likely need to be identified over time, possibly through a mix of philanthropic, state/county agency, DSRIP 2.0, and Medicaid funding for these services. Management of these types of services may also require some potential agency reorganization and/or organizational augmentation.

- **Major Recommendation 2e**: Community-based quality measures will need to be established. This could include such measures as timely access to necessary medical/psychiatric services, access/utilization of home-based treatment, family centered/coordinated care, and outcomes related to school, family, and legal functioning. Please see accompanying white paper by MMHPI team on child and family functional outcomes for more information. Additional information can also be provided on this, if desired.

- **Major Recommendation 2f**: Establish an engagement team to work with the Bexar County partners around policy development, program expansion and interagency agreements. While recognizing that Clarity has been an active participant with the Bexar County MH Consortium and has submitted a resource for consideration as an official board member, expansion of its model to include more community-based services would be helpful to the system at large. This is essential to designing a county-wide system of care and promoting understanding of Clarity's potential expansion goals.

- **Major Recommendation 2g**: Work with Bexar County partners to assess program sustainability and consider collaborative, multi-agency strategies to develop and sustain services that fit with system goals. This strategy will help Clarity determine the long-term viability of potential new services it develops, both independently and in partnership.

Clarity Major Recommendation 3: Clarity should increase it system-leadership role in helping to define an overarching system of care for children and youth. Clarity has many current partnerships with individual agencies and payers, but the system-level recommendations noted above will require greater leadership in forming a partnership framework. Clarity is well positioned to work alongside CHCS and other child and family providers in such an effort. Whether Clarity wants to expand its scope of services or maintain focus on inpatient and outpatient office-based care, extending its participation as a partner in system of care planning will go a long way in helping Clarity to engage its partners, enhance relationships, clarify its role versus the role of others (versus gaps that nobody is filling), and coordinate care across multiple agencies and levels of treatment intensity.

Clarity Major Recommendation 4: Clarity and CHCS Children's Program should establish routine program

manager / clinical manager meetings to improve coordination of care for children and families served by both agencies. MMHPI is making the same recommendation to CHCS to assist with the transition of care for individual children.

Additional specific programmatic recommendations were also identified and provided to Clarity for review.

Haven for Hope

Haven for Hope (H4H) is a non-profit organization in Bexar County that is home to a variety of programs and services to support people who are homeless. Its mission is "to offer hope and new beginnings." Haven for Hope carries out this mission "by providing, coordinating and delivering an efficient system of care for people experiencing homelessness…" Haven for Hope was designed to create an environment that aligns the participation of community organizations to address various aspects of homelessness and has 92 partners: 35 On-Campus partners, 45 community referrals sources, and 12 Community Support Partners. Demand for services from these partners is substantial enough that Haven for Hope maintains a waiting list of social service agencies that want space on the campus. It is a highly successful example of private and public collaboration to develop a system of care.

The creation of Haven for Hope stems, in large part, from the involvement of Bill Greehey, Chairman of NuStar Energy and NuStar GP Holdings, a business and civic leader who is also the current Board Chairman and Treasurer of the Haven for Hope Board. Haven for Hope opened in April of 2010 with a 37 acre complex that has the look and feel of a college campus, with two main areas: the Courtyard, which provides shelter and basic services to homeless individuals, and the Transformation Campus, which has a rich array of housing options, employment opportunities and supportive services. The Courtyard focuses on maintaining a safe environment, providing shelter, meals, showers and laundry facilities. In addition to meeting these basic needs, the Courtyard staff work to engage its visitors in the transition from homelessness utilizing an integrated behavioral health and primary care clinic. The Transformation Center, the larger part of the campus with a college-like atmosphere, helps people with their recovery journey. There are transitional living quarters for children, sober living for people with addictions, sober living for women, as well as employment services and permanent supportive housing.

Highlighted Agency Strengths

- Haven for Hope has many strengths, but a particularly noteworthy one is the evolution towards a trauma-informed, Recovery Oriented System of Care (ROSC).
- Haven for Hope understands that a large percent of the homeless population struggles with substance abuse disorders and/or mental illness.
- Haven for Hope has actively sought consultation and training to equip staff with the knowledge and skills needed to create a hopeful and positive environment and experience. The organization provides staff training in best practices such as trauma informed care, motivational interviewing, and person-centered recovery planning, as well as peer support.
- The close vicinity of the CHCS Restoration Center, which offers recovery services and CentroMed, a Federally Qualified Health Center (FQHC), its primary care partner located immediately outside the Haven for Hope Transformation Campus, provides good access to health care services. Haven for Hope also has an integrated care clinic run by CHCS on the Courtyard as well as vision and dental partners providing care immediately outside the Haven for Hope Transformational Campus.
- The biggest challenge facing Haven for Hope is that its current services do not meet demand.

Haven for Hope Major Findings

H4H Major Finding 1: The strong emphasis on a recovery-oriented system of care (ROSC) framework and incorporation of peer providers (people with lived experience of mental health, substance use, and/or homelessness) working in a variety of roles is a positive example for the larger system of care and a model to emulate more broadly.

Haven for Hope currently employs between 30-40 peers: of those, 18 are working as peer support specialists in various programs including permanent supportive housing where they meet with program participants in their homes. One peer provides outreach to people with criminal justice involvement. In this role, the peer support specialist meets with individuals during incarceration who do not have permanent housing options upon release. This peer helps with their transition to Haven for Hope campus and services, a critical effort to prevent recidivism into the jail system as well as to support recovery.

Part of the evolution to a recovery-oriented system of care is represented in the changes occurring on the Courtyard. When originally designed, the Courtyard was an open air, outdoor space with almost no protection from the elements. Cold meals were served and people were encouraged to make a commitment to life transformation in order to access the richer, and more comfortable environment of the Transformation Campus. Recent changes in operating philosophy have acknowledged the complexity in terms of the determinants of intrapersonal change, and environmental modifications are in progress to create a more comfortable and engaging environment on the Courtyard. These changes include construction of an additional impermeable cover over the Courtyard for protection from the elements, renovation of existing indoor space to encourage interaction among people visiting the courtyard, less emphasis on a disciplinarian-mentality and more emphasis on compassionate engagement of visitors by staff, including peer specialists with the intention of offering services to those in need. Haven for Hope is in the process of renovating 38,000 square feet of space in a building adjacent to the Courtyard to provide additional employment opportunities and housing for married couples without children. This space will also house other community partners whose missions align with the work in the Courtyard.

H4H Major Finding 2: The Intake Center, the key entry point for services at Haven for Hope, is a model for screening, assessment, referral, and triaging of those most in need. Through the assessment process individuals are identified at standardized levels of risk and severity of need for housing and support services. Services are then arranged to meet their needs. Yet, the intake unit was intended to screen about 300 people per month but now serves 1,700-2,000. This is largely due to word of mouth that Haven for Hope is a good place to get connected to services and resources.

H4H Major Finding 3: Haven for Hope has been operating at and above capacity within the Courtyard for the last two to three years serving a large number of individuals with complex needs. The Courtyard was built for approximately 400-500 individuals, and it currently serves about 700 each night. The over-capacity is a significant strain on resources and staff. There are about 850 individuals served each day on the Transformation Campus, which is the current capacity.

H4H Major Finding 4: Recognizing that demand is greater than the services available, Haven for Hope is expanding through the acquisition of a new building adjacent to the existing campus. There are three phases to enhancing expansion:

- Phase 1 is operational and includes a business enterprise that employs Haven for Hope residents in a call center that reaches out to VA eligible veterans to assess their experience with VA services as one of their contracts.
- Phase 2 is a build-out of the basement to accommodate married couples who reside at Haven for Hope who have to sleep in separate dorms at this point, which has discouraged them from residing there. There also will be beds for singles available as a 'step-up' from the Courtyard. There will be 20 rooms for couples and an additional 76 beds for individuals.
- Phase 3 is to create a mini-Transformation Center to bring full services to those who reside on the Courtyard.

H4H Major Finding 5: CHCS is the partner with the most services on the Haven for Hope campus. Overall, these tend to be model services, but need exceeds current capacity. These include:

- The Projects for Assistance in Transition from Homelessness (PATH) – Homeless outreach and case management services;
- The Wellness Center – An adult mental health clinic which offers psychiatric and other mental health services;
- The In-House Wellness Program for Women – A mental health clinic designed for women's issues;
- The In-House Recovery Program –A sober living environment for individuals with addiction disorders;
- An integrated care clinic for primary care and behavioral health services – A clinic that offers primary care and the services of the Wellness Center, which is in the process of being co-located within the Haven for Hope campus.

Immediately adjacent to the campus, CHCS operates the Restoration Center which includes a variety of programs such as a Sobering Center, a medical detox unit, intensive outpatient services for substance use disorders, a 48-hour observation and mental health evaluation center, the injured prisoner program, a methadone clinic, a program for pregnant women with heroin addiction problems, and a primary care clinic.

H4H Major Finding 6: The scope and complexity of homelessness contributes to the perception by the community and the city government that Haven for Hope has not "solved" the homeless problem. While it can serve a key role for the most complex cases of homelessness, a single program – even one with the impressive service array provided through Haven for Hope and its providers – cannot address the lack of affordable housing for Bexar County residents. San Antonio relies on tourism in the downtown area as a major source of income. Similar to other cities with large problems of homelessness, as housing prices increase and treatment resources decline, there is a significant need for a broad community response. A recent Summit to bring the faith community together with Haven for Hope to discuss the downtown mission work where homeless people are fed led to discussion of coordination strategies. This type of effort is needed system-wide to support recovery and assist people with obtaining homes and jobs.

H4H Major Finding 7: Access to affordable health care is an ongoing challenge, in part due to funding and regulatory requirements. While CentroMed provides primary care services, as does the CHCS-run integrated care clinic on the campus, it is insufficient for the population that resides there. There are a number of people from Haven for Hope that end up being transported to the emergency departments of area hospitals. Often these individuals are experiencing a crisis due to unmanaged chronic conditions that ideally would be served in a primary care setting where the crisis could be adverted. Beyond primary care, access to specialists and resources to pay for medications and other treatments is a challenge noted by multiple individuals. CentroMed does not practice outside of its facility, thus eliminating access for people who will not or cannot enter their facility. It should also be noted that the University Health System indigent care program (Carelink) does not serve Haven for Hope residents. Instead, University Health System has another program that provides a reduced benefit for these individuals. This secondary CareLink program call Homeless Assistance Program (HAP) is available only to those residing on the Transformational Campus. People residing on the Courtyard still do not have access to specialty healthcare. Also, the integrated care clinic run by CHCS does not specifically meet the definition of a clinic that is eligible to receive free vaccines through public health or the lower pricing for medications under the 340b program. Staff must find other ways of providing vaccines, particularly adult vaccines, and affordable medications. Finally, there is no continuum of care for individuals exiting homelessness but still needing ongoing assistance with medical care.

H4H Major Finding 8: Required data systems for the various funders require redundant data input into multiple systems in order to maintain compliance for the same client when multiple needs are served. For example, at Haven for Hope they report information into the Homeless Management Information System (HMIS), Anasazi, Red Rock and two Clinical Management for Behavioral Health Services (CMBHS) portals. The two CMBHS interfaces do not connect to allow cross communication and single entry. Delivery System Reform Incentive Payment (DSRIP) projects, while providing an incredible opportunity to fund innovations targeted at high need populations, have the unintended consequence of creating discrete programs for target populations. Due to

the strict requirements for reporting on metrics and achieving milestones in order to draw down funds, these projects limit their innovations to target populations, rather than open them to all who need the services. In addition, providers report they are very concerned about double-counting program participants.

Haven for Hope Major Recommendations

H4H Major Recommendation 1: Continue to build on the ROSC framework, including expanding use of motivational interviewing and training on trauma-informed services for all health and human services providers, as well as expanding the peer workforce. These best practice strategies require ongoing training and continuous quality review to assist staff in tapping the strengths that all individuals possess, assist them to find the motivation to recover, and to obtain housing and employment, despite the serious challenges of mental illness, substance use and homelessness.

H4H Major Recommendation 2: Taking programs to scale is necessary to address the health and social needs of homeless individuals. Prioritizing the resources and cross-agency efforts to accomplish this will need to be addressed by the county-wide BH leadership process described above – Haven for Hope cannot achieve this on its own. Establishing a County BH leadership role in collaboration with system partners is a necessary step to plan, over the long-term, how to prevent people from becoming homeless and respond when they do by providing low-income housing, services and employment opportunities. Leveraging the interest and perspectives of the health and human services committee, cities, and home builders, police, schools, community colleges, and other stakeholders, employers and businesses is essential to a systemic long-term strategy.

H4H Major Recommendation 3: Adopting a county-wide policy that promotes access to affordable housing is a critical step towards moving people from the streets to recovery. National best practices and evidence tends to favor "housing first" approaches that rapidly establish individuals in permanent housing, with necessary supports. This approach, which focuses on prioritizing homeless individuals for permanent rental housing and then wrapping services around the individuals / families. This has been successful in decreasing homelessness in other communities. The policy will need to be reviewed and embraced by the County Leadership structure to encourage the development of affordable housing through federal, state, and local resources. Under this model housing is not contingent on compliance with services. Rather, individuals/families must have a standard leasing agreement and support to maintain their tenancy. Housing should not be a reward; it is what homeless people need and it also gets people off the streets.

H4H Major Recommendation 4: Haven for Hope should seek agreements to further connect integrated primary and behavioral health care services, create health homes for people with complex needs, and take fuller advantage of resources to fund indigent care, particularly for access to specialists, vaccines, and affordable medications. Over the long-term, address this through a county-wide leadership structure, potentially through the Southwest Texas Regional Advisory Council (STRAC) or some other forum with medical provider involvement and leadership buy-in. In the short term, explore formal relationships that would improve access through the hospital district, FQHCs and other health providers. Consider developing public health care outreach models that could team health care staff with peer specialists and behavioral health clinicians to serve people who cannot or will not go to a health care facility.

Collaborate with program partners to improve cross-system coordination and identify strategies for reducing access barriers for individuals needing primary care and specialty care, including BH services, as well as medicine and vaccines. Consider the cost benefit of this approach versus high ED utilization and public health challenges such as the individual impact and spread of infectious diseases.

H4H Major Recommendation 5: Work with HHSC, the health information exchange (HIE), and local providers to streamline reporting on individuals and programs, improve efficiency and allow better reporting approaches to population management. This will specifically require work with HHSC and its agencies to streamline DSRIP and other state reporting requirements. Streamlining metrics and allowing full access to programs for high utilizing populations would facilitate access and improve local level systems operations. This seems like an opportunity area to work with the state and CMS bring the focus on population health while maintaining clear expectations for establishing and meeting metrics. The importance of health and human services organizations

having an Electronic Health Record (EHR) and the ability to provide data to HealthCare Access San Antonio (HASA), the Health Information Exchange (HIE), is essential for effective population management and care coordination. This is a long-term strategy but investment at the state and local level is necessary to produce accurate information and manage care.

Nix Health

Nix Health offers an array of behavioral health (BH) inpatient and crisis intervention services and has expanded its array of services over the course of 2015. Nix is becoming an increasingly important partner in the public behavioral health system of Bexar County, operating acute psychiatric beds for children, adolescents and adults, as well as a specialized geriatric psychiatric inpatient program, a Crisis Intervention Unit (CIU) and a Psychiatric Emergency Services (PES) program. Nix also offers an Intensive Outpatient Program (IOP) and a large Mobile Assessment Team that not only covers Bexar County but other facilities and programs in central and southern Texas.

Nix Health offers an array of behavioral health (BH) inpatient and crisis intervention services. Operating since 1930 in San Antonio and South Texas, Nix is supported by its parent company, Prospect Medical Holdings, Inc., and provides behavioral health services including a total of 180 inpatient and crisis beds in multiple San Antonio locations for children and adolescents ages five to 17, adults 18 and older, and seniors.

Nix has expanded its array of services over the course of the past year and is becoming an increasingly important partner in the public BH system of Bexar County, operating:

- Nix Specialty Health Center, with 58 "high-acuity" acute psychiatric beds for adults, and an 18-bed specialized geriatric psychiatric inpatient unit.
- Nix Behavioral Health Center, with 26 "moderate acuity" acute inpatient psychiatric beds for adults ages 18 and above, and a 31 Child & Adolescent Unit.
- Nix downtown geriatric "heritage" inpatient unit with 15 beds.
- A 16-bed Crisis Intervention Unit (CIU) that accepts voluntary patients; and a 16-bed Psychiatric Emergency Services (PES) that accepts voluntary and involuntary patients and provides complete psychiatric needs assessments, 24 hours a day, 7 days a week. Nix also provides a Mobile Assessment Team for individuals living in Bexar and outlying counties in central and southern Texas. The Team provides mobile assessment at other hospitals, nursing homes, detention facilities, and for other mental health providers. Also at this site, Nix provides a small mental health intensive outpatient program (IOP) for adults, primarily those transitioning from its own higher levels of care (PES, CIU, and inpatient) as well as appropriate referrals from outpatient providers and other organizations. Nix is planning a merger with Enlightened, a Partial Hospital Program (PHP) with capacity for 40. Once the merger occurs, the PHP program will open during the day and the IOP program during evenings, using the same space.
- All patients admitted to any inpatient program, or the PES and CIU, are cleared for medical stability through its own medical clearance at the Nix Emergency Department or through PES, where there is also a telemedicine program that allows access to remote physicians who are able to provide medical clearance. At the time of the initial site visit to Nix in July 2015, the Nix Psychiatric Emergency Services (PES) and Crisis Intervention Unit (CIU) were underutilized. However, changes begun in November 2015, such as clarifying the referral process for the University Health System, refining medical clearance procedures to be consistent with state hospital medical clearance guidelines, and expanding access to dually diagnosed intoxicated persons at PES have all resulted in increased utilization of these important services, with about 200 individuals served in January and February of this year.

Nix served 1,104 children and youth, 2,960 adults, and 658 older adults in FY15. Nix accepts Medicaid, Medicare and other third party insurance. Nix contracts with CHCS for provision of 15 adult uninsured beds and also provided inpatient care to over 60 unfunded patients in FY15 that were not covered by CHCS funding.

The CHCS contract beds are spread across both of its adult inpatient units.

Nix primarily relies on DSRIP funds for its PES and CIU services, which are subcontracted to Nix by University Health System. The University Health System DSRIP budget is $16 million each for PES and CIU over three years (starting in 2013, with year 3 being the current year). Nix recently contracted with Molina to provide their members access to the PES program. Nix also operates two other 3-year DSRIP projects: Intensive Outpatient Program (IOP) and Care Transitions for Behavioral Health patients post-discharge. The Care Transitions program, which navigates patients for 30-days post discharge to help them address any barriers they might face that could result in readmission, is fully funded through the DSRIP payments, whereas the IOP is funded in part by DSRIP funds and is also billed to insurance payers and a charity application, based on a sliding scale, is available to assist patients with their copayments for the IOP.

Highlighted Agency Strengths

- Nix has an excellent crisis continuum service array, the elements of which represent most of the components of a crisis hub that can respond appropriately to any level of crisis and manage individuals through the continuum as needed, including provision of medical clearance. The utilization of this crisis continuum is increasing. Furthermore, Nix is accepting direct referrals from the San Antonio Policy Department rather than having individuals flow through University Health System for medical clearance. This continuum is something that both Nix and the system as a whole can build on.
- Nix has recently appointed stable administrative and medical leadership and, as a result, their potential to partner in an ongoing way with the larger system has substantially increased.
- Nix is very willing to play a larger role in the County continuum, provided they are adequately funded. The leadership and staff appreciate the potential for developing crisis hubs in different sectors of the county, including PES, Crisis Intervention Units, mobile crisis, and walk-in crisis/meds.

Nix Major Findings

Nix Major Finding 1: Nix operates a nearly complete array of crisis services that represent a model for a crisis continuum, which can serve as a model for a county-wide crisis system. Strategies in place for medical clearance and mobile crisis as well as the strong efforts to coordinate care represent strengths to build on, both for Nix and the broader Bexar County system.

Nix Major Finding 2: Nix's crisis continuum is welcoming to challenging patients (particularly the PES site, given its non-institutional design). While Nix utilization has increased with close to 200 individuals served in January in the PES/CIU, and with February also on track to serve a similar number, there is no consistent plan in the community for how people flow through the PES/crisis system and, subsequently, no county-wide coordination of response to crisis, either for individuals, families, or Emergency Departments. Consequently, it is somewhat random whether people are brought directly to PES, University Health System, or other places.

Additional specific programmatic findings were also identified and provided to Nix for review.

Nix Major Recommendations

Nix Major Recommendation 1: Work with other crisis and emergency room providers in Bexar County to develop a system-wide strategy and plan for delivery of crisis services that better defines the role of the Nix continuum.

Nix Major Recommendation 2: As part of the work designing the crisis system, collaborate with the BH leadership planning effort to develop consensus for consistent county-wide policies, procedures, and protocols for medical screening ("medical clearance") for adults who present in psychiatric crisis, and those who are intoxicated and require admission to psychiatric crisis facilities or hospital beds.

Additional specific programmatic recommendations were also identified and provided to Nix for review.

University Health System

University Health System is the hospital district for Bexar County, and as such it is a separate political subdivision of the State of Texas owned by the people of Bexar County. It employs approximately 6,000 staff, including 1,000 physicians and 700 resident physicians (as the primary teaching partner with the University of Texas Health Science Center at San Antonio School of Medicine). University Health System operates University Hospital (a 496-bed acute care hospital, including a Level 1 Trauma Center) and a county-wide array of 19 outpatient health centers (including one in each region of the county) that provide preventive, primary, and specialty health services, primarily to indigent and Medicaid/Medicare populations. University Health System also provides medical and behavioral health care for the Bexar County Adult Detention Center and Juvenile Detention Center. University Hospital has a total of nearly 50,000 annual admissions and over 76,000 emergency department visits. Community Medicine Associates (CMA), a 501c provider practice group owned by University Health System, together with UTHSC-SA, provide primary and specialty care for well over a half million ambulatory visits per year (2014).[100]

University Health System collaborates in the community through multiple forums. It was a strategic partner in the development of both the CMDRT and the Mental Health Consortium, along with the Bexar County Mental Health Court and the expansion of the Mental Health Public Defenders office. Each of these laid the foundation for the creation of the Bexar County Mental Health Department, the first of its kind in Texas. University Health System is also represented at STRAC and various other Bexar County councils, including the Criminal Justice Coordinating Council (and its Committee on Homelessness) and the Central Magistration Mental Health Coordinating Committee.

University Health System currently offers the following behavioral health services across the continuum:

- **A 20-bed Acute Inpatient Psychiatric Teaching Unit.** The unit has approximately 1,000 annual admissions per year and an average length of stay of 5.0 days (calendar year 2015). When the unit opened in the early 1990's, it targeted inpatient services for indigent voluntary patients, based on the case mix at the time, and was designed with semi-private rooms. With the nationwide trend since then toward more acute populations, the unit has evolved into a mostly (at least 70%) involuntary unit, and therefore the level of patient acuity has risen. The need to maintain single rooms for some patients has led to somewhat lower average capacity. Physician (faculty and resident) services are provided through contract with the UTHSC-SA Department of Psychiatry.
- **Inpatient Psychiatric Consultation Service.** Psychiatric consultation is available to all University Hospital inpatient adult and pediatric medical/surgical services. It is staffed by UTHSC-SA psychiatrists, a psychologist, psychiatric residents, and psychology interns. The service currently sees approximately 90 new consults per month, along with follow-up visits.
- **Behavioral Health Services for Bexar County Adult and Juvenile Detention Centers.** The Adult Detention Health Care Mental Health staff provide care to approximately 11,250 adult patients annually (54,375 contacts), of which approximately 60% are individuals with serious mental illnesses. University Health System staff provide crisis intervention, medication management, levels of care approximating community inpatient and outpatient services, suicide assessment and prevention, and contracted forensic services for competency and sanity evaluations. The Bexar County Adult Detention Center includes 280 designated mental health beds, making it the largest provider of mental health services in the county.
- **Integrated Behavioral Health Care in Patient Centered Medical Homes.** In 2010, behavioral health positions were created to integrate behavioral health services into five primary care patient centered medical homes. With the opportunity presented by the 1115 Waiver, this program was expanded and Community Medicine Associates (CMA) currently employs three full-time psychiatrists (including one child/adolescent psychiatrist), six full-time therapists (including one licensed chemical dependency counselor), and two full-time psychiatric nurse practitioners. Many of the behavioral health providers are bilingual (Spanish-English). Behavioral health services are provided through a collaboration of CMA, University Health System, and UTHSC-SA. CMA also contracts with the UTHSC-SA Department of Psychiatry for an additional 10% FTE psychiatrist. The behavioral health team served over 4,500 unduplicated patients in DSRIP Year 4 (October 1, 2014 – September 30, 2015).
- **Emergency Department.** The University Hospital Emergency Department has an area designed for those patients with behavioral health needs who present to the hospital with acute psychiatric and/or emergent/urgent medical issues. In the past two years it has added psychiatric social workers that report to a newly added position of Care Coordination Behavioral Health Manager. Given UTHSC-SA development of an Emergency Medicine Department and a residency training program in Emergency Medicine, and in order to align with Accreditation Council for Graduate Medical Education training requirements, several years ago the Psychiatric Emergency Service (then operated and managed by psychiatry) was transitioned to the current area operated and managed by the Emergency Department. The Emergency Department provides evaluation for the largest proportion of persons detained by law enforcement in the county (emergency detentions or mental health warrants – approximately 2,700 per year). With the opportunity offered by the 1115 Waiver, a DSRIP project was developed with Nix Behavioral Health. The Psychiatric Emergency Service and Crisis Intervention Unit at Nix's Babcock location became operational October 1, 2014 (within two blocks of University Hospital).
- **Care Coordination/Social Work.** University Health System operates a care coordination department that includes social workers and nurse case managers who facilitate transitions of care between services.
- **Addiction Treatment.** There are three fulltime licensed chemical dependency counselors (LCDCs) providing consultation for inpatient services within University Hospital. Their activities focus on screening and brief intervention, and they are actively engaged and integrated into the trauma service to address the high comorbidity of addiction in this population. In addition, one fulltime LCDC works in the outpatient integrated care services provided in primary care clinics (as outlined above). Inpatient medical/surgical units routinely provide detox services, and the inpatient psychiatric unit integrates an LCDC in daily rounds to develop planning for the next level of care at discharge.
- **Leadership.** In 2013, University Health System created the position of Chief of Behavioral Medicine and shortly thereafter Director of Behavioral Health Services, underscoring the importance of developing the behavioral health service line across the continuum of care. These positions, in collaboration with the Community Medicine Associates President/CEO, the CMA Associate Medical Director for Outpatient Behavioral Health, the UTHSC-SA chair and faculty, and University Health System operations leadership, have begun to effect changes leading to a better coordinated system of care and improved collaborations with community partners. The partnership with UTHSC-SA Department of Psychiatry has been strengthened with the selection of a new Chair of the Department who is community focused and aligned with the University Health System's strategic and operational goals and objectives.

Partnerships. University Health System has also developed numerous local partnerships through both informal collaborative processes and formalized contracts:

- **The Center for Health Care Services (CHCS)**: CHCS receives about $4 million from University Health System.
  - This includes funds for the services listed below:
    - Detoxification services,
    - CareLink outpatient services.
    - Mommies Program (treatment of opioid addiction for pregnant women),
    - Methadone medication services, and
    - Direct local match funding (varies as a proportion of the required state general revenue funds for the LMHA).

100 All data were obtained on February 12, 2016 via personal communication with Dr. Sally Taylor, University Health System, unless otherwise noted.

  - During 2015, University Health System and CHCS developed and executed a Business Associates Agreement and Memorandum of Understanding allowing for access to CHCS' electronic medical records by providers within University Health System providing continuity of care to CHCS patients. This has helped with continuity and transitions of care.

- **Nix Behavioral Health**: This partnership is centered on the development of the 1115 Waiver DSRIP-funded services noted above (the Nix Psychiatric Emergency Service and the Crisis Intervention Unit).
- **Haven for Hope**: In 2015, University Health System provided 33% of a $1 million grant for a Jail Outreach Program (the rest was provided in equal shares between Bexar County and CHCS). This program targets jail inmates or detainees (with and without mental illness) arrested and brought to Central Magistration, and who would have been bonded out had they not been homeless. Collaboration between Haven for Hope, the Bexar County Criminal Justice Re-Entry Program, and University Health System Mental Health staff inside the Bexar County Adult Detention Center supports identification of potential candidates for the program who go on to receive peer support services and treatment for mental illness and addiction on the Haven for Hope campus.
- **Clarity Child Guidance**: University Health System partnered with Clarity Child Guidance, providing intergovernmental transfer (IGT) funds to leverage development and implementation of a psychiatric emergency service for children and adolescents.
- **University of Texas Health Sciences Center San Antonio (UTHSC-SA)** Department of Psychiatry: In addition to the contracts with UTHSC-SA for psychiatric coverage of University Hospital's psychiatric services, there is close coordination between UTHSC-SA and University Health System psychiatric leadership on system development.

University Health System Highlights, Findings, and Recommendations:

This section of the report focuses on highlights, findings, and recommendations related to the organization and performance of University Health System as the hospital district, as well as its leadership potential for the larger behavioral health (BH) system of care in Bexar County. The findings and recommendations are organized according to specific services: inpatient, emergency room, and ambulatory primary health/behavioral health integrated (PHBHI) care (consultation services and jail services were not reviewed), followed by discussion of the connections of University Health System with CHCS and other providers, and recommendations about the overall behavioral health system in the Bexar County system as a whole. This section also identifies opportunities for improvement in each of the various categories discussed.

Highlighted Agency Strengths

The following points frame the overall discussion of findings and recommendations:

- University Health System, as the hospital district, is an important and critical partner in establishing a BH leadership structure for the overall county BH system to leverage the full array of collaborative partnerships addressing health outcomes across populations served. Key strategic leadership collaborations have already been established and can be built upon.
- University Health System has hired an effective BH leadership team as a foundation on which to build and improve BH services system-wide.
- An initial review of the prevalence of BH conditions among the current University Health System patient population found that a high percentage of people and families served have BH conditions. University Health System continues to look for ways to expand integrated behavioral health services into primary care settings.
- Lessons learned from collaboration between University Health System and Nix to establish a psychiatric emergency service (PES) and a crisis intervention unit (CIU) have helped build the foundation for establishing a system-wide crisis response system that facilitates access and manages utilization of these important resources. University Health System is in an excellent position to contribute in the design of a system-wide crisis system.
- University Health System utilizes LEAN quality improvement methodology, which can be useful in moving toward both improvement and expansion of integrated physical health (PH) and behavioral health (BH) care, as well as towards improving coordination and collaboration with system partners.

University Health System Major Findings

University Health System Major Finding 1: University Hospital's Psychiatric Inpatient Service's capacity is a key community resource, well suited to the highest acuity patients, but it is at times somewhat constrained by factors related to the care of these high acuity cases. University Health System operates a 20-bed secure inpatient unit. The unit is reasonably well configured physically (other than the dual occupancy issues noted below), and the patient acuity is well managed. However, capacity is at times limited because the high acuity of patients (and their mostly involuntary status) restricts them to single rooms, which may at times limit the use of the full 20-bed allocation. Some payer limitations, such as assertive carve outs, also limit capacity.

Nursing staff were very positive about the unit's ability to accept individuals with all levels of acuity and with all levels of co-occurring substance use. One challenge when evaluating emergency department patients who need inpatient psychiatric care is matching multiple private and Medicaid insurance plans with inpatient units where care will be covered. The unit is a residency and medical student training site and psychiatric staffing is provided by UTHSC-SA faculty. University Health System and UTHSC-SA leadership have collaborated to identify faculty with an interest in acute care psychiatry and to ensure a positive and effective teaching environment for trainees. UTHSC-SA is also working to expand continuity of care opportunities for the residents, particularly by expanding opportunities for residents to follow patients from the inpatient unit to UTHSC-SA's Transitional Care Clinic, which is a major resource for discharged patients who do not already have or cannot make a timely connection to an outpatient appointment. University Health System leadership is actively investigating the opportunity for peer support specialists and enhancing a trauma-informed, recovery-oriented framework for care.

Recently, an additional six-bed medical unit has opened proximal to the psychiatric inpatient unit, which provides for more collaborative management of patients needing the level of care of a medicine bed but who have comorbid behavioral health conditions requiring closer psychiatric consultation. The unit has proven successful in moving patients from other medical beds and decompressing the Emergency Department. Three additional beds have been approved. The unit potentially may serve as a pilot program for potential development of a medical-psychiatric unit with dual staffing.

University Health System Major Finding 2: The University Health System Emergency Department serves a growing number of people and continues to see the highest proportion of persons detained by law enforcement. The Emergency Department has been recently renovated to be a much larger (approximately 10,000 square feet) and more modern facility.

The area designated for patients with behavioral health comorbidities is strategically located for access by law enforcement to bring individuals who are under emergency detention or detained under mental health warrants, and for those being brought for medical emergency services from the jail who do not need the level of care of the resuscitation area. Jail and psychiatric patients are treated in separate pods with a shared nursing station. The Emergency Department receives individuals with severe BH needs (when possible, the staff attempts to address milder, voluntary requests for help in the general Emergency Department), whether voluntary or involuntary. With the collaboration between University Health System leadership and that of the UTHSC-SA Department of Psychiatry, efficiencies have been realized with discharges from inpatient psychiatry early in the day to free up beds, and improved clinical collaboration between the inpatient unit and the Emergency Department. Additionally, a collaborative effort to address patient flow between the Emergency Department and the Nix PES has led to smoother transfers of patients. Both initiatives have led to improved movement of patients out of the Emergency Department to both sites (with Nix functioning much better in that role since late 2015).

In late 2014, psychiatric social workers were added to the Emergency Department to provide crisis intervention services and lend additional expertise to emergency medicine physicians and the emergency department team. The unit where behavioral health emergencies are addressed is currently involved in quality improvement processes using LEAN methodology, addressing care transitions, transfers, policies, clinical management and treatment of psychiatric conditions, and training of nursing staff.

University Health System has been tracking the new PES and CIU programs at Nix to determine if these programs are reducing utilization of its emergency room (ER). The data shared indicated that, while these services have ramped up significantly in 2016, in 2015 the volume of emergency detentions in the University Health System ER actually increased from 85.3 per month in 2014 (January to May) to 139.8 per month over the same time period in 2015. However, length of stay for discharged or transferred patients went down from 11.4 hours to 9.3 hour for discharged patients, and from 15.4 hours to 11.9 hours for transferred patients. The reduction from those transferred was seen as primarily due to the availability of the Nix PES. Together with the UTHSC-SA Department of Psychiatry, planning is in progress to increase coverage of the Emergency Department with psychiatric consultation. Nix staff is continuously engaging in community education regarding the availability of the PES for direct access, particularly by law enforcement. Evaluating how patients move through the emergency/crisis system might uncover opportunities for efficiencies and referral patterns that better serve patients at the right location, in addition to targeting high utilizers in a community-wide, organized strategic plan.

University Health System Major Finding 3: Services through the Health System's outpatient clinics have expanded primary health/behavioral health integrated (PHBHI) services, and capacity should continue to be developed to align with needs. As noted earlier, University Health System has developed an extensive network of outpatient (OP) primary care and specialty services for the medically needy populations of Bexar County. As outlined above, University Health System began to expand and integrate behavioral health services and continues to evaluate strategic opportunities for expansion. Collaborative efforts with CHCS are ongoing in order to define and offer the right level of care at the right location. While, initially, diagnostic categories helped define the scope of services, the goal now is to more closely align with the Four Quadrant Clinical Integration Model[101] to target those patients best served in primary care settings and to refer those who have intensive behavioral health treatment needs to CHCS. Psychiatry residents rotate through these clinics on a limited basis, and opportunities for further expansion are being evaluated. With the 1115 Waiver, University Health System obtained funding for a project to expand BH capacity and integrate BH services in six of the major regional OP clinic sites.

Sharing an electronic medical record, having all providers (therapists, psychiatrists, and advanced practice nurses) employed by Community Medicine Associates (except for a 10% contracted FTE with UTHSC-SA Department of Psychiatry), and appointing an Associate Medical Director for Outpatient Behavioral Health have allowed for sharing of treatment plans, facilitated collaboration with primary care and specialty medical services, and provided for more unified policies and procedures between behavioral health and physical health providers.

University Health System is also evaluating strategic opportunities to expand access (e.g., telepsychiatry, addition of midlevel practitioners, etc.) for child and adolescent psychiatry, which would address a major gap. University Health System reports that managed care organizations have identified this as a major need for members as they struggle to offer timely (within seven days) follow up after hospital discharge and access to outpatient care in general.

University Health System Major Finding 4: Care coordination is key for improving cross-system care transitions. Over the past several years, University Health System has expanded its Care Coordination Department, and utilizes social workers, nurses, and psychiatric social workers to facilitate discharge planning and transitions of care. Treatment resource limitations continue to be a challenge, and robust efforts to identify next appropriate levels of care and improve processes to access them are continually underway. The Care Coordination Department is in an excellent position to identify barriers to care transitions. Patient navigation across agencies is a challenge, and transitional case management provided by a CHCS liaison position at University Hospital is being planned to operationalize in the second quarter of 2016.

101 Mauer, B. 2006. Behavioral Health/Primary Care Integration: The Four Quadrant Model and Evidence-Based Practices. Rockville, MD: National Council for Community Behavioral Healthcare.

University Health System Major Finding 5: University Health System's BH leadership is involved in and dedicated to system-level collaboration. University Health System leadership is regularly involved with community-wide system collaboration activities and University Health System has been an important partner for jail-based services in the current Council of State Governments/MMHPI project to increase Central Magistration Unit (CMAG) diversion. Two other major areas of collaboration have involved the county's Behavioral Health Consortium and the Community Medical Director's Round Table (CMDRT). With the creation of the Bexar County Mental Health Department, there is a great opportunity for ongoing gap analysis activities and, with University Health System as an important collaborative partner, for addressing gaps as a community through CMDRT and the Consortium. One goal that is important to all strategic community partners, including University Health System, is to develop county-wide care coordination capacity to track all the patients in crisis through the continuum (including access to ongoing outpatient care) to see what is happening and to work collaboratively to improve outcomes. LEAN methodology (which University Health System has adopted, as noted above) would be a helpful tool for improving system level processes.

One area of continued opportunity is strengthening community partnerships, including but not limited to that with CHCS. As a sponsoring agency of CHCS (and appointing four of its board members), University Health System has an interest in strategic alignment, and defining the right treatment at the right location is critical to maximizing access to care across the continuum. In addition, shared accountability for preventing unnecessary emergency room visits and admissions/readmissions should be a guiding principle across the entire system of care.

University Health Major Recommendations

Recommendations for University Health System as a Whole:

University Health System Major Recommendation 1: The Health System's leadership should continue to lead the overall County BH System, and may require expanded involvement to help the system move to the next level. University Health System, as the hospital district, is a critical and influential partner in establishing a more comprehensive and effective BH leadership structure for the overall county BH system, with capacity for sharing responsibility for BH outcomes across the population served. No single public agency alone (i.e., University Health System and/or CHCS) can be effective in taking on this broad challenge. Therefore, public-private partnerships are needed and should include Bexar County, University Health System, CHCS, UTHSC-SA, and other key stakeholders (including private providers), especially other health systems and the multiple Medicaid managed care organization (MCO) payers. This will be key to developing a strong, functional, and well organized collaborative in which resources and capacity are shared and enhanced, and in which multiple payers invest in a single continuum rather than each payer primarily managing its own.

University Health System Major Recommendation 2: Continue to commit to a vision to expand integration of behavioral health into the Health System's total business of providing health care, and incorporate behavioral health into the Health System's overall strategic plan. This is clearly the direction of the future to achieve key goals, including the Triple Aim, the shift toward population management, and wise stewardship of limited health resources. A strategic plan establishes an overall direction for the organization, as well as achievable small-step targets of progress that allow for meaningful change to occur slowly. University Health System is deeply involved in both the direct delivery of the BH services described above and the delivery of health care services to people and families who suffer from comorbid BH conditions. As University Health System continues to articulate this vision over time, partnerships with other agencies will also need to be part of the strategic vision, allowing University Health System to leverage the full array of needed services while defining which services are best provided internally.

University Health System Major Recommendation 3: Continue to refine data collection on the current baseline of BH needs across the entire University Health System patient population. The move to Midas is expected to potentially allow for better data-driven planning. An important aspect of care to evaluate will be the cost of high utilizer/high cost/poor outcome populations, and the cost impact to the Health System of unmet / under-met BH

needs in the form of medical ER visits, medical hospitalizations, etc. It will also be critical for the Health System's clinics to quantify their capacity to provide integrated care.

University Health System Major Recommendation 4: University Health System should view itself as a full partner in designing and implementing a county-wide psychiatric crisis system. Bexar County is in a public health emergency regarding unmet need for response to individuals and families in psychiatric crisis. University Health System is a natural leader in helping to convene all partners to have a high level public health response that would parallel what is starting to happen in the criminal justice system and the homeless system (via Haven for Hope). Key to this will be continuing engagement with the planning process of the STRAC, which manages emergency response capacity regionally. Note that the crisis system is only one element of system response for both adults and children that should be addressed by system-wide BH collaborative leadership. It is essential to focus on the entire continuum of care in the overall movement from a crisis model to a recovery model.

Recommendations for University Health System Programs and Program-Level Collaboration
Inpatient Recommendations
University Health System Major Recommendation 5: Look for additional ways to improve capacity. High patient acuity and the subsequent need for private rooms should continue to be evaluated so that this program is not constrained by unintended space limitations (this evaluation is already underway).

University Health System Major Recommendation 6: Continue to explore the development of medical-psychiatric unit capability to meet system needs.

Assessing the volume of need based on current baselines in acute medical and specialty units for people demonstrating significantly unstable BH needs is an essential next step. This will then inform planning to allocate sufficient capacity and space to respond to this complex population for which University Health System is positioned as a highly qualified provider.

University Health System Major Recommendation 7: Continue to partner with UTHSC-SA to address academic training and leadership in the provision of acute care. This is already under way and should be actively continued.

University Health System Major Recommendation 8: Develop a plan for improving recovery-oriented, trauma-informed care on the inpatient unit, as well as for adding peer support specialists in the staffing mix. Discussions are currently underway internally regarding this. While the need for this is particularly important for inpatient care, this recommendation applies to all inpatient, crisis, and outpatient services across all providers in Bexar County. These best practice approaches should be embedded across the system. The plan should include identifying and partnering with peer-run programs (including the San Antonio Clubhouse) and identifying peer leaders who can assist University Health System with implementing recovery-oriented approaches. There are also national resources available to assist organizations with best practice approaches for learning about and providing trauma-informed care.

Emergency Department Recommendations
University Health System Major Recommendation 9: Partner with other hospitals, crisis providers, the county, and the STRAC to develop a coordinated system of all crisis services (at all levels of care, and for mental health and substance use disorders) in the county, with an ongoing care coordination hub and the ability to provide mobile and onsite service in all parts of the county. Right now, the crisis services in the county are fragmented and disconnected. University Health System is well positioned to help lead this county-wide quality improvement initiative. In addition, there is a need to review utilization of hospital-based services for high utilizers and explore additional resources to address needs to prevent avoidable ER visits and admissions. True success will depend on a plan of action with active participation by all health systems, and not just University Health System alone.

University Health System Major Recommendation 10: Work actively to establish adequate psychiatric crisis response across the community, so that University Health System is not disproportionately responsible for psychiatric emergency services. The county needs a full range of psychiatric crisis response (not just PES) in each geographic area of the county. University Health System has modeled this type of design with its distribution of outpatient primary health services. While the recommended collaborative BH leadership described earlier in the report should take responsibility for its development, rather than University Health System alone, the same geographically distributed model is needed for psychiatric crisis services. Potential strategies include: specifically reviewing policies and procedures regarding where to transport people in need; providing ongoing education regarding the capabilities of the Nix PES; defining the PES as an appropriate site for mental health warrant examinations; and potentially expanding medical capacity on site at the Nix PES, so that only the most serious medical needs require University Hospital evaluation. In addition, individuals should be transferred as quickly as possible to the PES from the Emergency Department.

Outpatient Physical Health/Behavioral Health Integrated (PHBHI) Services
University Health System Major Recommendation 11: All PH services should continue to develop capacity for integrated BH service delivery within an integrated strategic, data-driven process. The goal should be to maximize existing resources within primary care (including UTHSC-SA family medicine clinics) to improve integration of BH services into primary health settings.

Improving integration is an important system component that requires a clear hospital-wide directive and a step-by-step strategic improvement plan to build on and leverage existing resources. The Department of Family and Community Medicine at the University of Texas is a potential ally in this effort.

University Health System Major Recommendations 12: Develop an organizational strategy for improving the identification of and response to substance use disorders in primary health. Again, this is a nationwide trend that every community is struggling to address at one level or another, and it is best to face it head-on at a strategic level. The UTHSC-SA Department of Psychiatry is hiring an addiction psychiatrist and discussions are underway regarding collaborative opportunities for consultation, referral, and coordination of efforts. Expansion of the use of Screening, Brief Intervention and Referral to Treatment (SBIRT), which has been implemented by UTHSC-SA in primary care residency programs as a recognized strategy for identifying and engaging individuals with substance use disorders (SUD) at the earliest possible stage, should be encouraged. There is also an opportunity for University Health System to be an important collaborator in partnering with CHCS, as well as the City Metropolitan Health District, the San Antonio Council on Alcohol and Drug Abuse (SACADA), and other substance use providers to develop a county SUD treatment and prevention strategy that is integrated into producing better health outcomes and lower costs.

Partner Collaboration Recommendation
University Health System Major Recommendations 13: Use LEAN methodology collaboratively with other providers to improve collaboration, care coordination, and care transitions for patients, including high utilizers of hospital-based services. Both CHCS and University Health System have adopted LEAN methodology. This quality improvement tool is an excellent framework for documenting baseline results and developing an improvement plan with measurable targets for specific indicators. For example, LEAN can be used to measure the "successful patient experience" moving from University Health System (acute care) to CHCS (or other specialty providers) and back again to continue services in primary care. Developing a collaboration to use this technology would be a potentially useful strategy for making progress on these issues. A focus on quality improvement can potentially enhance collaboration.

University of Texas Health Science Center – San Antonio

The University of Texas Health Science Center (UTHSC) at San Antonio, Department of Psychiatry, staff and psychiatric residency program provides significant psychiatric services throughout the region, both directly and through contracts with other providers, including:

- The Transitional Care Clinic, a short-term clinic that helps individuals transition from hospitals to community care;
- Medical staff and/or residents for key providers, including University Health System, Clarity, Laurel Ridge Hospital, San Antonio State Hospital (SASH); Cindy Krier Juvenile Correctional Treatment Center, the Kerrville Veteran's Administration, San Antonio Military Medical Center, the UT Student Counseling Center, and many other community sites;

- Model integrated behavioral health services;
- Expanding addiction and co-occurring mental health / substance use services; and
- Telehealth linkages to other parts of South Texas.

The University of Texas Health Science Center (UTHSC) at San Antonio, Department of Psychiatry (Department), has been under new leadership since February 2015. Steven Pliszka, MD, Chair of the Department and formerly Chief of Child and Adolescent Psychiatry, is committed to community psychiatry, as well as to having the Department partner within the larger pubic delivery system in Bexar County on system development efforts. Dr. Pliszka has established a framework for community-oriented training with the child and adolescent population and is introducing training for the adult psychiatry community system continuum. He has created a new Division of General Psychiatry within the academic department to coordinate the vision for a comprehensive training program. At the time of the review, Dr. Pliszka was recruiting a chief for this new division.

The Department's staff and psychiatric residency program provides significant psychiatric services throughout the region, both directly and through contracts with other providers. It directly operates the Transitional Care Clinic (TCC), a short-term clinic that helps individuals transition from hospitals to community care. Referrals are made to the TCC by institutions that have an agreement with the Department and includes the provision of medication management, psychotherapy, in-home Cognitive Adaptation Training (CAT) services, and care coordination through social work staff. The TCC provides important transitional services for 90 days and was established to address the community services wait lists and other challenges of accessing community-based services.

University Health System contracts with the Department to staff its psychiatry services, including a 20 bed inpatient unit, consultation liaison services for patients with medical/surgical conditions co-existing with psychiatric conditions, outpatient psychiatric care, and provision of psychiatric consults in the Emergency Room (ER). This contract provides the majority of the direct service and residency training function for adults. Clarity Youth Guidance (Clarity) contracts with the Department for its psychiatry program and is the main site for training child fellows. The Department has relationships with other behavioral health providers where faculty and residents provide services: the Laurel Ridge Hospital; Krier Correctional Treatment Center; the Kerrville Veteran's Administration (VA); San Antonio Military Medical Center (SAMMC); SASH; and the UT Student Counseling Center.

The Department has ten (10) civilian slots and five to eight 5-8 active military slots for individuals on active duty in the Air Force in each year of the four year general psychiatry program, for a total of approximately 65 residents. It is the only residency program in the country for active military. It also has between seven and eight (7-8) child and adolescent resident stipends.

Highlighted Agency Strengths

- The Department's child program has extensive community presence. The primary child training site is Clarity, which has its own independent MD group composed mostly of former Department child fellows. Dr. Pliszka is very positive about this relationship. He also is supportive of working with Clarity to develop community based models of care such as consultation, wraparound services, and home based interventions, etc., in addition to facility and outpatient services. The Department also has a strong relationship with Juvenile Justice with services provided by fellows at the Juvenile Detention Center, Cindy Krier Juvenile Correctional Treatment Center, and Roy Maas Youth Alternatives (The Bridge and Meadowlands). Dr. Pliszka directly provides services at Meadowlands and at the Mission Road Development Center. School consultation with the San Antonio Independent School District is also available. Most notably, the Department is open to building relationships with a wider array of community partners to help the residents learn best practice community psychiatric approaches for children and families within a Children's System of Care partnership. In addition, the Department has obtained 1115 Waiver funds to establish a pilot primary health behavioral health integration (PHBHI) program for children, called Proxima.

- The Department is revising its adult psychiatry program, which is currently centered at University Health System. The changes underway emphasize a broader mission on provision of community oriented behavioral health care. These include developing a better training experience on the University Health System inpatient unit by seeking teachers who are interested in inpatient care for seriously ill individuals and having a mission that includes community based care, emphasizing the continuity of experience for the patients and residents. The focus is on enhancing linkages between psychiatric inpatient services, emergency room (ER) consultation, and the Transitional Care Clinic (TCC), as well as ongoing outpatient services. Currently there is some continuity of care available at SAMMC and the VA, but there is not as much continuity emphasis at University Health System training sites. The goal is to implement a more organized approach to training at multiple sites. Dr. Pliszka is open to promoting more experiences for residents at community sites rather than university sites (e.g., CHCS is one of the possibilities), provided that the training experiences are positive and not simply using the residents to provide service
- The TCC space is being expanded by relocating the bipolar clinic to UTHSC-SA (primarily a research clinic). Dr. Pliszka believes the TCC is a model that is an important element of services the department should promote, and is assigning residents to follow patients to the TCC from ER and inpatient program, believing: "The residents need to know they are still our patients."

Another advance is recognizing the need for training in addictions. The Department has recruited an addiction psychiatrist from John Hopkins University, Van King, MD, who will be starting in March 2016. Currently, the Department operates an adolescent substance abuse program run, and a DUI specialty program funded through 1115. The Department also has a consultative relationship with the Mommies program for opioid addicted mothers that is operated by CHCS and funded by University Health System. They want to start an Intensive Outpatient Program (IOP) for adults and provide opportunities for training in buprenorphine, a cost-effective medication assisted therapy. At the same time, the Department recognizes they need time to build co-occurring capability throughout the service continuum and the training program, rather than one circumscribed service element. They also recognize the importance of identifying training needs to address substance issues in individuals with severe BH needs in all stages of change as a concept, but have not yet begun to plan at this level.

- The Department has reached into parts of South Texas through telehealth, which they are interested in expanding. They provide telehealth services to La Esperanza, an FQHC in San Angelo.
- The Department is beginning to provide integrated health and behavioral health services in their community health clinics, such as Medical Drive (see below). Dr. Pliszka has asked Dr. Kenzler to take on a larger role in recruiting additional staff to support a larger PHBHI presence, and in the future would like to have more resident experiences in integrated health for adults.
- An important collaboration is the close relationship with the Department of Community and Family Medicine. They have begun training their faculty and residents in integrating BH care into their services, particularly at the Family Health Center, which has 35,000 patients. Thirteen (13) promotores were hired to improve patient engagement for individuals with complex needs, using an 1115 waiver funding to expand integration. Irma Sanchez, Department Administrator, is very interested in expanding inter-department collaboration and PHBH integration across the multiple university health service settings.

UTHSC-SA Major Findings

Major Finding 1: The Medical Drive Clinic for Physical Health Behavioral Health Integration (PHBHI) is modeling implementation of integrated care for the UTHSC-SA clinic system and the broader community. While limited in scope, it offers many best practices.

Major Finding 2: The Transitional Care Clinic is another program that can inform design of programs more broadly across the community. While limited in its community reach, many of its clinical practices are exemplary.

Additional specific programmatic findings were also identified and provided to UTHSC-SA for review.

UTHSC-SA Major Recommendations

Major Recommendation UTHSC-SA R-1: UTHSC-SA should become more engaged as a major partner in system design and implementation at the system level. Expanding its residency and training programs is essential to addressing local (and regional) workforce gaps, and that expansion should ideally combine best practice community psychiatry, relevant applied research, and expanded capacity to address priority gaps in the local system of care.

Major Recommendation UTHSC-SA R-2: As it expands, UTHSC-SA should prioritize major system gaps identified by the BH leadership team, including the potential to increase training opportunities in community-based service settings and primary health behavioral health integrated care settings, as well as additional emphasis on integrated MH/SUD service delivery across the continuum.

Major Recommendation UTHSC-SA R-3: UTHSC-SA should expand the reach of its TCC and PHBHI programs through community partnerships to increase both the scope and relevance of these programs within the community.

Additional specific programmatic recommendations were also identified and provided to UTHSC-SA for review.

Primary Health and Behavioral Health Care Integration Provider Findings

Four Bexar County outpatient providers offering Primary Health/Behavioral Health Integration services were also reviewed in depth, including two federally qualified health centers (CentroMed and CommuniCare), the Wesley Health & Wellness Center, and the Center for Health Care Services's PHBHI program at its Northwest Clinic. All four providers embed behavioral specialists within the primary services they offer, and PH/BH staff work closely and collaboratively in planning and delivering care. The FQHCs offer PHBHI in several clinic locations to children, adolescents and adults. In fact, CommuniCare has several child psychiatrists and an even greater capacity to provide PHBHI to children and youth. The Wesley Health & Wellness Center also serves children, adolescents and adults, focusing primarily on mild to moderate levels of need. CHCS offers PHBHI to adults with SMI at its Northwest Clinic.

PHBHI Major Findings

PHBHI Major Finding 1: PHBHI is a precious resource in Bexar County, as these four providers meet much less than 10% of the PHBHI need among lower income residents and an even smaller fraction of the need among adults with SMI. We estimate collectively that three of the agencies – the two federally qualified health centers (CentroMed and CommuniCare) and the Center for Health Care Services Northwest Clinic) – currently have the capacity to provide PHBHI to about 7,000 people at any given point in time. The 200% FPL population in Bexar County was 455,824 in 2013, and if approximately 25% of the population has a diagnosable condition in a given 12-month period, then PHBHI availability to lower income persons is extremely limited in Bexar County.

PHBHI Major Finding 2: Despite the need to increase its scale, these four providers model various best and emerging best practices and offer a strong base on which to build a broader array of supports system wide. Brief summaries of the capacity of each provider and the major site visit findings are included in Appendix B, C, D and E.

PHBHI Major Recommendations

PHBHI Major Recommendation 1: Safety net providers in Bexar County, higher education training programs, advocates, families, consumers, and payers/funders need to work together to develop a formal, strategic plan for increasing access to PHBHI in Bexar County.

The plan should delineate the following:

- **PHBHI Major Recommendation 2**: Building on the findings of this report regarding PHBHI training capacity at UTHSC-SA, the plan should determine the specific residency and training mechanisms whereby more clinicians will be trained in PHBHI, including primary care physicians, psychiatrists, and behavioral specialists.
- **PHBHI Major Recommendation 3**: Building on the capacity findings noted for each of the four PHBHI providers reviewed in this assessment, the plan should prioritize the PH/BH conditions and severity levels that will be the focus of capacity expansion (including specification of the providers best positioned – and willing – to develop that capacity).
- **PHBHI Major Recommendation 4**: The plan should also identify the collaboration, co-location and referral mechanisms and inter-agency agreements that need to be established to ensure that people (including those with the most difficult to serve comorbid medical and psychiatric conditions) obtain access to PHBHI in the most appropriate clinical setting.
- **PHBHI Major Recommendation 5**: The plan should also identify the financing mechanisms that can be used to sustain PHBHI in both primary care and specialty behavioral health settings.

Other System Partner Findings and Recommendations

In addition to interviewing the agencies identified as priority partners by Methodist Healthcare Ministries, MMHPI made a purposeful effort to interview other system partners to gain their perspectives on the strengths and gaps of the service delivery system, as well as to assess their interest and capability in participating in a collaborative effort to improve the Bexar County system as a whole. This section of the report focuses on highlights, findings, and recommendations related to the perspectives of these other system partners and stakeholders.

The system partners we interviewed included representation from the following important partners:

- Entities representing existing system stakeholders and collaboratives (MH Taskforce, NAMI, Community Medical Directors Roundtable, San Antonio Council on Alcohol and Drug Abuse, Southwest Texas Regional Advisory Council, and Uncle and Aunt),
- Medicaid and Medicare health plans doing business in Bexar County (Anthem/Amerigroup, WellMED, Molina, Cenpatico), and
- Acute care / crisis providers (San Antonio Behavioral Health, Baptist Hospital Urgent BH Clinic, La Paz, Methodist Specialty and Transplant Hospital, SAFD Mobile Integrated Health EMS Team and proposed IMPACT program).

While there were many issues discussed by system partners, the findings and recommendations below focus on the major themes that emerged from these discussions. Many items discussed are addressed in other sections of this report.

System Partners Major Findings

Similar to other findings in MMHPI's analysis of Bexar County, interviews with system partners demonstrated that there are considerable resources among health plans, stakeholder organizations, and inpatient and crisis providers in Bexar County to bring together a collaborative organized process to develop systems of care that

enhance population based service delivery. It is important to note that many of the system partners either facilitate or participate in system coordination functions, such as NAMI and San Antonio Council on Alcohol and Drug Abuse (SACADA). The Mental Health (MH) Task Force, which is widely representative of providers, also has a key coordination function. The Southwest Texas Regional Advisory Council (STRAC) is particularly effective in engaging leaders in effective collaboration regarding related system components (such as emergency room capacity management), and, though its scope regarding BH planning is currently limited, its leadership has great interest in this topic. Health plans and payers are also trying to fund systems of care for their specific populations. Providers are trying to coordinate care across a range of conditions and populations. Other stakeholders report the goal of having a system that responds to needs in a coordinated way.

Key cross-cutting findings included the following:

SP Major Finding 1: There is tremendous interest and energy already expended in an array of collaborative forums where agencies and leaders at multiple levels come together to attempt to better manage services across providers and systems. However, as noted in the system level section, these forums lack the necessary scope and operational infrastructure to address major system needs. In addition, all of these efforts, while important and representative of the interest in collaborating and creating systems, are more disconnected than connected.

With regard to stakeholder groups for example, the MH Task Force is well organized, with a remarkable interfaith work group effort, NAMI is a great resource representing families and consumers, with resources to provide training and outreach, the Community Medical Directors Roundtable is organized to look at crisis program data for the purpose of improvement, and Uncle and Aunt provided specific recommendations for system improvement on behalf of families. The San Antonio Council on Alcohol and Drug Abuse (SACADA) has capability to organize SUD providers and community wide prevention efforts. The STRAC is one of the most effective planning and coordination entities, but its scope is narrow and focused (which is also related to its effectiveness). All of these organizations are represented to some degree in the Consortium (and/or the Consortium is represented in their forums). However, at present there is not a formal, well-structured county-wide framework and associated infrastructure to coordinate all the existing stakeholder efforts and constituencies into an overall county-wide behavioral health system collaborative leadership entity, with capacity to organize a county-wide strategic implementation plan.

With regard to payers, we found that each payer is working in isolation from other payers (including the Hospital District, CHCS oversight of state funds, as well as Medicaid, Medicare and private insurance) to develop its own "network of services," rather than there being a collaborative approach to coordinate multiple sources of scarce funding into a coherent system of care.

With regard to acute care and crisis providers, we found that there are numerous entities offering distinct elements of capacity and capability. However, as discussed in greater detail in the overall system findings, there is no coordinated crisis "system" to provide both care coordination for clients and families county-wide, as well as to organize coherent coordination and planning of resource utilization county-wide.

All of these stakeholders are critical to bring together in a coordinated planning effort. As discussed in greater detail in the overall system findings, the current Consortium managed by Bexar County is a step in the right direction but requires more formal and deliberate structure, as well as resources for infrastructure, planning, implementation, and evaluation, to coordinate efforts built on existing capacities to drive quality and the development of population-based systems of care.

SP Major Finding 2: Other system partners also universally expressed interest in a stronger planning approach that focuses on coordination and development across (rather than within) silos. Planning needs to focus on development of systems of care for target populations that addresses clinical characteristics including mental health and substance use conditions, needs (serious and moderate), ethnic, linguistic and cultural issues, and financing (e.g., dual eligible Medicaid/Medicare, Medicaid, indigent, and insured).

SP Major Finding 3: There is interest among current providers and payers to expand capacity to address system needs. Many of the other system providers interviewed expressed interest in expanding capacity to serve individuals with serious and persistent mental illness (SPMI) and children with serious behavioral health challenges, especially high utilizers of services. While there is strong support for existing services through CHCS and others, there is acknowledgement that state-funded capacity to serve the total population of individuals with SPMI and children addresses only a fraction of the need and that this will require all funders, providers, and stakeholders to coordinate local efforts to more effectively in order to fill existing gaps.

Specific system gaps most often noted include:

- **SP Major Finding 4**: Crisis services are available across the system but are not coordinated, and there is no overarching crisis system of care. While there are some excellent crisis services, it is not always clear to these organizations, as well as many of the first responders they work with and the individuals and families in crisis who they serve, how to gain access to the right services. This is discussed in more detail in the overall system findings.
- **SP Major Finding 5**: There are gaps in treatment modalities for individuals with SUD and co-occurring substance use and mental health conditions (COD). System partners report challenges in gaining access to prevention, as well as SUD treatment and COD services in inpatient and community settings. They describe silos that inhibit planning across behavioral health conditions and stronger focus on "MH" planning than SUD and COD needs of the population.

System Partner Major Recommendations

The recommendations below focuses on strategies to support a system-wide, locally guided, empowered BH leadership collaborative to build on the Bexar County's leadership progress as described in the System Level System Framework section of this report. To address the systemic public health challenges facing Bexar County, the need to include system partners in the development of a vision for the system and coordination strategies that can more effectively leverage existing resources is essential. These matters are discussed in greater detail in the overall system findings, so the recommendations below should be viewed in the context of those more detailed and broader findings.

SP Major Recommendation 1: A broad set of stakeholders should be involved in system of care planning. BH leadership team and broader collaborative membership should be representative of key constituencies in a formal structure and should include the existing collaborative structures that we met with (e.g., MH Consortium, STRAC), as well as the business community, other family member, consumer, and faith-based organizations, as well as a comprehensive range of payers, service providers, and County programs. SUD providers and prevention specialists, such as SACADA, should also be included in system planning to minimize current barriers between the MH and SUD community.

SP Major Recommendation 2: It is important to include diverse members representing the major cultural, ethnic and linguistic minorities to build alliances and understanding, as well as to engage these community leaders in the planning to develop the quality and capacity of services that address diverse populations.

The collaboration recommended under SP Major Recommendations 1 and 2 should be expected to add capacity and resources to address the system challenges and recommendations identified in this report. The participation of broader set of stakeholders will enable focused efforts in the areas identified by system stakeholders as challenges:

- Addressing the input of primary consumers and families into system design and operations.
- Development of a county-wide crisis intervention/inpatient and jail diversion system that has clear access information for system partners will be easier to develop.
- Improving access to SUD prevention and treatment as well as COD treatment capacity throughout the system.
- Identifying service expansion opportunities and providers willing to either expand capacity or capabilities.

Appendix A: List of Participants in Mental Health Systems Assessment

Table 26: Bexar County Systems of Care Assessment 2015 Participants

Name	Title	Organizational/Departmental Affiliation
Center for Health Care Services		
Leon Evans	President / CEO	Administration
Sherry Bailey	Vice President	IDD and Long Term Care Services
Carmen Choumont, BSN, RN	Director, Nursing Supervision and Quality	Medical Services
Brian Clark, PA-C	Assistant Medical Director	Restoration Services
Cindy Green, LCDCI	Quality Assurance Analyst, SA	Restoration Services
Allison Greer	Vice President	External Relations
Robert Guevara	Vice President	Finance and Technology
David Hnatow, MD	Medical Director, Public Safety Unit & Primary Care Integration	Restoration Services
Mysty Johnson	Project Support Analyst	Adult Behavioral Health Services
April Johnson-Calvert	Director	Business Support Services
Natalie Kohdr	Director	Business and Process Improvement
Diana Lara	Harvard Place Outpatient Clinic Administrator	Adult Behavioral Health Services
Bren Manaugh	Vice President	Adult Behavioral Health Services
Millard Marshall	General Counsel	
Cynthia Martinez	Interim Vice President	Restoration Services
A. Camis Milam, MD	Executive Vice President	Medical Services
Jessica Molberg, LPC	Quality Assurance Administration	Restoration Center
Alna Oyibo	Director	Josephine Recovery Center
Paul Ramos	Case Manager	Zarzamora Clinic
Sarah Rasco, MD	Psychiatrist	Integrated Care Team
Jennifer See (and QAI Team)	Director of Consumer Access Engagement & Experience	Restoration Services
Ron Stringfellow	Program Administrator, Homes & Veterans Programs	Community and Transformational Services / Restoration Services
Amanda Ternan	Project Manager	High Utilizer Program
Melissa Tijerina	Vice President	Children's Behavioral Health
Amanda Tinsley-Mathias	Clinical Director, Integrated Care, High Utilizers Team	Adult Behavioral Health Services
Trey Tschoepe	Vice President	Organizational Development
Sandra Vale, MD	Medical Director	Adult Behavioral Health Services
Troy Williams	Director, Medical Care Integration	Medical Services
Agnes Zacarias	Diversion & Packard Outpatient Clinic Director	Adult Behavioral Health Services
Josie Alcala	Director	Northwest Clinic
Denise Arevalo	Certified Peer Support Specialist	Northwest Clinic
Joey Enriquez	Case Management Team Leader	Northwest Clinic
Margit Gerardi, PhD	Advanced Psychiatric Nurse Practitioner	Northwest Clinic
Sarah Hogan	Clinical Coordinator High Utilizers Team	Northwest Clinic
Mary Tolle	Certified Peer/Recovery Support Specialist	Northwest Clinic
Clarity Child Guidance Center		
Fred Hines	President and CEO	Administration
Christina Attebery	Director of Admissions, Intake, Referral & Social Services	Patient Access
Mike Bernick	CFO and Executive Vice President	Finance
Chris Bryan	Vice President of Information Technology and Public Policy	Information Technology and Public Policy
Rick Edwards	Director	Inpatient Program
Geoff Gentry	Senior Vice President	Clinical
Rebecca Helterbrand	Senior Vice President of Marketing and Resource Development	Marketing and Research
Karl Koch	Director	Outpatient Psychology/Program
Gina Massey	Vice President	Human Resources
Soad Michelsen, MD	Senior Medical Director	
Haven For Hope		
Mark Carmona Kenny Wilson	President/CEO (Former) President/CEO (Present)	Administration
Scott Ackerson	Vice President	Strategic Relationships
Steven Aidala	Intake Specialist	
Dawn Bishop	Peer Support Specialist, Case Management	
Elisia Carr	Transformational Support Coordinator	Transformational Services
Teshina Carter	Director	Campus Programs (CHCS)
Leti Cavazos	Director	In-House Wellness Program (CHCS)
Lina Garcia	Peer Support Specialist, Case Management	
Richard Hamner	Director	In-House Recovery Program (CHCS)

Sue Hornsby	HMIS Manager	
Shawn McCoy	Peer Support Specialist, Case Management	
Camis Milam, MD	Medical Director	Medical Services
Evita Morin	Vice President	Transformational Services
Gayl Newton	Director	People Services
Sam Samani	Director	Information Technology
Nix Health		
Tanya Anderson	Director of Social Work	Inpatient Services
Angela Diehl	Chief Operating Officer	
Olin McCormick, MA	Behavioral Health Administrator	Behavioral Health
Jessica Miller	Director	Outpatient Services
Laura Thomas	Division Chief Financial Officer	
University Health System		
Arnulfo Ojeda, PhD, MSW	Director of Behavioral Health Coordination Services	Care Coordination
Larry Parsons	Director	Behavioral Health Services
Pablo Rojas	Assistant Director	Emergency Center
Theresa Scepanski	Senior Vice President, Chief Administrative Officer	Organizational Development
Jean Smith	Executive Director of Nursing	Hospital Psychiatric Services
Sally Taylor, MD	Senior Vice President, Chief of Behavioral Medicine	Behavioral Medicine
University of Texas Health Science Center – San Antonio		
Rosie Cantu, MSW	Social Worker	Transitional Care Clinic
Roger Enriquez	Associate Professor and Director, Policies Studies Center	University of Texas San Antonio
Megan Frederick	Clinical Research Project Manager	Transitional Care Clinic
David Greenwood, APRN	Nurse Practitioner	Transitional Care Clinic
Mike Hererra, LVN	Licensed Vocational Nurse	Transitional Care Clinic
Carlos Jaen, MD	Chair	Psychiatry and Family & Community Medicine
Katie Kenzler, MD	PHBHI Lead	Medical Drive Clinic
Monique Lopez	Manager of Financial Operations	Department of Psychiatry
Laura McKieran	Associate Professor	UTHSC
Elisa Medellin	Licensed Professional Counselor Intern	Transitional Care Clinic
Stephanie Mitchell	Patient Services Representative – Lead	Transitional Care Clinic

Steven Pliszka, MD	Medical Director; Dielmann Distinguished Professor and Chair, Department of Psychiatry	Department of Psychiatry
David Roberts, PhD	Clinical Director	Transitional Care Clinic
Stacy Ryan, PhD	Psychologist; Assistant Professor	Department of Psychiatry
Irma Sanchez	MPA Associate Director	Finance and Administration for both Psychiatry and Family & Community Medicine
Cynthia Sierra	Research Area Specialist – Lead	Transitional Care Clinic
Dawn Velligan, PhD	Director, Division of Community Recovery, Research and Training Henry B. Dielmann Chair Department of Psychiatry	Transitional Care Clinic
Other Providers		
Greg Seiler	Chief Executive Officer	Metropolitan Methodist Hospital
Doug Beach	Chair of the Steering Committee	Mental Health Task Force
Marcey Davis	Vice President of Behavioral Health	Methodist Specialty and Transplant Hospital
Liza Jensen	Executive Director	Methodist Health Care Specialty Psychiatric Department
Jonathan Turton	President	Baptist Medical Center
Eric Epley	Executive Director	Southwest Texas Regional Advisory Council (STRAC)
Kelly Abbott	Fire Engineer, EMT	San Antonio Fire Department
Yvette Crandato	Deputy Chief of EMS	San Antonio Fire Department
K.C. Dohmen		San Antonio Fire Department
Andrew Estrada	Assistant Chief of Operations	San Antonio Fire Department
Emily Kidd, MD	EMS Medical Director	San Antonio Fire Department
Mike Stringfellow	EMS	San Antonio Fire Department
Chris Valasquez	Fire Engineer	San Antonio Fire Department
Charles Wood	Chief	San Antonio Fire Department
Abigail Moore	Chief Executive Officer	San Antonio Council on Alcohol and Drug Abuse
Melanie Lane	Program Director	San Antonio Council on Alcohol and Drug Abuse
Kirk Kureska	Chief Executive Officer	San Antonio Behavioral Healthcare Hospital
Judge Michael Ugarte	Central Magistrate	Bexar County
Judge Oscar Kazen	Judge	Bexar County Probate Court
Jeannie von Stultz	Deputy Chief, Mental Health Services	Bexar County Juvenile Justice
Mark Stoeltje	Executive Director	San Antonio Clubhouse
Jarvis Anderson	Director	Bexar County CSCD (Probation)

Jose Banales	Assistant Chief	San Antonio Police Department
Brian Reyes	Lieutenant	San Antonio Police Department
Susan Pamerleau	Sheriff	Bexar County Sheriff
Christina Sorenson	Executive Director	NAMI San Antonio
Stacy Baker	Outreach Program Director	Chrysalis Ministries
Stacey Lenn		Oxford House
Clyde Keebaugh	Director, Outreach, Screening, Assessment and Referral	Mid-coast Family Services
David Phipps	Executive Director	Lifetime Recovery
Ramon Gonzales	Regional Director of Treatment Services	Volunteers of America
Richard Castillo	Representative	La Paz
Adediran Adedeji	Chief Executive Officer	La Paz
George Patrin		Serendipity
Gilbert Gonzales	Director, Mental Health Department	Bexar County
Mike Lozito	Director, Judicial Services	Bexar County
Velma Muniz	Mental Health Department Coordinator	Bexar County
Karen Gregory	Associate Vice President	CMHS-Behavioral Health at Amerigroup
Ken Hopper	West Regional Vice President	Amerigroup
Diana Barrionuevo	Project Manager	Amerigroup
Martha Medrano, MD	Director of Behavioral Health	CommuniCare
Carlos Moreno, MD	Medical Director	CommuniCare
Richard Switzer, MD	Pediatrician	CommuniCare East Clinic
Tranda Rathey	Nurse Practitioner – Psychiatric Specialist	CommuniCare East and West Clinics
Eleanor Grays	Nurse Practitioner – Women's Health	CommuniCare East and West Clinics
Aurora Sanchez	Budget Manager	CommuniCare
Ernesto Gomez, PhD	President/ CEO	CentroMed
Maggie Hoover	Physician Assistant	CentroMed
Lilian Lima	LCSW	CentroMed
Don Macaulay	Vice President and Chief Operating Officer	CentroMed
Lady Martinez, MD	Psychiatrist	CentroMed
Elizabeth Moreno	Health Informatics Technician	CentroMed
Delma Ochoa	Director of Healthcare for the Homeless Services	CentroMed
Norma Parra, MD	Chief Medical Officer	CentroMed
Anna Serrano, DrPH, MBA	Vice President and Chief Population Health Officer	CentroMed
Chuck Walzel	Vice President and Chief Financial Officer	CentroMed

Ed Schumacher	Professor, Department of Health Care Administration	Trinity University
John Hornbeak	Executive in Residence, Adjunct Faculty, Department of Health Care Administration	Trinity University
Dolapo Sokunbi	Student	Trinity University
Brin Hjalmquist	Student	Trinity University
Rebecca Phillips	Student	Trinity University
Fred Cardenas	Project Manager	Family Services Association

Appendix B: CentroMed Federally Qualified Health Center

Overview of PHBHI at CentroMed

CentroMed has eight social workers (including seven LCSWs) embedded within primary care clinics, and a new child psychiatrist, Dr. Martinez, who is also board certified in psychiatry, as well as neurology/child and adolescent psychiatry. Social workers provide counseling services and assistance to families in meeting basic needs; they offer consultation to primary care providers and by all accounts work collaboratively with them. Sessions with patients are lengthy (50 minutes, typically), which reduces productivity and renders behavioral health inefficient from a financial point of view. CentroMed uses clinical guidelines embedded in its EHR to help guide prescribers in their medication management of psychiatric conditions.

Among the 71,079 people receiving services from CentroMed in 2014, 3,612 received mental health and 930 received substance use disorder services. Two-thirds of patients (69%) are best served in a language other than English (usually Spanish). The CentroMed staff is likewise culturally diverse across executive leadership, support staff, and clinical care categories. The three most common mental health conditions assessed in CY 2014 were depression and other mood disorders, anxiety disorders including PTSD, and attention deficit and disruptive behavior disorders. Overall, 6% of CentroMed patients (about 4,265 people) had depression and 4.5% (about 3,200) had anxiety disorders. Overall, 5.3% (about 3,767) had an SUD.

Table 27: CentroMed Services

	Behavioral Health Severity Low	**Behavioral Health Severity** Moderately High to High
Physical Health Severity Low	***Adults*** – CentroMed serves them ***Children*** – CentroMed serves them	***Adults*** – CentroMed does not serve them ***Children*** – CentroMed does not serve them
Physical Health Severity High	***Adults*** – CentroMed serves them ***Children*** – CentroMed serves them	***Adults*** – CentroMed does not serve them ***Children*** – CentroMed does not serve them

In August 2015 CentroMed clarified its scope of BH practice. The scope excludes schizophrenia, bipolar disorder, chronic suicidal ideation, substance use disorders, eating disorders, moderate to severe autism. Patients recently treated in an emergency room or hospitalized for psychiatric reasons, patients who have exhibited disruptive/antisocial behavior, and patients in violation of CentroMed's missed appointments policy also are excluded.

Integrated Care Capacity Ratings

The primary tool guiding our reviews was the COMPASS PH/BH. The Table 28 summarizes our findings and highlighted recommendations across all PHBHI domains.

Table 28: CentroMed Integrated Care Capacity Ratings

PHBHI Domain	Implemented?	Notable Strengths	Selected Recommendations
Program Philosophy & Leadership Culture	Somewhat (3)	BH is seen as integral – embedded with PCPs	Include PHBHI in the Center's strategic plan
Administrative Policies	Somewhat (3)		Add brief BH service model to make PHBHI more sustainable
Quality Improvement and Data	Somewhat (3)	Chief Population Health Officer position	Document costs/outcomes for PH/BH patients, high utilizers
Access	Slightly (2)	Multiple locations, including near PCY/H4H	Gradually expand scope of PHBHI services
Screening & Identification	Mostly (4)	Routine screening with PHQ-2	
Integrated Assessment	Mostly (4)	Routine follow up assessment (PHQ-9 etc.)	
Integrated, Person-Centered Planning	Mostly (4)	Staff ask: "What is most important to you?"	
Treatment/Recovery Programming	Mostly (4)	Holistic social work model, Use some EBPs (e.g., CBT)	Bolster stage-matched and treat-to-target approaches
Treatment/Recovery Relationships	Mostly (4)	Collaborative, warm hand-offs, rapid appointments	Consider using formally identified small PHBHI teams
Integrated/Welcoming Program Policies	Slightly (2)	Very welcoming within scope of practice	
Medication Management	Fully (5)	Practice guidelines and medication algorithms	
Discharge/Transition Planning	*Not Assessed*		
Program/Organization Collaboration	Somewhat (3)	Dr. Martinez actively engaging BH providers	Participate in county-wide strategic PHBHI collaboration
Staff Competencies and Training	Slightly (2)	Combine treatment with meeting basic needs	Consider adding LPCs and peer specialists and refining triage of PHBHI patient needs
Staffing and Care Coordination	Mostly (4)	Expert social workers and child psychiatrist	
Homeless Services	Slightly (2)	Committed to homeless; e.g., S. Davidson Clinic	Collaboratively study ED problem

Appendix C: CommuniCare Federally Qualified Health Center

Overview of PHBHI at CommuniCare

Upon arriving at CommuniCare five years ago, Dr. Martha Medrano, CommuniCare's Director of Behavioral Health, was the only staff psychiatrist employed by CommuniCare, and there were only three to four licensed clinical social workers (LCSWs) available to provide behavioral health services. There was also one contracted 0.6 FTE psychiatrist. Now there are three child psychiatrists serving various clinics, along with psychiatric nurse practitioners and other behavioral health staff. One of the key achievements of CommuniCare's IBH program is that instead of developing a separate behavioral health clinic, CommuniCare embedded behavioral health clinicians in family medicine, pediatric offices, and women's health. In addition, some primary care providers have been prompted by Dr. Medrano to retool so that they can provide more behavioral health care to patients. An example of this is a pediatrician in the East Campus clinic, Dr. Switzer, who has developed expertise in managing ADHD medications.

CommuniCare did not provide extensive data on its services, but it did submit data indicating that it is currently providing IBH services to 1,788 children and adolescents and 1,574 adults. The table below shows how Dr. Medrano estimated these patients are distributed across broad PH/BH co-occurring groups. The table reveals a burgeoning sophistication at CommuniCare concerning their understanding of the nature and severity of the patient population's co-occurring PH and BH conditions.

Table 29: CommuniCare Services

	Behavioral Health Severity Low	**Behavioral Health Severity** Moderately High to High
Physical Health Severity Low	***Adults*** in counseling (15-20% of all BH adults) ***Children*** with routine BH conditions (40% of all BH children)	Young ***Adults*** with significant MH problems, e.g., panic disorder (20% of all BH adults) ***Children*** with very difficult BH conditions (60% of all BH children)
Physical Health Severity High	***Adults*** with severe PH needs but low BH (15-20% of all BH adults) (***Children*** much less frequently have severe PH conditions)	***Adults*** with severe PH conditions & moderately severe BH conditions (40% of all BH adults) (***Children*** much less frequently have severe PH conditions)

Integrated Care Capacity Ratings

The Table 30 summarizes our findings and highlighted recommendations for CommuniCare across all PHBHI domains.

Table 30: CommuniCare Integrated Care Capacity Ratings

PHBHI Domain	Implemented?	Notable Strengths	Selected Recommendations
Program Philosophy & Leadership Culture	Mostly (4)	Championing of IBH by Dr. Medrano	Embed wonderful IBH philosophy in key documents
Administrative Policies	Mostly (4)	Financial strength of BH; good billing approach	
Quality Improvement and Data	Somewhat (3)	Collaboration with UIW on quality studies	Conduct studies of BH/PH conditions – e.g., diabetes/ depression and ER use
Access	Mostly (5)[54]	Ability to serve moderate-severe MH conditions	Develop capacity for SUD services, referral strategies
Screening & Identification	Mostly-Fully (4-5)	Universal MH screening, tailored to patient age	Develop SUD screening
Integrated Assessment	Somewhat (3)		
Integrated, Person-Centered Planning	Somewhat (3)	Formal PH/BH Integrated Assessment Plan	
Treatment/Recovery Programming	Mostly (4)	Broad BH perspective: e.g. trauma, tobacco, sleep	Provide motivational/stage-matched services, illness management; SUD services
Treatment/Recovery Relationships	Mostly (4)	Embedded BH specialists; continuity of care	Consider implementing more formal, small IBH teams
Integrated/Welcoming Program Policies	Somewhat (3)		
Medication Management	Mostly (4)	Expansion of PCP capacity and expertise	
Discharge/Transition Planning	*Not Assessed*		
Program/Organization Collaboration	Mostly (4)	Collaboration and referral with other providers	Help develop stronger county-wide IBH strategies
Staff Competencies and Training	Somewhat (3)	Mentoring of PCPs; excellent collaboration	Develop more formal staff training & development plan
Staffing and Care Coordination	Mostly (4)	Strong psychiatric staff; UIW collaboration	Consider bolstering staffing to meet adult IBH needs
Homeless Services	Slightly (2)		Develop plan to help meet IBH needs of homeless persons

Appendix D: Wesley Health & Wellness Center

Overview of PHBHI at the Wesley Health & Wellness Center

On May 27, 2015, Dr. Katie Kanzler, Director of Integrated Behavioral Health at the University of Texas Medicine Primary Care Center, and Dr. Jim Zahniser of MMHPI conducted a review of PHBHI services at the Wesley Health & Wellness Center. The review consisted primarily of a group interview with Kathryn Jones, Methodist Healthcare Ministries' Director of Behavioral Health, and nine of the Wesley Health & Wellness Center's clinical and administrative leaders. In addition, staff provided a visual overview of the Wesley Health & Wellness Center's electronic health record and a tour.

The Wesley Health & Wellness Center is a comprehensive medical, dental and behavioral health (BH) treatment center, which also provides numerous health promotion and health education services. Located in San Antonio, it serves approximately 27,000 people per year, all of whom do not have health insurance, many of whom are undocumented persons, and the majority of whose primary language is Spanish. After providing stand-alone BH services for many years, in 2014 the Wesley Health & Wellness Center embedded behavioral health specialists in two of its primary care provider's clinics. In the summer of 2015, the Wesley Health & Wellness Center added a psychiatric advanced nurse practitioner (also trained in family practice) and another behavioral health consultant to its PHBHI program.

At the time of the Wesley Health & Wellness Center PHBHI review, MMHPI was pilot testing a somewhat different PHBHI capacity assessment battery than what was eventually used when the Bexar County mental health system began in the fall of 2015. The review at that time divided findings into administrative and clinical aspects of PHBHI, and it is within these two broad domains that we highlight the most important findings from our PHBHI capacity assessment.

Administrative PHBHI Capacity

- Methodist Healthcare Ministries and the Wesley Health & Wellness Center have leaders who actively and strategically promote PHBHI.
- The Wesley Health & Wellness Center provides a very welcoming environment for people seeking treatment.
- PHBHI is controlled by Methodist Healthcare Ministries and is not contingent on insurance or state reimbursement.
- In meeting needs, the Wesley Health & Wellness Center collaborates with many social and health/BH agencies.
- The EHR is not yet integrated and population health is in a very nascent stage.
- Quality improvement/evaluation staff are available and can conduct ongoing QI studies.

Clinical PHBHI Capacity

- The Wesley Health & Wellness Center has embraced a BH Consultant model, setting the stage for BH capacity expansion.
- The Wesley Health & Wellness Center has initiated universal screening for MH conditions, but not yet for SUDs.

- Staff use motivational interviewing and, to some extent, stage-matched interventions.
- The Wesley Health & Wellness Center's PHBHI capacity is limited by the fact that it serves only people with mild-moderate MH conditions and does not offer treatment for substance use disorders.
- More systematic use of brief, evidence-based clinical interventions and development of shared clinical pathways for co-occurring conditions (e.g., diabetes-depression) are needed.

Appendix E: Northwest Clinic, Center for Health Care Services

Overview of PHBHI at the Northwest Clinic

MMHPI evaluators primarily focused the review on the High Utilizers (HU) Team, but also obtained information and summary data on the Integrated Care Clinic (ICC). The ICC was in transition at the time of the review, as a full-time Advanced Practice Nurse (APN) was about to be hired and to replace a part-time physician, whose primary care services were somewhat limited to a small percentage of consumers with SMI being served through the 2403 program (a comprehensive BH services program, providing routine medication management, groups and social skills training, and routine case management). At the time of our September 2015 review, Josie Alcala, the Clinic's director, anticipated that a full-time APN would, unlike the part-time physician, be willing to serve all consumers at the clinic, regardless of health insurance status, thereby dramatically increasing the clinic's current capacity to provide PHBHI to only 300 of the 2403 program's 1,900 consumers. The APN would be stepping into a setting where a strong PHBHI model, characterized by co-location and close collaboration within a team of PH and BH providers, has been embraced by ICC staff. Fully equipped exam rooms, routine PH screening, warm hand-offs, and the like have become the norm at the Northwest Clinic.

The High Utilizer Team (the 4105 program) was serving 174 people at the time of review. Under the leadership of Dr. Amanda Mathias, the program has blossomed into a very intensive, outreach-oriented service to people with the most difficult to serve BH conditions and social challenges (e.g., homelessness, criminal justice system involvement). The HU Team utilizes trauma-informed care, motivational interviewing, intensive case management, and collaboration with housing and other social services programs to meet consumers' extensive needs. Like other clinic staff, the HU Team also has fully embraced PHBHI and works closely with the Northwest Clinic's ICC, as well as primary care and specialty care PH providers in the community to integrate PH needs into their ongoing provision of treatment, case management, and care coordination efforts. While not benefitting from a strong evaluation design, the HU Team has nevertheless produced findings indicating they have helped reduce ER and hospital use among the people with utilization whom they have served, potentially reducing overall costs considerably. Both the HU Team and the ICC are very important resources for the Bexar County system and its array of available services to people with SMI.

After the time of our review in September 2015, a decision was made to move the CHCS ACT teams over to the Northwest Clinic. Given the success of the HU Team, this is probably wise.

Integrated Care Capacity Ratings

The following table summarizes our findings and highlighted recommendations for the Northwest Clinic across PHBHI domains.

Table 31: CHCS Northwest Clinic Integrated Care Capacity Ratings

PHBHI Domain	Implemented?	Notable Strengths	Selected Recommendations
Program Philosophy & Leadership Culture	Mostly (4)	Leadership has established PHBHI culture	Develop explicit vision/mission statement with PHBHI
Administrative Policies	Somewhat (3)	Working collaboratively to share clinical information	Develop registries; explicate PHBHI documentation
Quality Improvement and Data	Somewhat (3)	Use of Lean Six model; university collaboration	Include all staff in team-like approach to Lean Six
Access	Somewhat (3)	"No wrong door" culture	Expand HU capacity; CHCS – reconsider central intake
Screening & Identification	Some-what-Mostly (3-4)	Routine PH screening in exam rooms	Document rate at which routine screening is conducted
Integrated Assessment	Slightly (2)	Strong commitment of staff to integration	Need to develop EHR with PH/BH integrated capacity
Integrated, Person-Centered Planning	Mostly (4)	Person-centered, trauma-informed orientation	Policy-level: TRR/LOC system is too constraining
Treatment/Recovery Programming	Mostly (4)	Use of recovery-oriented EBPs –TIC, WHAM, MI	Adopt smoking cessation, WRAP, and IMR EBPs
Treatment/Recovery Relationships	Some-what-Mostly (3-4)	"One stop shop" with re-sourceful HU staff	Consider creating small, identified PHBHI "teamlets"
Integrated/Welcoming Program Policies	Somewhat (3)	Staff committed to wel-coming orientation	More formally articulate welcoming policies
Medication Management	*Not Assessed*		
Discharge/Transition Planning	*Not Assessed*		
Program/Organization Collaboration	Somewhat (3)	Collaboration with MCOs and Methodist Healthcare Ministries on high utilizers	Develop data portal capacities with other providers
Staff Competencies and Training	Somewhat (3)	Staff commitment to recov-ery oriented EBPs	Develop formal staff development/training plan
Staffing and Care Coordination	Mostly (4)	Comprehensive staffing, including peers	Formally articulate care coordination protocols; Must hire the APN to meet PH need

Footnotes

1 Estimated by MMHPI based on: McGrath, J., Saha, S., Chant, D., & Welham. (2008). Schizophrenia: A concise overview of incidence, prevalence, and mortality. Epidemiological Reviews, 30, 67-76.

2 Estimated by MMHPI based on: McGrath, J., Saha, S., Chant, D., & Welham. (2008).

3 Estimated by MMHPI based on: Kirkbride, J.B., Jackson, D., et al. (2013). A population-level prediction tool for the incidence of first-episode psychosis: Translational epidemiology based on cross-sectional data. BMJ Open, 3(2), 1-12. Estimated upwards to account for urban effect noted by McGrath et al.

4 Rowan, P.J., Begley, C., Morgan, R., Fu, S., & Zhao, B. (2014, September).

5 The "% of LOCs" exclude crisis and crisis follow-up.

6 SMI population estimates: Texas estimates are based on Dr. Holzer's refined SMI prevalence estimation methodology. California: state-level estimates are based on applying SAHMSA's 2012-2013 model-based prevalence estimates for serious mental illness among adults 18 years or older (based on the National Survey on Drug Use and Health – NSDUH) to each respective state's 2013 federal census population (adults 18 years or older).

7 Based on an analysis by Cuddeback, G.S., Morrissey, J.P., & Meyer, P.S. (2006). How many assertive community treatment teams do we need? Psychiatric Services, 57, 1803-1806. The Cuddeback et al. estimate was applied to people with SMI, regardless of income level.

8 State-level figures are based on state authorized mental health services, including Medicaid enrollees, reported in the SAMHSA's NOMS system in 2012, retrieved from http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx.http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx

9 When we have benchmarks for EBPs outside of Texas, we use the total estimated number of people with SMI in each region, applying a 58% factor based on Texas data to estimate the number who are living at/below 200% FPL, in order to better facilitate comparisons to the communities outside of Texas.

10 Generally, state-level figures are based on state authorized mental health services, including Medicaid enrollees, reported in the SAMHSA's NOMS system in 2012. Retrieved from http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx. New York State and New York City "Received SH" data were estimated based on average lengths of stay and quarterly capacity and occupancy data.

11 The unemployment rate for people with SMI served in publicly funded mental health systems is approximately 90%, but research shows about 50% of people with SMI want vocational help. These rates were applied to SMI prevalence of each region to determine estimated need for supported employment.

12 State-level figures are based on state authorized mental health services, including Medicaid enrollees, reported in the SAMHSA's NOMS system in 2012. Retrieved from http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx.http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx.

13 Number of FY14 trained peer support specialists by county (not LMHAs). Data obtained on February 13, 2015 via personal communication with Dr. Stacey Manser, University of Texas. Number of Peer Specialists at the LMHA is different.

14 The "% of LOCs" include all LOCs that provide ongoing outpatient care for children.

15 Number of certified family partners by LMHA. Data obtained on February 13, 2015, personal communication with Dr. Stacey Manser, University of Texas.

16 Number of certified family partners by LMHA. Data obtained on February 13, 2015, personal communication with Dr. Stacey Manser, University of Texas. According to DSHS data, MHMRA of Harris County had no turnover in CFPs from FY13 to FY14. MHMRA also reported nine CFPs on staff in December, 2014.

17 Data are number of children's services delivered, by LMHA, that were coded as "Family Partner" in FY 2014. Data received from DSHS on February 20, 2015. Service provided by CFPs may in many instances be coded as something other than "Consumer Peer Support."

18 Data received from MHMRA of Harris County in December, 2014.

19 Source: Unless otherwise noted, capacity data comes from the DSHS 2014 Hospital Survey.

20 Sources: Texas DSHS. (2015). 2014 DSHS/AHA/THA Annual Survey of Hospitals. Published at http://www.dshs.state.tx.us/chs/hosp/hosp2.aspx; DSHS and CHCS report of current allocation; Note: San Antonio State Hospital operates just over 300 beds, but just under 153 beds on average are allocated for the use of Bexar County.

21 Source: Nix Health

22 16 of these beds are in the psychiatric emergency services unit.

23 Source: CHCS; Notes: In FY 2015, this included 25 beds purchased by CHCS using state funds; in FY 2016, the number of beds increased to 30, but are now purchased at Nix Health and Southwest General.

24 Source: University Health System documentation

25 Note: Beginning in FY 2016 with the expansion of beds purchased by CHCS using state funds from 25 to 30, CHCS began to also purchase beds within the 30-bed total from Southwest General in addition to Nix Health.

26 Source: Interview with CEO Jonathon Turton, November 4, 2015.

27 Source: Texas DSHS. (2015). 2014 DSHS/AHA/THA Annual Survey of Hospitals. Published at http://www.dshs.state.tx.us/chs/hosp/hosp2.aspx; data confirmed with facility.

28 Source: Texas DSHS. (2015). 2014 DSHS/AHA/THA Annual Survey of Hospitals. Published at http://www.dshs.state.tx.us/chs/hosp/hosp2.aspx; data not able to be confirmed with facility.

29 Source: Texas DSHS. (2015). 2014 DSHS/AHA/THA Annual Survey of Hospitals. Published at http://

www.dshs.state.tx.us/chs/hosp/hosp2.aspx; data confirmed with facility and updated, as they differed from the survey data.

30 University Health System. (August, 2015). Presentation for Senator John Cornyn Mental Health Roundtable. FILE: University Health System Meadows.pdf (page 21). Note: Based on presentation, 60% have SMI.

31 University Health System. (August, 2015). Presentation for Senator John Cornyn Mental Health Roundtable. FILE: University Health System Meadows.pdf (page 21).

32 Interview notes: admissions unit has capacity to provide mobile crisis assessment 24/7, all over the County.

33 Data provided by Restoration Center (Sylvia Soriano). Reporting period includes September 2014 through August 2015.

34 Data provided by Restoration Center (Sylvia Soriano). Reporting period includes September 2014 through August 2015.

35 Data provided by Josie Alcala, Northwest Clinic Administrator, September 15, 2015. The sobering unit "beds" include 13 beds, 3 mats, 3 sleeper chairs and 9 chairs for a total of 28 slots – data provided from correspondence with the Restoration Center (Sylvia Soriano).

36 Data provided by Restoration Center (Sylvia Soriano). Reporting period includes September 2014 through August 2015.

37 Smith, A. (2015). Mental Health Consortium Meeting Invitation. FILE: CMDRTReportsSeptember22,2015.pdf

38 Total calls (28,029) minus non-assessment/information only calls (14,695) FILE: CMDRTReportsSeptember22,2015.pdf

39 Smith, A. (2015). Mental Health Consortium Meeting Invitation. FILE: CMDRTReportsSeptember22,2015.pdf

40 Source: Unless otherwise noted, capacity data comes from the DSHS 2014 Hospital Survey

41 Source: Clarity Child Guidance Center

42 Clarity does not have designated "acute" and "sub-acute" beds. However, approximately 90% of the patients are considered "acute."

43 Source: DSHS report; Note: San Antonio State Hospital operates 30 adolescent beds; these are managed separately from the overall allocation and none are "set aside" for Bexar County (all state hospital child and adolescent beds are available to anyone in need statewide).

44 Source: Texas DSHS. (2015). 2014 DSHS/AHA/THA Annual Survey of Hospitals. Published at http://www.dshs.state.tx.us/chs/hosp/hosp2.aspx; data not able to be confirmed with facility.

45 Source: Texas DSHS. (2015). 2014 DSHS/AHA/THA Annual Survey of Hospitals. Published at http://www.dshs.state.tx.us/chs/hosp/hosp2.aspx; data confirmed with facility and updated, as they differed from the survey data.

46 Partial hospital program is provided at two (2) different Clarity locations.

47 Unduplicated count. There were 316 total admissions.

48 CHCS. (n.d.) (Poster Presentation). Crisis-Respite Residential Center. Projected total 12-month served). FILE: CBH (Crisis Respite Residential Center) 2015 07-13-15.pdf

49 Restoration Center. (May, 2015). Restoration Center Report: Community Medical Directors. (Annualized estimates for Crisis Helpline calls for children with mental health needs). FILE: CMDRT slides May 2015 data Final. Slide 9

50 All data from FY 2014 unless otherwise noted.

51 Lopez, M., & Stevens-Manser, S. (2014, September). Texas 1115 Medicaid Demonstration Waiver: Review of 4-year behavioral health projects. Austin, TX: Texas Institute for Excellence in Mental Health.

52 Meadows Mental Health Policy Institute and Texas Conference of Urban Counties. (2015). Survey of County Behavioral Health Utilization. Unpublished Document. Dallas, TX: Meadows Mental Health Policy Institute. Data was provided directly by Harris County.

53 Meadows Mental Health Policy Institute and Texas Conference of Urban Counties. (2015). Survey of County Behavioral Health Utilization. Unpublished Document. Dallas, TX: Meadows Mental Health Policy Institute. Estimates were based on a 2012 Texas Health Care Information Collection hospital survey of 580 hospitals and costs from a 2013 Dallas Fort Worth Hospital Council Foundation report.

54 CommuniCare receives a fully implemented rating in mental health, but they do not provide substance use disorder services.