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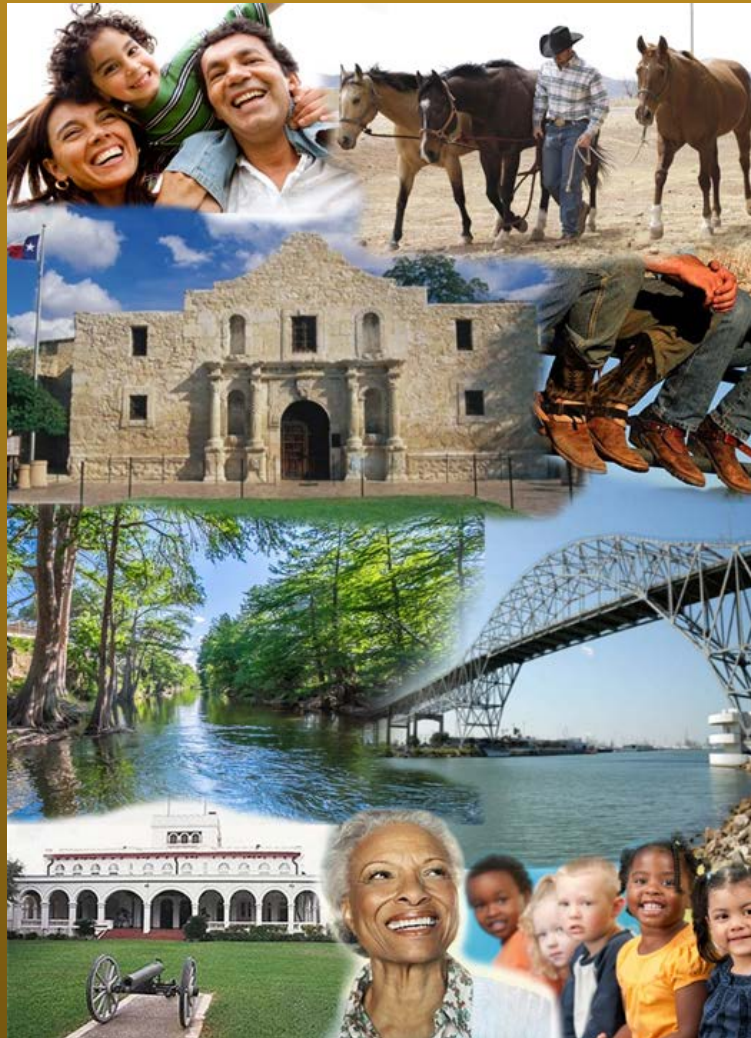
Mending Lives.



Big Hearts.

Nourishing Hope.

THE SOUTH TEXAS WAY

















Planning Report for the Redesign of San Antonio State Hospital and Reinvigoration of Behavioral Health Care in South Texas



Redesign of San Antonio State Hospital and Reinvigoration of Behavioral Health Care in South Texas

Prepared by the University of Texas Health Science Center at San Antonio for Texas Health and Human Services under contract HHS000099200001, authorized by S.B. Bill 1, Riders 145 and 147 of the 85th Texas Legislature.

Developed in collaboration with:

-  Methodist Health Ministries of South Texas
-  Bexar County, Sheriff's Office and Department of Behavioral & Mental Health
-  Center for Health Care Services
-  City of San Antonio, Department of Human Services & Fire Department's Emergency Medical Services
-  Clarity Child Guidance Center
-  Gulf Bend Center
-  Haven for Hope
-  Hill Country MHDD Centers
-  Meadows Mental Health Policy Institute
-  National Alliance for Mental Illness, San Antonio
-  Southwest Texas Regional Advisory Council for Trauma
-  Texas Health and Human Services, Behavioral Health
-  University Health System
-  University of Texas at San Antonio School of Architecture

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The Joe R. & Teresa Lozano Long
School of Medicine

Department of Psychiatry

Steven R. Pliszka, MD
Dielmann Distinguished Professor
and Chair

December 31, 2018

Mike Maples

Deputy Commissioner for the Health and Specialty Care System
Texas Health and Human Services
Austin, TX

Dear Commissioner Maples:

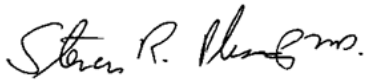
On behalf of the San Antonio State Hospital (SASH) Stakeholder Executive Committee, I am pleased to present this "Planning Report for the Redesign of SASH and Reinvigoration of Behavioral Health Care in South Texas". This report is the result of the dedicated work of many individuals in San Antonio and the South Texas communities. This report was unanimously approved by the committee on December 20, 2018 and represents the consensus of our community. In the following report we lay out the rationale for a series of recommendations which we believe will greatly enhance behavioral health care in our region. In summary, we recommend:

- Replacement of the SASH at its current location with a client-friendly state of the art design, as laid out in our architectural master plan. SASH should retain its current capacity. We further recommend a number of enhanced clinical services at SASH as well as greater family involvement and use of peer support programs.
- Development of a master plan for the current SASH campus to allow a range of services that reduce readmission among patients and enhance recovery from mental illness.
- Development of added regional inpatient services in rural areas to deliver intensive services closer to clients' homes.
- Expansion of community mental health services and better integration of inpatient and outpatient care.
- Expansion of child and adolescent mental health services to help prevent the development of chronic adult mental illness.

- Expansion of substance abuse treatment services and recognition of the need to treat individuals with both mental illness and substance abuse disorders.
- Increase capacity to treat individuals with dual diagnose of intellectual disability and mental illness.
- Identify areas where UT Health San Antonio can collaborate with Local Mental Health Authorities (LMHAs) and with SASH in clinical care, research and education.
- We propose a number of legal reforms to speed care to mentally ill individuals in acute crisis, as well as to deal with the growing challenges posed by forensic commitments.

Many individuals and organizations made this report possible, as noted in our acknowledgement section. It has been a pleasure to work you and the staff of Health and Human Services on this project. The SASH Executive Stakeholder looks forward to working with you in the future to bring this vision into reality.

Sincerely,

A handwritten signature in black ink, appearing to read "Steven R. Pliszka, MD". The signature is fluid and cursive, with the first name "Steven" being the most prominent.

Steven R. Pliszka, MD
Dielmann Distinguished Professor and Chair
Department of Psychiatry

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Executive Summary

Buildings themselves do not cure behavioral health disorders. However, their design and upkeep do affect the successful implementation of direct treatments. They can make the difference between life and death for many patients who rely on their environment to provide safety and to instill hope that they might overcome

crushing despair. The impact of facility design on staff morale and safety also has a growing evidence base (1-3).

“It is obvious that every State hospital should be made good enough for the highest class of its citizens, for it should not be forgotten that what is good enough for them... is none too good for the humblest of the unfortunate”

-- T. S. Kirkbride, 1856

Just as importantly, a facility’s characteristics broadcast how a community values, disdains, or merely tolerates those whom it serves. Bleak and austere surroundings convey expectations for deprivation, sacrifice, or repentance. Bright and enriched settings suggest optimism and affirms that the community holds those residing there in high regard. Whatever its original design and intended ambience, poor maintenance signals that residents and staff

are a low priority for the community’s resources and concern. Bearing in mind that state behavioral health inpatient facilities are often one’s home for extended periods, the physical environment exerts a profound impact on how patients regard themselves and can either aggravate families’ worst fears about their loved ones’ plight or nourish hope that even severe disorders can be surmounted.







The purpose of behavioral health care is to help people become well. Hospital services are an important element of that. However, the vast majority of those obtaining treatment at San Antonio State Hospital (SASH) have longer-term care needs that no single inpatient stay, no matter how magnificent the building, can fully alleviate. Many people may not have needed SASH’s services if less restrictive community-based treatments and services had been either better available or more effectively delivered. Therefore, this report addresses pressing issues around behavioral health care in our communities because of their profound implications for both the individuals who are the users of inpatient services and for the efficient use of hospital resources to yield the greatest benefit.

To fulfill the requests that Texas Health and Human Services specified in our contract’s Statement of Work, this report’s organization progresses from assessment of current and future needs to recommendations for the planned replacement of SASH. Accordingly, Section I establishes context by summarizing the development of hospital care for those with behavioral health disorders and discusses recent trends nationwide that shape the role of state hospitals and the challenges they face today. Section II contains an assessment of needs that reflects extensive consultation with

community stakeholders. Section III presents recommendations concerning the new facility and covers both clinical care models and building characteristics. Their goals are to be responsive to community and staff concerns, issues raised in prior assessments of the facility, and grounded in contemporary best-practices. Section IV likewise contains recommendations for the broader public mental health system in our region. Section V presents a vision for a better integrated and effective system of behavioral health care that overcomes its current shortcomings.

The table below summarizes our recommendations. In the electronic version of this document, each recommendation contains a link to its more detailed presentation and to the other parts of this report that contain additional relevant background.

At a Glance: Key Recommendations of the Executive Committee for the Redesign of San Antonio State Hospital

	Go to page	Additional Background
I. Clinical Practice Models and Processes		
1. Refocus SASH's Service and Admission Patterns to Serve as a Tertiary Treatment Center We strongly endorse the recommendations from numerous prior reports that Texas' state-operated psychiatric hospitals become almost exclusively "tertiary care facilities for the most complex mental health patients and a significant portion of the forensic population."	 51	 9, 16, 21, 38, 44
2. Improve Regional Collaboration Form a Regional Council involving SASH, LHMA's, and local law enforcement to improve transparency and consistency for admission criteria, waitlists, and other processes.	 51	 21, 28
3. Promote Recovery and Readiness for Community Life a. Implement a robust rehabilitation program. b. Incorporate principles of trauma-informed care.	 51	 28, 27, 40, 46

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- c. Maintain and expand peer support collaboration.
- d. Make physical fitness and health a priority, reduce established risk of early mortality

4. Improve Discharge Planning & Transitional Programming



- a. Upgrade technology and available personnel to insure access to benefits.
- b. Improve coordination with external agencies before discharge.
- c. Create transitional housing programs to evaluate and foster readiness for community residence.
- d. LMHAs that pursue Certified Community Behavioral Health Clinic status are expected to enhance their range of services, accessibility, and care coordination capacities. State hospitals may benefit from these developments, and the state should support LMHAs in these efforts.

5. Insure Timeliness and Continuity of Pharmacotherapy



- a. Improve communication on current and regimens and response between inpatient and outpatient providers.
- b. Anticipate potential problems with postdischarge implementation of treatment.
- c. Visit with prescriber should occur within 7 days of discharge.

See additional recommendations for system-wide continuity of care, p. 81ff.

6. Develop ECT Program and TMS Capability



In addition to inpatient program, also consider possible role of facility for outpatient treatment and maintenance when private local providers are not available to the patient.

7. Upgrade Communication and Information Technology Capabilities

- a. Adequate supply and quality of computer and related facilities for patient training and personal use, with appropriate controls for content and security.
- b. Install a dedicated wi-fi network for visitors.
- c. Replace current card-stamp system to record patient program engagement with wristband scan system, use data for treatment monitoring and regulatory purposes.
- d. Adopt silent personal alarm system, staff have alert button on their person that notifies team of location when assistance is needed and is less inflammatory for agitated patients.
- e. Video/telephonic capabilities to enable, among other things:
 - Contact with family members in therapy sessions and 'virtual visitation'
 - Telemedicine with outside specialists
- f. Integrate technology systems between campuses and within state hospital system and its partners.

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58



15, 17,
35, 45,
81, 58,
75, 78

8. Facilitate Family Participation in Treatment and Provide Support

- a. Leverage technology to overcome limitations of significance distance.
- b. Maintain and enhance overnight lodging capacities for families with long travel times.
- c. Establish convenient Family Resource Center staffed by peer support and benefit specialists.
- d. Enable communication between direct care/nursing staff and caregivers for education, modelling of beneficial approaches to help patient, and support.



60



27, 42,
44, 53,
60, 71,
75, 78

9. Capacity for On-Site Medical Care

- a. A suitably equipped examination room should be on each unit.
- b. Maintain and enhance general ambulatory medical care on site, as well as dental and ophthalmic/optometric services.



60



48, 42,
44, 60,
71, 75,
78

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- c. HHS should study the issue of pregnant women who need admission to state hospitals.
- d. Take care in the design of living units at SASH that they are accessible to persons with physical limitations or in need of “in-home” medical procedures such as portable oxygen and GI tubes.

10. Develop Clinical Program and Aftercare for those with Early Phase Psychosis



- a. Consider dedicated unit or subcluster within unit for early-episode young adults.
- b. Develop facilities on-campus and in aftercare locations that are inviting and appealing to non-chronically ill patients.

11. Adolescents



35, 44,
44ff








- a. Restrict SASH resources for those with demonstrable need for extended-stay inpatient care and fill need for acute-care hospitalization services closer to home communities.
- b. Maintain and enhance school-based educational services. Create charter school or similar entity if the campus’ local school district opts to scale back resources.
- c. Recognize special training required for direct care staff.
- d. Insure adequate rehabilitation staff to maintain activity and structure.
- e. Facilitate family partnerships and peer support services.
- f. Make overnight lodging available for families travelling significant distances so that travel burden does not detract from optimal visit time and interaction.







12. Develop Alternatives to Hospitalization for Long-Stay Elderly Individuals










9, 57

Locate or devise care settings more appropriate for life-long placement than state psychiatric hospitals.

	Go to page	Additional Background
13. Base Admission for those with Developmental Disorder on Functional Criteria and Improve Range of Services	 64	 44
<ul style="list-style-type: none"> a. Diagnoses of intellectual disability, autism spectrum disorder, and other developmental conditions should not automatically preclude admission to SASH. Suitability determinations should instead be based on functional capacities and needs. When these can be accommodated within the hospital's resources, such supports should be available. Consultation from the adjacent state living center may be helpful. b. Solutions for those with longer-term behavioral-support needs should be developed in collaboration with other agencies. 		
14. Reduce Suicide Risk with Programmatic Solutions	 64	
<ul style="list-style-type: none"> a. Patient routine must include activities which are gratifying and where one experiences making a positive contribution that is useful and appreciated. b. Constant observation for patients at high self-harm risk cannot be passive but need to include engagement and encouragement to engage in activities as appropriate. 		
15. Substance Use and Addiction Treatments	 65	 40, 47, 54, 82
<ul style="list-style-type: none"> a. Enhance substance abuse treatments tailored to needs of those with behavioral health disorders and perhaps age group. b. Recognizing the contextual nature of many addictions, early and vigorous liaison with aftercare providers is important to relapse prevention. 		
16. Forensic Commitments: Reduce Reliance on SASH for Competency Restoration	 65	 11, 17, 30
<ul style="list-style-type: none"> a. Heed prior state reports emphasizing the drain on clinical capacity that arises when state hospitals are overused to treat individuals who lack adjudicative competence due to psychiatric illness. 		

	Go to page	Additional Background
<ul style="list-style-type: none"> b. Improve resources for outpatient treatment of those posing no imminent danger. c. Strengthen treatment capacity for those held in jails pending transfer to state hospital on incompetent-to-stand-trial commitments. d. Disallow extensions of inpatient commitments for those with conditions unlikely to improve to attain adjudicative competence. 		
17. Forensic Commitments: Develop Benchmarks for Adequate Pharmacotherapy Trials	 66	 11, 17, 30
18. Ensure Adequate Staffing and Address the Chronic Problems of Workforce Recruitment and Retention	 66	 17, 48, 51
<ul style="list-style-type: none"> a. Create realistic staffing ratios for the patient group served that comport with best practices. Factor in periodic needs to address behavioral crises, 1:1 assignments, adequate break times, etc. without detriment to the care of other patients (see also Safety, p. 75) b. Improve the career appeal of state hospital employment through competitive compensation, professional development opportunities, and the positive experience of longer-term engagement with patients than other settings. 		
II. The Built Environment: New Facility Characteristics		
1. Design and Construction Incorporates Current Best-Practices and Guidelines for the Environment of Care	 68	 16, 17, 48
<ul style="list-style-type: none"> a. Optimize social density. b. Create homelike, noninstitutional environment. 		

	Go to page	Additional Background
2. Unit Size	 70	 16, 17, 48
<ul style="list-style-type: none"> a. Limit maximum adult census to 24 per unit. b. Limit maximum adolescent census to 16 per unit. c. Design and program for smaller groupings based on age, functional status, or treatment needs. 		
3. Design Layout to Optimize Social Density	 70	 16, 17, 42
<ul style="list-style-type: none"> a. Prevent sense of crowding and social compression. b. Respect patient privacy to the extent compatible with individual safety and therapeutic needs. c. Provide variety of smaller, distinct social and seating arrangement for patients to self-calibrate degree of social engagement they find manageable. 		
4. Design Admission and Facility Entryways to Convey Therapeutic Atmosphere	 71	
5. Create Unit Entry & Reception Areas that are Inviting and Secure	 71	
<ul style="list-style-type: none"> a. Situate observation area within view of entry to promote security and visitor orientation and welcome. b. Create “coves” or circular arrangement of seating; avoid linear seating arrangements that evoke “bus station” ambience. c. Incorporate mixture of social areas rather than a single overwhelming and compressed single traditional dayroom. 		
6. Insure Easy Access to Fresh Air and Outdoor Spaces	 71	
<ul style="list-style-type: none"> a. Design for open feeling, rather than confining/courtyard-like outdoor areas. b. Landscaping and hardscaping suitable for strolling and safe use with wheelchairs, walkers, etc. minimizing risk from falls. 		

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- c. To the extent practicable, design barrier enclosure to blend with environment and avoid prison-like visual cues.
- d. Provide adequate shaded spots for relaxation. Provide drinking water outdoors.

7. Patient Rooms and Bathrooms

- a. Use predominantly single-patient bedrooms.
- b. Include some bedrooms meeting double-room requirements to flexibly accommodate handicap needs, other alternate bedding, patient preference or clinical desirability for roommate, room for staff member doing 1:1, and to *temporarily* go above desired unit census.
- c. Bathrooms adjacent to bathroom, mostly all with direct access from bedroom; hall access considered for certain settings.
- d. If bathing and showering facilities are not in the bedroom-adjointing bathroom, provide easy access that maintains privacy to extent possible.



72



16, 42,
48, 53

8. Create Open Setting that Encourages Interaction

- a. Reduce “fortress” like intersection of patient and staff areas consistent with safety and privacy needs.
- b. Social areas with mixture of seating arrangements and densities; lets patients self-calibrate range of exposures to social stimulation.



72

9. Maximize Exposure to Natural Lighting and Use Appropriate Artificial Light Sources

- a. Allow greatest exposure to natural light consistent with interior climate control needs.
- b. Minimize use of fluorescent fixtures in patient living areas.
- c. Allow patient control of bedroom lighting, especially at nighttime, consistent with supervision needs.



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10. Use Layouts and Materials that Prevent Unfavorable Acoustics



- a. Avoid long, straight corridors.
- b. Use noise-dampening flooring.
- c. If preponderance of hard furnishings adversely affects sound absorption, consider other methods to dampen reverberant sound (e.g., wall and ceiling design or texture).

11. Create Adequate Spaces for Treatment on or Close to Unit



16, 17,
42

- a. Insure enough separate spaces to enable several activities simultaneously.
- b. Provide adequate number of offices for clinicians to meet with patients comfortably.
- c. Create staff meeting spaces near patient areas to maximize direct care staff involvement.
- d. Strive to make medication administration an interactive and positive experience.
- e. Provide calming comfort room as resource for patients to regain composure and defuse escalating behavioral situations.
- f. Medical examination areas.

12. Staff Support



17, 42,
48, 66

- a. Include break, rest and dining areas with access to comfortable, shaded outdoor areas.
- b. Spaces for training and conferences, both without and outside the secure patient-care perimeter.
- c. Design for staff washroom facilities close to worksite.
- d. Staff exits to include security stations to provide nighttime escort to vehicles.

13. Create Accessible, Centralized Off-Unit Facilities and Amenities



51, 53

- a. Locate off-unit areas to facilitate unescorted access by patients who can do so.
- b. Consider off-unit dining areas to develop patient autonomy and decision-making, as indicated.

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14. Incorporate Dedicated Space for Positive Visiting Experiences Close to Patient Living Areas



35, 45,
53, 54,
60

- a. Visiting areas to include comfortable homelike surroundings and consideration of child-friendly materials. Provide informational materials.
- b. Establish Family Resource Center
- c. Include infrastructure for 'virtual visiting' through private yet supervisable audiovisual facilities.

15. Safety Factors



53, 58,
64, 66,
73, 74








- a. Ligature resistant fixtures and hinges, modern locking devices and so on are required are costly. Prices may rise as new requirements are enforced while there are few vendors. These costs must not be borne at the expense of other clinically important factors and recommendations.
- b. Furnishings must avoid an institutional character while being appropriate to the security needs of the setting.
- c. Appropriate staffing patterns must be adopted that are suited to the patient populations served. Staffing calculations to meet patient care and therapeutic needs should be based on realistic scenarios that allow for periodic behavioral crises, 1:1s, escorts, etc., not just ideal ones in which staff are not occupied with these responsibilities.
- d. Evaluate adoption of newer staff personal alert devices that lead to efficient dispatch of assistance and avoids escalation associated with raised voices for help.
- e. Clear, distance-legible, reflective, and pictographic signage.

16. Educational Facilities for Patients



8, 44,
51

- a. School-Age: Collaborate with school authorities to establish classrooms and furnishings to provide an educational setting most similar to age-appropriate school surroundings in the community. Include areas

	Go to page	Additional Background
for special services that minimize disruption to the school day of students who receive them.		
b. Adults: Include space and facilities for adult educational opportunities such as GED completion.		
17. Training, Continuing Education and Staff Development	 78	 17, 55, 66
a. Include space and facilities for training and staff development.		
b. Provide education, conference space and facilities outside of secure patient areas so SASH can serve as a regional resource for continuing education programs for community providers.		
18. Patient Resource ‘Mall’	 78	 28, 27, 53, 54, 55
Provide a designated patient-accessible area for benefits counseling and to obtain other supportive services such as housing, transportation, vocational and other community resources in preparation for discharge.		
19. Medical Capabilities and Flexible-Use during Crises or Disasters	 78	
Incorporate building elements that can support an emergent need for isolation areas, care for evacuees, moving patients to nondamaged locations within facility, staff accommodation, etc.		
III. Enhancements to the Regional Systems of Care and Prevention in South Texas		
1. Improve Continuity of Care	 81	 22, 25, 28, 35, 55, 56, 57
a. Establish a standard of care that psychiatric prescribers may accept a discharge summary from a psychiatric hospital as the basis for renewing medication prior to a full evaluation they conduct themselves.		
b. Improve tracking of the clinical course of patients as they move through the mental health care system, identifying high utilizers and prioritizing for intensive case management.		

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- c. Shared medical records between pharmacies, state hospitals, LMHA's and private hospitals, accessible to front line clinicians.

2. Assisted Community Treatment & Adherence

- a. Expanded capacity for AOT programs at LMHA's
- b. Increased ability to provide extensive case management, particularly for homeless or marginally housed individuals.
- c. Supports to enhance adherence with medication and other outpatient treatments
- d. Allow for return to hospital if outpatient treatment non-adherence results in significant worsening of function.
- e. Encourage programs to adopt best-practices for determining individual contributors to nonadherence, collaborative goal-setting, incentives, and advance directives.



82



8, 25,
27, 89

3. Expand Substance Abuse Treatment Services

- a. Enhance treatment programs for pregnant women with substance abuse disorders.
- b. Increase number of fellowships in Addiction Psychiatry and Medicine through state funding to medical schools.
- c. Acknowledge resurgence of methamphetamines as a Texas crisis; in some areas it is more prevalent than opioid abuse.
- d. Increase availability of and access to opioid antagonists. Incorporate availability of medication assisted treatment for opioid addiction (MAT; buprenorphine) behavioral health treatment in sites providing these services.
- e. Review funding rates to substance abuse service facilities as capacity to provide treatment is impacted by rates and the current rates do not support growth.
- f. Support changes in CFR Part 2 to remove prohibition on the sharing of substance abuse and other medical records. Current law makes establishing substance abuse clinics in multi-specialty medical or mental health clinics extremely cumbersome.



82



8, 33,
40, 47,
53, 87

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- g. Commercial insurance plans should provide adequate coverage for substance abuse services.
- h. There is a gap in substance abuse treatments for those with developmental handicaps that needs to be addressed systemically.

4. Increased Support for Guardianship Arrangements



- a. Identify patients who lack capacity for making financial and medication decisions.
- b. Assign qualified guardians when families are unable or unwilling to carry out this role.
- c. Manage patient funds (especially disability payments) such they are appropriately spent on food, housing, and medical care.

5. Forensic Patients and Competency Restoration Outside the State Hospital: Outpatient and Jail-Based Services



15, 21,
30, 65

Improve alternatives to hospital-based commitments for competency restoration and broaden options for conditional discharges that fulfill public safety goals.

6. Develop Facilities for Intensive Acute Care in Rural Areas



23, 26,
33, 35,
38

- a. Create state-funded, but locally-operated psychiatric hospitals that serve as regional “hub” facilities.
 - b. Each serves several LMHAs.
- Combine local community funding for construction with state appropriations for operation.

7. Children and Adolescents: Behavioral Health Care



21, 35,
44

- a. Improve access to timely and high-quality outpatient care for youth.
- b. Integrated behavioral health and pediatric services improved access but have proved unsustainable when reliant on fee-for-service revenues. HHS will need to be proactive in supporting these endeavors.

Go to
page

Additional
Background

- c. School-based mental health services can improve access, and Texas has some strong models for doing so.
- d. Collaboration with local educational authorities to develop an appropriate spectrum of day programs is essential to improve long-term outcomes of the most at-risk youngsters.
- e. Expansion of the number and quality of residential treatment centers is desirable to offset demand for hospital-based care and as a more positive alternative for youngsters with unsuccessful foster care placements.
- f. Substance use services for adolescents must be robust.

8. Children and Adolescents: Prevention

- a. We encourage further support to prevent and intervene early for the abuse and neglect of children whose contribution to mental health problems is now well established.
- b. Improve supports to foster parents caring for children with behavioral health disorders.
- c. Actively address the needs for youth aging out of foster care.



9. Recommended Statutory and Process Changes

- a. Limit lengths of stay for individuals committed by criminal court for competency restoration.
- b. Expedite action when court orders to compel treatment are necessary
- c. Allow Crisis Stabilization Units to obtain compel-medication orders when needed to preserve safety.
- d. Allow judicial orders for compulsory pharmacotherapy in assisted outpatient treatment when needed to avert deterioration in illness.
- e. Allow electronic applications for Emergency Detention by LMHA and MH Officers in the jails, as well as physicians.



11, 30,
51, 23,
25, 33,
38

On behalf of our communities throughout South Texas we want to acknowledge the strong collaboration and support that HHS and the Legislature have extended our group. We value this unique opportunity to have participated in the development of these proposals as we prepare for what we anticipate will be a new golden era in public health.

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Section I: Context of Inpatient Services for Behavioral Health Disorders



Historical Perspective on the Confinement of Individuals with Behavioral Health Disorders

Severe disturbances of emotion, thought, and behavior are prevalent in all human communities, and are among the leading sources of disability, morbidity, and suffering in every age group worldwide. The personal discomfort and dysfunction they cause are compounded by their wider adverse impacts. The latter includes harmful and unsettling behaviors, which can lead to greater social marginalization, disrupted relationships, and other hardships.

The terms for these conditions as a group have shifted over time, to some extent reflecting each era's understanding and attitudes toward them. Widely-used terms in recent times include *mental* disorders or illnesses, *psychiatric* disorders, *brain* or *neuropsychiatric* disorders, and *behavioral health* disorders. The latter is perceived as less pejorative than the alternatives, and, consistent with the usage of other relevant state and local government documents in Texas, is preferred in this report.

At the most general level, the prevailing scientific view of behavioral health disorders is that (a) vulnerability arises through abnormalities of the brain that are intrinsic (e.g., genetically-based) or acquired through events that damage it; (b) their onset, course, and outcomes are influenced by experiential factors, interventions, one's other personal characteristics, and the environment; and, (c) some experiences *in extremis* – such as trauma – can be sufficient to precipitate significant disturbances.

Today's understanding of these conditions reflects the cumulative research and experience, especially that acquired in the last 130 years or so. The current view of behavioral disorders as treatable, rather than progressively deteriorating or intractable, arose amidst the development of medicinal and other therapies whose beneficial impacts would have astonished earlier generations. Until quite recently, developed societies set those afflicted with severe behavioral health disorders apart from the community, usually to live out their days in grim yet minimally protected circumstances.

Centers that provided compassionate and humane care for the mentally ill flourished intermittently since classical times. For instance, healing temples offered care and serenity, at least for the elite of these societies. Priests, perhaps exploiting a person's delusions, impersonated gods to provide patients with reassurance or to command changes in behavior. Ancient Greek physicians are thought to have been among the first to offer physiological explanations for behavioral disturbances to replace supernatural ones. However, such proto-scientific views fell in and out of favor in various societies over the centuries that followed.

For most of Western history, however, the treatment of people with psychiatric illness was among the more deplorable of human undertakings. One influential Roman, Aulus Cornelius Celsus (25 BC – 50 AD), advocated a calm environment, encouragement, and herbal remedies for melancholia (4). However, for agitated behavior he called for punitive measures:

‘If however, it is the mind that deceives the madman, he is best treated by certain tortures. When he says or does anything wrong, he is to be coerced by starvation, fetters and flogging... To be thoroughly frightened is beneficial in this illness.’ (p. 303)

This strain of thought sanctioned a range of odious practices toward people with severely disordered behavior for centuries to come. In medieval times, demonic explanations for aberrant behavior and thought resurged and motivated the confinement, persecution, shackles, and harsh and neglectful treatment that dominated until the late 18th century. Around that time the leadership of a few institutional facilities for the behaviorally disturbed catalyzed changes whose legacy we inherit as the basis for hospital care of those with severe behavioral disorders.

The contemporary model of the psychiatric hospital originates with reforms during the 1790s. In Britain, William Tuke, founded the York Retreat, which in turn influenced Benjamin Rush in America. In France, Philippe Pinel at the Bicêtre and Salpêtrière Asylums introduced human care rather than physical restraints. In Italy, Vincenzo Chiarugi at Florence’s Hospital of Bonifazio similarly reformed clinical practices. All of these men’s writings contributed to the modern approach to classifying psychiatric illness based on lucid descriptions of symptoms and observed

The larger historical context of psychiatric hospitalization, and enduring apprehensions about the people who need it, continue to imbue inpatient psychiatric care with arguably the most negative stigma among medical treatments today.

course. In the United States and Britain facilities for the care of those with chronically debilitating mental illness ultimately became a function of local government. Reformers such as Dorothea Dix in the U.S. were instrumental in improving the facilities and standard of living for those destined to spend much of their lives in them.

This wave of reform and the infusion of public investment, along with an optimistic view that more humane treatment would also cure patients, helped stimulate a significant growth of

institutions for the mentally ill beginning in the mid-1800s.

Texas was part of this trend. Austin State Hospital was established in 1854, SASH was established as the “Southwest Insane Asylum” by an act of the Texas Legislature in 1889. We are indebted to the research of Franklin Redmond, M.D. who documented the early history of SASH (5) The current site in southeast San Antonio was chosen based on a number of requirements set by the Legislature, including, “...its accessibility and convenience to the greatest number of inhabitants, the supply of

water, building material and fuel, drainage, fertility of the soil [as the hospital would have its own farm], together with railroad connection; and the same shall contain not less than 640 acres...". The initial building was to have the capacity of 500 patients, at a time when San Antonio had 37,673 residents. Sadly, Section 10 of the Bill rings true to use today:

"Sec 10. The fact that there is a large number of insane persons in the jails of the state who are in need of immediate treatment, creates an emergency, and imperative public necessity exists which requires suspension of the constitutional rule which requires bills to read in each house, and said rule is hereby suspended.."

The facility opened on April 6, 1982. The central administrative building was flanked by three story wards on each side, segregated by gender,

A novelty for its day, the facility had open wards rather individual cells. This favorably impressed a reporter from the San Antonio *Daily Express* (forerunner of the *Express-News*) who wrote on August 26, 1894:

"Instead of finding them confined to narrow cells, they are allowed to roam at will throughout broad corridors and halls with regular outings twice day...the inmates were seen sitting about the corridor or congregated in the large open apartments in the center of the room where they talked together, played or did what they saw fit."

Dr. W.L. Barker, the superintendent, remarked how the layout of the hospital reduced the violence of patients and the need for "severe" treatment, stating proudly that a straitjacket had not been applied in six months (5, p. 34). Five new buildings were completed by 1939, several of which are still in use today. One unit, built in 1934, serves as the Adolescent Unit.

It was almost inevitable, though, that the burdens of increasing urbanization and migration, economic dislocation, and the infectious epidemics of subsequent eras, along with the fact that more humane care was not necessarily curative, combined to strain these resources. Underfunding, public discouragement and a growing patient

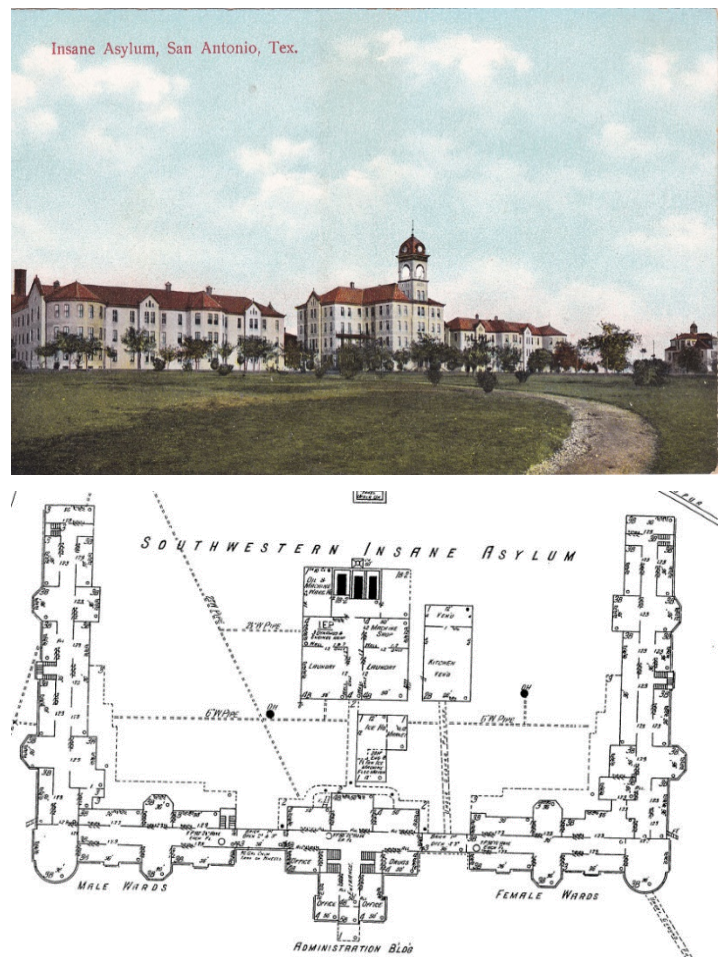


Figure 1: San Antonio State Hospital c. 1920

population degraded many publicly supported facilities into quite dismal places well into the 20th century. By 1955, over 550,000 individuals lived in inpatient psychiatric facilities in the United States, or about 300 per 100,000 Americans. In 1940, the patient population at SASH was 2,854 with a waiting list of 700 in the state jails (5). By 1950, although definitive census figures are difficult to find, Redmond (5) estimates that number grew to between 3,500 and 4,000 with no additional building during that period. This nationwide overcrowding and neglect facilities enabled the image of the psychiatric hospital in popular culture as a “snake pit” to take root, and depictions like those shown in *One Flew Over the Cuckoo’s Nest* to epitomize them. One tragedy of this era is that these images largely upended earlier progress that transformed psychiatric hospitals to becoming widely perceived as humane places for healing, not of imprisonment and abuse.

Beginning in the early 1960s, however, several trends contributed to the depopulation of state hospitals throughout the United States. The development and widespread use of effective pharmacotherapeutic agents for psychosis and major mood disorders finally turned the tide, and the age of “asylum psychiatry” began its descent. The creation of Supplemental Security Income (SSI) and Medicaid meant that persons with severe mental illness could afford to live and seek medical care in the community. Elderly patients with dementia could have nursing home care funded by Medicaid. In 2014, *all* psychiatric beds combined (acute and long-term, private and public) would account for 33 per 100,000 people.

During the same period, vigorous advocacy, progress in treatment, and the deinstitutionalization movement culminated in the Community Mental Health Act (CMHA) of 1963. The growth of local, smaller inpatient psychiatric units caused hospitalizations to be regarded as a time-limited health service, rather than a custodial setting far from home for disorders that caused lifetime disability. Acute-care units in general hospitals proliferated, where comparatively short stays for episodic crises became the norm. Nevertheless, the ambitious aims of the CMHA were never fully funded, and it is unlikely that adequate outpatient supports ever existed to offset the reduction of inpatient beds for those with severe behavioral health disorders. Despite treatment advances and a transformation in both lay and scientific understanding of behavioral health disorders, the historical context of psychiatric hospitalization, and enduring apprehensions about the people who need it, continue to imbue inpatient psychiatry with arguably the most negative stigma among medical treatments today.

Inpatient treatment remains vital to a system of care that calibrates interventions with one's current needs. Although contemporary treatments and other supports alleviate many of their hardships, behavioral health disorders remain chiefly chronic conditions whose severity and impairment often fluctuate. Exacerbations that threaten safety or signal alarming changes in mental status often require inpatient care. Advances in pharmacotherapies, psychosocial treatments and rehabilitative methods combined with a broad commitment – ideologically if not always fiscally – to

community-based care had nourished a hope that restrictive treatment settings like hospital wards would become anachronisms. Ongoing outpatient treatment that is timely, consistent, effective and utilized as prescribed may reduce the crises that result in inpatient care, but, on a population level, current interventions do not eliminate them. Regrettably, those with psychiatric disorders are still overrepresented in the nation's jails and prisons; trends shown in Figure 2 leads to a plausible inference that the depletion of inpatient behavioral health capacity contributed to the steep rise in the incarcerated population. 130 years after the Texas Legislature established SASH, the need to provide timely care in secure settings persists.

Recent developments in the United States have provoked widespread concerns that there is a shortage of hospital-based inpatient care resources for behavioral health disorders. Along with other trends, these developments have impacted, if not transformed, the role of state hospitals. We now turn to describe these developments because they are relevant to our consideration of how a reinvigorated San Antonio State Hospital can best serve the residents of South Texas.

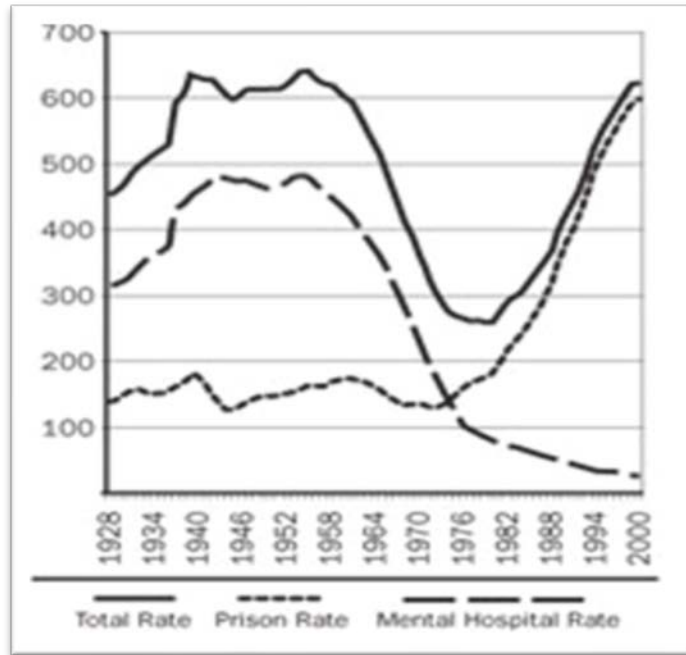


Figure 2: Institutionalization in the United States' Prisons and Psychiatric Hospitals.

Rate per 100,000 adults.

Recent Developments and the Role of State Behavioral Health Facilities in Today's Continuum of Care

1. Ultra-Short Stays and Serial Admissions in Acute-Care Hospital Settings

In the 1980s and early 1990s there was immense growth in private psychiatric hospitals, resulting in a period of oversupply and overutilization. From the mid-1990s, however, vigorous cost-containment and utilization authorization requirements for care led to a significant paring of the nation's behavioral health inpatient care capacity. Payers implemented more stringent criteria to approve admissions for which they would reimburse costs, and ongoing review had the effects of dramatically reducing lengths of stay. Average lengths of stay became markedly shorter, reflecting the view that acute-care inpatient treatment serves a crisis stabilization role, with patients transitioning to outpatient care as soon as extreme behavioral disorganization, emotional volatility, agitation, or suicide risk seems to abate. This approach eclipsed the goal of ensuring that treatments implemented in the hospital were likely to yield remission or at least a durable reduction in symptoms.

At the same time, the number of admissions to acute-care settings rose, most significantly for children and adolescents. In principle, more admissions and shorter lengths of stay could be a good thing – there may have been a high demand for inpatient care that was unfulfilled because of needlessly long lengths of stay reducing availability. Instead, however, it appears that for many seriously ill patients the result is a “revolving door”. Among patients with psychotic disorder, the current care paradigm might be justifiable for early phase treatment, where lower doses of antipsychotic agents are helpful and the likelihood of good response emerging within two weeks is higher. But with more episodes, chronicity, and suboptimal response to medications, short stays become counterproductive. After 14 days of unsatisfactory response to antipsychotic therapy, the probability of a robust response with continuation drops significantly. In these situations, short stays typically result in layering of additional medications, since there is little time nor inclination to risk discontinuation of a treatment that may not be beneficial.



Local Connections

See p. 21 and p. 23 for the impact of short behavioral health LOSs on our region

Locally, there are some indications that short hospital stays are also associated with sooner and more frequent likelihood of rehospitalizations. Comparing short-term patients, readmission rates are lower for patients discharged from a state hospital than from a contracted bed, reflecting greater challenges in maintaining close communication and coordination with private psychiatric hospitals.

2. Recovery, Not Just Symptom Reduction, is the Goal of Behavioral Health

As public-sector behavioral health strives to meet the challenges in caring for people who have severe illnesses, today's aspirations for treatment outcomes embody a quality of life that is satisfying and meaningful, ideally approximating as near as possible what one would experience if unencumbered by illness. This principle is the core of today's emphasis on recovery (6). HHS's Behavior Health Services' vision statement now incorporates that goal: "Hope, resilience and recovery for everyone".

The concept of recovery in mental health was initially developed by service users and has led to disparate conceptualizations but broadly refers to 'a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness', while developing new purpose or meaning. The importance of addressing service users' personal recovery alongside more conventional ideas of clinical recovery is now supported in guidance for all key professions (7).



Local Connections

See p. 40 for challenges our region faces in fulfilling the aim of recovery.

In practical terms, organizations with a recovery orientation strive to promote autonomy and individuality, informed choice, peer support, focus on strengths, integration in community life and workforce, and service quality improvements. The axiom that behavioral health services should be available "at the right time, in the right place, and with the right resources" has long been endorsed in principle by nearly every service organization and government. The recovery movement's significance partly stems from its emphasis that the "right" things promote individual recovery, not just temporizing measures that suppress symptoms but leave individuals adrift because they lack the supports to lead a productive and meaningful life.

The experience, threat, or witnessing of extreme harm, especially interpersonal violence, is a risk factor for behavioral health disorders. Growing appreciation of this relationship has led to a related principle, that recovery for many individuals must include interventions that take account of traumatic experience, as well as resources to alleviate post-traumatic stress disorders *per se*. Many aspects of such trauma-informed care include processes that most would agree should be part of treatment for everyone. For instance, the Substance Abuse and Mental Health Service Administration's (SAMHSA) guidance on trauma-informed care includes six principles: safety, trust and transparency, peer support, collaboration and mutuality, promoting autonomy (empowerment, voice, and choice), and appreciation of an individual's context (cultural, historical and gender issues). But trauma-informed care also means the development of therapeutic environments that factor in how certain features

3. Reduced Capacity for Inpatient Behavioral Health Care

The successes of psychiatric therapies to relieve debilitating symptoms and enable those affected to lead more independent lives are remarkable scientific and

public health achievements. However, there is widespread concern that the move away from hospital-based services may have gone too far. In the U.S., a growing consensus is that the shortage of inpatient resources that resulted has adverse impacts (8). Reduced capacity of publicly-supported facilities seems to have been especially severe. For example, between 1970 and 2014 state and county psychiatric hospital beds decreased 93% (9). In Texas between 1982 and 2010, such beds declined by 36%. Some observers have implicated the general trend toward fewer inpatient beds to rises in incarceration of those with behavioral health disorders and rising suicide rates (10,11), though a direct causal connection is controversial.

Naturally, a major driver of these trends is cost. In fiscal year 2015, states spent \$9.4 billion to operate psychiatric facilities, representing 23% of total state mental health agency expenditures. Averaged over total state hospital bed capacity nationwide, that equates to more than \$242,000 annually per patient. Medicaid's Institution for Mental Diseases exclusion (IMD) prohibits cost recovery for patients aged 22-64 in larger (> 16 beds) inpatient behavioral health facilities, although some states have obtained waivers. Federal Mental Health Block Grants cannot be used for inpatient services. These factors contributed to states encouraging the development of inpatient services in general hospitals, where Medicaid would reimburse treatment. However, declining reimbursement from payers to private hospitals for this service makes conversion of beds to other purposes financially attractive.

"Rightsizing" inpatient capacity in various types of behavioral health contexts (acute, longer-term, crisis stabilization, forensic services) is difficult. Need is partly a function of alternative care availability and other safety-net services. Compounding these challenges, population dispersion in a large state makes it hard to efficiently have state hospital services at distances advantageous to patients and families.

4. State Hospitals Fill the Gap for those Needing Longer Episodes of Inpatient Care

Until about 15 years ago, state behavioral health hospitals' role in the continuum of care was to provide a safe and therapeutic environment for individuals with disorders for which improvement was likely to be gradual at best. However, the shift toward reduced inpatient behavioral health capacity and shrinking lengths of stay in nearly all facilities has led to state hospitals filling the need to care for those having less chronic illnesses but who need hospital level care to establish an effective treatment regimen. Often, either the intrinsic severity of their disorder or a lack of supports causes them to need 24-hour care until treatments gain traction. This may mean discontinuing treatments, titrating others, and establishing core skills to resume care in outpatient settings, neither of which one-week hospitalizations are suited for. The timeframe to initiate and safely optimize pharmacotherapy for patients who already had insufficient response to treatment is, realistically, at least one to two months. State hospital services have increasingly become the site for individuals requiring this length of stay to attain remission adequate to resume outpatient care and community living.

Locally, San Antonio State Hospital has assumed this role. Many stakeholders agreed that SASH is excellent at providing extended stabilization services for people with complex and difficult-to-treat disorders, usually psychotic illnesses, frequently with concurrent substance abuse. These extended stabilization services were identified as a critical component of the care system that needs to continue into the foreseeable future. Family members of former patients also pointed out the need for continuing extended stabilization services, stating that acute care provided in private hospitals often does not provide the stability their loved ones need; they often cycle through emergency rooms and inpatient stays because of a lack of extended care that could be provided by SASH. As one stakeholder stated, "All beds are not created equal."

5. State Hospitals Provide Care and Shelter for the Very Ill who Lack Safe Alternatives even after Lengthy Hospitalization

Even with optimal care and adherence, current treatments are insufficient for a number of individuals with severe, treatment-refractory conditions. Many of these patients would not be safe residing in even supervised group home settings, or lack skills that would be expected of them in these or other supported living arrangements. At the present time, the state hospital continues to be, in effect, their home.

Many inpatients then become elderly. As they become progressively more disabled, both physically and by virtue of pernicious psychiatric illness, the range of care alternatives is frequently unsuitable. Compounding these problems is the dwindling availability of kin who might have played at least some role in helping with transfer to a less restrictive setting.



Local Connections

See p. 26 for local difficulties in meeting some patients' life needs with current community resources.

The severity of the patients at SASH is illustrated by the following case study (identifying data removed):

YR, a 45-year-old man with schizoaffective disorder, was admitted to SASH on a forensic commitment. He is charged with attempted sexual assault of hospital staff; he exposed himself and asked to have sex with a female. He had eloped from a small group of patients that were being escorted from one unit to another in the same building.

YR has a long history of sexually provocative and aggressive behavior plus treatment-refractory delusions that include his affiliation with popular music groups. He was first admitted to a state hospital nearly 25 years ago and has been in various facilities almost continuously since. Even before then, he had numerous psychiatric hospital admissions in other states dating from adolescence. YR has a supportive family. His brother is an accomplished professional and serves as his legal guardian. One sister is a nurse. They relate that YR was quite intelligent and outgoing prior to a traumatic event as a preteen—he was raped by a gang.

His illness has proved very difficult to treat. An extensive array of medication trials has yielded only minimal benefits. He currently resides on the hospital's psychiatric intensive care unit, which is designed for the most aggressive and disturbed patients. He has made no progress in terms of attaining competency regarding his criminal charge and is unlikely to ever do so.

YR requires physical restraint by staff on almost a daily basis, often 2-3 times per day. He is profoundly intrusive and insists that essentially all food items and the personal possessions of other patients belong to him. He remains sexually disinhibited. Still, at times he is articulate and able to joke with staff.

6. State Hospitals are Increasingly Used by Government for Criminal Justice Mandates

The increase in the past 10 years or so in the use of state hospital beds for defendants undergoing evaluation or treatment because a criminal court must address whether they are competent for proceedings to continue is major development nationwide. In many localities, it is perceived as an encroachment on the public health system that is thwarting limited inpatient capacity to fulfill its clinical mandate (9,12). The impact on SASH's clinical mission is significant and compels discussion in several sections of this report.

Briefly, *adjudicative competence* or *competence to proceed* is a legal construct that refers to an accused person capacity to participate in proceedings related to an alleged criminal offense (13,14). *Competency to stand trial* is used practically as a synonym, although the competence at issue pleas without trials, ability to share with counsel exculpatory information, ability to exercise one's right to withhold self-incriminating material, and ability to participate in



Local Connections
See p. 30 for the
outsized role of IST
commitments at SASH.

other legal processes (14). The requirement that defendant possess understanding and capacity to defend himself or herself against accusations has long been part of Anglo-American legal doctrine. The specific elements in the determination of competence in this country come from a Supreme Court decision, *Dusky v. U.S.*, in 1960. The Court determined that the tests for competence to stand trial are whether the defendant has “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him”. Competence is also a characteristic of the person to participate in proceedings *now*, unlike determinations of not guilty by reason of insanity, which is a determination of the person’s state of mind at the time of the offense.

States differ in some important aspects of how competence is ascertained and what follows a determination of incompetence. In general, if charges are not dropped, defendants can be remanded for treatment to “restore competence” (notwithstanding that the term is a misnomer for individuals have never fully possessed such competence in their adult lives). Several decades ago, when commitments for individuals found incompetent to stand trial (IST) were used more sparingly, such treatment occurred almost exclusively on inpatient psychiatric settings. More recently, competency restoration may take place, at judicial discretion, on an outpatient basis (OCR), within a detention facility (jail-based competency restoration; JBCR), or in an inpatient setting. Some states limit the range of alleged offenses for which inpatient commitment may be ordered, given that such placement does deprive one of liberty for charges that could, in other circumstances, result in posting bail or other pretrial release terms.

Growth in non-dismissed charges against those found IST contributed to a swelling of the incarcerated and psychiatrically hospitalized population by nonsentenced individuals. Suits brought against state agencies in Federal courts successfully argued that those found IST have a right to be treated in a hospital rather than correctional setting (e.g., *Trueblood et al. v. Washington State DSHS*). This further increased demand on public hospital services. Although there has yet to be a ruling with nationwide applicability, the trend in Federal district and appellate courts has led many state mental health planning authorities to take notice of the settlements reached in these cases, and to take proactive measures that insure timely access to appropriate care that does not unduly deprive individuals of liberty.

Regardless of where it occurs, competency restoration comprises (1) psychiatric care appropriate for the individual’s illness and (2) education on criminal court procedures. Patients are periodically reassessed to gauge improvements in adjudicative competence, and courts are advised accordingly. A variety of structured evaluation tools are available for these assessments (e.g., the Georgia Competency Evaluation Assessment, the MacArthur Competence Assessment Tool – Criminal Adjudication) though their use is not required by courts in Texas.


7. Summary

The U.S. has shed inpatient bed capacity drastically. In this context of diminishing resources, behavioral health inpatient services operated by state agencies have come under several increasing pressures from:


- (1) reimbursement practices that led other hospital facilities to abandon treatment that is more than minimally necessary to 'stabilize' an acutely impaired person;
- (2) rising, yet appropriate, expectations for the role of services in promoting more complete recovery from behavioral disorder than symptom suppression alone; and
- (3) heightened utilization of these facilities by criminal justice systems to admit individuals for adjudicative competence at the expense of other patients whose clinical needs better match the care state hospitals provide.

Accordingly, the state hospital has assumed responsibility for patients who have had serial hospitalizations with brief lengths of stay with little lasting effect on their course of illness. They have also assumed responsibility for patients who have no alternatives to hospital care for safety and functional support, patients who need intensive rehabilitation efforts to prepare for resumption of community life, and ill individuals whose behavior leads to legal entanglements but whose cognitive impairments preclude ordinary criminal justice processes from going forward.

These general nationwide trends combine with the specific inadequacies of San Antonio State Hospital to make its reconstruction and reinvigoration of the greater care system of which it is part one of the most urgent public health objectives in our region today.



Section II: Current and Future Needs for the Care of those with Behavioral Health Needs in South Texas



Background to the Redesign of San Antonio State Hospital and Community Resources for Behavioral Health

1. Legislative History

In 2017, the 85th Texas Legislature recognized the need for improvements to the deteriorating conditions, outdated building designs, and inadequate information technology capabilities of the state hospital system. In response, the Legislature appropriated \$300 million and authorized development of a master plan for each state hospital's catchment area for neuropsychiatric healthcare delivery. This authorization followed several comprehensive reviews of the state of behavioral health services in Texas conducted by executive agencies and the Legislature. It also occurred alongside other ongoing state and local government efforts to improve the processes, resources, and facilities for care.

The 85th Legislature directed that, where feasible, a public or private entity would lead development of the master plan. Accordingly, Texas Health and Human Services (HHS) contracted with the University of Texas Health Science Center at San Antonio (UTHealth San Antonio) to develop in collaboration with stakeholders a planning guide for (a) facilities and clinical models to replace or enhance those currently at SASH, and (b) processes and care models in the community that can improve the outcomes of those with behavioral health disorders. The present document is the result of that undertaking.

2. Relevant Highlights of Select Prior Studies and Reports

Texas Legislative Budget Board Staff (2013): "Texas State Government Effectiveness and Efficiency Report. ID 187, Use alternative settings to reduce forensic cases in the state mental health hospital system"

This report (15) highlighted the tension between court rulings that admonish against holding individuals found incompetent to stand trial in jails for an unreasonable time and the limited capacity of the state mental health hospital system to meet current demand for services. Recommendations included (a) development and expansion of jail-based and outpatient competency restoration resources and other conditional-release dispositions, and (b) appropriation of funds to educate judges, prosecuting attorneys, and criminal defense attorneys on alternatives to inpatient treatment.

(i) CannonDesign (2014): “Analysis for the Ten-Year Plan for the Provision of Services to Persons Served by State Psychiatric Hospitals (SPHs)”

Authors (16) with architectural and engineering expertise conducted site visits to several state behavioral health facilities, including SASH. Their assessment of the infrastructure at SASH was blunt and dismal: “On average, across all three campuses, more than three quarters of all assessed buildings are either in poor or critical condition and only one in eight buildings was assessed to be in good condition.” Many hospital rooms lodge four or more individuals, exceeding accepted best practice of single or double rooms.

Based on 2014 utilization and service demand estimates, authors projected that SASH’s service region would need to add 56 beds for extended-stay hospital capacity.

At the same time, the continuum of care throughout Texas for those with severe behavioral health disorder had significant gaps. Moreover, integration between existing service providers at and between levels of care (inpatient and outpatient) was deemed inadequate.

Rural communities suffer from insufficient access to acute assessment and stabilization programming. This leads to increased burden on already-stressed emergency medical services and law enforcement when psychiatric crises culminate in behavioral disturbance needing intervention.

(ii) Department of State Health Services (2015), “State Hospital System Long-Term Plan”

Citing findings in the CannonDesign report, this plan (17) called for the renovation or rebuilding of facilities. It also proposed drawing a finer line between the tertiary care that state hospitals should provide, while striving to locate shorter-term assessments and acute care in individuals’ communities. Its recommendation to initiate or broaden contracting with local inpatient service providers, often through Local Mental Health Authorities (LMHAs), has been implemented.

(iii) Statewide Behavioral Health Coordinating Council (2016), “Texas Statewide Behavioral Health Strategic Plan: Fiscal Years 2017-2021”

This (18) comprehensive assessment and action plan specified “urgent challenges and needs to both state-funded and state-operated inpatient psychiatric facilities by 2021” as a major goal. Facilities and maintenance upgrades and improved access were cited. Strengthening of the behavioral health workforce and improved coordination across resident-serving agencies were named among the long-term strategies with relevance to state hospital care.

(iv) *Department of State Health Services (2016), "State Hospitals and Academic Partnerships"*

This document outlined possibilities to involve the state's academic medical centers into the operation of state behavioral health facilities. Such arrangements have been implemented at Texas Tech University Health Science Center at El Paso, and with UT Health Northeast in Tyler. Benefits that might result for patient care might include enhanced staff recruitment and retention, training and development of clinical staff in various disciplines, improved linkages with community services the academic center may operate, and access to leading-edge innovations. However, shortcomings in the hospitals' current infrastructure and the exposure to financial risks for the medical schools were recognized as potential deterrents.

(v) *Texas Health and Human Services (2017), "A Comprehensive Plan for State-Funded Inpatient Mental Health Services"*

This report (19) proposed priorities and time lines for upgrading inpatient services statewide as earlier reports strongly advocated in three phases. Phase I's proposal included the request for the preplanning phases preparatory to replacement of San Antonio State Hospital, which gave rise to the work of our group and this document. It also included requests for planning and design services and renovation of a vacant 40-bed unit to help alleviate current shortcomings in bed capacity. Construction of the replacement facility in San Antonio is a component of Phase II. Phase III, projected for the 2022-23 biennium, includes occupancy, implementation of evaluation processes, and the demolition, pending additional funds, of vacated, non-repurposable facilities.

(vi) *House Select Committee on Mental Health (2016) "Interim Report to the 85th Texas Legislature"*

The Committee's assessment (20) of the state of behavioral health care in Texas covered the full continuum of concerns from prevention to caring for chronic illness. Hearings concerning the state's own inpatient facilities included observations long-term plans to preserve their unique role have been hampered by infrastructure issues, increased demand for care, and reductions in bed availability. Facilities often did not operate at optimal capacity because of maintenance issues, outdated facilities, repairs mandated by regulatory and certifying agencies, and workforce recruitment and retention.

(vii) *Center for Sustainable Development, UT Austin School of Architecture (2017): "A Texas Hospital: Planning Modern Psychiatric Care Facilities"*

The Department of State Health Services (DSHS) engaged the authors to develop a model for new facilities on the site of Rusk State Hospital. The department had envisioned that this work could provide a reference point for other projects in the state psychiatric hospital system. This work aptly summarizes current data on the impact of design and the built environment on the well-being of people with severe behavioral health disorders, and current trends in the construction of such facilities.

The authors' synopsis of best-practices in this area reflects innovations that, that have been influential in recent and ongoing projects in the U.S. and elsewhere. The leading themes emphasize structure and design that are more homelike than institutional, are safely accessorized and furnished to avoid the barren and sensory-deprived character of earlier settings, and endeavor to provide natural views and sunlight to the interiors. Easy access to the outdoors in pleasing but secure surroundings is also a prominent feature.

Patient rooms are predominantly single-occupant, with selective use of duplex rooms. Placing bathrooms *en suite* with each bedroom is also now widespread practice.

Common areas should contain subdivisions that allow congregation of both larger and more intimate groupings, as well as spots that provide individual calm space. The overall goal is to enable people to adjust the level of stimulation they experience to their current needs. Similarly, a recurring principle is to reduce perceptions of density and confinement. Some studies indicate that lessening the sense of compression caused by many people in a single limited space reduces aggressive behavior (1,21).

Estimated Trends in Behavioral Health Service Need

1. Population Growth

The Texas Demographic Center recent population projections for the San Antonio State Hospital's service area (December 2018) indicate overall growth of 18% to occur between 2020 and 2030, from 6,493,188 to 7,664,279 civilian residents (22).

Projections predict that those aged 65 and older will constitute a larger proportion of the service area population, increasing from 13.8% to 16.4%. Younger age groups will decline by a percentage point or so. The 45-54 year-old population is projected to rise from 27.15% to 28.4%.

The data also project that the proportion of those residing in Bexar County will change only nominally, from 32.24% to 32.65%. However, younger age groups (children, adolescents, and young adults) will become proportionately more concentrated in Bexar County.

2. Trends in High-Acuity Behavioral Health

Unfortunately, rates of psychiatric hospitalization and psychiatric emergency visits for children, adolescents, and young adults have continued to rise (10,23-25). These events are triggered most often in these age groups by mood and impulse control disorders. Among young adults, however, the largest increase in suicidal thoughts and behaviors is among those *without* a psychiatric disorder. This finding signals perhaps despair stemming from more adverse psychosocial circumstances rather than chronic psychopathology. On the other hand, psychiatric hospitalizations for the elderly declined considerably between 1997 and 2007.

Diagnoses of autism spectrum disorders have reportedly risen. In large part this trend reflects a less stringent threshold for diagnosing these conditions. This increase appears chiefly among youngsters with less severe impairments, most of whom also meet criteria for other disorders. Nevertheless, there are reasons to suspect that more severe forms of autism, such as those with comorbid intellectual disabilities or requiring significant assistance in daily functioning, will also increase. The suspicion stems from increases in those with risk factors for autism, such as the vastly improved survival rate for neonates experiencing neural insults, and the older age of fatherhood in the U.S.

There is no evidence that the conditions that are most prevalent among those in state hospital settings (schizophrenia, schizoaffective, and bipolar disorder that includes psychotic features or is treatment refractory) are becoming more common in the population.

Substance abuse among young people has been, fortunately, trending downward recently. In contrast to severe psychopathology whose prevalence in the U.S. is generally unrelated to geographic region, substance use does show regional variation. Texas is below the U.S. mean for most forms of substance abuse, though it is among the high-prevalence states for methamphetamine abuse and binge drinking (26, see state-level data).

3. Implications for State Hospital Inpatient Capacity

With a current population of approximately 6.4 million, a 300-bed inpatient facility represents 4.69 beds per 100,000. This is substantially below the national rate of 11.7 state hospital beds per 100,000 residents. Recent analyses (27,28) indicate that 20 per 100,000 is the minimum supply of this resource, bearing in mind that local variation in private inpatient services, utilization for forensic rather than strictly clinical objectives, and community-based resources can influence the impact of public hospital inpatient capacity on fulfilling actual need. The current wait list and length of time to admit referred patients (see Appendix B) amply show the latent need that current capacity leaves unmet.

The CannonDesign report from 2014 recommended that SASH add 50 beds to meet its projected needs. That proposal assumed that Rio Grande would take on portions of the SASH catchment area, but it has only 55 adult beds. On the other hand, the Casa Amistad 16-bed facility in Laredo, which functions administratively as part of SASH and was included in its bed count, is set to shift to operation by a local agency. A replacement facility for SASH that maintained the current nominal number of beds would gain 16 or so on campus.

It is unlikely that replacing SASH and slightly expanding its census in San Antonio would translate into an oversupply in the foreseeable future. It appears to be below the bed supply in comparable states. Nevertheless, expansion of a single facility beyond 300-350 patients pushes the limits of its ability to meet the objectives of current design principles and management resources. As population growths spurs increases in service demands, a more appropriate expansion of inpatient capacity would probably involve developing additional facilities to the south and west of San Antonio, which would also be closer to the home counties of many patients currently coming to SASH.

Optimal use of the bed supply in a rebuilt SASH will require more efficient use of the time patients spend in the hospital in order to reduce time to discharge and minimize readmissions. It also means reversing the tide of hospitalizations purely for trial competency goals that lack compelling clinical need for hospitalization. This report endeavors to provide a foundation for hospital-specific and system-wide innovations to achieve these objectives.

Stakeholder Concerns & Challenges for the Region's Behavioral Healthcare System

1. Access to Care and Inpatient Capacity

a. Overall Shortage of Behavioral Health Inpatient Beds and Brief Lengths of Stay

Reflecting the diminishing supply of inpatient services for behavioral health, the limited availability of bed for individuals who need extended treatment in a state hospital is among stakeholders' leading concerns. LMHAs that operate short-term stabilization facilities or have access to local inpatient facilities through private-purchased beds (PPB) contracts experience frustration that many individuals who seem unsafe for discharge lack appropriate postdischarge alternatives. "Our biggest challenge is discharging patients regardless of stability since [ours] is not a long-term facility, rather a short-term crisis stabilization facility", said one program director at an LMHA. Public safety officials express similar concerns with respect to the short lengths of stay prevalent in community settings. "When we send a patient to a community hospital, they are only there for 2-4 days and we are constantly having to pick them up again and bring them somewhere," said one officer. A community psychiatrist observed, "I work with patients that need long term stabilization. When the patient is chronically ill, they require longer stays than a free-standing psychiatric hospital can offer. SASH should serve this population."

Law enforcement agencies, especially in rural areas, encounter similar difficulties with those who come into their custody for behavioral disturbances and have clear treatment needs. One law enforcement official said, "There are patients that we are uncomfortable with releasing, because they are a danger to themselves and to others." The problem of appropriate discharge options for behavioral health patients who come to local hospital emergency departments is a persistent demand on staff resources. Emergency rooms report waits of 36-72 hours for a suitable behavioral health bed. Law enforcement personnel often need to locate an appropriate facility and provide transport for them. Bexar County has improved this process through an integrated system implemented by the Southwest Texas Regional Advisory Council (STRACC) that shows dispatchers in real time where available beds are located, but rural areas with fewer overall facilities remain encumbered with these frequent situations.

HHS currently provides local LMHAs with funding to contract with inpatient facilities to enable access for patients who need hospital level care, especially those without health care funding. Referred to as PPBs (private-purchase beds), some of these contracts involve acquisition of a specified number of beds for LMHAs to fill as need required, while others pay for each bed-use day. The latter has a greater risk

that there is no bed available to the LMHA. Stakeholders report that this is an extremely valuable resource, “a game changer” as one put it. They also have the significant advantage of proximity to a person’s home community. But community providers recognize that their role is chiefly a temporizing one, and it does not fulfill the same care functions that longer-stay hospitals perform. They are unsuited programmatically (oriented around short lengths-of-stay), and their physical characteristics are generally not conducive to extended stays. One recent report from an HHS advisory group indicated that readmission rates are lower for patients discharged from a state hospital than from a contracted bed, reflecting greater challenges in maintaining close communication and coordination with private psychiatric hospitals.

In our meetings with family members and patients, some lamented that inpatient treatment resources for early illness were not more like SASH. Instead, the frequent short-stay hospitalizations they experience seldom allow for adequate cross-titration of medications to determine a regimen’s effectiveness. The pressure imposed by insurance and other payers to “do something” often leads to starting new medications. The practical effect is an accumulation of medications used simultaneously whose individual benefits are unclear, but whose adverse effect risks are well established.

The net result is that LMHAs care for many individuals with treatment needs that exceed that emergency departments and local acute-care psychiatric settings can provide. This exacerbates demand for beds at SASH. This gives rise to concerns about the long wait time for SASH admission, and broad uncertainty about how admissions to SASH are prioritized, as discussed next.

b. Desire to Standardize Admission, Discharge Processes and Wait List

Throughout the SASH catchment area, there is near-unanimous frustration among stakeholders regarding the lack of predictable access to SASH. Many noted that the lack of standardized processes has led to barriers in care. Reports of inconsistencies in admission criteria were related in all local stakeholder sessions. For example, it was reported in some areas that admission had been denied to people who reported any substance use, while other areas stated that they have never had an issue placing someone who reported substance use. Similarly, there is also a need for clarity around placing clients at SASH who have a co-occurring intellectual or development disorder and a serious mental illness, with key informants reporting that those admissions are determined on a case-by-case basis.

Relatedly, the wait list data available to community providers is an ongoing source of confusion. Local Mental Health Authorities (LMHAs) are responsible for adding individuals to a list of civil patients for whom SASH admission is requested. HHS central office maintains the Clinical Management for Behavioral Health Services (CMBHS) wait for SASH, which LMHA’s update when a person in their catchment area is requesting admission. Concurrently, SASH itself has an informal internal list that

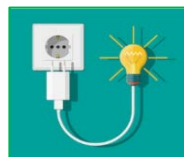
can be highly discrepant from the CMBHS list. This list includes additional referral sources beside LMHAs, such as clinicians, clients, and agency and law enforcement officials. Nevertheless, the CMBHS's is the outward-facing "official" list that LMHAs consult. On a given day, the CMBHS list may have 10 or fewer people, while SASH itself has 30-40 potential admissions pending.

Discrepancies between the two lists have led to the troubling perception that admission to SASH is an unpredictable process. That perception in turn spurs clinicians and families to forgo the formal admission process and instead work through informal channels. This further contributes to the number of referrals not reflected in the CMBHS data. As a result, enormous effort of SASH's clinical staff goes toward screening phone calls from clinicians, clients and officials seeking an admission for a client.

Another problem is that LMHA staff find the CMBHS system itself unwieldy and difficult to enter patients needing inpatient care, which makes its use error-prone and inaccurate. This problem has been recognized, and SASH has provided education, and referrals to their local contact person for further support. Despite these efforts, the follow up is very poor, and this results in few individuals being added to the list and numbers are discrepant with other rosters maintained in Austin.

Stakeholders throughout the catchment area expressed concern that what constitutes "medical clearance" appeared unpredictable over time. Stakeholders find it difficult to prepare people for SASH admissions without knowing exactly what will be accepted and declined, how best to advocate for patients, and what case information is necessary for admission.

In addition to individuals with comorbid substance abuse or IDD, other patient groups that posed significant placement problems for local providers included pregnant patients and adolescents. These populations require special consideration in the current redesign effort and future development of the campus since they are most at risk of experiencing adverse outcomes because of lack of services.



Solutions Connection

Go to **p. 51** for proposals that address communication around admission and discharge criteria

c. Acute-Care Patients Admitted to SASH

On top of the role that state hospitals play for individuals who require inpatient care that exceeds the programmatic and length of stay limitations of other settings, SASH also admits patients for acute care that ideally other hospital settings provide. This obviously hampers the state hospital's ability to fulfill its more unique function in the system of care, which should be meeting the needs of patients who have had prior hospitalizations with insufficient benefit. Scenarios leading to SASH admission for those preferably served in local short-stay acute inpatient settings often involve rural counties that have no beds available and unfunded patients needing hospitalization but the LMHA's private-purchase bed allotment cannot be applied or is depleted.

Various reports by state agencies recommended phasing out state hospitals' use in this context, but the lack of alternatives continues to compel it. Hospitalization of youth at SASH in clinical circumstances that would ordinarily warrant other inpatient services closer to home is a major concern discussed below (p. 44).

Another route by which patients not in demonstrable need of longer hospitalization are admitted have included those where SASH is fulfilling a mandate under the Emergency Medical Treatment and Labor Act (EMTALA), despite SASH's more specialized services. Relatedly, individuals often present to SASH by themselves for evaluation; sometimes families literally drop a patient with serious mental illness off at the front gate. In these situations, urgent clinical need may warrant admission even though other inpatient providers would be more suitable.

Table 1 contains length-of-stay (LOS) information for adult patients discharged during fiscal years 2012 and 2017. These data do not differentiate between those in civil and forensic commitments. Three notable trends are:

	FYs	# d/c	LOS Mean	LOS SD	Min	Max	25 th %ile	Median	75 th %ile	90 th %ile
All Adult	2012-3	2,793	49.7	146.3	1	3,684	6	17	44	99
	2014-5	2,172	71.2	222.9	1	3,800	7	21	64	134
	2016-7	1,301	88.2	245.4	1	6,019	9	29	87	201
18-19 y/o	2012-3	124	26.6	44.5	1	323	4	13	23	80
	2014-5	100	28.5	54.9	1	464	5	10	27	74.5
	2016-7	57	41.4	59.0	2	356	6	18	56	120
20-29 y/o	2012-3	804	32.1	59.5	1	963	6	14	33.5	83
	2014-5	638	45.2	87.0	1	905	6	16	48	108
	2016-7	403	68.6	104.7	1	812	7	26	87	182
30-49 y/o	2012-3	1,171	40.4	73.6	1	855	7	17	42	93
	2014-5	927	66.7	192.3	1	3,211	8	21	59	127
	2016-7	598	72.4	145.8	1	1,975	9	26	76	192
50-64 y/o	2012-3	547	107.1	295.2	1	3,684	13	31	79	191
	2014-5	410	131.2	388.1	1	3,800	14	43.5	103	231.5
	2016-7	225	180.6	511.1	1	6,019	19	57	123	364
SA/HIV, 18-64 y/o	2012-3	147	25.7	55.2	1	436	3	7	22	76
	2014-5	97	75.4	222.9	1	2,087	5	12	91	202
	2016-7	18	44.8	76.2	3	295	4	10	66	154

Table 1: SASH Lengths of Stay of Discharged Adult Patients (days).

Source: THCIC public use data file.

Ages are clustered in wider intervals for SA/HIV individuals to protect privacy.

Abbreviations: d/c, discharged. SD, standard deviation. SA/HIV, ICD–CM code contains alcohol or drug abuse, or an HIV-related diagnosis.

1. The number of discharges dropped dramatically over this period, coinciding with a substantial longer average length of stay. Increased forensic commitments are

a known contributor to these trends. Start shortages that compelled restrictions in admissions at various times during this period were also contributory.

2. At least one-fourth of patients had hospitalizations shorter than 10 days. It would appear this represents at least in part those admitted to SASH for acute intervention because there were no other acute-care facilities available.

3. Length of stay increases with age. This is consistent with some aspects of severe mental illness over time. They are often progressive conditions, so chronicity begets greater impairment. The pattern fits the “downward drift” finding that as individuals age their familial support network dwindles, which, in tandem with worsening illness, increases the likelihood of poverty and medical indigence, and thus fewer discharge options.

d. Individuals Frequently Using Inpatient or Emergency Facilities for Behavioral Health Support

In 2017 Capital Health Care Planning, in conjunction with Methodist Health Ministries and the Meadows Health Policy Institute undertook a study of “Super utilizers”, defined as persons in the “Safety Net Population” who had either 1) three inpatient hospitals, 2) two inpatient hospital stays and a serious mental illness diagnosis or 3) more than nine (9) emergency room visits. They identified 3,717 individuals. Features of this population include:

- One of five were homeless
- Annual Emergency Department visits ranged from 0 to 71.
- Annual inpatient admissions ranged from 0 to 23
- 50% had a serious mental illness
- 20% had an indication of a substance abuse problem
- Most had one or more chronic medical conditions.

The Capital Planning study broke down the diagnoses (both mental health and non-mental health) and looked at the costs to the health care system of the failure to stabilize these patients. Table 2 shows these costs which total over \$136 million a year.

Difficulties in helping these individuals maintain functioning to avert the events that precipitate emergency department (ED) visits or hospitalization would improve access for limited inpatient resources and reduce the high costs to the system that ensue from serial crises.

Diagnosis	#	# Hospital Admissions	\$ Hospital Admissions	# Emergency Room Visits	\$ Emergency Room Visits	# Hospital Outpatient Visits	\$ Hospital Outpatient Visits	# Clinic Visits	\$ Clinic Visits	Avg Cost
MH/SA	1,913	2,723	16,443,568	1,806	1,124,237	429	442,274	11,316	1,870,544	10,392
Digestive	1,400	1,086	12,134,194	1,754	1,327,278	665	948,692	1,344	392,136	10,573
Cancer	594	695	10,851,812	155	150,515	1,314	2,653,236	898	537,775	23,895
Heart	1,289	875	10,681,592	1,150	776,192	681	1,411,744	1,411	272,480	10,196
Endocrine	1,081	955	8,552,968	702	433,399	321	470,848	1,439	283,769	9,011
Infectious Disease	580	379	8,561,120	182	103,314	53	58,882	329	122,018	15,251
Neurological	923	460	7,177,373	867	536,057	256	328,776	607	181,009	8,909
Kidney/Urinary	797	593	5,460,152	608	478,830	459	1,159,771	620	537,314	9,581
Pulmonary	763	565	6,663,152	564	353,660	150	176,434	583	118,453	9,583
Other	2,083	341	5,030,880	1,521	596,524	1,704	829,836	4,462	783,523	3,476
Orthopedic	946	261	6,071,566	874	492,230	339	385,327	1,070	274,483	7,636
ENT	521	125	3,157,630	343	127,097	51	144,757	339	75,268	6,727
Skin	641	256	2,880,680	316	135,775	263	242,518	550	120,038	5,271
Injuries/Poison	804	152	2,286,933	914	566,425	124	211,333	189	41,265	3,863
Neurological Injury	61	36	2,861,370	27	30,844	14	49,607	18	3,303	48,281
Pregnancy	256	383	2,307,804	383	230,542	236	190,057	500	128,876	11,161
Orthopedic Inj	381	71	1,191,362	362	200,142	58	133,784	88	24,090	4,067
Gynecology	269	49	549,494	203	139,030	44	89,524	211	52,871	3,089
Burns	23	4	73,589	19	10,239	-	-	5	565	3,669
			\$112,937,239	12,750	\$7,812,329	7,161	\$9,927,400	25,979	\$5,819,778	\$41,064
			\$136,496,745	83%	6%	7%	4%			

Table 2: Service Use and Costs of High-Intensity Behavioral Health Utilizers, 2017.

From Capital Planning Group and Methodist Healthcare Ministries.

e. Lack of a Crisis System

Several LMHA leaders stated their system of care lacks necessary crisis alternatives for people experiencing a mental health crisis. While inpatient bed options may exist, the wait time for admissions is lengthy. Psychiatric crisis options include extended observation units, crisis respite, or 23-hour observation units. However, these types of options are not available in many of SASH's rural counties, which leaves the burden of care on general emergency departments at community hospitals. This situation is often exacerbated when an emergency detention warrant is not in place or expires, and emergency departments must discharge a person before a transfer option is in place to move that person to an inpatient psychiatric facility. In several focus groups, organization leaders voiced the need for more acute care options, stating they currently only have pre- and post-crisis treatment services available. LMHA staff noted that they have no contract options for clients who need detoxification services, which is another alternative that has potential to alleviate back up and wait times in the crisis care system.

In one focus group, LMHA administrators indicated that due to a lack of crisis respite services in their area they must send clients for crisis respite in other areas. This particular rural LMHA sends those clients to a neighboring LMHA for adult crisis respite, but the cost for these services drains their already limited resources. The LMHAs touched on the need for crisis respite services, especially since many clients do not meet YES Waiver program or intellectual and development disability qualifications for community respite. These stakeholders indicated there is not enough crisis respite

for families in their community, and that they are often left to refer people to an emergency shelter instead. While LMHAs may contract with respite services in other areas, LMHA leadership estimated that 90% of their clients decline these services because of the lengthy travel required to access it.

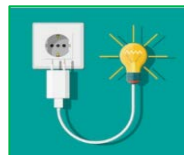
f. Limitations on Satisfactory Options for Post-Discharge Care

Behavioral health services need a range of intervention and support models that straddle the traditional inpatient vs. outpatient office visit dichotomy. However, implementing and sustaining programs that do so has proved difficult not only in South Texas but across the country.

Our region has a range of outstanding delivery models that serve the goals of maintaining individuals within their communities and supporting their functioning. Examples include day treatment programs, respite centers for youth, assertive community treatment, wraparound services for youth, and other interventions. Crisis stabilization units, operated by LMHAs or other entities, have been beneficial in preventing many flare ups from culminating in hospitalization. However, essentially none are universally available, and some instances service need increases caseloads beyond what is considered appropriate for these supports to be optimally effective.

Community providers in the SASH catchment area spoke about many unique and innovative programs that help local communities fill gaps in services. The most commonly mentioned innovative programs included efficient triage and referral services, crisis beds, and opportunities to contract with hospitals outside of their facilities. These initiatives help reduce boarding people with psychiatric issues in emergency rooms. Other programs help to reduce front-end crisis wait times, like the Law Enforcement Navigation System in Bexar County. People needing emergency services are triaged by MEDCOM, a dispatch center that accepts calls 24 hours a day, seven days a week for trauma clients in the region, and psychiatric facility referral calls.

Nevertheless, many individuals with severe illness have few community options. Hospital-level care or other high-supervision variants (ESUs, CSUs) seems necessary for the foreseeable future.



Solutions Connection

See **pp. 54–57, 60, and 81–86** for proposals to augment and optimize efficient delivery of post-discharge

One patient seen recently at University Hospital epitomizes the predicament of individuals for whom appropriate community placements are lacking.

JD is a 45 year-old man with mild intellectual disability and schizophrenia. He received special education services until age 21. He had numerous psychiatric hospitalizations beginning in childhood, due to severe behavioral disturbances, including aggression. When he was 24, JD had the onset of unremitting hallucinations and paranoia. He began antipsychotic medications while a psychiatric inpatient at University Hospital. He resided with his mother whose worsening renal disease left her unable to provide supervision of treatment adherence and structure; mother died when JD was 30. He frequently stopped taking his medication and would respond to command auditory hallucinations. Neighbors would find him wandering the street. He rang doorbells and demand food, and his interactions were increasingly belligerent and for which police were called. After mother's death, he briefly lived with his sister.

Ultimately JD was taken into the custody of adult protective services, but few group homes would accept him. Persistent aggression and disorganization made his time in a group home precarious. Police were called following an incident of genital exposure to a female staff member followed by attempted physical contact of a sexual nature. He was hospitalized at UH where, despite resumption of medication, he required 1:1 supervision for poor interpersonal boundaries, lack of independent ADL skills, and severe behavioral outbursts that followed the slightest frustration. When asked how he was feeling, he responded, "Pumpkin pie is very good".

While waiting for an opening at SASH, his behavior became somewhat more settled and adapted to routine, and a community group home offered him a trial stay. Upon arrival, conflicts with began almost immediately. He became agitated over something, and he exited the back door of the group home. He wandered down the street and banged his leg against a piece of sharp, exposed concrete on a neighbor's use. EMS was called and transported him to a local emergency department so that his leg could be sutured. He then waited for 36 hours for a new psychiatric bed to become available. The cycle would begin again.

2. Care Coordination, Communication with Local Providers

a. Community Views on Care Coordination

Community providers and public safety agencies also expressed a range of views concerning discharge planning. "When we send a patient to SASH, they will stay for 90 or so days and we won't get a call about them afterwards," said one law enforcement official. Others were appreciative of SASH discharge planners' collaboration, especially LMHAs whose staff make regular visits to maintain contact with patients they have hospitalized there.

Stakeholders also reported significant variation in the discharge process. While providers in some regions reported that they participated in discharge planning and

had been given notification prior to patient release, some law enforcement stakeholders reported they had little to no notice and “lost” people when they left the SASH campus. According to one sheriff’s office representative, “[SASH] would call and say that we need to pick them up right away, or they will release them, even if the patient has a court order. They ended up releasing [patients] on the streets and we [have] to go and find them. They need to give rural counties time to [plan] and travel there.” In addition to the variability in the notification of client release, stakeholders shared that discharge paperwork, which includes medication, treatment, and related information, is often unavailable and can take well past 14 days from discharge to receive. This has led to a lapse or change in treatment by the community provider of origin, which could be avoided with a proper discharge protocol. Families mirrored this sentiment and reported that they did not receive any sort of aftercare planning or coordination. Several family members of SASH clients reported that they located resources on their own, and often shared that their loved one had relapsed back into their illness because of lack of connection to treatment.

In addition to stakeholders repeatedly reporting a lack of collaboration with SASH staff for discharge and aftercare planning, several catchment area stakeholders expressed concern about the unavailability of information about the treatment plan itself. Families of former patients mirrored this concern, noting that they had difficulty accessing and communicating with SASH treatment team staff regarding the patient’s care. While key informants routinely characterized treatment at SASH as excellent, community providers and family members indicated that it was more difficult to share information about the patient’s treatment and behavior history with SASH staff once the patient had been admitted. In interviews with family members, many people reported how carefully they keep histories of their loved ones (including information about medications, doctors, and treatments) that could be helpful in expediting decisions about medications while the client is at SASH.

Community providers also reported a strong desire to continue support and communication with their patients during their treatment with SASH for better continuity and transition of care, regardless of whether community providers collaborated directly with SASH staff. When community providers are able to maintain communication with their clients during the clients’ stay at SASH, they are better able to engage and encourage clients’ progress beyond discharge from SASH.

b. Appropriate Information at Admission

At the same time, inpatient clinicians feel stymied the lack of important treatment-relevant data when patients arrive. Among things of utmost importance is an up-to-date record of pharmacotherapies, current and past. For instance, patients are admitted and if they have received treatment with a long-acting injectable antipsychotic preparation, there’s no information on when it was last administered nor, often, at what dose. This obviously complicates getting symptom-relieving treatment under way.

The majority of those coming into state hospital care have illness that has proved treatment-refractory to date. Very few, certainly of the adult patients, are treatment-naïve. That makes treatment history essential to guide interventions in the hospital. If a person had treatment with a medication at an adequate trial and duration and experienced either no benefit or adverse effects, then it is at best pointless, and at worse life-threatening to use it again simply because today's prescriber didn't have enough details about it. On the other hand, records may indicate that a certain regimen was prescribed and discontinued, but with insufficient information about dose, duration, and outcomes it is hard to know whether re-initiation of the compound might be useful.

3. Rising Forensic Utilization Constrains Service Availability Based on Clinical Need

Another major driver of reduced inpatient capacity is the increased use of the state hospital for court-ordered evaluation and treatment following determination that an individual is incompetent to stand trial (IST). In Fiscal Year 2018, 27.4% of state hospital admissions in Texas admissions were transferred directly from a jail or correctional facility, preponderantly for IST commitments. Cited often by local stakeholders as a throttle on SASH availability for individuals who need longer term hospital care, it is also a growing concern nationwide (29). However, Texas' proportion of state hospital beds used for this purpose has shown among the largest growth relative to other states (9). Our percent of forensic admissions relative to total state hospital admissions was 45% in 2014, while the national median was 18%. The problem is well-known to Texas state government. Among other reports on the topic, in 2013 the Legislative Budget Board recommended developing alternatives to state hospital beds, such as expansion of outpatient competency restoration programs, especially for misdemeanor defendant (15).

The trend toward a larger proportion of publicly-funded inpatient capacity for hospitalizations related to the judicative competence of those facing criminal proceedings has continued in the state. Mike Maples, the Deputy Executive Commissioner for Health and Specialty Care, shared data presented to the Judicial Council on Mental Health, which indicated that patients in the state hospital system on forensic remands surpassed those admitted under civil procedures in FY2016. The former now constitute 60% of the population (Figure 3). Within the forensic population, those hospitalized due to adjudicative incompetence now represent the largest segment cared for in the state hospital system (Figure 4). In growth terms, the largest proportional increase is in occupancy by those found not guilty by reason of insanity, although few of these individuals are at SASH. Average length of stay for the forensic patient population is far greater than for civil patients, 170 vs. 71 days.

This development was spurred by Federal rulings that detainees with behavioral health disorders should be placed in treatment settings rather than jails. Nevertheless, the wait for defendants in Texas to transfer from jail custody to a state hospital bed averaged 296 days.

The current situation manages to combine the systemic disadvantages of constricting state hospital beds for those with clinical need for this unique service and persistence of the problem greater hospital use sought to solve.

Local mental health care providers blame the diversion of SASH resources toward forensic roles, especially IST, for the difficulties they encounter with admitting patients to SASH. "Eventually the state hospital will be all forensic", was a lament heard more than once. These agencies receive mixed messages about discretion in allocating beds between civil and forensic patients at SASH. One LMHA

representative expressed concern that the designation of beds for forensic commitments contributes to the lack of available beds for civil commitment patients at SASH, even when these beds are not in use. This executive was told that unused forensic beds could be used for civil commitment purposes, but he has yet to see these beds used for civil commitments. The majority of stakeholders we interviewed were adamant that beds for civil commitments should be protected at all costs, and civil beds that have been transferred for forensic use should revert back to their original use for the region.

In Texas, the initial remand of a defendant to an inpatient psychiatric facility for competency restoration lasts 60 days for misdemeanor charges and 120 days for felonies, after which a single 60-day extension may be granted. Where studied, approximately 70% to 80% of those referred for competency restoration inpatient

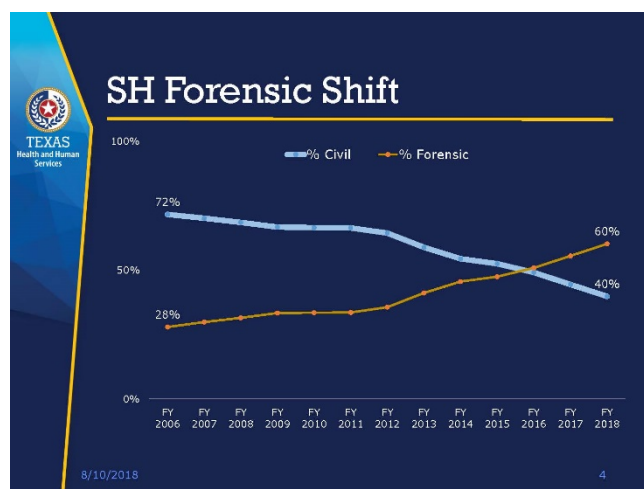


Figure 3: Trends in Forensic vs. Civil Occupancy in Texas State Hospitals, FYs 2006- 18. From M. Maples, 8/10/2018

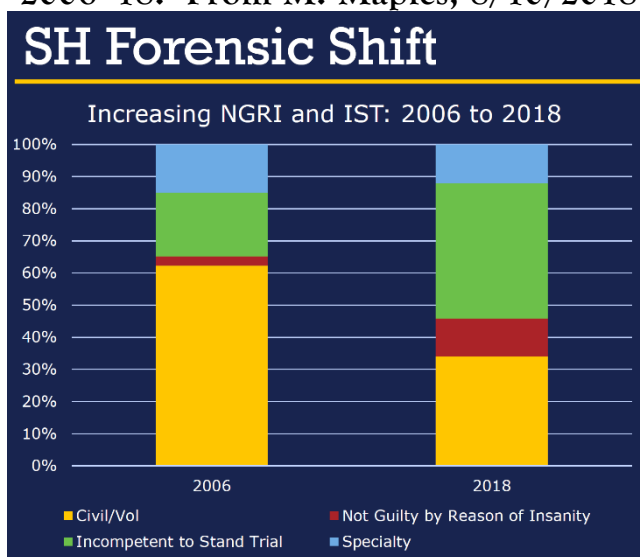


Figure 4: Changes in State Hospital Patient Population by Judicial Status. From M. Maples, 8/10/2018.

services attain competency. Differences between localities in their thresholds for IST determinations, latencies to begin treatment, and treatments themselves hinder generalizations, but it seems that most defendants who attain competence do so within 1-2 months, with the likelihood of competence diminishing with longer periods; within a 6-month period, about 80% of defendants attain adjudicative competence (30-32).

The factors correlated with attainment of competence are the chronicity and initial assessment of severity of psychotic symptoms, initial assessment of judicial knowledge, and age (30-34). Younger individuals who may not have had prior treatment or have been sufficiently adherent with treatment for psychotic illness are more likely to experience greater improvements with adequate care. Those who have been ill for longer and perhaps more refractory to pharmacotherapy have a less favorable course. This will not surprise psychiatric practitioners, for whom the prediction of who is 'restorable' within, say, six months or even less is not difficult when history and current deficits are accounted for.

Nevertheless, it is not uncommon for individuals who will not attain competence to be held on IST commitments for much longer periods based on judicial direction to care providers to, essentially, 'keep trying'. Concerns about public safety influence these determinations, especially for individuals who would not fulfill criteria for civil commitments based on the usual criteria of dangerousness to oneself or others. For instance, an individual who has shown problematic behavior in his home community (disorderly conduct, assaults, domestic violence), may receive an extension of IST commitment to keep him or her from posing risks when civil commitment criteria would not apply. The Supreme Court's 1972 *Jackson* ruling found that essentially open-ended involuntary commitments based on IST violate the Constitution's due process provisions. However, it is widely known that state compliance is poor, both in statute and in practice, partly due to ambiguities in the ruling itself, especially the vagueness of a "reasonable period of time" for IST-related confinement (35).

It is also no secret that in many communities and judicial districts hospital commitment of an individual found IST is a well-intentioned maneuver to get proper care for him or her. Well-meaning defense attorneys may pursue this course to obtain treatment for their clients, even when the charges at issue would not ordinarily result in incarceration. Defendants/patients may not regain competency but treatment may have improved the patient's condition to the point they are no longer dangerous to self or others, and thus not civilly committable.



Solutions Connection

See p. 65 for proposals that address IST-related hospitalizations.

There are also significant consequences for the state's county jails when IST patients cannot be discharged from state hospitals. Patients with more severe illness in jails also cannot be transferred to SASH for treatment.

4. Episodes of Behavioral Disturbance in the Community Place High Demand on Law Enforcement Resources

After families and health care professionals, police officers are perhaps those most involved with individuals suffering from acute behavioral disturbances that arise from psychiatric illness. It is underappreciated by the community how much police work is devoted to successfully managing situations in which an agitated or desperate person with grossly impaired judgment poses a risk to self or others. Only a fraction of these incidents culminates in chargeable offenses. Far more often officers assume the difficult work of defusing a situation and frequently transporting an individual for appropriate behavioral health or medical care. The legal mechanism for holding and transferring a person in this context is issuance of an emergency detention order or, less often, a mental health warrant by a judge or magistrate.

Bexar County recently implemented a regional system to expedite efficient dispatch and triage of emergency calls to appropriate facilities. Operated by the STRAC and developed by its Crisis Collaborative program, its innovations include real-time information about which facilities are suited to the individual's safety and treatment needs and can accept him or her. Besides the immense operational benefits the system yields, it also furnishes vital data on law enforcement's engagement with those in behavioral crises. Information on the services to which individuals are 'navigated' provides a particularly vivid picture of community need and law enforcement activity in this area.

From January 2018 through September 2018, STRAC's navigation system captured 11,762 episodes of law enforcement involvement owing to behavioral health disturbances (Figure 5). Averaged over time, this represents 43 per day in Bexar County alone.

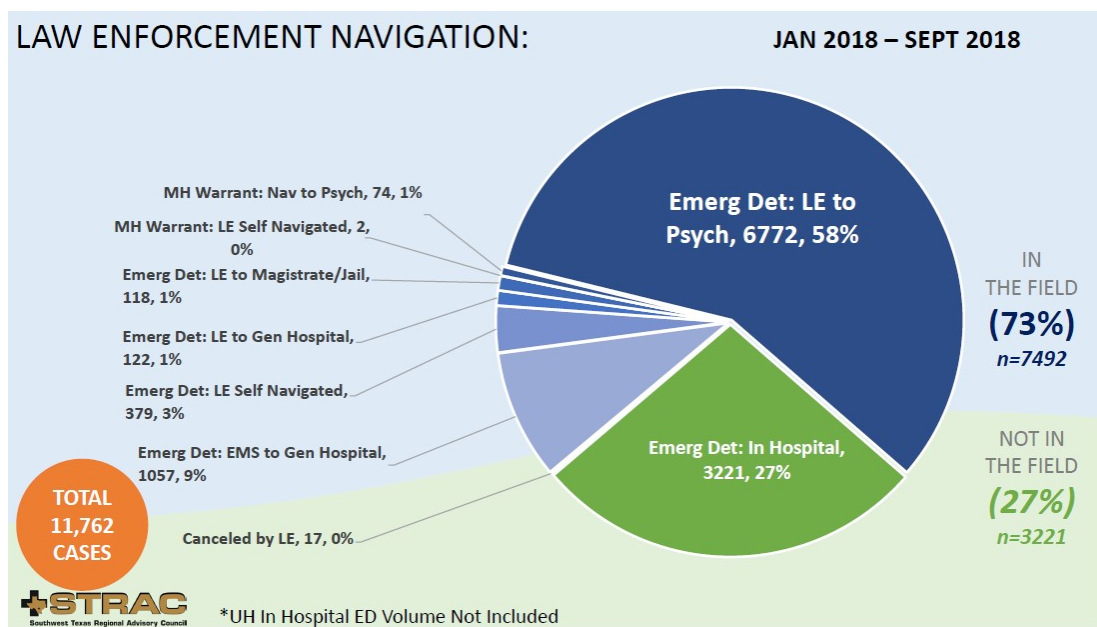


Figure 5: MEDCOM Navigations for calls relating to behavioral disturbance or transfer needs. From D. Miramontes.

A significant number of calls (27%) were from hospital emergency departments requesting police officers to obtain an emergency detention order to effect transfer to a specialty psychiatric facility. Combining these incidents with the 6,846 that culminated on transfer to psychiatric facility “from the field” yields a total of 10,067 episodes resulted in an individual brought for care to a behavioral health facility. The latter include crisis stabilization and extended observation services operated by the Center for Health Care Services as well as hospital-based psychiatric services. Of course, these data exclude emergency situations that lead to inpatient or similar admission but do not involve calls law enforcement.

Although the law enforcement navigation system has made triaging mental health crises more efficient, the number of incidents is still alarming. More detailed clinical information from these encounters is expected when the TAVHealth system comes online, but it is common knowledge that most of the individuals who required law enforcement involvement to address a behavioral crisis have extensive treatment histories, compelling the inference that gaps or ineffectiveness of community care and other supports may have been inadequate.

The implications for law enforcement outside of Bexar County are even more severe. Given fewer resources and options nearby, time and travel to locate an accepting facility and complete the transfer involves an enormous devotion of law enforcement effort.

5. Large Service Region: Long Travel Times and Diverse Local Care Resources

Even by Texas standards, the area served by San Antonio State Hospital is immense.

Figure 6 shows the number of adult patients discharged in fiscal years 2015-2017 coming from individual counties in Texas. It is not the case that SASH's patients are predominantly from the San Antonio area with the numbers of patients falling off as a function of distance. In fact, only 31.7% of adult patients come from Bexar County, as do 44.3% of adolescents. A substantial number (11% of adults, 5.3% of adolescents) come from Webb County, but it is unclear how many adults were treated at the Casa Amistad site in Laredo or at the main SASH campus.

Figure 7 and show estimated travel times by automobile under ideal conditions from patient's home counties other than Bexar; computations used the county seat and SASH main address as origin and destination points. Over half (51.4%) of adult patients from outside Bexar County, or about a third of all SASH patients, come from communities with a minimum one-way auto travel time over 2 hours. Assuming patients' main social and familial supports reside in the same area, clearly being so far removed is isolating for them and complicates effective transitional programming.

There is, moreover, a significant burden on families to maintain contact with their hospitalized kin, because many of these households do not have extensive resources to afford lost work time, travel expenses, etc. The presence of family housing on campus to reduce the drain of one-day roundtrip travel is an important asset that stakeholders felt should be expanded.

Distance also makes it problematic that SASH serves as the resource for acute care for many patients from rural areas. When transport is the responsibility of law enforcement, there is the added consideration that resources are diverted from other public safety duties. Many key informants, particularly those in counties located a great distance from SASH, agreed that alternative treatment options for adults are also needed to meet acute care needs and provide extended observation and screening to identify appropriate referrals to the state hospital. At the SASH retreat, many participants voiced support for a regional approach to developing these capacities.

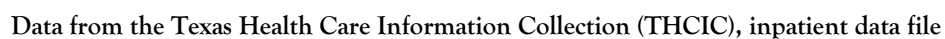


Solutions Connection

See [p. 60](#) and [p. 81](#) for proposals to meet behavioral health needs for a widely distributed population.

One corollary of the high geographic dispersion of patients' home counties is the number of local mental health authorities (LMHAs) with which the state hospital needs to coordinate (see Figure 8). The map shows SASH serves several culturally and geographically diverse areas, from the urban areas of San Antonio and Corpus Christi to the growing areas of the Rio Grande Valley, as well as large swaths of the Hill Country and West Texas. To illustrate how vast this region is, Figure 9 shows that several European countries could fit into the SASH catchment area.

Note that for the larger urban counties such as Nueces and Bexar SASH is “primary”, indicating that both adult and adolescent patients are served by SASH. “Secondary” counties are parts of LMHA’s for which only adolescent patients are served by SASH. For example, in Hill Country Mental Health and Developmental Disabilities Centers has only one primary county (Comal) that sends adult patients to SASH, while the all the other 18 counties are secondary, meaning that their adolescent patients are served by SASH. This leads to considerable confusion among the public and mental health providers to which counties are served and by whom. One patient in Comal County may be sent to SASH, while another just over the county line in Kendall County will be sent to Big Spring State Hospital in Wichita Falls.



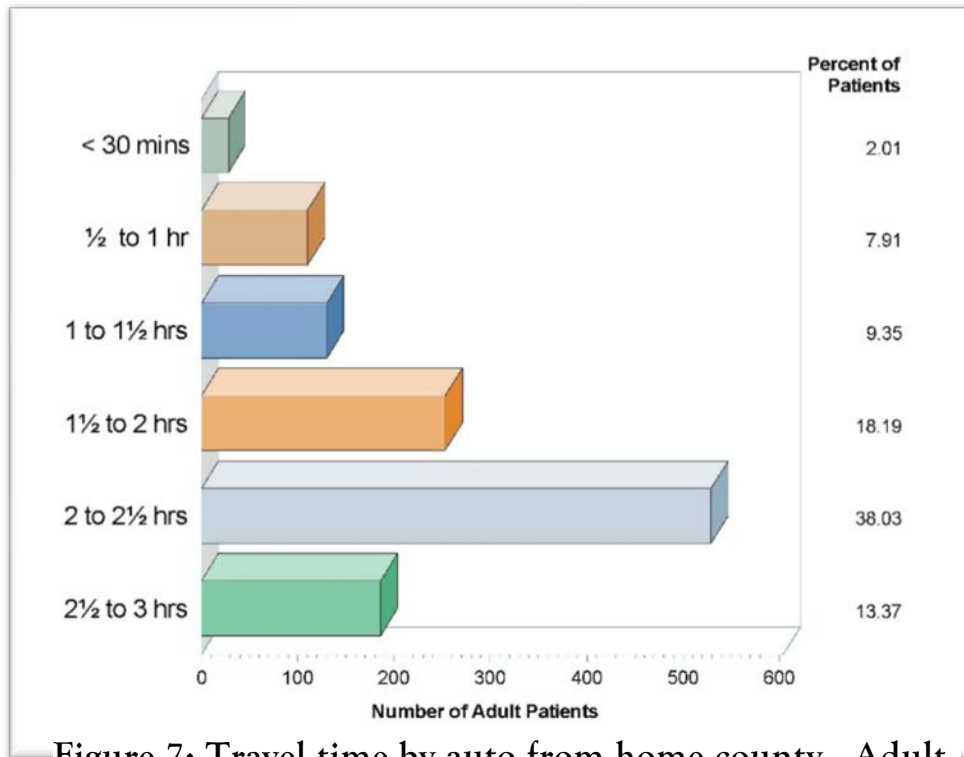


Figure 7: Travel time by auto from home county. Adult patients discharged FYs 2015-7. Excludes Bexar County.

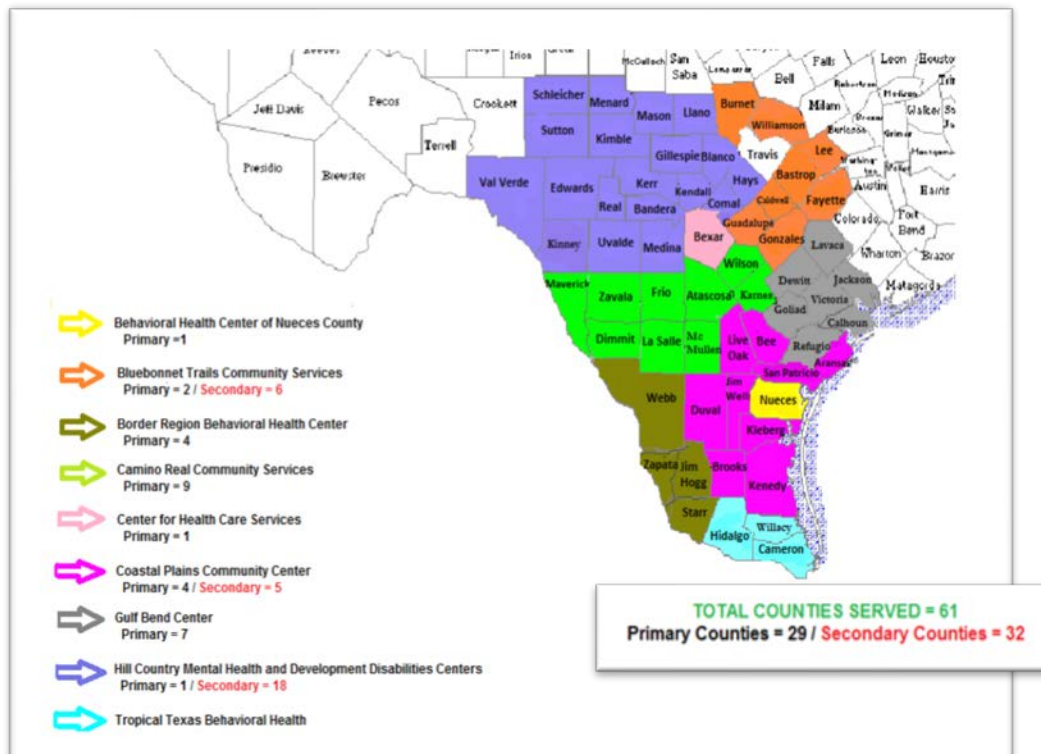


Figure 8: Catchment Area for San Antonio State Hospital and its Local Mental Health Authorities



Figure 9: SASH Catchment Area in Relation to Area Occupied by Several Countries

6. Rural Areas Need Inpatient Capacity Beyond EOUs and CSUs

The state provides funding to Local Mental Health Authorities (LMHAs) for a patchwork of other programs including Extended Observation Units (EOUs) which are 8-16 bed small units that can serve persons admitted under a Warrant for Emergency Detention for up to 48 hours, five Crisis Stabilization Units (CSUs) of 8-16 beds that may serve persons under Warrants for Emergency Detention or Orders for Protective Custody for up to 14 days, and a variety of contracts for the purchase and use of inpatient beds in private psychiatric hospitals. These programs are intentionally designed and funded to provide short-term, acute psychiatric stabilization services and not long-term psychiatric treatment.

EOU, CSU, and private psychiatric beds are consistent with the state plan and are extremely necessary and appropriate for persons who require only a few days of intensive treatment. These services allow for the person's condition to stabilize to the point where that individual may safely return to the community and continue with his/her recovery in outpatient treatment. They exemplify cross-agency coordination, and state/local and public/private partnerships along with access to services. They are not designed or funded to provide treatment for persons whose psychiatric deterioration is so severe that they require inpatient services beyond a fourteen-day period. Moreover, private psychiatric beds are the most expensive forms of treatment in the inpatient continuum in terms of their costs per bed day, the private hospitals are located only in urban areas, and they are not designed nor do they desire to serve persons with extremely serious psychiatric disorders who require longer term treatment.

The problem remains that once an individual has reached a maximum length of stay in an EOU, CSU, or private psychiatric hospital, that person still must be transferred to a facility that has the capability of serving people on 45-day civil

commitment orders. These facilities do not have adequate numbers of beds to serve a state of over 28 million people, and in most cases are hours away from the communities in which the individuals in crisis are located. For example, the nearest psychiatric facilities, either state- funded or private, are a three-hour drive in any direction from Del Rio and nearly as far from Eagle Pass. Likewise, the state hospital is a three plus hour drive from the Rio Grande Valley and more than two hours from Victoria even on those rare occasions when a bed at the hospital is available. This is extremely traumatic for a person in psychiatric crisis who must endure the transport while handcuffed in the back seat of a law enforcement vehicle. It also causes hardship to an already overburdened law enforcement system that must remove personnel from their regular duties to provide the transport, resulting in a shortage of manpower available for routine law enforcement functions and often extremely high overtime costs. It is counter-therapeutic as the individuals often are indigent and their families cannot afford the time or costs to travel those distances to visit and participate in their loved one's treatment.



Solution Connection

See **p. 84** for proposals to establish regional LMHA-operated hubs to meet local acute-care needs.

Another negative impact is that EOUs, CSUs, and private facilities either are forced to hold persons beyond the time for which they are legally authorized because to release them would endanger the individuals or they are forced to release them, and if needed, re-apprehend and recommit them which causes additional and unnecessary trauma to already psychiatrically compromised individuals. It also places short-term facilities in direct competition with hospital emergency rooms and law enforcement environments for already scarce or unavailable beds in the existing state-operated or funded system.

7. Impediments to Recovery and Community Tenure after Discharge: Insufficient Housing, Healthcare, and Treatment Continuity

Stakeholders uniformly expressed grave concerns about difficulties the chronically ill individuals whom SASH treats in obtaining stable housing, healthcare, and behavioral health treatment continuity after discharge. Community providers remarked that there is a lack of benefits upon discharge, which makes it hard for patients to obtain necessary follow-up services.

At least 16% of adults admitted to SASH during FY 2018 from settings other than correctional/jail facilities were homeless. It is unknown how many of those transferred from jails were homeless prior to their arrests. It is uncertain how many individuals discharged from SASH become homeless or in unstable residential situations (e.g., bouncing between relatives, shelters, and others for brief periods), but state hospitals do frequently discharge patients to homeless shelters. Federal data indicate that point prevalence of the total homeless population varies year to year, but while the overall trend between 2010 and 2015 for Texas overall showed a marked

decline of 32.6%, Bexar County experienced a reduction of only 12% (36). If, as 2016 estimates indicate, half of the state's residents with SMI, SPMI, and SED are medically indigent (no property, not someone's dependent, unable to reimburse care, and below 150% of Federal) poverty level, that would be the lower bound of medical indigence among state hospital inpatients, a strong correlate of homelessness. Precarious living arrangements are obviously not conducive to a treatment regimen over an extended period, and homelessness is both hazardous and likely to sustain psychiatric disability. Few would include homelessness and the social isolation it often entails as compatible with recovery. There was strong interest and support for transitional housing to help re-establish an individual's skills at negotiating community life, and for more permanent housing solutions.

Sustaining medical treatments is also a growing concern, especially for the large cohort of discharged patients without insurance. We heard of successful integrated primary care projects, in which internal medicine practitioners treated patients in behavioral health settings but were discontinued due to reduced funding or due to changes in 1115 waiver projects. Even when patients received medical attention, problems filling prescriptions were frequent. Changes in pharmacy benefits between inpatient and outpatient care led to instances where the latter's formulary did not include medications patients had received in the hospital.

Uneven availability of behavioral health and supportive services after discharge remains a generic feature of health care throughout the country, especially when urban and rural areas are compared. However, in our region stakeholders from even relatively resource-rich portions perceive large gaps. Some reflect the difficulties obtaining or maintaining adequately staffed specialized services. Others reflect discontinuities created by weak communication and planning with the state hospital. "We need a strong ACT team when a patient transitions to the community after discharge; there are no consistencies or protocols put in place for transition services at the state hospital when they discharge a patient", was how one provider put it. Inpatient services should "create an environment of recovery and resiliency as a person transitions into the community; we need coordination and continuity of care for these patients".



Solutions Connection

See pp. 54–57 for proposals that address continuity of care and meeting patients' other postdischarge needs.

8. Infrastructure and Location

Nearly all the previous studies and reports noted on page 15ff (“Relevant Highlights of Select Prior Studies and Reports”) recognized the dire situation of SASH’s physical infrastructure, with particular concern about patient care areas. The inpatient units themselves have completed their useful lives, and their replacement is timely if not overdue. Setting aside their current condition, even the basic layout of these units does not comport with what has been best-practice for some time now (37).

Forty-bed units are relics, and not conducive to comfort and engagement by patients. Single-person bedrooms are preferred, and double rooms the guideline-concordant maximum for adults. *En suite* bathrooms that contain at least a toilet and sink are preferred and should be accessible from bedrooms without requiring corridor entry unless extenuating circumstances compel otherwise. The minimum standard is one bathtub or shower for every six occupants who do not have a bathing facility at their bedroom. The number and areas of consultation, conference, group activity and social spaces are often below specifications for a service with 40 patients. Stakeholders also found the layouts not conducive to easy staff-patient interactions, which perhaps contributes to some patients becoming agitated to gain attention.

“The space now for adult’s visitation is one just one big room with the TV on. The staff members are watching television, which makes it hard to talk without distractions. The environment is not conducive to having good communication with the patients – we need less noise. We aren’t allowed in residential areas, so we are stuck with the room that has loud TVs, couches and some tables.”

– Family member

Besides these core deficiencies, stakeholders and other visitors find the general ambience on patient units as exceedingly institutional and unappealing. Experiences with the destructive behaviors of a few patients on furnishings has contributed to an even more barren and austere environment. The building housing the adolescent unit is from another era entirely and its lack of sound-absorbent furnishings led one visitor to liken it to an “acoustic torture chamber”.



Solutions Connection

See pp. 68–78 for proposals to improve the physical environment.

Visiting currently takes place in a central area to which patients are escorted. This has some advantages for supervision and safety compared with on-unit visiting but is also out of step with family and patient centeredness and the contemporary practice of nursing staff providing informal, individually tailored psychoeducation and functional support strategies to families. It is therefore common to have a number of comfortable visiting facilities adjacent to an inpatient unit to facilitate interaction with both loved ones and with the staff caring for the patient.

Food is delivered by service trucks from a central facility that chiefly reheats the partially pre-cooked meals vendors provide. Delivery time to patients on the units is likely to exceed the thermal insulation capabilities of the trays so hot meals do not arrive at the appropriate temperature. Today's preferred practice is overwhelmingly to provide fresh food when possible. Proper nutrition for those with behavioral health disorders is virtually life-extending due to their susceptibility to cardiometabolic dysfunction (38).

Stakeholders also observed that the lack of modern information technology infrastructure hampered staff use of wireless devices now routinely used to, among other things, track point-of-service events like medication administration, vitals, and so forth.

A major asset of the SASH campus is its open landscape and varied topography with hills that afford pleasing natural views.

Its location in San Antonio is currently distant from other health care providers and potential vocational or rehabilitation settings that would ordinarily be accessible to individuals in the process of transitioning to community living. The planning group is very interested in making transitional living services available to SASH's discharged patients, and the current site is an appealing location, notwithstanding distance to other resources that would promote community involvement.

"As we begin to look at safety as the only thing, we are missing the point of treatment. We started with privacy curtains, but that became dangerous. A patient is in a room with three other people who are also going through mental illnesses. Our doorknobs were taken off and we started to lose our sense of being a human. There are people restrained, which I think is a power control to keep people safe. We constantly heard "code green." There are times where you feel stripped of humanity and your belongings could get stolen, which made you feel on edge. It is hard to feel safe with all these environmental factors"

-- Recent SASH patient

9. Individuals with Intellectual and Developmental Disorders

Community providers expressed concern that patients, both youth and adult, with developmental disorders cannot access inpatient behavioral health care:

- ✚ “We are seeing more kids that are diagnosed with autism and aren’t getting admitted into SASH. We need more opportunities for extended care.”
- ✚ “One of the criteria for admission is that our patients cannot have an IQ below 70, but that is our whole population. There is nothing here to provide services and they need 1:1. When hospitals hear about IDD, they don’t admit the patients.”
- ✚ “It is almost impossible to get autistic adolescents into a hospital, especially when they are aggressive or a danger to their parents and themselves.”
- ✚ “There are some respite centers, but they do not admit patients who are aggressive.”
- ✚ “We are told to go to a respite center or a state school.”
- ✚ “SASH needs services for co-morbidities with IDD individuals. Insurances won’t cover nonverbal patients because they can’t successfully complete mental health treatments a respite center or a state school”.

This is not a new problem nor one unique to SASH, although it remains a complex one in the context of inpatient services.

We recognize this as an area of unmet need, one that can be addressed satisfactorily only in the context of the range of local day program capacities, specialized behavioral support services that help community caregivers to promote adaptive behaviors, and clear expectations for the indications for psychiatric inpatient care.

10. Children and Adolescents

a. Proper Role for SASH in Continuum of Care for Youth

Even more than for adults, state hospital services for youth are ordinarily for those who, despite previous inpatient stays and other community-based educational, family, and mental health services, require a secure setting for an extended period to ameliorate severe symptoms. Acute-care, short LOS facilities seldom have the infrastructure for appropriate education and activities, including out-of-door recreation needed for youth in 24-hour care settings for long periods. On the other hand, they are *usually* more abundant and geographically distributed, which makes them better suited for family involvement and school liaison which are fundamental elements of child and adolescent psychiatric care.

Accordingly, state hospital inpatient services are to be used sparingly for youth with demonstrable need. Above all, SASH is distant and burdensome for many families, who often have other children and limited resources to support travel. However, the limited availability of secure services for youth experiencing behavioral health crises has led to SASH serving as the main acute inpatient resource for many adolescents, especially those residing in rural areas.

Lengths of stay data reflect the high reliance on SASH for short-stay clinical care, concurrent with a substantial cohort who have longer-term hospitalizations. For patients discharged in FY2016-7 combined, the average stay was 26.45 days. However, 50% were discharged in less than 17 days, which is the median LOS. At the same time, 25% were in hospital for more than 31 days, and 10% more than 62.

	FYs	# d/c	LOS Mean	LOS SD	Min	Max	25 th %ile	Median	75 th %ile	90 th %ile
Adolescents	2012-3	720	24.1	30.5	1	279	7	14	27	57
	2014-5	660	24.1	31.3	1	249	8	14	27	59.5
	2016-7	377	26.5	33.0	1	380	8	16	31	62

Table 3: SASH Lengths of Stay of Discharged Adolescent Patients (days).

Source: THCIC public use data file.

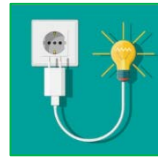
Abbreviations: d/c, discharged. SD, standard deviation.

b. Distance and Family Separations are Burdens that May be Counterproductive for Treatment

If short-stay episodes are highly beneficial and associated with low readmission (e.g., <15% over six months would be impressive for this patient group) then perhaps current utilization is justifiable. Provider stakeholders are concerned about the shortage of psychiatric beds for youth, and concentrating them at SASH, which should serve those with longer-term care requirements, is probably not the most effective way of satisfying community need. Providers in some locales experienced a significant reduction in number of beds available from adolescents while need for them has risen. "One of the hardest things for children is the separation of families. It would be ideal to keep the children closer to home". "Parent cooperation is very important during treatment. When families hear they have to travel far, families are not as interested." Consequently, many stakeholders questioned the appropriateness of treating children and youth at a state hospital at all.

A single site located far from communities imposes burdens and possible adverse impacts on care. Law enforcement or LMHA personnel often devote full days to transporting youngsters to and from SASH: "We have to have some of our employees transport the patient and often have to also pick them up because the parents can't go." "Because of our financial situation, we have to worry about transportation and maintenance costs to transport our children."

Separation of families at the time of hospital admission, only for logistics and resources and no compelling safety concerns, is worrisome. Law enforcement officials, who often arrange transportation from rural areas to state hospitals, are troubled by the experience for youth and families: police car transport for a child or youth, coupled with an active mental health crisis while leaving family behind can be traumatic and worsen rather than improve the child or youth's mental health. No doubt there are situations in which youth have no adult on hand to accompany them to the hospital. This alone testifies to the immense care needs of children who have experienced unsuccessful surrogate-care placements. Admitting these youth to an inpatient setting without family or at least a familiar social service worker present to provide essential information for clinical assessment, not to mention to minimize the sense of abandonment, is atypical of good child psychiatric practice. The adolescent clinical staff at SASH is talented and committed; they should have the benefit of these individuals on hand for clinical decision making. Only rarely, in our experience, are written records alone of adequate quality for this purpose.



Solutions Connection

See **p. 51** for proposals that address youth needs.

The majority of stakeholders expressed a preference for alternative options within the child and youth's community in lieu of a stay at SASH or any state hospital. Several key informants noted that the majority of children and youth have access to health care benefits for behavioral health inpatient services; therefore, payment for services becomes less of a concern should alternative community treatment options be developed.

c. Day Treatment and Educational Services

There are lifelong adverse implications when youngsters lack resources and opportunities for academic skills development commensurate with their abilities. Many young people with behavioral health conditions also have difficulties at school, which can be a direct complication of their behavioral/emotional disturbances, often compounded by a comorbid learning disorder (39). Many hospitalized youth need specialized educational and psychiatric services in an integrated day program, for at least a brief period to help them experience success, academically and socially, in age-appropriate milieus including school. For some, it may be the only path to graduation. There are a few such day treatment or partial hospitalization programs in Bexar County, including at Clarity Child Guidance Center. However, attendance is limited by the requirement that parents provide transportation back and forth. In many other localities in the country, the local school district is to provide this service for students attending special programs for mental health reasons. Recouping tuition costs from the home district can also be cumbersome and affects the sustainability of these services.

11. Substance Abuse Worsens the Outlook for those with Behavioral Health Disorders

Substance abuse (SA) disorders are practically endemic to many severe psychiatric illnesses. Persistent drug and alcohol abuse are known to worsen prognosis for these conditions. Unfortunately, for those at high risk for the development of psychiatric disorders, substance use may hasten their onset, essentially cutting short the period to consolidate good premorbid functioning, which is an important predictor of functional outcome. The direct neurotoxic effects of many drugs of abuse may in some instances be etiological factors, the pathophysiology of which may result in disturbances less treatable with current medications. Of course, substance abuse also has its own heightened risk for early mortality.

At University Hospital, 80% of patients admitted to the inpatient psychiatric service test positive for either illegal drugs or alcohol on admission. Among patients who are admitted to the medical-surgical services and who also have a psychiatric condition, rate of positive drug/alcohol screen is 50%.

An analysis was done of patients admitted to the University Hospital psychiatric inpatient unit over the period July 1 to September 30 of 2018. As shown in Figure 10, of the 247 admissions to the service, 138 (56%) were formally diagnosed with a substance use disorder. Not everyone who tests positive for a drug on admission receives a full diagnosis of substance abuse, but often the use of substances exacerbates the underlying mental health condition.

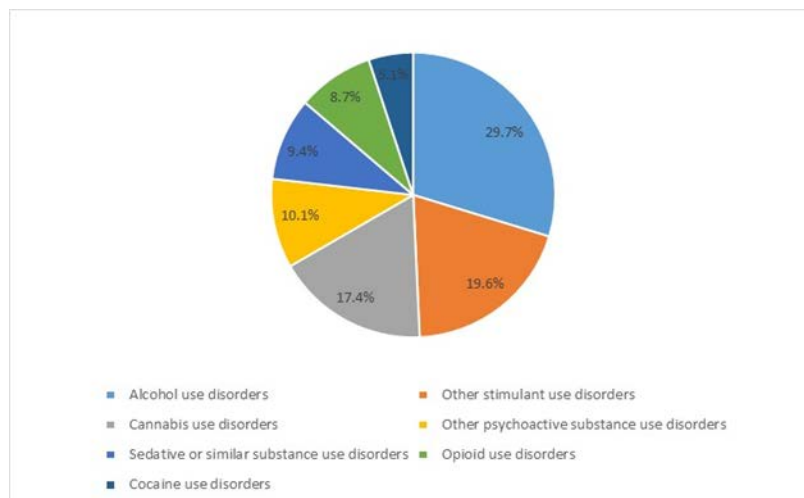


Figure 10: Substance Use Diagnoses among Adults Admitted to Inpatient Psychiatric Care (n=138)

Source: University Health System, San Antonio

Stakeholders were consistently alarmed about the challenges and service gaps in treating patients with comorbid SA disorders. Many community psychiatrists have a policy of not treating individuals with SA. Some LMHAs have detoxification and

sobering units that fill a major service need and offer a singular opportunity to engage individuals in treatment to alter their pattern of use.

Overall, there was strong endorsement by provider and family stakeholder of the need for those hospitalized at SASH and elsewhere to have interventions that target substance abuse.

12. Caring for Patients with Medical Needs

Stakeholders also raised concerns about what type of primary medical care is available at the state hospital for pregnant females and geriatric patients. It was stated throughout the interview process that people with co-morbid medical needs are often turned away because of a lack of physical health care at SASH. If a need arises for urgent medical treatment during a person's stay at SASH, he or she must be moved to a neighboring general acute care hospital for services. Many stakeholders from across the catchment area expressed the opinion that, at minimum, the state hospital should be able to treat urgent medical treatment needs and certain chronic illness such as diabetes and high blood pressure.

Stakeholders affiliated with emergency service agencies also advocated that the replacement facility have infrastructure flexibility and capacities to care for injured patients and house staff in the event of natural disaster that hinders movement to other locations. Preparedness for power outages was also recommended.

13. Behavioral Health Workforce, San Antonio State Hospital

Stakeholders and the public at large are keenly aware of the precarious workforce situation at SASH. Periodic unit closures and suspension of new admission over the years because of staff shortages and widely known in the community. In most open-ended discussions about SASH within this region, the topic comes up early. Curtailments in service, including recent unit closures, due to staff shortages were perplexing and upsetting for many community providers. "There is a staffing issue for SASH – the reduction of staffing is counter-intuitive to the level of acuity in patients they serve," said one. In addition, frequent departures of colleagues can be demoralizing to the staff that remain.

The problem systemwide is also well known to state agencies and the legislature. For instance, the 2017 "Comprehensive Plan for State-Funded Inpatient Mental Health Services" noted, [S]taff recruitment and retention challenges have further strained the system, with approximately 150 beds offline due to staffing shortages. These reductions and an increased demand for services result in a lengthy wait for state hospital beds and more pressure on jails, emergency rooms, and community-based psychiatric hospitals."

In our interviews, stakeholders expressed the view that workforce shortage issues are even more severe at SASH, even relative to other Bexar County psychiatric facilities. Recruitment and retention problems with front-line direct-care staff (nursing

staff and related job classifications) are especially acute. The reasons stakeholders cited included lower salaries and adverse working conditions. Shortages lead to increased safety concerns, which act to further deter potential new hires. For instance, "Insecurity is within the assistance staff. Recruiting nurses is timely and expensive; after looking at situation of security and work conditions, nurses do not last very long." Rapid turnover militates against team cohesion, which is crucial in frontline medical care.

Stakeholders frequently expressed concern that a rebuilt campus will have similar issues if staff cannot be recruited and retained at the new campus. More broadly across the region outside of Bexar County, "workforce challenges are often even more severe," as one LMHA official stated.

Across our region's communities there are significant shortages in the behavioral health care workforce that greatly restrict the ability to effectively meet community needs. These were generally seen as greater outside of Bexar County. Across the catchment area, stakeholders highlighted the need to address psychiatrist workforce shortages by staffing other advanced practice providers such as nurse practitioners and physician assistants to meet the overwhelming need for services. Hospital leadership in one session reported that a nursing shortage in their area forced their facility to turn away patients who need one-to-one care because this would lead to a lack of proper nursing supervision for other patients. The expanded use of telehealth was also suggested.

Similarly, several LMHA administrators described a general shortage in the mental health workforce, which greatly affects their area and compounds the issue of long forensic wait lists for mental health care. For example, one LMHA director said there are not enough professionals within the LMHA's seven-county service area to assess everyone with mental health needs who are in jail. Stakeholders also stated that they are most concerned about the workforce shortage of child and adolescent psychiatrists, especially since there has been an increase in youth needing psychiatric care in their areas. Leadership from another LMHA described having difficulty in retaining staff because of the LMHA's proximity to Bexar County, where hospitals are able to recruit employees by offering higher salaries. Local hospitals with nicer amenities are another draw for rural employees. Difficulty competing with other hospitals for staff was one barrier cited for SASH's high rates of vacancy and turnover among staff.

Many of the key informants we engaged expressed concern that the SASH redesign would be a fruitless effort if it develops a state-of-the-art building without the necessary staffing to keep units open. Because of staffing shortages, SASH has often had to go on diversion or close units, further reducing access to its beds and services. Of particular note is SASH's lack of staffing for patients with intellectual and developmental disabilities. It is important to note that interviews suggest that SASH has more difficulty with this than other hospitals in Bexar County.



Section III: Redesign of Facilities for San Antonio State Hospital



Facility Redesign I: Clinical Practice Models and Processes for Optimal Care During and After Hospitalization

1. Refocus SASH's Service and Admission Patterns to Serve as a Tertiary Treatment Center

We strongly endorse the recommendations from numerous prior evaluations that Texas' state-operated psychiatric hospitals become almost exclusively "tertiary care facilities for the most complex mental health patients and a significant portion of the forensic population" (16,17,19).

2. Regional Cooperation to Standardize Admission Criteria and Readiness for Transfer

It is important to address the perception that SASH's and LMHAs' admitting, discharge, and follow-up processes waitlist are inconsistent, inadequately informative, or just inscrutable to one another. We propose organization of a regional council comprising LMHAs, SASH, and other relevant groups charged with improving communication concerning, among other things, admission criteria, timely exchange or accurate clinical data at admission and discharge, availability of appropriate post-discharge services, coordinating follow-up care, and so forth.

"Whatever we build, there needs to be an adequate number of beds for the territory you are responsible for. SASH is not insurance driven, so the treatment and discharge plan can be fulfilled. There are staffing issues due to wages, but discharge and treatment plans should be standardized."

—Family member of SASH patient

3. Beyond 'Beds and Meds': Promote Recovery and Readiness to Resume Community Life

a. Functional Assessments and Preparation for Community Reintegration

Besides being a worthwhile goal in itself, helping patients to attain the skills for living in nonhospital settings is essential to the behavioral health service system. There is no desire to keep increasing inpatient psychiatric capacity; this means that the 300 or so state hospital beds planned for this growing region must keep lengths of stay as short as possible and the time patients spend as productive as possible.

For individuals with longstanding impairments, symptomatic relief does not spontaneously lead to recovery of functions that were at their peak perhaps years earlier, if indeed they were ever attained. And, naturally, time in hospital only contributes to their atrophy. A robust rehabilitation program is not a luxury nor just a humane gesture to help people spend their time enjoyably – it is now central to the mission of state hospitals that aspire to discharge patients in better shape than when they entered. Length of hospitalization may contribute to establishing an effective medical regimen for symptom reduction. The countervailing force is the functional debility that accompanies long term disuse of daily living skills.

Direct assessments of functional status and needs will be vital if SASH beds are to turnover to meet community needs. Even if an appropriate range of outside support services develop, they vary in the degree of independence expected on users. Determining optimal settings for a given person using evidence-based methods to evaluate level of functioning is a critical need for SASH to perform. Over-restrictiveness contradicts the state's proclaimed objectives of fostering independence and recovery. Exposing patients to new environments without adequate preparation is also unwise, with potential for disastrous consequences (40).

The new facility's infrastructure and appropriate staffing should therefore have robust rehabilitation capacities. These need to be in the areas of personal care/hygiene, management of unstructured time (cultivation of affordable and enjoyable pastimes), financial management, independent travel, the logistics of making and keeping appointments, medication adherence, nutrition, social engagement, and spiritual development.

The current vocational services offered include a half-day program for selected patients, and on unit experience in some work-related tasks. Home skills and cooking groups are offered weekly at most. It is unclear whether the latter provides adequate assessment and rehabilitative opportunities, and new infrastructure must support an appropriate availability and frequency to serve both purposes.

Adequate staffing and transportation must be available to enable off-grounds trips and activities. There will always be risk inherent in every undertaking, and we all do our best to avert bad outcomes. However, it is alarming when the institutional response to an unauthorized departure by a patient during an outing, or even a series of them, leads to the curtailment of such important experiences for everyone.

Our consultations with the rehabilitation team left no doubt of their commitment, competence, and ingenuity. They are huge asset because the interpersonal aspects of cultivating and sustaining motivation for healthy lifestyle changes are perhaps the most important. The replacement facility affords an exceptional opportunity to overcome the limitations in space, access, and physical capabilities that have hampered engaging patients and the optimal frequency and range of activities.

b. Trauma-Informed Care

The experience or threat of extreme or chronic harm, especially interpersonal violence, or witnessing horrific incidents of this nature, is a risk factor for behavioral health disorders. Growing appreciation of this relationship has led to a related principle, that recovery for many individuals must include interventions that take account of traumatic experience, as well as resource to alleviate post-traumatic stress disorders *per se*.

Many aspects of such trauma-informed care include processes that most would agree should be part of treatment for everyone. For instance, SAMHSA guidance on trauma-informed care includes six principles: safety, trust and transparency, peer support, collaboration and mutuality, promoting autonomy (empowerment, voice, and choice), and appreciation of an individual's context (cultural, historical and gender issues).

Trauma-informed care also involves tailoring treatment that takes due account of one's traumatic experiences and the unique risks that some exposures hold. For instance, a youth removed from a home where maltreatment included having been locked in a closet may suffer terribly when forcible seclusion is used for out-of-control dangerous behavior; other avenues may be more appropriate. Situations associated with physical vulnerability, such as disrobing, bathing, toileting, and physical examinations, may also be avoided by traumatized individuals. Therefore, reluctance to shower or use the bathroom may not just be symptoms of psychiatric illness but can be addressed in a manner that gradually affords greater comfort in doing them in an environment of safety and privacy. Those exposed to emotionally abusive environments may have strong aversive reactions to criticism – that does not mean a person should just be pacified and get no corrective feedback, but that what some may tolerate is inordinately distressing to others.

We encourage staff education and training in these issues and that such staff development be continuous to stay current as this area advances.

c. Peer Support Specialists

A robust peer support program helps make positive adjustment outside the hospital a more tangible reality for patients when those who have navigated this journey provide information, support, and encouragement. We encourage SASH to integrate peer support programs and ensure their quality through training, patient and family feedback, and due appreciation of the roles peers play. The latter might include assistance with travel, a formal recognition program, educational opportunities and other benefits for those making this important contribution.

d. Physical Fitness and Health

Age-adjusted death rates among individuals with behavioral health disorders are consistently found to be higher than general population rates, with the worldwide estimate of increased mortality risk of 2.2 (38). Using data from 1997-1999, those served by public mental health services in Texas had a standardized mortality ratio

relative to other Texans of 4.6. Comparable estimates for other states were lower except for Oklahoma.

Fitness has a connotation of recreation, and therefore, by association, an optional activity one can just as soon take or leave. However, their elevated risk for all-cause mortality makes physical fitness critical for those with behavioral health disorders. Benefits of exercise on mood are strong and effects on cognition are also becoming recognized. Providing resources, support, and incentive to follow physical activity guidelines is more similar in importance to moving a medical inpatient to avert bedsores than to an optional way to pass the time for those who are interested.

Infrastructure that enables staff to provide and monitor fitness activities includes a mixture of resources close at hand to inpatient units (for guided moderate exercise, outdoor walking and other activities), and some centrally located facilities (such as for more extensive strength training and specialized physical therapy services).

4. Aftercare and Transitional Programming

Many states require localities to have a nominal agency or other entity to support the public mental health system. However, few are as robust as Texas' system of local mental health authorities, and those in our region were especially impressive to committee members with experience in other areas of the country. The counterparts in other states often serve chiefly a coordinating or regulatory role. The fact that our LMHAs are providers with a broad range of services and attract individuals with strong qualifications, is an enormous asset that can be leveraged for our state to be the leader in posthospital outcomes in behavioral health.

a. Discharge Planning

(i) Case Management and Benefit Coordination

Access to aftercare services and medications is improved when those discharged have their benefits obtained and confirmed. Of course, this involves personnel, but also access to information technology that at the very least expedites this effort rather than hampers it because of slowness and other inadequacies.

Orienting patients or caregivers to the potentially extensive array of benefit cards, documentation, access locations, scheduling processes, and so forth, is worthwhile as a prelude to discharge. However, the likelihood that such knowledge will generalize to behavior in a drastically different environment after discharge is slim if not reinforced and supported by individuals providing post-discharge support to patients.

Some local providers reported value in using SAMHSA's *SSI/SSDI Outreach, Access, and Recovery (SOAR)* portal (<https://soarworks.prainc.com>) for enrollment to those Federal programs and to locate resources, such as housing assistance, for their beneficiaries. If HHS does not have a comparable capability for service access, it might be a worthwhile system-wide investment because of the huge geographic dispersion

and constant flux in providers makes it difficult for workers to rely on personal familiarity for every location.

(ii) Improving Coordination with External Agencies Preparatory to Discharge

We noted earlier that local providers perceive serious gaps in communication about pending discharges. Some pointed to the process used by the Waco Center for Youth as a successful model: “We received a letter that had a specific person for coordination and setting up for discharge. They attached a letter for the parents on how to communicate and the services they will provide. I think we need that at SASH. Parents are completely in the dark and are unable to drive to SASH to see the patient. There is no communication involving the parents.” Obviously, the issues underlying these perceptions need remediation.

(iii) Local Mental Health Authorities’ and CCBHC Certification May Facilitate Care Transitions

Texas’ LMHAs are charged with, among other things (41), facilitating the admission, continuity and discharge of patients in coordination with State Mental Health Facilities (SMHF), also known as State Hospitals. It is the responsibility of a LMHA to facilitate the continuity of services for the patient upon discharge from the SMHF. This includes coordination with community-based providers if the LMHA will not be the provider of services for the individual.

The LMHAs in Texas are pursuing certification as Certified Community Behavioral Health Clinics (CCBHCs). The certification standards or program requirements for a CCBHC were developed by SAMHSA and are administered by Texas Health and Human Services (HHS). The CCBHC program requirements address: 1. Staffing; 2. Availability and accessibility of services; 3. Care coordination; 4. the scope of services; 5. Quality (CQI) and reporting; 6. Organizational authority, governance and accreditation. The program requirements which directly apply to the SASH redesign are availability and accessibility of services and care coordination.

b. Subacute and Transitional Residential Facilities

A resounding message from stakeholders across the catchment area was that a phased transitional step-down section of the hospital needs to be created. Many stakeholders noted that most people coming out of the extended stabilization services at SASH are not ready for a full immersion back into the community. Additionally, because of a lack of discharge and aftercare planning prior to discharged, most people are discharged without resources, such as transportation, housing, and community treatment, that is necessary for success in their recovery long-term.

One promising opportunity is to create supportive housing and other services at the SASH campus. Their goal would be transitional and a way-station to evaluate readiness and needs for suitable living arrangements closer to patients’ home communities. A study should determine if any of the current buildings can be repurposed for an array of needed services to help maintain patients functioning outside the hospital.

- a. We endorse the decision of HHS to seek a Request for Information to determine what community entities might be interested in providing mental health and/or social services at the SASH campus.
- b. Housing options for patients who have severe mental illnesses, especially those with chronic, difficult to remit psychotic symptoms and need secure facilities.

Vermont has developed a number of homelike settings that are actually staffed and equipped more like inpatient psychiatric settings than the high-quality group homes they outwardly resemble. Patients discharged from the sole state hospital near Montpelier can locate to a setting close to their communities of origin. The settings house around 8 to 12 individuals. Patients on civil commitments have their order amended to remand to these settings, while allowing return to the secure hospital setting in the event of unsuitability or unauthorized departure. Vermont obtains daily-rate reimbursement for these services. We strongly recommend HHS investigate these options.

5. Timeliness and Continuity in Pharmacotherapy

a. Effective Transmission of Vital Current Treatment and Treatment History

The vital importance of an accurate and up-to-date treatment history lies in its potential to shorten time to symptom relief hospitalization itself. Problems with data exchange are not unique to San Antonio, but if HHS is looking for operational efficiencies, then optimizing treatment history data available to state hospital clinicians is a good opportunity. UT Austin's School of Pharmacy is at the forefront of research on improving methods for tracking treatments across settings and could be a valuable partner.

b. Anticipating Potential Problems with Medication Maintenance

Improved coordination with aftercare services can factor in aspects of an individual's medication regimen that may improve adherence. Relatively complex, multi-agent treatment requiring three or four administration times per day, for instance, are feasible in a hospital setting, but have sustainability challenges in less intensively supervised settings.

Access to monitoring and clinical lab specimen collection sites may also need pre-planning. For example, patients discharged from SASH following good response to clozapine (Clozaril®) require periodic blood monitoring with satisfactory results before pharmacies can renew a prescription, due to the risk that agranulocytosis can develop regardless of how long one has been taking it. Changes in FDA guidance has lessened the burden somewhat (weekly for initial six months, biweekly for months 7 to 12, and monthly thereafter). However, we learned that difficulties in obtaining labs lead to clozapine discontinuation with the risk of symptom resurgence. Missing three or more days of clozapine requires restarting titration and the CBC monitoring schedule, rather than resumption of the last dose. Abrupt reintroduction at even doses well tolerated

previously is thought to increased risk of blood dyscrasias and the risk of seizures which is in fact greater than that of agranulocytosis (42).

It turns out that treatment discontinuities are perhaps even more prevalent for some of the medications, psychiatric and other medical, because of variation in the outpatient pharmacy benefits for which patient may qualify. HHS's management of contracts with its managed Medicaid vendors may help is smoothing out the more frequent sources of disruption, but other beneficiaries and the health-care-unfunded patients further work may be warranted to evaluate the scope of the problem and possible solutions.

c. Ensure that Discharged Patients have a Medication Management Visit with a Prescriber Within Seven Days of Discharge

The current quality metric of an appointment with a mental health provider within a week of discharge does not necessarily require that it involve a medication prescriber. Doing that sooner rather than later contributes to treatment continuity and adherence and allows sufficient time to remedy kinks that may arise in dispensing (such as prior authorizations) with less disruption to therapy.

Other continuity-of-care recommendations for implementation on the outpatient side are described on page 81.

6. Development of ECT and TMS Programs

Electroconvulsive therapy's (ECT) well-established indications are for pharmacotherapy-resistant mood disorders and catatonia. It may be advantageous for antipsychotic-refractory schizophrenia without catatonic features although there is less data (43-45).

Of the 22 facilities registered in Texas with clinical ECT programs, only one, in Terrell, is within the state hospital system (46) ECT is available at two San Antonio hospitals, Laurel Ridge Treatment Center and Methodist Specialty and Transplant Hospital. SASH patients may be transferred to Terrell for ECT.

Statewide during FY 2017, 2,773 individuals received at least one ECT treatment. Their age distribution, shown in Figure 11, indicates that the most patients were in middle- to later-age adulthood (45-64 year-olds: 40%; 25-44 year-olds: 35%), while 18% would be classified as elderly/geriatric (46).

Insofar as those in state hospital care for extended periods have been, almost by definition, refractory to numerous pharmacotherapies and other interventions, improved access to ECT at SASH may be warranted. Public sector funding for this treatment has been in recent years decline and this is unlikely to reflect improved efficacy of other interventions over this period. If ECT underutilization contributes both to patient hardship and prolonged state hospital bed occupancy, then establishment of an ECT service at SASH is warranted. Postdischarge outpatient maintenance treatment can be performed at other sites, or conceivably at SASH itself if it would improve accessibility to patients and contribute to sustainability of the service. We recommend the new facility include infrastructure to establish an ECT program.

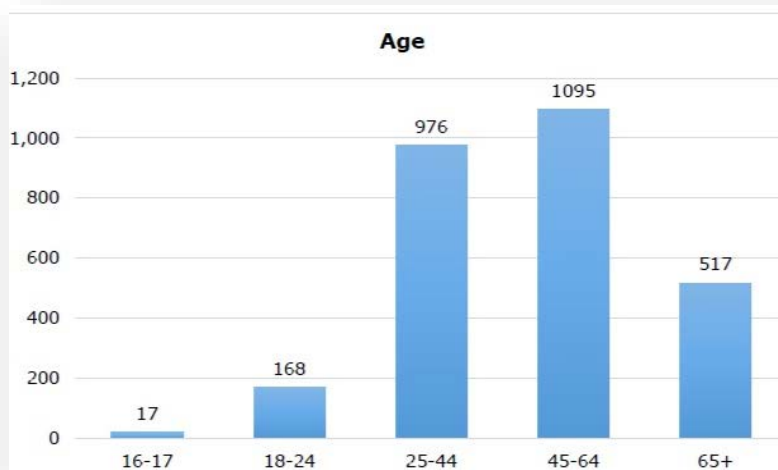


Figure 11: Ages of ECT Recipients in Texas, FY 2017

Source: Texas HHS.

Repetitive transcranial magnetic stimulation (rTMS) is a noninvasive, nonconvulsive treatment whereby an external magnetic field is applied to specific brain areas in a repeating, pulsatile fashion. It has FDA-approved indications for pharmacotherapy-resistant depression and has been studied in other psychiatric conditions that include schizophrenia, PTSD, and neurological conditions that include chronic pain and sequelae of stroke. Infrastructure requirements for rTMS, besides the equipment itself, are minimal, but should be incorporated into the new facility.

7. Install Modern Technologies for Communications, Patient & Visitor Use, and Service Integration

Stakeholders, both external and internal to SASH, lamented its antiquated and at times dysfunctional technology capabilities. New construction is anticipated to upgrade them, but we urge consideration of functions that, beyond the boilerplate capacities of telecommunications and internet access, would enhance quality of service, care, and visitor experience.

Specific recommended functions, discussed in other sections as well, include:

- ✚ Fulfill the objectives in earlier HHS reports to improve patient-care related information technology, including more modern and

integrated electronic health records (17,18). Given patients' extensive treatment, and at times judicial, histories, the capacity to scan select paper records should be incorporated to this system.

- ✚ Patient computer stations for training and personal use, appreciating the necessity of greater control over content and communications to ensure safety and appropriate use of state-owned equipment.
- ✚ A dedicated wi-fi network for visitors.
- ✚ Adoption of a wristband scanning or similar system to record patient activity attendance. Currently, patients have cards stamped for attendance as part of an incentive program in which they are redeemable for desirable activities or goods. Unsurprisingly, many patients lose these cards. Just as importantly, documentation of patient attendance at specific therapeutic activities is extremely useful for gauging progress, team summaries, and regulatory purposes.
- ✚ Some newer facilities use a silent alarm system in which a staff member needing assistance from others to help a patient's behavioral stability can privately activate his or her own key-fob-type device that conveys information about his or her location. Those we spoke with in one adopting facility found enormous advantage because overt verbal calls for assistance are apt to agitate and inflame a patient further, and the electronic system communicates need beyond hearing distance.
- ✚ Videoconference capacities will be important to facilitate therapy sessions that involve distant family members, and the latter can participate alongside the LMHA clinician to foster continuity. This type of technology would remove transportation and communication barriers currently experienced by families and providers from rural communities. Installation of such equipment is not complicated in offices, and the main infrastructural factor will be quality of the internet broadband to handle the expected traffic. A method to arrange incoming calls needs to be established.
- ✚ On the other hand, spaces for "virtual visiting" for patients outside of staff offices does need special consideration with respect to equipment, balancing privacy with appropriate supervision and technical assistance, and access. We understand virtual visit stations have been installed at Rusk, and lessons from that experience will be useful in the SASH installation.

8. Family Participation in Treatment and Support

Specific building and landscape design recommendations to promote positive interactions with patients' visitors are in the next section (p. 75), so we address other programmatic factors here.

We strongly recommend that teleconference/telemedicine capabilities that link SASH therapist with their LMHA counterparts be used to maintain linkages and continuity. This offers an excellent way to involve families, especially for adolescent patients, given the difficulties families face in consistent visiting during therapist availability times.

Maintenance and enhancement of SASH's current family overnight lodging capacities is also strongly encouraged.

We encourage development of a Family Resource Center within the new facility. Some informational materials such as booklet and DVDs can also be distributed in visiting areas to be situated nearer to patient units. The FRC we envision would involve peer support and benefit specialists who can aid families to obtain benefits for the patient or themselves, offer support and linkage to local advocacy, respite service, and other meaningful help that alleviates some of the burdens they experience.

Many hospitals encourage direct care nursing staff to provide guidance and support to families and acquaint them with practices used in the inpatient setting to help patients be consistent with self-care and activity involvement. The current skeletal pattern of staffing at SASH makes this difficult, but we highly encourage such communication nonetheless.

9. Issues Regarding On-Site Medical Care

Several key informants expressed interest in SASH developing the capability to treat non-life-threatening physical health conditions. This could enhance primary care services on the SASH campus, reduce costs of transporting people from SASH to a primary care facility, and decrease potential disruption in care. In March 2018, STRAC distributed a Bexar County study conducted by Capital Healthcare Planning that analyzed data on homeless individuals and people with complex needs who routinely cycle between jails, emergency rooms, and inpatient care. The study's findings suggested that people who frequently receive crisis services (e.g., emergency department visits and hospitalizations) have both mental health and physical health diagnoses. In fact, out of 18 categories of primary physical health diagnoses, from burns to cancer, at least 65% of the people in each category had co-morbid mental health problems, and across all 18 categories, 79% of the people had co-morbid behavioral health problems (47).

While our interviews revealed multiple positive outcomes of integrated care in the SASH catchment area, particularly at Tropical Texas Behavioral Health and Coastal Plains Community Center, the SASH capacity for integrated primary and mental health

care services is limited. One medical director described his hopes that SASH would handle basic medical care, and that an integrated care infirmary on the SASH campus would help provide that care. It was pointed out that anyone who can receive medical care in the community while living at home should be able to have these medical conditions treated at SASH. Suggested examples of medical conditions that could be treated at SASH included pneumonia, hypoglycemia, cellulitis, urinary tract infections, and wound care. Further, this key informant described the need for an infirmary for the geriatric population, including closed rooms that could be quarantined to address contagious viruses, like influenza or norovirus, which is more likely to infect and harm geriatric patients. In a separate interview, LMHA and local hospital leadership staff indicated that SASH admissions can be problematic because no standard testing has been established for medical clearance, though medical criteria can sometimes prevent people from being admitted to SASH, even when their medical needs are not serious. For example, pregnant women cannot be admitted to SASH, even if there are no prenatal complications.

Another major concern of stakeholders was the growing rates of activity-limiting conditions among the seriously mentally ill population. The most prominent of these conditions are obesity and a variety of medical illnesses directly affecting mobility, including osteoporosis, osteoarthritis, neuropathies, and lower-extremity amputations resulting from complications of a patient's chronic diabetes (48-50). The rising prevalence of these conditions among those with mental illness present challenges to psychiatric hospitals, which were seldom designed to accommodate people needing wheelchairs or walkers.

Other common medical comorbidities among individuals with chronic and severe psychiatric disorders include those requiring portable oxygen or gastrointestinal tube placement. In current medical practice, these needs are ordinarily met in the home setting rather than necessitating specialized personnel or major equipment. However, psychiatric hospitals have generally declined to admit patients with these needs.

When SASH had a census of over 3,000 in the 1950's, it operated a three-story general hospital on-site. Combined with its then-remote location from other medical facilities, this patient volume made on-campus service delivery efficient. Currently, however, there seems little reason for SASH to duplicate the provision of complex medical services that are now available nearby. On the other hand, there are several high-frequency medical services that should be accommodated on-site both for expedient care and to alleviate the burden of off-campus medical consultations.

Both medical providers and community stakeholders offered recommendations:

- ✚ SASH should develop more standardized criteria of medical conditions that are exclusionary for admission to SASH and better coordinate with LMHA's regarding these criteria.

- ✚ SASH should continue to provide general ambulatory medical care on site, along with dental services as well as on site EEG and EKG capacity. Medical exam rooms on each unit (or with very easy access) to allow physical examination and minor medical procedures without a client crossing the campus to a separate medical building is felt to be a paramount issue in design of the living units.
- ✚ HHS should perform study the issue of pregnant women who need admission to state hospitals. While this situation is not a common occurrence, fertility among patients with schizophrenia is rising (51) and making it prudent to anticipate a rising number of pregnant patients with serious mental illness the coming years. To not have SASH as an option for these situations may present a high risk for both mother and child.
- ✚ Take care in the design of living units at SASH that they are accessible to persons with physical limitations or in need of “in-home” medical procedures. Consider expanding the range of medical needs that can be served at SASH, given the limitations of staff number and training.

10. Special Programming and Aftercare Clinical Pathway for Individuals with Early Phase Psychosis

There is growing recognition that untreated psychosis is essentially neurotoxic, so that psychosis itself is frequently, though not universally, prone to worsen functional status. Early, aggressive intervention that supports and extends premorbid functioning as much as possible stands to reduce the burden of severe illness. Unfortunately, youth and early onset of illness currently militate against treatment adherence (52).

Consequently, there are numerous specialized clinical pathways and services tailored to the needs of young adults and adolescents experiencing early phase psychotic symptoms. Well-developed approaches have long been standard of care in parts of Australia, Canada, and some countries in western Europe (53). Interest and program development in this country has accelerated recently, spurred in part by a large effectiveness trial for first-episode psychosis (54).

An important observation is that the standard clinical settings that provide treatment for those with chronic and severe mental illness are frightening and alienating for those with recent onset of symptoms or those at high risk. Considering that the surroundings are often bleak and other patients show quite advanced debilities, young people are apt to reject the notion that they have much in common with these more chronically ill individuals, if indeed they acknowledge having an illness at all.

We therefore suggest consideration of distinct unit or subcluster within a unit for younger, early phase patients so that programming is better attuned to their needs and more likely to promote engagement with the self-care and other resources that can optimize the chance of a favorable outcome.

11. Educational Needs and Staff Development for Adolescent Patients

a. Focus on Adolescents with Demonstrable Need for Longer Stay Inpatient Care

There is a significant need to develop short-term inpatient services closer to adolescents' homes and to phase out SASH's use for this role.

b. Maintain and Enhance Full-Day School Program

A strong educational program with class settings that approximate as much as feasible what patients would encounter outside is vital, as discussed earlier (p. 46). The new facility must have a school program capable of meeting the needs of patients of diverse ages and academic skills. It should not be so distant from the inpatient unit that an overly high threshold of behavioral calm is needed to attend. When school attendance is inadvisable on a given day, there should be a mechanism for educators to provide assignments for unit completion. The school program at SASH is provided through the school district of the hospital's location, the San Antonio Independent School District. If the current agreement is to be altered so that it curtails staff and hours so that a school environment can't be maintained, we urge HHS to establish a charter school or other entity to serve this essential need.

c. Recognize Skills and Augment Programming Needed in Care for Adolescent Patients

Direct care of adolescents in 24-hour settings requires specialized skills that differ from those developed in the course of working with adults who have severe mental illness (55). High staff turnover and the need to on-board and train new staff is deleterious to the management of these services, which demands consistency in the implementation of treatment plans, unit policies and tolerance for behavioral issues between staff members and over time. There are various means to promote consistency. Mentoring of new staff is vital to that process.

Clinical programming for adolescent patients needs to balance the need for constant structure with appropriate downtime. The involvement of rehabilitation staff is likely to be greater here than elsewhere.

12. Develop Alternatives to Hospitalization for Long-Stay Elderly Individuals

A number of elderly patients reside on the geriatric unit with no prospects for discharge. HHS should locate or devise care settings more appropriate for life-long placement than state psychiatric hospitals.

13. Caring for Individuals with Intellectual Disabilities and Developmental Disorders

It is important for HHS and other agencies serving individuals with these disorders to develop plans for those who may need inpatient time-limited behavioral health care to address acute crises.

Nevertheless, we encourage that screening of patients' suitability for state hospital admission focus on *functional criteria that reflect their needs* rather than diagnostic terms alone. Individuals now diagnosed with autism spectrum disorders experience a broad range of functional capacities. It is by no means a forgone conclusion that every person so diagnosed would not benefit from existing inpatient services nor that they would require intense support. The same is true of many people with IQs in the mild intellectual disability range, few of whom need more help with basic ADLs in a hospital setting than other behavioral health patients. One appealing feature of a hospital configuration with smaller units and subclusters within them is that it facilitates programming suited to the functional needs of individual patients.

For those individuals with chronic psychiatric symptoms or highly impairing and persistent behavioral disturbances, suitable post-discharge services are often problematic. However, stays in state hospitals are seldom appropriate, and community alternatives or specialized units within the state living center should be cultivated.

14. Eliminating Inpatient Suicides, Programmatic Solutions

Data from the 1990s and 2000s appeared to suggest that suicide is the first or second most frequent sentinel event in US hospitals, with an annual incidence of approximately 1,500 (56). However, an analysis published in November 2018 based on sentinel event reports to two databases show the incidence is far lower, ranging between 49 to 69 hospital-associated suicides per year (57). More recent data indicate growth in suicide-related behaviors most steeply among young adults (24,25), which may have ramifications for heightening suicide risk among inpatients with severe behavioral health disorders. Among adult inpatients, risk for suicide attempt and completion increases with psychosis, history of previous suicide attempts, bereavement, and feelings of hopelessness and self-deprecation (58-60). It had been suggested that one-third of suicides among behavioral health inpatients occur in the hospital. The remainder occur equally among patients who elope and who are on approved leaves; these estimates have been disputed, but it is certain that a number of inpatients elope with the intention of suicide by drowning, jumping from fatal heights, causing themselves to be struck by automobiles or inducing gunfire from others. Importantly, the months following discharge also incur high suicide risk.

It is important to keep people from committing suicide, but that is not quite the same as cultivating and supporting a desire to live. Psychiatric medications may remove some of the neural obstacles to the experience of positive mood (delusions,

anhedonia, unsurmountable sadness), but they are generally not euphoricants – one become more susceptible to the satisfactions and pleasures that one’s life circumstances and interactions with the environment would normally provide, but they (for the most part, cf. ketamine) do not create them.

It is quite possible that improved environmental conditions that will accompany the new facility will help to create a more inviting milieu that encourages patients to engage positively. It is critical, nonetheless, that patient routines include gratifying activities and opportunities to make positive contributions that help one feel useful and appreciated.

Many if not most inpatient suicides occur among patients who are on a special observation status (61). Current best practices for patients on 1:1 for self-harm risk includes not just passive monitoring but engagement with patients and support in helping them be as close to meaningful social activities as possible. Training and supervision in doing so is strongly recommended.

Discharge planning should include at-risk patients making contact with those LMHAs with a designated role in triaging individuals with heightened vulnerability for self-harm. In several, this will be the team locally involved in HHS’s Zero Suicide Initiative and its Pathways Project which we encourage enhancing and broadening.

15. Substance Use and Addiction Treatments

The urgent need to address substance use disorders among patients with severe behavioral health disorders poses a major challenge to inpatient settings to implement treatments that will have durable impacts. Inpatient care obviously enforces a period of nonuse, which itself can be significant for those caught in a cycle of unrelenting craving and use to alleviate it. Important elements of substance use treatment that can at least be introduced in the inpatient setting include psychoeducation about the hazards it poses to their illness and functioning, problem solving on alternative ways to get the gratification and relief that substance use offers, skills to resist triggers for use, and so forth.

Substance use and addiction are in large part dependent on context and environmental cues. Preparation for return to the same settings in which drug and alcohol misuse occurred is itself a risky proposition. This is especially true for individuals who may lack other activities to occupy their time. We therefore urge strong coordination with aftercare services to sustain the momentum toward desistance that the inpatient stay began.

16. Forensic Services: Reducing Reliance on SASH for IST Competency Restoration

The Texas Joint Committee on Access and Forensic Services (JCAFS) focuses on gaps in system coordination and has made recommendations to improve access to mental health care for individuals in the criminal justice system. For instance, efforts to drop charges if an individual is admitted to a state hospital would help the state avoid costly

criminal justice processes, and, if programs are effective in reducing recidivism, the state can save money on repeated incarceration. Initiatives like this, however, require beds to be readily available.

We strongly urge and support all agencies and judiciaries of state and local government to take a holistic view of the problem that overuse of state hospital resources for IST commitments are importing on the public mental health system.

When it is apparent that treatment is unlikely to ameliorate an individual's psychiatric status so that they fulfill criteria for adjudicative competence, it is time for the justice system and defendants' counsel to deal with that predicament and agree on suitable dispositions for the large majority of hospitalized defendants who would not meet criteria for civil commitment. Accordingly, we also suggest time frames in the recommendations section concerning statutory changes beginning on page 89.

17. Forensic Services: Timeline and Structure for Incompetent-to-Stand-Trial Competency Restoration

Among those committed to inpatient settings to attain adjudicative competence, North American studies indicate that approximately 70% to 80% become fit to continue their legal proceedings. In practical terms, attainment of competence chiefly reflects response to pharmacotherapy for psychotic symptoms. Reductions in psychosis severity are significantly greater among those who attain competence than among those who don't, with the latter group largely unchanged from initial assessment (34,62). In addition, competency non-attainers are older, have more neurocognitive or developmental impairment, and more extensive treatment histories.

As a practical matter, then, it does not take very long, especially with the benefit of a well-documented patient history, to establish whether an individual current lacking adjudicative competence will gain it in the near future.

We recommend that our state's forensic experts in this area establish best-practice parameters to anchor expectations for treatment trial duration and to harmonize determinations of when one is unlikely to attain adjudicative competence. Addition of a standardized competency assessment tool may engender confidence in the judiciary that current competency and prognoses for attaining it can be reliably determined. The working group might consider the value of doing so across state hospitals.

18. Enhancing the Behavioral Health Workforce for SASH

Besides the obvious role of compensation, other factors can contribute to recruitment and retention. If done well, the new SASH facility is a potential asset to attract care providers.

We support HHS's development of a campaign to publicize the benefits of working in a behavioral health state hospital setting. Among them is the opportunity to complete a treatment plan tailored to an individual's needs. This may not sound all that innovative, but it is in fact a glaring contrast with the very short hospitalizations

that predominate in other community settings where discharges occur at the moment a patient is minimally beyond the threshold needed for inpatient admission.

Engagement with training programs afford the opportunity to make a positive impression on future professionals. Attentiveness to mentoring and teaching that complements technical training are highly valued by students. It also bears pointing out that trainees who pass through on rotations are greatly affected by the general collegial atmosphere and morale in their appraisal of a worksite.

Facility Redesign II: The Built Environment. Developing a World-Class Facility for SASH

1. Contemporary Standards in Behavioral Health Facility Design

a. General Trends

Most behavioral health facilities built or refurbished in North America and Europe over approximately the past 15-20 years share aesthetic themes of openness, access to natural light, easy proximity to pleasing outdoor areas, patient privacy, variety in the density of social areas, acoustic comfort, and furnishings that strive to be homelike rather than institutional, yet also safe. The Facilities Guidelines Institute, American Institute of Architects, and other organizations provide guidelines that incorporate these elements.

At the same time, the persistence of patient suicides and other self-harming incidents has led to revised standards for physical precautions in patient areas, notably those that eliminate opportunities for intentional strangulation or hanging.

Table 4 contains a summary of design features currently adopted or strongly considered in recent projects. This summary is drawn chiefly from Ulrich and colleagues' report (1) on reductions in aggressive incidents that accompanied a behavioral health facility design, but the same characteristics are recur in recent literature by others (2,3,63-66). Other facility features are drawn from Hunt and Sine's (67) specifications for patient-centered design that are also cognizant of recent Joint Commission standards for safety.

"[F]rom the existing research..., there is a strong preference for the familiar, the humane and deinstitutionalized environments. Furthermore, studies have shown environments that prioritize the familiar to be economically and medically effective. However, ... we are too often left with stark and institutional settings. Indeed, with regards to hospital design generally, Waller and Fine wrote: "We have now reached a position where far too many hospitals succeed in making people feel worse than they did when they came through the main entrance" (63)

Table 4: Partial Summary of Current Best Practices in the Design of Inpatient Psychiatric Settings

Patient Space and Social Density	
	One bedroom per patient
	Private bathroom adjacent to bedroom
	Movable seating in common areas
	Variety of 'clusters' where more or fewer people can congregate to allow patients to self-calibrate social involvement.
	Adequate space to eliminate experience of crowding.
Reducing Environmental Stress	
	Walls, flooring, and furnishings absorb reverberant sound
	Affording patients environmental control consistent with safety needs (over lights, personalization or room, etc.)
	'Comfort rooms' to provide room for de-escalation when one's agitation that poses risk of seclusion/restraint
	Off-unit dining areas allow greater quality and patient choice in nutrition.
Positive Environmental Stimulation	
	Daylight exposure
	Garden or other natural feature accessible to patients
	Windows look out onto natural or other pleasing features
	Artwork and decoration that are colorful but not overly complex
Safety	
	Good visibility from central areas
	Minimizing distance to areas with high potential for emergency interventions.
	Secure entrance/egress to/from staff-only corridors.
	Unit entrances are sallyport configurations
	Tamper-proof fixtures
	Eliminate opportunities for jumping and hanging (ligature points)

b. Specific Standards

There are a number of recent behavioral health inpatient projects worldwide that endeavor to adopt or establish cutting-edge best practices. Some of these ideas are noted in the following sections on specific building elements. In general the standards set forth by the Facilities Guidelines Institute, Inc. (FGI) on psychiatric hospitals are an appropriate touchstone and realistic reference in fulfilling HHS's request that we describe "best practices used in the design of the proposed facility". Texas does not adopt or require FGI standards in its regulatory framework, but nearly all architects and designers are likely to, and they do embody what current literature in mental health emphasizes as appropriate for inpatient care.

It may warrant mention that the existing patient care areas at SASH only seldom comport with these guidelines, even earlier editions.

2. Unit Size

There is surprisingly little research on what is the optimal maximum patient census for self-contained behavioral health inpatient units serving various populations. Nevertheless, by modern standards, the current SASH layout of 40 adults and 20 adolescents is excessive. Some expert consensus reports place the maximum unit size for acutely ill adults at 15. (e.g., ref e.g., ref 69)

However, staffing difficulties and fulfilling community demand in an era of dwindling bed capacity makes this seldom attainable in the U.S. A common desired maximum unit census is around 24 and 18 or fewer for adolescents.

As unit size grows, it is desirable to form groups of patients who follow the same schedule, have the same staff members associated with them, and participate in group activities together. These arrangements often correspond to treatment teams (psychiatrist, psychologist, social worker, etc.). Groups of this sort may be advantageous when a wide range of patient age and functional status complicates programming, so that smaller cohorts of similar individuals can be better served. Physical layout can also structure these smaller groupings into individual wings for further impart a more intimate and less intimidating social unit.

The deleterious effect of mental hospitalisation, attributable in part to depersonalising, regimenting and sensorily deprived environments are widely known ... [d]rab surroundings communicate to the patient 'nothing matters' which fosters the apathy being produced by other pressures.

-- Barton, 1976 (68)

3. Design to Optimize Social Density and Patient Privacy

Built-environment researchers have distinguished spatial density, which is the area per person of enclosed space, from social density, which is the number of people

in each space. Several studies have shown that social density is highly associated with crowding stress and patient aggressive behavior. Reduced spatial density, or room size per se, is less significant beyond a certain minimum area that avoids feelings of compression.

Achieving goals for comfortable social density often involves creating a range of distinct and sometimes differently sized social and seating arrangements. This enables patient to self-calibrate to the degree of social exposure they find manageable.

4. Design Admission and Facility Entryways to Convey Therapeutic Atmosphere

Building features upon entry must be calming and welcoming.

5. Create Unit Entry and Reception Areas that are Inviting and Secure

Patient areas in modern medical/surgical facilities have relatively open-access floor plans, in which nursing stations or other staffed areas do not serve as barriers for visitors and patient movement. Psychiatric settings, in contrast, usually have locked doors, but often retain the placement of a reception or other well-staffed area some distance from the unit entry. In some experts' view, this is inadvisable because it creates an unwelcoming entry and disorienting to visitors. While cameras and remote entry buttons are ubiquitous in these situations, eyes-on surveillance of those passing through the door becomes inconsistent. Placement of nursing station and other points of observation are among the most significant design elements in behavioral health settings, and its prominence to entering visitors is another important consideration (2,66,67).

There is some evidence that small-group circular arrangements of furniture may promote socialization. Exclusively linear arrangements, in any event, create a "bus depot" environment that is alienating and unattractive.

6. Access to Fresh Air and Outdoor Spaces

Facilities in urban areas with predominantly vertical construction contend with the challenges of providing open space and natural light for patients. The SASH site, fortunately, has an abundance of open space, with a pleasing landscape and topography to meet these needs.

Patients and staff have a distinct preference to avoid overly-enclosed outdoor space because they feel confining, lack desirable natural views, and are not found conducive to walking. A fully-enclosed courtyard-type arrangement is therefore disadvantageous. Moreover, in our climate enclosed outdoor space threatens to reduce air flow in high heat, complicates drainage, and can hamper the efficient maintenance and watering of plantings.

Landscaping and hardscaping should be suitable for strolling, and at least a portion should provide safe surfaces and grading for walkers, wheelchairs, etc. Nature

trail-type, curved walking paths and other outdoor activity areas are inviting for outdoor recreation.

Shaded areas and outdoor drinking water facilities will be necessary.

7. Patient Rooms and Bathrooms

Current guidelines call for a minimum of 100 square feet of net usable/clear floor space for a single room, and 80 sq. ft per person in multi-patient rooms. Two patients per room is now the accepted maximum.

Single-patient rooms are preferred in most settings to minimize conflict, allow enough personal space, individualization of light at nighttime, and allow a personal calming space when needed. The use of built-in rather than movable furnishings (bed platforms, desks, storage, etc.) can offer an appealing design element and reduces risks of damage or injuries from such items being misused or weaponized. There are guidelines, though, for the accommodation of persons of size and satisfying these requirements with built-ins is to be determined.

Some rooms may be sized as doubles to provide additional flexibility and fulfill requirement for handicapped accessibility or other bedding for medical and personal size needs, and so on when needed. They would also provide patients on 1:1 constant observation with adequate space for the staff member to stay with patient comfortably. We urge that rooms designed as legal doubles to provide this flexibility not be routinely used to increase patient census.

Adjoining bathrooms comprising at least a toilet and sink are now standard practice. Guidelines specify preference for direct entry from the bedroom, though some facilities also install doors from the main corridor.

Shower and bathing facilities not within the adjoining bathroom may serve several bedrooms, though a minimum of one shower/bathing area for every six beds is specified (37).

8. Create Open Settings that Encourage Interaction

In general, unit design should strive to reduce the “fortress”-like intersection of patient and staff areas.

Nursing stations can combine an open-counter space behind which is a glass-enclosed room for privacy and safe completion of tasks.

The exact configuration and degree of openness is a matter of debate with no single solution. We can report our discussions with nursing leadership in a new facility that replaced older inpatient units that incorporate a more open nursing station than staff were accustomed. When the design was presented, there were widespread threats to resign rather than move into the new building. A year after their move-in, however, staff are extremely satisfied, patient aggression has declined, and there is a sense of disbelief that they tolerated the former layout so long.

9. Maximize Exposure to Natural Lighting and Use Appropriate Artificial Light Sources

Besides the visual appeal of the sky and sunlight, diurnal variation in natural light exposure regulates many physiological functions in a circadian fashion. Individuals with mood disorders are exquisitely sensitive to dysregulation of one of them, the sleep/wake cycle, that is largely governed by patterns of exposure to natural light. Chronic exposure to artificial light that disassociates one from the prevailing regional rhythm of sunlight worsens mood disorders. Both mania and depression can be exacerbated when one's sleep/wake patterns desynchronize from the natural environment.

Unremitting exposure to interior overhead fluorescent lighting is suspected to be especially problematic. Current design practices favor LED lighting, which offer a wider choice of light spectra appropriate for each installation area. They are also more reliably controlled by dimming mechanisms.

10. Use Layouts and Materials that Prevent Unfavorable Acoustics

Chronic exposure to highly reverberant spaces is noxious in general, and there are certain patient groups for whom this form of stimulation is especially aversive. Patients, notably those with IDD, are discomforted by high stimulation of this sort. It is also believed that psychotic patients, for whom auditory hallucinations are the most common perceptual disturbances, a high noise environment is deleterious. Long, echoic corridors are also discouraged by built-environment experts for psychiatric patients. They also amplify the sounds of patients in distress, making it difficult to redirect other patients and avoid contagion of upsets. Flooring material plays a significant role in managing ambient sound. Newer sound-absorbing products have high durability resilience to dirt and liquid penetration.

11. Create Adequate Spaces for Treatment on or Close to Units

a. Consulting Room and Activity Space

One of the greatest concerns by SASH staff was the limited on-unit space for seeing patient and running group activities.

We recommend a minimum of two rooms per inpatient unit for seeing patients individually or with family. Adequate distinct spaces for group activities should be available both on the units and nearby. A separate meeting room for staff on the unit helps to maximize the participation of direct-care staff.

Adequate space for therapeutic activities on or near patient units should enable a mixture of activities or groups to occur simultaneously. Enough storage for equipment used in these activities should be anticipated.

b. Staff Office Locations

It may be desirable for some team members to have their offices on the unit itself. This has the advantage of promoting team integration, efficient access for seeing patients, and more opportunities to observe and evaluate functioning. On the other hand, off-unit office space is more conducive to meeting with individuals from outside without need to bring onto unit and can be more efficient for those caring for patients on more than one unit.

c. Medication Administration

We assume that a modern pharmacy system (such as Pyxis, Omnicell, etc.) will be part of the new facility. Many behavioral settings have also adopted mobile carts that integrate with this system to enable dispensing where patients are. When it works well, it is perceived as less disruptive to patients' day and enables a higher quality of interaction around this important part of one's therapeutic routine. From a design standpoint, we heard from facilities occupying newly completed projects found some door widths can be problematically narrow for some equipment. Earlier experience at SASH with a similar mobile point-of-service system was not favorable. It is not hard to imagine some patients becoming intrusive and fiddling with the devices since they are, at least initially, among the more novel things they encounter. Nonetheless, old-style wickets and passthrough windows are more institutional and restrict interaction at an important moment of personalized attention. We recommend reconsideration with the design team toward implementing a system that is conducive to interaction, teaching, and avoids associating medication with an impersonal or imposed experience.

d. Spaces to Promote Patient Calm and Regain Composure

Guidelines recommend a 'comfort room' that is a calm space for patients to regain composure and defuse escalating behavioral situations. Ideally, it averts the need for seclusion orders in a number of instances.

e. Medical Examination Room

Each unit should have a medical examination and treatment room with at least basic capacities for physical examinations, phlebotomy, treatment of minor injuries, first aid, and computer access to electronic medical record and ordering portals. Other equipment may be desirable for which practitioner input would be useful (e.g., glucometers). Net usable space should be adequate to allow other staff to be present for procedures, as indicated.

Defibrillator equipment needs to be available at locations that state requirements or those of other accrediting bodies specify.

12. Staff Support

There must be adequate off-unit space for staff breaks, rest, and dining. Given short break times, these must be close to their work sites, and incorporate comfortable outdoor areas.

Facilities for training and conferences are important for staff development. Some can be within the building secure perimeter, while others can be elsewhere in the building or in new or rehabilitated structures on campus to permit outside attendees.

Washroom facilities for staff should be easily accessible from the inpatient units and numerous enough to accommodate the maximum expected workforce at a given time.

There are guidelines for the number of parking spaces that consider the number of employees. Providing secure escort to one's vehicle at night should be included in design of the employee exits.

13. Accessible, Centralized Off-Unit Facilities and Amenities

The facility will have a variety of centralized patient services and amenities. Their location should be convenient and safe enough to enable for as many patients as possible to go them unescorted if they are capable. These will include on-site hair salon/cosmetologist, dental care facility, patient store, worship areas, library, gymnasium and fitness center, independent living rehabilitation areas, and so on.

Policies and physical infrastructure should support appropriate patient access to telephones and computers.

14. Family Space for Visiting

We urge that comfortable, homelike surroundings for visitors be created adjacent to inpatient units. One such area could serve up to two units.

For patients who can leave the unit accompanied by visitors, amenities like dining areas, activity areas that also include child-friendly elements, handicap accessible walking trails, and attractive shaded outdoor garden-like areas need to be incorporated.

Units should include 'virtual visiting' via audiovisual and computer facilities. Methods to arrange and accept incoming calls need to be developed as well.

15. Safety

The Joint Commission (TJC) promulgated new environmental standards for patient safety that aim to eliminate physical elements that patients could use to aid in suicide. Hanging was the cause of death in about 75% of cases reported to TJC, and elimination of ligature points is prominent in design efforts to mitigate suicide risk. Toxic chemicals used for cleaning or other purposes have been intentionally ingested to cause death, and special attention and training concerning their use and storage, as well a preference for nonlethal products, need to be considered.

The most common locations for suicide on inpatient units are bathrooms, bedrooms, and closets. Bathroom design now has an extensive number of features

and regulatory requirements intended to mitigate suicide. These are detailed in, among other sources, the 2018 *Behavioral Health Design Guide* (67), which is cognizant of recent TJC and other regulatory changes in recent years. There are vendors who provide pre-constructed bathroom modules that fulfill these requirements that may potentially reduce onsite construction times and perhaps costs, dependent on shipping and aspects of the building during construction that make it amenable to their installation.

There are now a multitude of guidelines and regulatory standards for patient and staff safety on behavioral health inpatient setting, which are well known to HHS and any qualified designers for a new facility, so they do not need to be reviewed in detail here. Elimination of ligature and hazardous jumping points are emphasized in current design. Outward opening doors prevent patient barricade, but if the open door is too prominent in the corridor it may conflict with other safety guidelines; recessing the entry into an alcove sometimes solves the issue but can compromise visibility that may require installation of mirrors. Sometime a wicket-type arrangement in which an outward opening smaller door is built into the main inward-opening door, but if not large enough barricading and inefficient access still can result. In any event, all these specialized features contribute to cost. These elements should not come at the expense of other clinically important resources.

Furnishings and fixtures that are pleasant, movable and noninstitutional but that also resist weaponization are a challenge. There are vendors currently who do produce seating and other items that are appealing yet weighted to prevent throwing and made of relatively durable materials. Fabric and other coverings have a limited useful life in these setting, but this should not deter their use when they can contribute to aesthetics and comfort. The more soil resistant and removable for laundering the better, but like any living facility periodic replacement has to be anticipated and budgeted.

One major factor not tethered to building infrastructure, though, is staffing pattern. Except for the Psychiatric Intensive Care Unit, the staff-patient ratio is low for a highly impaired patient group. The move to redesigned smaller units with single rooms is expected to reduce the safety risks from aggressive or agitated behavior. Nevertheless, lean staffing leaves little leeway if a behavioral emergency develops that requires many staff members exclusive attention, even if those from other units come to assist. One or two patients requiring monitoring while they are in seclusion/restraints or in need of 1:1 observation can easily detract from the ability to meet the needs of other patients. When these developments result in delaying or unfavorable scheduling for the already-brief break for a 12-hour shift, one can anticipate adverse impact on morale. Solving this issue goes hand in hand with workforce considerations, but a persistent bias toward lean staffing can be risky.

We noted earlier the adoption in some new facilities of silent call alarms that staff keep on their person. We recommend that HHS and designers evaluate this technology for its potential to more rapidly dispatch staff where needed in an urgent

situation, and the likelihood that it is less inflammatory to the situation than verbal shouting for assistance.

Clear and consistent signage about escape routes and other directions can be lifesaving in emergencies. The Whole Building Design Group refers to the Department of Veterans Affairs guidelines as a worthwhile example (<https://www.wbdg.org/ffc/va/vadeguid/signage.pdf>).

16. Educational Facilities for Patients

We discussed earlier that it is highly desirable for adolescents to receive instruction in an environment that best approximates a community school program. For adolescents that will mean changing classrooms between teachers with some degree of specialization. On smaller inpatient services without an associated day program, this often means a teacher for language arts and perhaps social studies and another for chiefly math and science. Rehabilitation staff often organize art and music and physical education. Many students will have individual education plans that require speech/language, OT, PT, and other services provided in the course of the school day. Designing the school should take careful account of the configuration of the planned educational program and meeting the needs of students receiving these additional support services.

Adult patients may be working toward their GED certification. Support for continuation of these efforts during extended hospital stays is strongly encouraged. Study space and tutoring areas, access to online material and ability to print all pose logistical issues that facility design should recognize.

17. Training, Continuing Education and Career Development

Some stakeholders expressed strong interest in SASH serving as a regional resource for training career development in the behavioral health fields, “so providers in the rural community can come to SASH and learn how to treat patients and take it back to their communities.”

18. Resource Mall

In a transitional living environment, the transitional team and providers from the client’s community of origin would work collaboratively to identify resource needs and complete aftercare and discharge planning. Stakeholders suggested a “resource mall” as part of a campus redesign to house benefits counseling, assist with obtaining identification cards, housing application, transportation planning, and related services to support people in their recovery as they transition to the community.

19. Plan Medical Capabilities and Flexible-Use during Crises or Disasters

We recommend building certain contingency plans into the design. Areas for consideration include:

Isolation areas in case of highly transmissible infectious diseases reaching outbreak proportions. Ventilation systems that enable one or more to become negative pressure rooms was also suggested. Of course, this is also useful for patients suspected of possible tuberculosis until active disease can be ruled out or antimicrobial treatment weakens its transmissibility.



Section IV: Enhancements to the Regional System of Care in South Texas



Regional System of Care Redesign: Effective Use of Inpatient and Outpatient Resources in the Continuum of Care

1. Community Strengths

a. Southwest Texas Crisis Collaborative

A major strength of the Bexar County service delivery systems is the Southwest Texas Crisis Collaborative (STCC), whose services could be extended far beyond Bexar County. STCC was created under the leadership of the Southwest Texas Regional Advisory Council (STRAC) after a series of studies conducted in Bexar County reviewed the effects of social determinants of health on people with mental illness, like housing/homelessness, income and education level, and the availability of behavioral health resources. In 2015 and 2016, the Meadows Mental Health Policy Institute was chosen by Methodist Healthcare Ministries of South Texas, Inc. to conduct an additional assessment of the mental health care system in Bexar County to identify system strengths and opportunities for improvement. The Southwest Texas Crisis Collaborative (STCC) was created to address service gaps identified in these studies, with a specific focus on finding ways to integrate service delivery and reduce high utilization of emergency department and

“There is a fear that the state will think all mental health problems will be solved with the new building, and that will make it harder to get funding to address the real need to solve the problems.”

– Mental Health advocate

“There is a mental health crisis and we need funding; it is only going to get worse.”

– ED nurse

jail services. STCC comprises hospital executives from the major hospital systems in Bexar County as well as leadership from the LMHA and the criminal justice system. STCC has overseen the creation of several programs designed to address these issues, including an online platform that combines client data for people with complex needs who cycle between jails, emergency rooms, and inpatient care; addressing law enforcement’s transport of emergency detention clients; and ongoing funding for psychiatric emergency service facilities. These interventions, particularly the online platform for tracking people across systems and the dramatic improvements in transporting emergency detention clients, can potentially be extended far beyond Bexar County.

b. Private-Purchase Psychiatric Beds

A primary method of addressing the lack of available beds at SASH is for LMHAs to purchase private psychiatric beds from local hospitals. For instance, each of the LMHAs in the SASH catchment area purchase private psychiatric beds using a combination of state and local funds. The following two tables illustrate that LMHAs expended \$12,136,503 to purchase 21,288 bed days from private psychiatric hospitals in fiscal year (FY) 2017, and expended \$13,223,689 to purchase 22,397 bed days in FY 2018.

Several rural LMHA administrators indicated that being able to purchase private psychiatric beds was a “game changer” for their areas. One group of stakeholders reported that economic disparities within its region have forced the LMHA to dedicate its financial resources to community-based programming, making it necessary to use state dollars for private psychiatric beds for higher levels of treatment. Because of the lack of inpatient psychiatric services in their communities, rural LMHAs need to coordinate with multiple hospitals in metropolitan areas to utilize the state’s allotted private psychiatric bed dollars.

However, there are concerns that this level of funding may not meet the needs of some areas. One LMHA had \$794,000 for private-purchase beds for the fiscal year starting in September, but those funds were depleted by February.


2. Continuity of Care

In addition to the recommendations discussed earlier that involve SASH providers in collaboration with community clinicians (p. 56), several proposals focus on processes and agencies outside of SASH.

a. Outpatient Clinicians Can Renew Medications Specified in Discharge Summary

To present disruptions in treatment premised on an outpatient prescriber’s discomfort with renewals before conducting his or her own evaluation. We recommend establishing a standard of care that a psychiatric prescriber may accept a discharge summary from a psychiatric hospital as the basis for continuing medication even if they have done a full evaluation of their own. This does not necessarily mean robotically continuing treatment one has concerns about – rather, inpatient clinicians should be contacted when questions or concerns arise and such communication should receive high priority for response.

b. Improve Quality of Information Available to Clinicians over Care Settings

-  Improve tracking of the clinical course of patients as they move through the mental health care system. Doing so facilitates the identification of “high utilizers” and their prioritization for hospitalization-preventive supports such as intensive case management.

- ✚ Shared medical records between pharmacies, state hospitals, LMHA's and private hospitals, accessible to front line clinicians.

3. Assisted Community Treatment and Adherence

Despite expansion of outpatient services and other recovery-oriented services a subset of patients with more severe mental illness often do not participate in outpatient services to the degree required to prevent relapse. For these individuals, Assisted Outpatient Treatment (AOT) is often beneficial as well as cost effective (70). These programs should have:

- ✚ Expanded capacity for AOT programs at LMHA's along with funding for proper implementation.
- ✚ Increased ability to provide extensive case management, particularly for homeless or marginally housed individuals.
- ✚ Ability to ensure adherence with medication and other outpatient treatments
- ✚ Allow for return to hospital if outpatient treatment is not followed and early deterioration occurs.

We also encourage strengthening AOT approaches that (a) address factors that contribute to an individual's nonadherence, (b) include incentives and other proactive measures to promote self-sufficiency with treatment adherence and reduce reliance on coercive measures, and (c) consider developing advance directives for patients to indicate what might help them during a crisis (71-74).




4. Expand Substance Abuse Treatment Services

There needs to be a recognition of the problem of dual diagnosis (mental illness and substance abuse disorder) wherein each disorder complicates the management of the other. To address these issues:

- Enhance treatment programs for pregnant women with substance abuse disorders with continued intervention for both infant and mother after birth in an attempt to break the inter-generational cycle of addiction.
- There are inadequate number of Fellowships in Addiction Psychiatry and Medicine in Texas, leading to a serious shortage of physicians skilled in this area. Additional state funded support to medical school to establish such programs should be considered.
- Identify methamphetamines as a Texas crisis, due to some parts of the state having more prevalence of methamphetamine use and abuse than opioids.
- Increase availability of and access to opioid antagonists. Encourage Medication Assisted Treatment for opioid addiction (MAT, i.e., buprenorphine) treatment centers to include on-site mental health providers, for a "one-stop shop," for co-occurring conditions. Encourage more prescribers to engage in MAT.




- e. Review funding rates to substance abuse service facilities, because capacity to provide treatment is impacted by reimbursement and current rates do not support growth. The state should perform a comprehensive rate study based on best practices for each level of care to determine the best rates for recommendation (per House Select Committee Report).
- f. Support changes in Federal legislation to Title 42 of Code of Federal Regulations (CFR) Part 2 which prohibits sharing of substance abuse and other medical records. This makes establishing substance abuse clinics in multi-specialty medical or mental health clinics extremely cumbersome.
- g. Individuals dually-diagnosed with substance abuse disorders and behavioral health disorders often encounter community providers unwilling to treat them, particularly those with commercial payers. Commercial insurers should be incentivized to develop provider panels for these patients and, both commercial and governmental insurers need to provide adequate coverage for their care.
- h. There is a growing need to develop substance abuse treatment for individuals with intellectual disabilities and other developmental disorders.

We expect that the following local initiatives will improve the targeting of substance abuse treatment and prevention resources to areas of greatest need.

-  Bexar County's Joint Opioid Taskforce has recommended that a Joint Substance Abuse Taskforce be created that focuses on all alcohol and substance abuse and that a Strategic Plan focused on needs assessment, asset inventory, and gaps analysis be completed.
-  This new Joint Substance Abuse Taskforce will create a "community dashboard" that tracks the incidence and prevalence of opioid, alcohol, and substance use/abuse.
-  The Joint Opioid Taskforce proposed the creation of and received funding for a full-time substance abuse planner/manager for County government.

5. Increased Support for Guardianship

A subset of patients with severe mental illness become so impaired in their reasoning due to psychosis, mania, or addiction that they lose the capacity to make medical or financial decisions. The mental health care system is ill-equipped to deal with these individuals. It is critical to provide, under the direction of the probate courts, guardianship for these individuals. To do so, we recommend:

-  Identifying patients who lack capacity for making financial and medication decisions.
-  Assigning guardians when families are unable or unwilling to carry out this role.
-  Manage patient funds (especially disability payments) such they are appropriately spent on food, housing, and medical care.

6. Forensic Patients and Competency Restoration Outside the State Hospital: Outpatient and Jail-Based Services

We discussed earlier the dire situation in which forensic placements are overrunning civil resources for inpatient care based on purely clinical criteria (p. 65). Another vital point concerns ameliorating psychiatric symptoms of defendants before they even get to SASH.

For defendants held in jail pending evaluation or treatment to address adjudicative competence, the wait for transfer to the state hospital is lengthy. Whether Federal court cases like *Trueblood* ultimately produce a national standard for the care and transfer of these individuals, obstacles to promptly initiating treatment for those who really must be in a jail setting for competency restoration must be overcome.

We recognize that not every jurisdiction can have psychiatric care providers for their jails. The Sandra Bland Act has catalyzed efforts to more effectively screen and when possible treat detainees with mental health difficulties, offering new options that may be advantageous in this context. Telemedicine has been piloted in some localities, and evaluation of its outcomes should be undertaken.

It is essential that the financial resources for outpatient providers to fulfill this role be adequately available. Some local officials were concerned about outpatient competency restoration becoming an unfunded mandate that drains from already limited resources.

7. Rural Areas Need More Facilities for Intensive Acute Care

In addition to, and not instead of, the replacement of current SASH campus, regional “hub” inpatient facilities should be established to address the lack of intensive services in rural areas. The state provides funding to Local Mental Health Authorities (LMHAs) for a patchwork of other programs including Extended Observation Units (EOUs) which are 8-16 bed small units that can serve persons admitted on Emergency Detention for up to 48 hours, five Crisis Stabilization Units (CSUs) of 8-16 beds that may serve persons on Emergency Detention or under Orders for Protective Custody for up to 14 days, and a variety of contracts for the purchase and use of inpatient beds in private psychiatric hospitals. The missing element of the psychiatric inpatient care continuum is a system of state-funded, but locally operated psychiatric hospitals that serve as regional “hub” facilities. The vision of these hubs would be as follows:

1. Their design and intent would be to supplement and complete, not supplant, the existing short-term, acute stabilization system that has many well-intended and effective outcomes, but is impaired by the inability to place individuals who require longer term treatment so that the system may continue to serve those who would benefit from the short-term treatment for which it is designed, funded, and regulated.

These facilities would have the capability and be intended to provide acute crisis stabilization services to individuals committed under a Warrant for Emergency Detention or Order of Protective Custody. Additionally, they would provide longer term psychiatric treatment as needed to persons whose severity of illness requires a 45-day course of treatment to remediate the danger that the person presents to himself/herself or others as a direct result of the psychiatric disorder.

2. A regional hub system would consist of state-funded 30-bed psychiatric inpatient facilities similar to the Sunrise Canyon facility in Lubbock and operated by the LMHAs. These facilities would be tasked to serve more than one LMHA and would be strategically located to maximize the workforce potential for the facility and reduce the amount of time required to transport a person to the site. They would be licensed and authorized to serve individuals on the same types of commitments as can be served by a state-operated hospital, so they would resolve the placement dilemma experienced by the existing acute care facilities (EOUs, CSUs, and private hospitals) and emergency rooms.

3. To demonstrate local commitment, communities could be required to provide the funds to construct these facilities. Operational funds would be appropriated by the Legislature.

8. Children and Adolescents: Behavioral Health Care

a. Improve Access to Timely and High-Quality Outpatient Care for Youth

Some adolescents who require hospitalization for behavioral health disorders experience relatively sudden onset of a precipitous decline in functioning. It is far more common, though, that the critical event that led to inpatient care was the cresting of a lengthy history of chronic behavioral and emotional distress that has already exacted a heavy toll in diminished quality of life and negative self-image. Families are beset by exasperation, frustrations in seeking help, and, quite often, self-reproach.

However, the opportunities to provide families with effective treatments before these problems escalate are usually missed. Access to behavioral health services in both the rural and urban portions of our region for youth remains poor. Wait lists just for intake evaluations are typically on the order of weeks to months. For many common disorders, such as ADHD and its related behavioral disturbances or depression, combined treatment modalities involving medications and psychotherapy are the standards of care and show the largest effect sizes in treatment studies. Combined treatments also have lower rates of premature discontinuation from care. However, resources for behavioral health therapies are scant, a problem that is exacerbated in our rural and frontier areas that send need to hospitalize adolescents when crises emerge.

Coupled with the shortage of child and adolescent psychiatrists in Texas and elsewhere in the U.S., the early onset and chronic nature of youth behavioral health

difficulties made service integration with primary care a viable means to improve access. Indeed, in Bexar County a behavioral health/primary pediatrics collaborative program was implemented in 9 pediatric care settings that evaluated and treated over 10,000 youngsters in four years, only a small minority of whom would have received services otherwise. This program was supported with 1115 waiver funding but had to be discontinued when the Texas DSRIP program reconfigured last year.

We therefore support the recent calls by others for the inclusion in the LAR for funding to enhanced community-based mental health services for youth. We also encourage development and evaluation of care models to improve access and quality.

It may take some time to establish the impact of better outpatient services on hospital admissions for youth, but there is no doubt at all that they would immediately affect quality of care for children discharged from inpatient care who often cannot be seen in a timely fashion for follow-up services. We return to the topic of follow-up care in the next section on improved post-discharge quality of life.

b. Education and Behavioral Health

School based mental health programs can make a significant impact in improved access for youth. The Meadows Foundation in Dallas has long supported nationally recognized programs of this type. The University of Maryland's Center for School Mental Health also sets the standard for these projects. When they can be implemented alongside school health clinics with prescribers who have access to specialist consultation via telepsychiatry then appropriate pharmacotherapy may be more widely available as well. However, one limiting factor has been engagement with families during school hours, and parents increasingly have less flexible work schedules. Some early evening hours in sites where this proves important would benefit from support.

c. Day Treatment

We noted earlier (p. 46) the need for more day treatment services. We urge collaboration with state and local educational authorities to improve the availability and programming for such services. Many youth facing adversity in school settings due to psychiatric disorder opt, on paper at least, for home schooling; while no doubt a valuable option for families, in practice the effect is tantamount to dropping out and stifling development of functional capacities outside one's home.

d. Non-State Hospital Alternatives as Both Diversion and Aftercare Resource

State agencies should consider expansion of Residential Treatment Center (RTC) beds for children with severe mental illness, both for children in foster care and for children in their own families. Moreover, families should not have to relinquish parental rights in order for their children to access necessary treatment. The long-term effects of child abuse/neglect often require extended treatment before a child is ready for adoption. Children with severe mental illnesses should not be "boarded" in psychiatric hospitals due to lack of RTC placements.

9. Children and Adolescents: Prevention

a. Child Abuse Affects Future Psychiatric Services Needs

Child Abuse/Neglect as factors in mental illness. An extensive body of evidence now shows that childhood abuse and neglect are among the major factors in both childhood and adult mental illness. It is important to note, however, they are not the only causes, many cases of serious mental illness, including depression and anxiety, occur in loving families where there has been no abuse or neglect. Nonetheless, studies strongly suggest that preventing or intervening with early life adverse events could prevent or lessen the impact of mental illness. A meta-analysis combining 37 studies that involved over 3 million individuals looked at the impact of sexual abuse as a risk factor for psychiatric disorder (75). They found a highly significant association of between sexual abuse in both men and women and lifetime diagnoses of anxiety, depression, PTSD, eating disorders, and suicide attempts but not schizophrenia. The Center for Disease Control (CDC) surveyed 17,337 adults enrolled in a health maintenance organization and looked at the relationship between numerous forms of Adverse Childhood Experiences (ACE) and adult psychopathology (76). For individuals with four or more ACE's, there was a highly significant increase in the risk for depression, anxiety, panic attacks, suicide attempts, substance and alcohol abuse but also in obesity, smoking, chronic obstructive pulmonary disease (COPD) and heart disease.

Of growing concern is that childhood abuse and neglect have long lasting effects on the brain development (77). Many studies report that individuals exposed to abuse as children show alterations in their endocrine stress response, referred to as the hypothalamic pituitary axis (HPA). In essence, persons with a history of abuse tend to have an excessive stress response by releasing abnormal amounts of cortisol and adrenaline in response to life events. Abuse persons may experience alterations to their immune systems, producing an inflammatory response that may be damaging to variety of organs and be related to chronic disease (77). In children, severity of early life stressors are associated with smaller brain volumes in areas that are critical for memory and advanced thinking.(78) This agrees with several other studies showing reduced hippocampal volume (a part of the brain also critical for memory and processing experience) and over-activation of the amygdala (a brain region critical in fear and anger responses) (78-80).

Child Abuse and Neglect are major problems in Texas. The data are sobering. According to the Texas Department of Family and Protective Services (DFPS) Databook (https://www.dfps.state.tx.us/About_DFPS/Data_Book/default.asp), there were 174,740 child abuse investigations in fiscal year 2017. "Reason to Believe" was ruled in 33,750 of these cases. Each "case" may represent many children in a family, thus there was a total of 289,796 victims of child abuse/neglect in Texas in fiscal 2017 (38.64 per 1000 children in the state). The number of children taken into state custody was 48,889, while 29,803 children were in state custody as of August 31, 2017, with only 7,236 eligible for adoption.

Accordingly, it would be worthwhile to promote and invest in prevention and early intervention programs, including Home Visiting, STAR, CYD, Child Abuse Prevention Grants, Project Healthy Outcomes through Prevention and Early Support (HOPES), among others.

There is a high rate of teen pregnancy among youth in foster care and young people who have aged out of foster care (81, Table 14b Pregnancies of Women Age 13-17, Table 14b Pregnancies of Women Age 13-17) Girls age 13 to 17 are five times more likely to become pregnant than the general population; 60% have given birth by age 24 (82). As a result, parents who were former foster children often have their children removed from them, continuing the cycle (83). Efforts to alleviate these trends emphasize prevention of teen pregnancy in foster care and the support pregnant or parenting youth in foster care by building their parenting skills. These efforts will support parents and reduce child maltreatment and the negative effects removals can have on children, parents, and the child welfare system. Current approaches to do so include the Helping through Intervention and Prevention (HIP) program, a program specifically designed to serve current or former foster youth who are pregnant or parenting.

b. Support Youth in Foster Care and Youth Aging out of Foster Care

Foster parenting is a heroic, voluntary commitment. Moreover, for children with special needs, Texas already recognizes that foster parents need additional resources. We encourage an evaluation of the adequacy of these supports specifically in the context of youth with behavioral health needs. The same supports should be consistently available to those providing care in the context of kinship fostering arrangements. Peer support by experienced foster caregivers is an important asset that agencies can formalize. Peer specialists can be “on call” when difficult situations arise.

Respite services are also highly valued by provider families.

Data from 2009 to 2015 shows roughly 4,000 psychiatric admissions for foster care children each year. Moreover, the number of total days foster care children together spend in psychiatric facilities past their initial 8 to 10 days of treatment covered under Medicaid has risen during this time. In June 2009, foster children spent a total of 10 extra days in the facilities but by August 2015 that number had grown to 768 days (84).

Despite growing appreciation of the need to support youth transitioning out of formal foster care as they become young adults, their outcomes remain highly problematic. They are at risk for behavioral health and substance use disorders that can escalate to crises needing hospitalization (82). Transition services for youth aging out of foster care to potentially reduce these risks include the Preparation for Adult Living (PAL) curriculum, whose expansion we encourage. Through life skills training, the PAL curriculum aims to help youth in foster care build core life skills, such as personal and social relationship skills, communication skills, and health and safety

skills. Early positive experiences with mental health care may promote sustained involvement as adults to meet one's needs.

10. Recommended Statutory and Process Changes

a. Limit Length of Stay for those on IST Commitments

Lengthy, and in some cases open-ended, commitments to restore competency for those found IST has had adverse impact on the state hospital system's ability to fulfill its clinical mission and role in today's system of care. We urge immediate firm adherence to current statutes that limit total competency commitments to 180 or 120 days depending on nature of defendant's charges. Based on literature reviewed above and what is common knowledge about latency of treatment response in psychotic illness among different patient groups, we also strongly recommend statutory change to limit hospital commitments for IST to 60 and certainly not more than 90 days. Of course, individuals posing serious threats to safety can be reviewed to determine if they fulfill civil commitment criteria. If a person with mental illness has recovered to the point that he or she can return to the community and is not committable on grounds of dangerousness, he or she should not be held in the state hospital simply because he or she cannot be restored to competency to stand trial.

b. Situations where Court Orders to Compel Treatment are Necessary

1. We recommend that a compel psychoactive medication order be enterable at the same time as the Order of Protective Custody (OPC), at same hearing. At present, is a delay between these two legal proceedings and a psychotic or suicidal patient can only receive emergency medication. Allowing scheduled psychoactive medication to started right after the OPC will actually speed the patient's recovery and reduce the amount of time in the hospital.
2. Allow Crisis Stabilization Units (CSU) to obtain compel medication orders on their clients. Currently, many individuals on 45-day commitments must remain in the CSU or other interim facilities because of the shortage of SASH civil beds. CSUs are not allowed by law to compel medications but routinely have obtained orders to compel those same medications at the State Hospital at the same time of obtaining the 45-day temporary commitment order. Individuals, who through no fault of their own, cannot be placed at the State Hospital may legally refuse medications at the CSU which are necessary to properly treat the individual. The CSU's inability to administer medications that the State Hospital would be authorized to compel means that the individual is being forced to stay at a location which cannot legally provide the very treatment the individual needs and would be receiving at the State Hospital. Such scenarios effectively "stall" the individual's treatment and lead to longer hospitalizations.

3. At present, persons committed to take to be involved in Assisted Outpatient Treatment (AOT) cannot be compelled to take medication, leading to deterioration in their condition. When clinically indicated, judges should have the capacity to issue compel medication orders for patients in AOT. This would allow caseworkers to use the moral authority of the court to encourage patients to take medication by mouth or to attend clinics where long-acting injectable antipsychotic can be administered. This will enhance the ability of the individual to remain in the community.

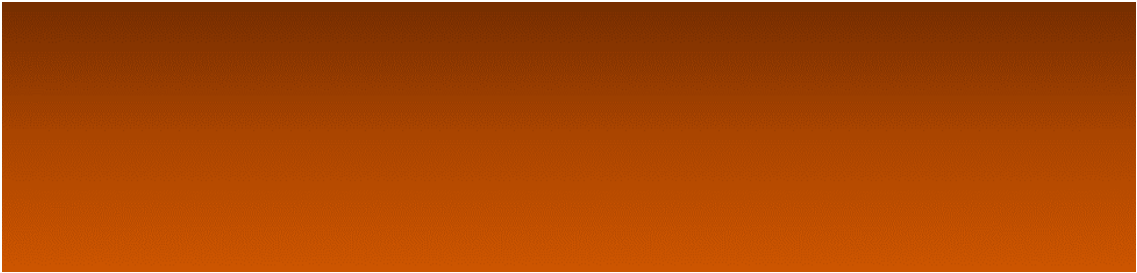
c. Allow electronic applications for Emergency Detention by LMHA and MH Officers in the jails, as well as physicians.

Allow electronic applications for Emergency Detention by LMHA and MH Officers in the jails, as well as physicians. At present, there are two ways to effect an Emergency Detention under Chapter 537 of the Texas Health and Safety Code (THSC):


- i. peace officer's apprehension without a warrant where officer completes only a "Notification of Emergency Detention (573.002); or
- ii. an adult files an application for emergency detention with a judge/magistrate to obtain a court-ordered warrant for apprehension of the individual 573.012):
 - a. application must be presented personally to the judge/magistrate (573.012(a)(1), EXCEPT...
 - b. an applicant who is a *physician* may present application via secure electronic means (email, closed circuit TV, satellite, etc.) as long as method allows for interactive communication between applicant and judge (573.012(h).

We recommend revising 573.012(h) to allow LMHA personnel and Mental Health deputies in the jails to apply electronically, as only physicians currently are permitted. The advantages of such a change are:

- a. Speeding up the detention process by cutting out travel time to and from the judge's site;
- b. get psychiatric patients out of the ERs faster, freeing up ER beds for medical emergencies or other psychiatric crises needing immediate stabilization;
- c. get the individual to the proper assessment and treatment facility more quickly;
- d. allow more individuals in psychiatric crises to be seen in the same time period;
- e. reduce travel time and exposure to danger for crisis workers, particularly in rural communities where there are long stretches of road without cell service in case of an emergency and which may be frequented by illegal drug traffic; and
- f. reduce the inherent rural danger of accidents on deer-infested roads



Section V: Summary —Today's Shortcomings and Tomorrow's Promise for Behavioral Health Care



A Framework for the Future

The SASH Stakeholder Executive Committee was asked to deliberate not only upon a new infrastructure for SASH, but also to reimagine an improved mental health system in South Texas. As we soon learned from stakeholders, it is clear that SASH, despite its vital role, impacts only a fraction of people with serious mental illness in our region. While about 280 people are hospitalized at SASH at any given time, over 76,000 people received services in the last fiscal year from one of the LMHA's in SASH's vast catchment area. This number does not include many others who seek services through private practices, private non-profit agencies or arrive at an emergency department of a local hospital in crisis.

It became clear in our deliberations that Texas today operates a “crisis-driven” public mental health system. Thousands of people remain outside the mental health system, often seeking access to it only when they are acutely ill due to psychosis, intoxication or suicidal thoughts. As Figure 13 depicts, we have become more skilled in reacting to these crises, through increased police training, coordinating law enforcement efforts, as well as short-term hospitalizations. Only a small minority of these patients are served by SASH. Many are discharged soon after stabilization, but the number who consistently avail themselves of the long-term treatment they require is far too few. This creates a cycle of “Crisis-Hospital-Discharge-Crisis” due to the factors illustrated by the red arrows.

What we have laid out in Figure 14 is an array of community supports that will lead to recovery for those with serious mental illness. In this model, we seek to prevent crises before they arise through a multifaceted approach of early intervention. Prevention now becomes a key feature.

Once individuals have developed a serious mental illness, we must have a broader array of interventions. In rural areas, we need intensive services closer to home. When crises do arise, emergency departments should not have to play the anchoring role, but LMHA Crisis Centers and short-term hospitalizations can have a greater impact. Equally important, however, is the kind of after-care we provide to those leaving the hospital. These services, illustrated by the green arrows, seek to reduce relapse and rehospitalization, and enable patients to attain long-term recovery.

Ima Hogg, the daughter of James Stephen “Big Jim” Hogg who was Governor of Texas from 1891-1895, established the Hogg Foundation for Mental Health in



Figure 12: Ima Hogg (1882- 1975)
Texas philanthropist and mental health advocate

memory of her brother Will in 1930. She developed her interest in mental health from visiting patients at the Austin State Hospital during her father's term as Governor. She also suffered from depression herself, for which she was hospitalized. In a 1970 interview, she recalled, *"I was also very much interested in mentally ill people in hospitals... My father was very interested, also... And often I went through with him and I'd hear him say to the superintendent or the doctor, 'What can be done for these people? What are you doing?'"*

Let us ask *ourselves* this question as we move forward to a new mental health system for South Texas.

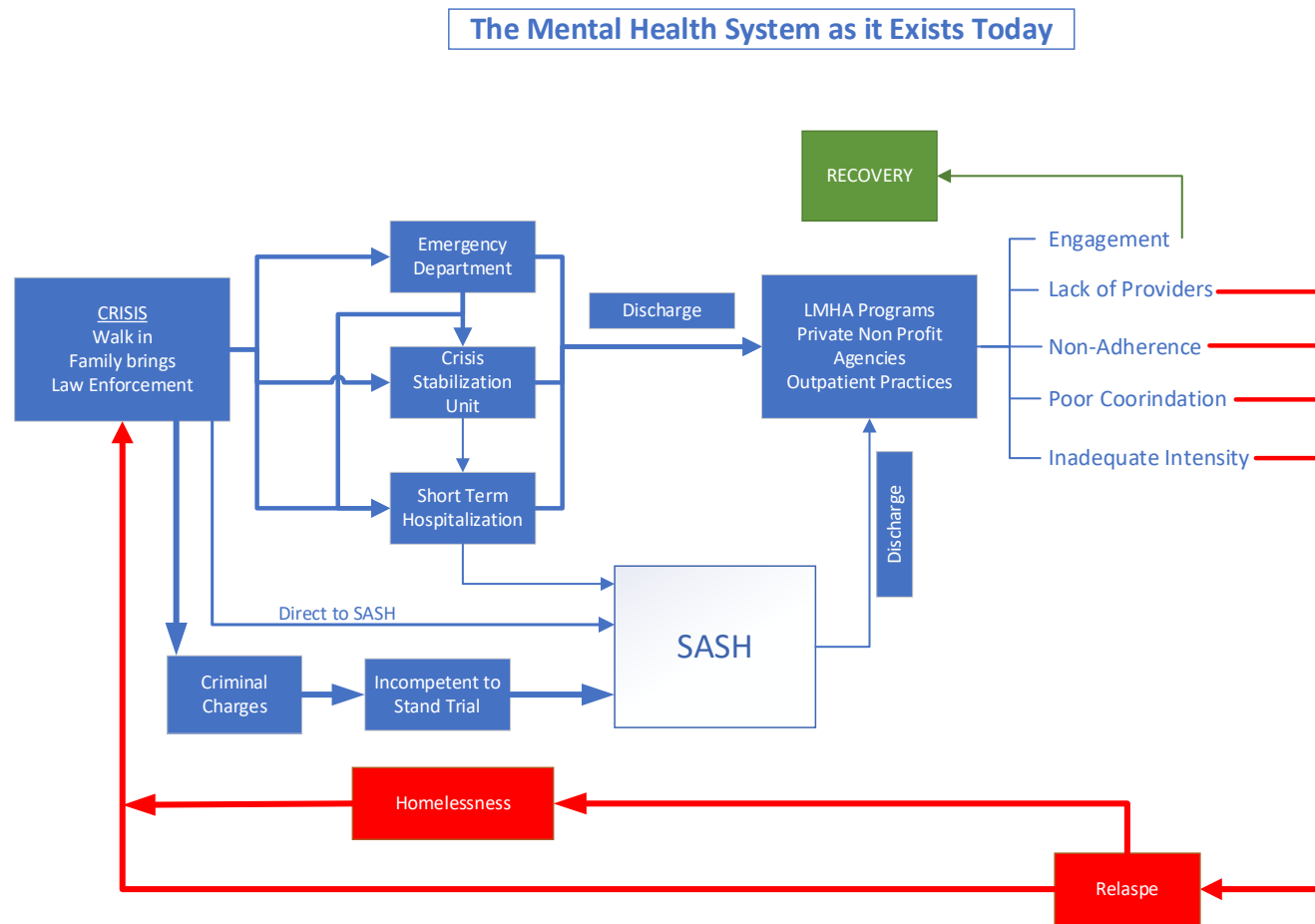


Figure 13: A Reactive, Crisis-Oriented System of Behavioral Health Care

The mental health system of today is focused on response to crisis. The region's Emergency Departments are often the first responders to mental health issues. The thickness of the arrows in the diagram indicated the most utilized pathways in the current system. Many patients, after stabilization of an acute crisis, fail to engage the treatments that lead to recovery. Instead, a variety of barriers lead to relapse, homelessness and new crises. In addition to replacing SASH, the mental health system must be re-imagined.

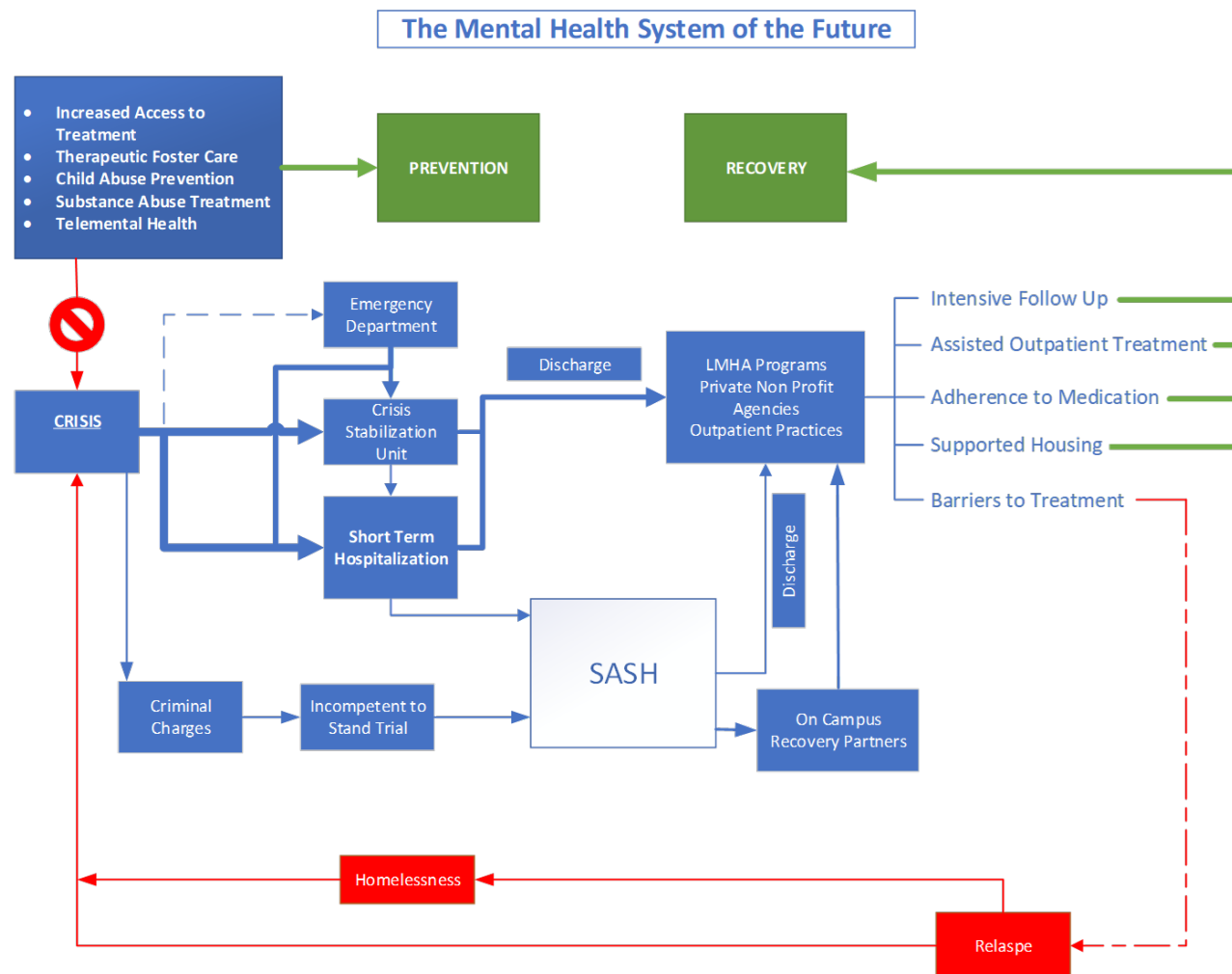
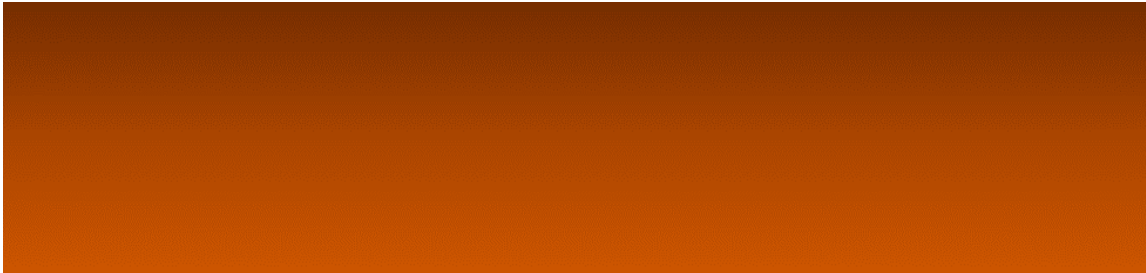


Figure 14: A Proactive, Patient-Centered and Prevention-Oriented System of Behavioral Health Care
Through early intervention and expansion of services, mental health crises can be avoided, either by preventing the development of mental illness or by intervening well before crisis. Once a patient is hospitalized, a discharge process should involve a wide range of interventions beyond traditional outpatient services. This will enhance recovery.



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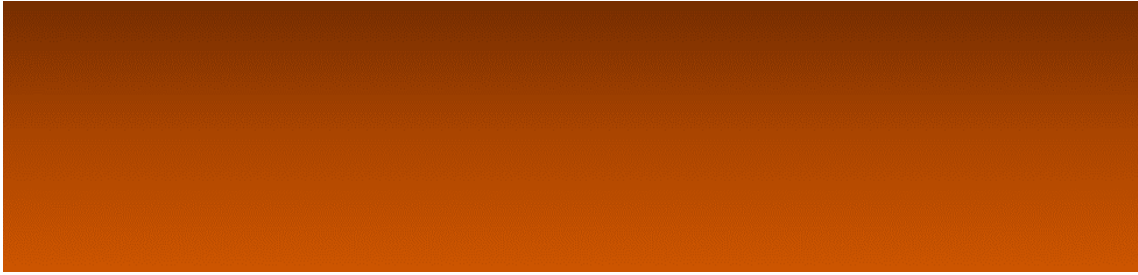
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Section VII: Appendices



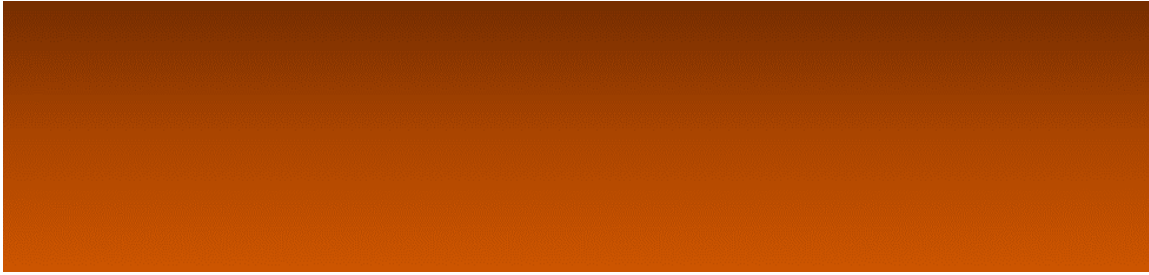


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Appendix A: Architectural and Design Options for the Rebuilt San Antonio State Hospital

The School of Architecture at the University of Texas at San Antonio prepared a range of building, interior, and landscape design concepts that are emblematic of current best-practices for construction and programming of behavioral health facilities.

Some printed versions of this document may contain only an abridged form of this Appendix, due to its length and high-resolution printing. The full 88-page document that the report's complete electronic version includes may be accessed at <http://bit.ly/SASHPlan>.

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SA | SH



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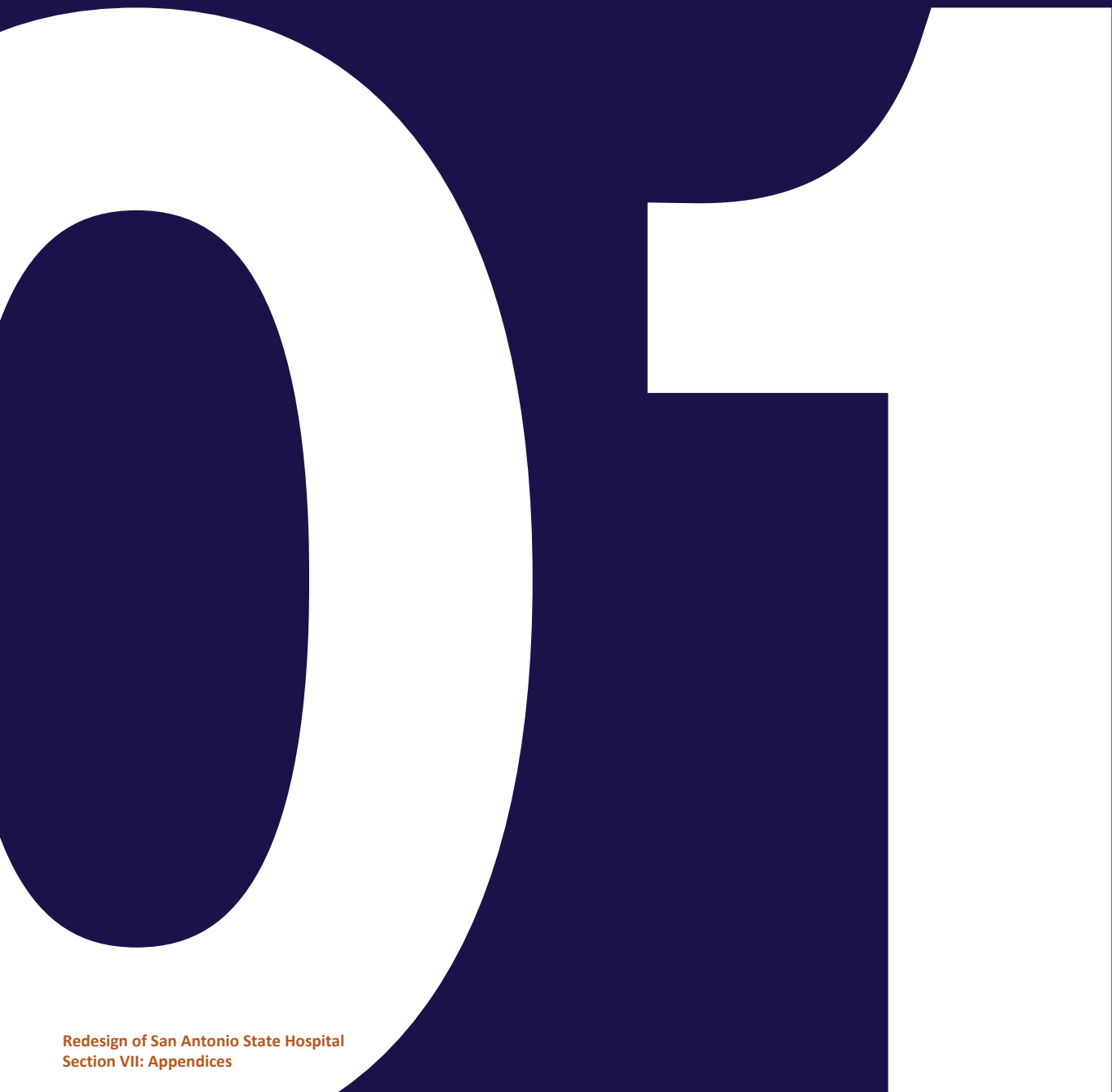
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VISIONING A NEW SAN ANTONIO STATE HOSPITAL

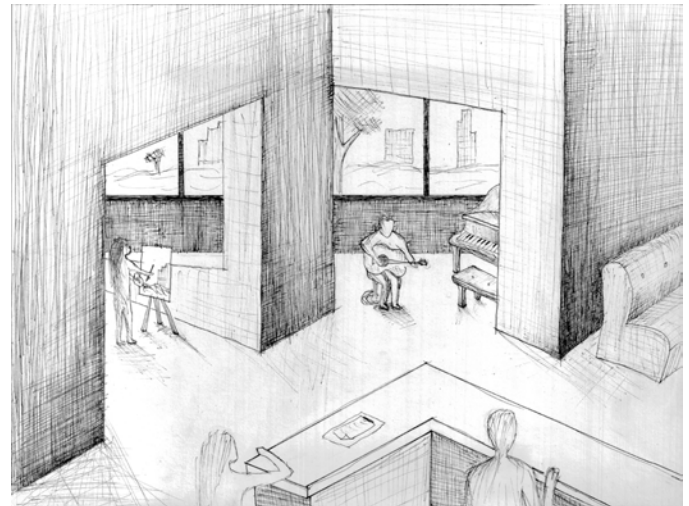
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Introduction

Mental healthcare environmental design is an important factor in patient care. The design of the environment has repeatedly found to be a critical component in how services and the efficiency of care are provided. Equally important is the influence of the design on health, safety, attitude, and behavior of the staff. Despite the knowledge of the relationship of environmental design characteristics with health and wellbeing of patients and staff, this type of study remains surprisingly unexplored in respect to psychiatric care facilities.

Most current articles are either focused only on patients and not staff or are comprehensive literature reviews of prior sectional studies. Although the knowledge provided by these articles are valuable, they lack the emphasis on involvement of staff, doctors, nurses, and patients in the design process of the hospital.

This study is in response to Texas Health and Human Services' request for proposal of design and pre-planning a new San Antonio State Hospital. The Department of Architecture at University of Texas at San Antonio (UTSA) formed a multidisciplinary team of faculty and students to work on design and pre-planning a state of the art, person-centered mental health facility that focuses on specific needs of San Antonio State Hospital.



Nursing station sightlines into therapy rooms

Assignment

The San Antonio State Hospital (SASH) is one of ten state mental health facilities within the Texas Department of State Health Services (DSHS) system. SASH provides intensive inpatient diagnostic, treatment, rehabilitative, and referral services for seriously mentally ill persons from South Texas regardless of their financial status. Admission may be voluntary or involuntary depending on whether the patient is determined by a court to be seriously mentally ill, dangerous to self or others, or if left untreated would deteriorate to the point of becoming dangerous to self or others. SASH attempts to involve the patients and their family in the treatment/rehabilitation process to the degree legally and clinically feasible. The hospital's distinctions include the Seidel Learning Center and a partnership with the San Antonio Independent School District.

San Antonio State Hospital is accredited by the Joint Commission. The Joint Commission is an independent, not-for-profit organization, which sets standards for, and evaluates health care organizations in accordance with nationally recognized guidelines. The standards include an organizations' level of performance in key functional areas such as: patient rights, patient treatment, infection control, medical staff and environment of care. To earn and maintain accreditation, an organization must undergo an on-site survey by a Joint Commission survey team at least every three years. SASH was last accredited May 2, 2013.

SASH has served San Antonio and South Texas faithfully for over one hundred years. Reductions in state hospital capacity have resulted in lengthy waits for hospital beds and results in pressure on jails, emergency rooms, and community-based psychiatric hospitals. The State hospital is now focused on a mixture of complex tertiary care and acute inpatient care, admitting individuals whose needs cannot be met adequately in the community. SASH sits on an aging campus with extreme infrastructure challenges, which present safety concerns for patients and staff...In addition, the multiple building designs are based on outdated models of inpatient care and lack the information technology infrastructure necessary to -

function as modern business practices, adding to the difficulties of recruiting and retaining a specialized and limited workforce. These challenges result in high cost emergency repairs and recurring bed closures. The time has come for not just a new building but a new vision for healthcare for South Texas.

– San Antonio State Hospital Planning, A Proposal for Planning the SASH Replacement.

The construction of a new SASH is an opportunity to “transform the network of psychiatric treatment for Texans of all ages.” Services to children and adolescents as well as older adults are critical given the special needs of these groups. The state has studied how the “design of behavioral health facilities impacts care”, and SASH is determined to act upon it. SASH is working to provide adequate services to its residents and to improve its facilities.

This study is in response to Texas Health and Human Services' request for proposal of design and pre-planning a new San Antonio State Hospital. The Department of Architecture at University of Texas at San Antonio (UTSA) formed a multidisciplinary team of faculty and students to work on design and pre-planning a state of the art, person-centered mental health facility that focuses on specific needs of San Antonio State Hospital.

Presented in this book, is students' research and design development ideas for Visioning a New San Antonio State Hospital. UTSA team started the project by researching and analyzing existing scholarly articles, visiting the San Antonio State Hospital Campus, and interviewing the executive staff of the hospital. The team continued their work by creating a list of requirements and developing an architectural design program for the hospital which led to eight different design ideas. This book illustrates three of the eight design ideas that received the highest number of votes from a focus group presentation. The focus group consist of architects, interior designers, and landscape architects with healthcare design expertise.

TIMELINE

REVISE DESIGN
REQUIREMENTS
& PROGRAM



Fall Architecture
Studio

40 semi-structural in
person interviews
with SASH staff and
patients



Fall Interior Design
Studio



RESEARCH



EXECUTIVE
INTERVIEWS

Literary analysis



List of requirements for
designing a new San
Antonio State Hospital



Patient- Centered
Care Facility



PRESENTATION TO SASH
EXECUTIVE COMMITTEE
AND STAFF



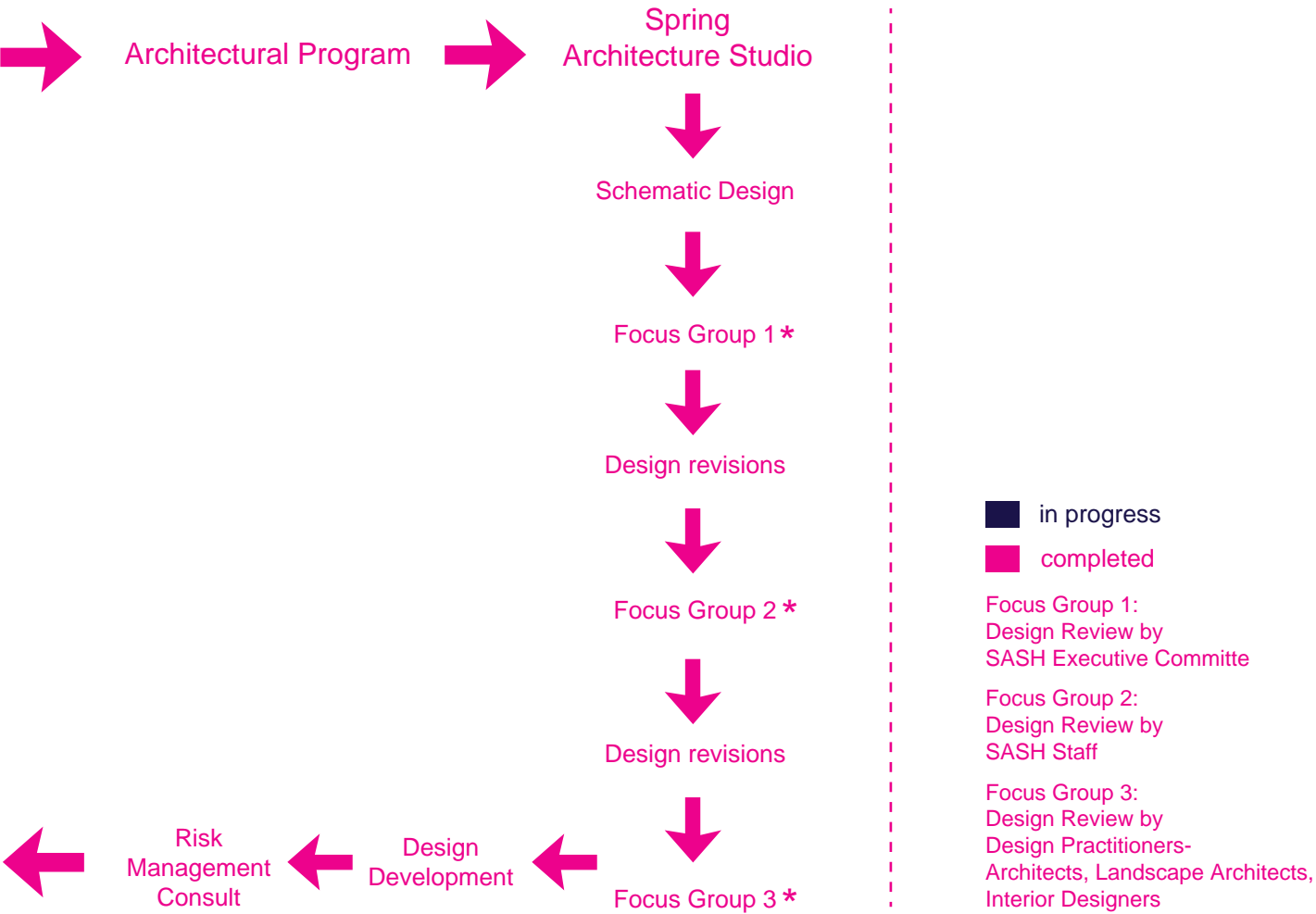
THREE DESIGN
IDEA FINALISTS



Design Review by
Healthcare design
practitioners



Design Revisions





RESEARCH

- Literary Analysis
- Executive Interviews
- Architecture Design Program
- Cartography
- S.W.O.T Analysis

Literary Analysis

Visioning a new San Antonio State Hospital, 16 UTSA Architecture students and their professor, Team A, conducted a study on evidence-based design. They started by reviewing A Texas Hospital report, produced at the University of Texas at Austin’s Center for Sustainable Development (CSD). CSD’s study, a literature review on best practices and successful precedents, concluded three innovative themes of (1) home-like therapeutic units around a directly accessible outdoor courtyard, (2) patient-focused treatment programs using passive surveillance, and -

(3) a series of buildings that are organized into compact, pedestrian-focused, campus-like setting expressed through an Idealized Model. In addition, Team A analyzed over 60 scholarly articles including Mental Health Facility Design Guidelines published by Department of Veterans Affairs to gain a better understanding of design strategies that could positively impact patients’ health and wellbeing. Findings of the literature analysis are presented in table 1.

Table 1: Findings of Literature Analysis

Provide

- Opportunities for the end users to be involved in the design decision-making process (Platt, Bosch, & Kim, 2017; Ilozor & Kelly, 2012; Brown, 2009)
- Patients with autonomy (Sorlie, Parniakov, Rezvy, & Ponomarev, 2010; Cleary, Hunt, & Walter, 2009)
- Opportunities for patients to be involved with everyday activities such as cooking, washing clothes, gardening (Golembiewski, 2010)
- Safe outdoor environments
- A place for reflection (Connellan, et al, 2013)
- A place for relaxation (Li et al., 2012; Westbrook et al., 2010; Connellan, et al, 2013)
- A place where patients can socialize with one another (Connellan, et al, 2013)
- Single bedrooms to improve patients’ sleep quality and control over noise and light exposure (Ryan at al., 2017)
- Maximum daylight and control over the environment (Platt, Bosch, & Kim, 2017)
- Maximum visibility from Nurse’s stations to patients’ room and open areas (Turlington, 2004; Carr, 2011; Ulrich, 2012)
- Open nurse station (Andes & Shattell, 2006)
- Private retreat area for staff to unwind during stressful times (Li et al., 2012; Rossberg & Friis, 2004; Westbrook et al., 2010)
- Colors that comfort staff and help in rehabilitation of patients (Qin, 2015)

Table 1: Continued.

- Physical and visual access to nature through artwork, aquarium, skylight, and ceiling panels (Daykin, Byrne, Soteriou, & O'Connor, 2008)
- Different sizes of indoor and outdoor multipurpose rooms to be used for meeting, therapy, and consultation (Graham, Gordon, & Lyn, 2002; Chen, Huang, Hwang, & Chen, 2010; Sorlie et al., 2010; Bryan, Rudd, & Wertenberger, 2013; Trzpuc st al. 2016)
- Different sizes areas with acoustical privacy for clinicians' conversations (Tapak, 2012)
- Small activity areas to enhance the sense of community (Townley, Kloos, & Wright, 2009)
- Views and access to the outdoors when possible (Gutkowski & Guttman, 1992; Trzpuc st al. 2016)
- Good way-finding, access, and egress (Golembiewski, 2015)
- Home-like features for doors and handle that are safe for patients (Hunt & Sine, 2012)

Avoid

- Anti-ligature building fixtures, alarms, and furniture (Platt, Bosch, & Kim, 2017)
- Long corridors that create institutional feeling (Whitehead, Polsky, Crookshank, & Fik, 1984)
- Designing living units and therapy areas in the same building (Connellan, et al, 2013; Dobrohotoff & Llewellyn-Jones, 2011; Golembiewski, 2010)
- Use of institutional materials with varied textures (Trzpuc st al. 2016)
- Fenced out door areas (Department of Veterans Affairs, 2014a)
- Specific color suggestions without identifying the end users, their identity, history, and culture (Tufle, Schwarz, Yoon, & Max-Royale, 2004)

Executive Interviews

Findings from literature analysis focused on patients’ mental and behavioral health, yielded the need to explore design elements and spaces contributing to safety and wellbeing of staff. The team further developed this study by visiting the existing SASH campus and interviewing the hospital’s director, executive nurse, executive doctor, and head of maintenance to gain valuable insights of SASH requirements and staff’s needs and desires of the hospital’s built environment.

Provide

- Bright and open public spaces
- 18 patients’ rooms per one nursing station
- Nurse’s stations with maximum visibility to patients’ room and open areas
- Physical separation between adolescent and adult's residential units
- Private work areas for nurses and staff
- Staff work areas separated from staff break areas
- Multiple quiet area/ comfort rooms
- Multiple activity and games rooms
- Doors that can be open easily by staff and close quickly afterwards
- Unbreakable glass

Avoid

- Institutional setting and design homelike environment
- Far distances between frequently used spaces
- Open nursing station
- Trees with low branches
- Swimming pools

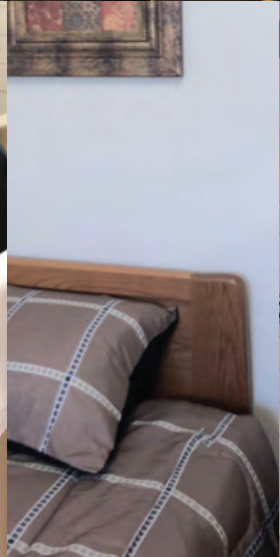
Outdoor Amenities



Amenities for Rehabilitation



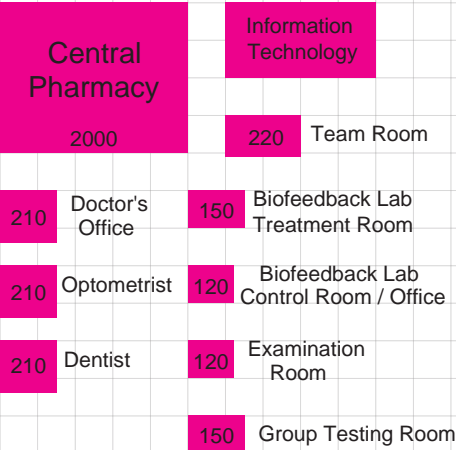
Elements of Safety and Comfort



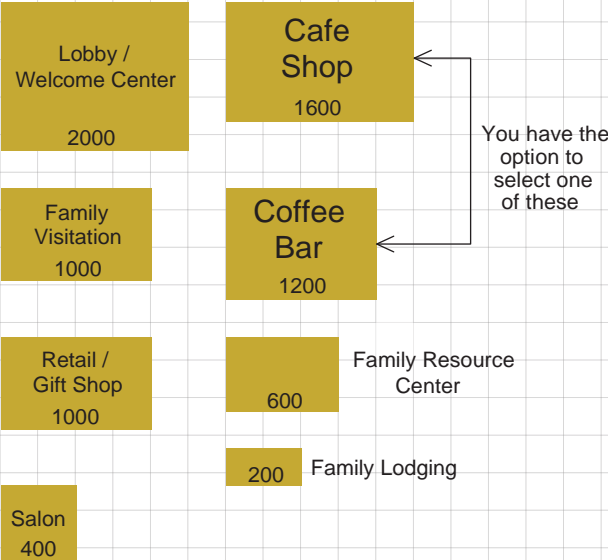
PROGRAM

THERAPY PLAZA

Medical Center



Public



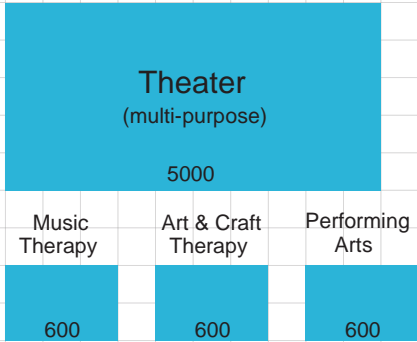
100 SQ FT

Therapy

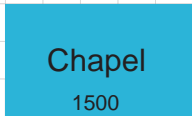
Active / Exercise



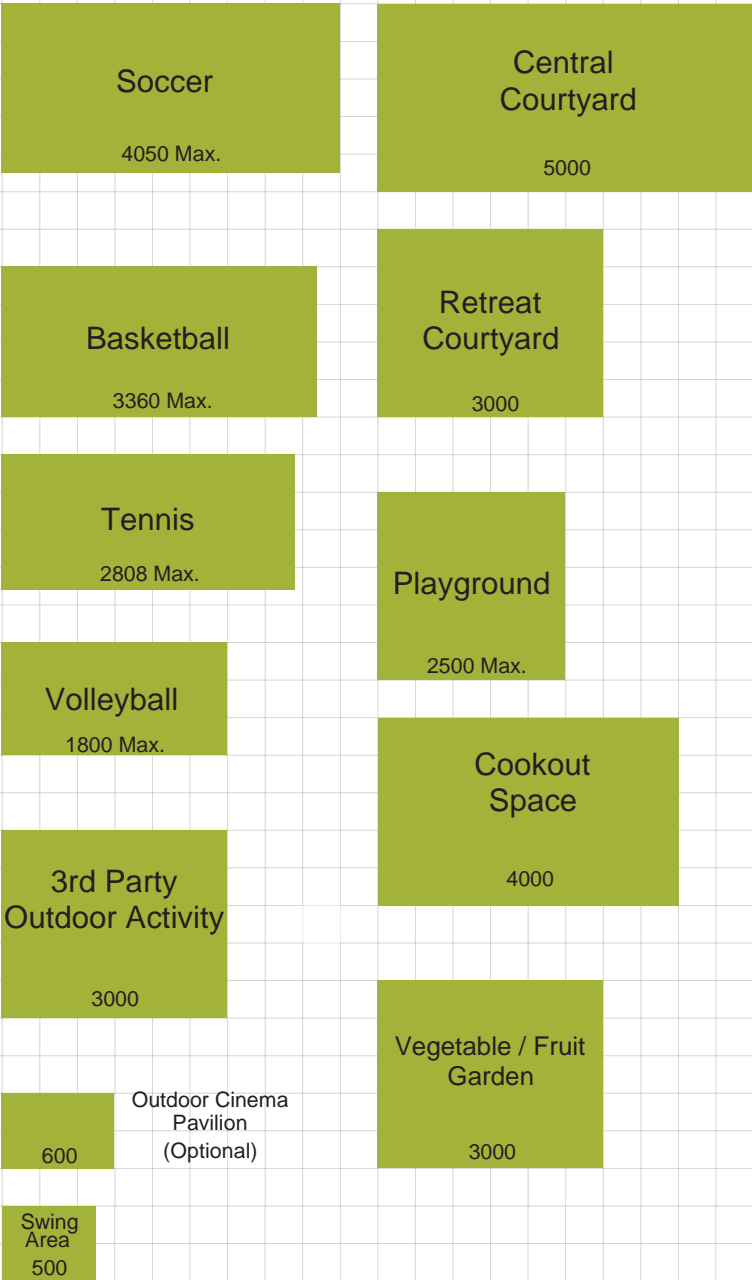
Fine Arts



Religion Center



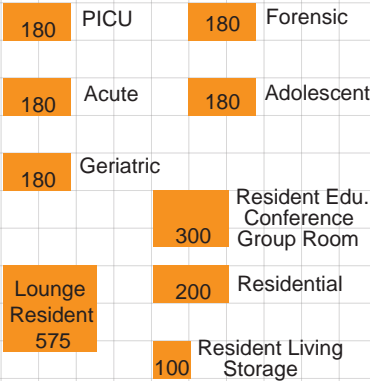
Outdoor Activity



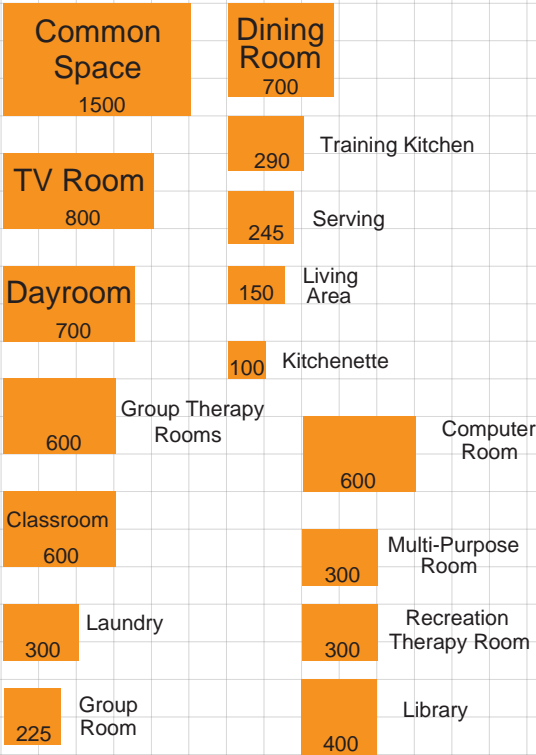
PROGRAM

RESIDENTIAL

Residential Units



Per Unit

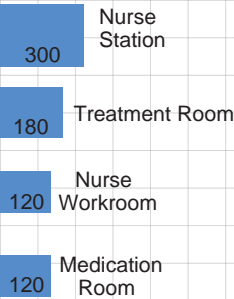


100 SQ FT

Staff Lounge



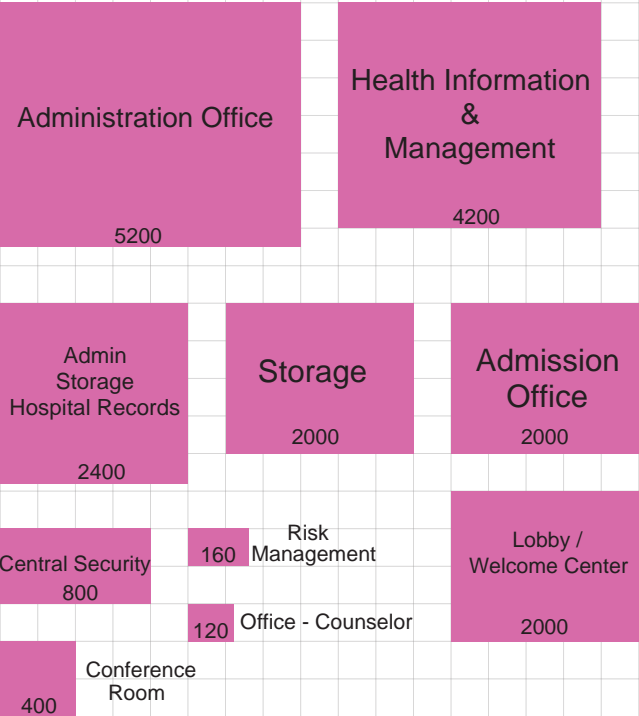
Nurse Station



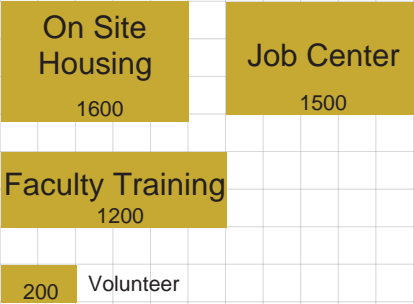
PROGRAM

ADDITIONAL AMMENITIES

Administration / Admission

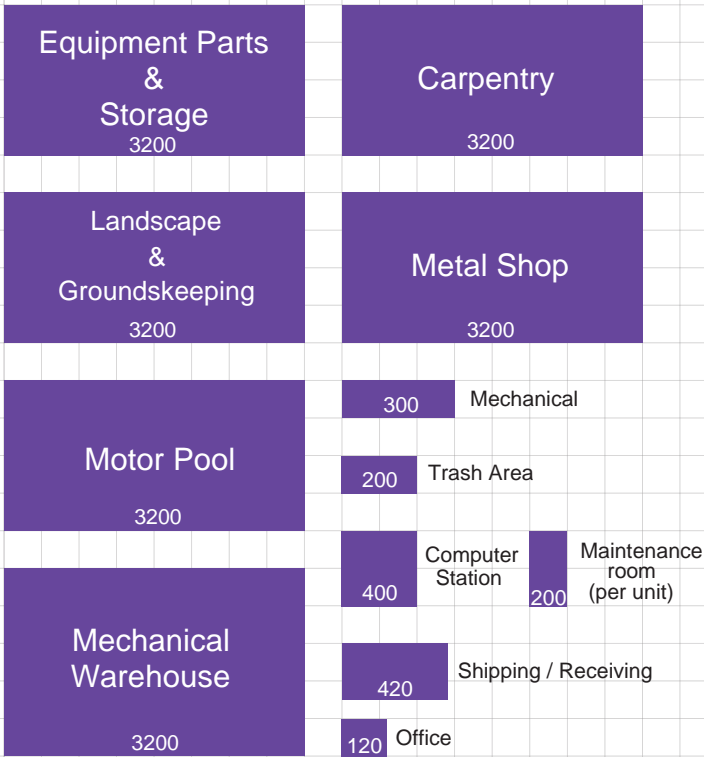


New Employee & Volunteers

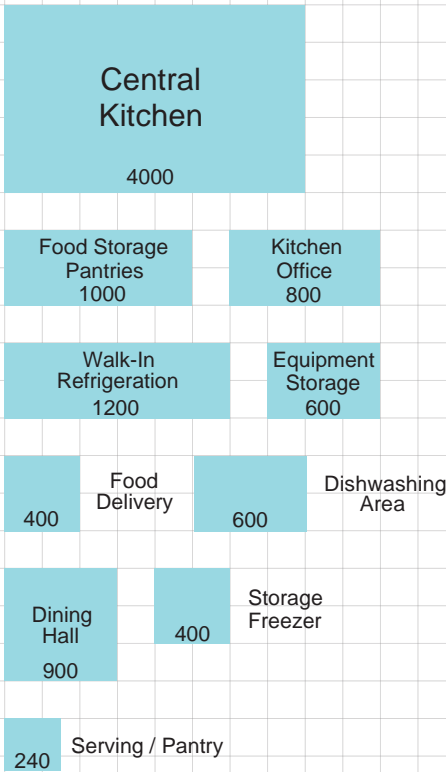


100 SQ FT

Maintenance



Food Service



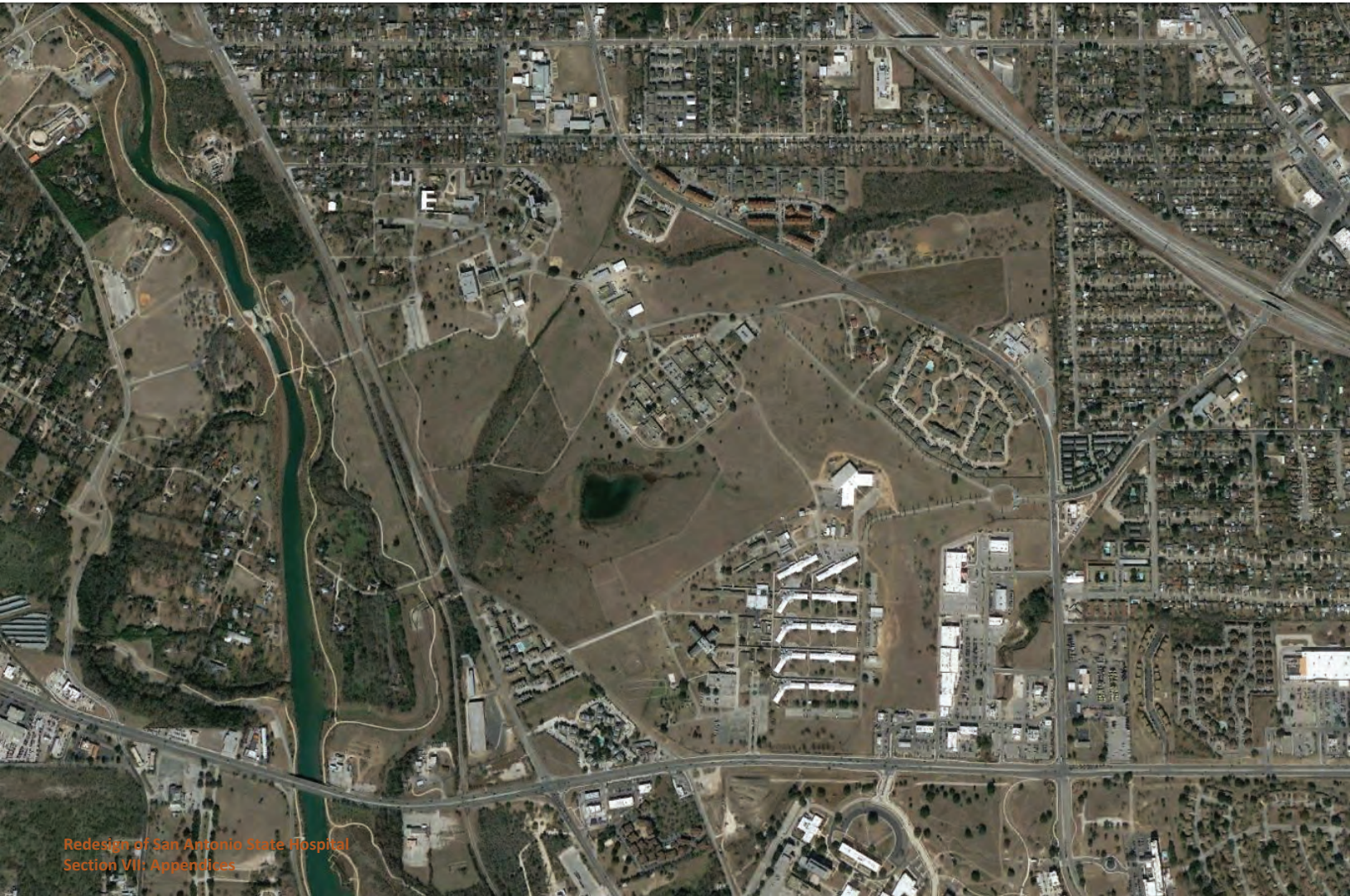
Nurse Station

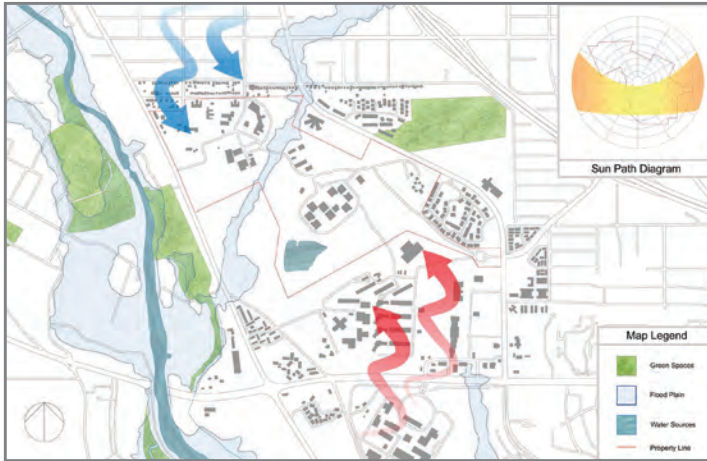


CARTOGRAPHY

The Site for the San Antonio State Hospital is very unique with a distinctive property shape, large undeveloped land, and several geographical features. The campus is located at 6711 S New Braunfels Ave. Ideally, it offers multiple points of entry for easier egress and ingress of the campus, with the second entry located off of S Presa St.

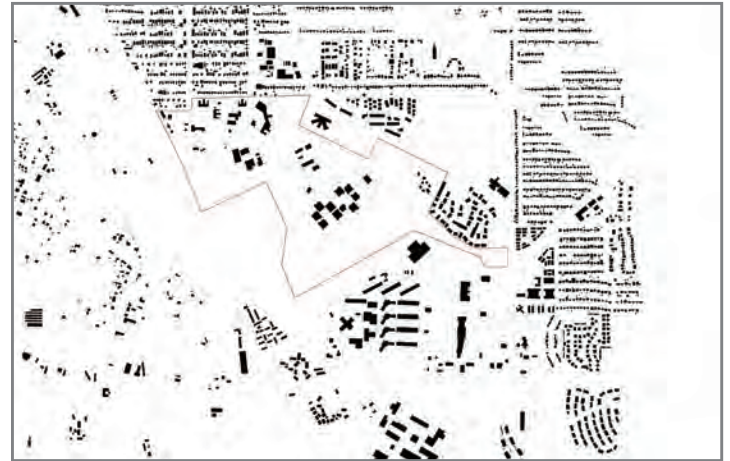
The Site in certain areas can be quite flat, but on the other hand, the topography also drops up to 200 feet steadily towards the lake. The size of the campus is rather large, offering a wide range of opportunity for a distinctive design, that can utilize its land in an adequate manner.





Site Conditions

Depicting the site conditions is crucial to how ones design will interact with the existing topography. This map shows the relationship of the sun and wind to the geographical location of the campus, water sources, and the flood plain.



Nolli Map

The Nolli Map is an old cartographic technique used to illustrate the density of the surrounding area. The black masses represent the location of buildings.



Residential / Commercial

Like the Nolli map, this map is also depicting the density of the surrounding area, but separating the masses by categorizing them as "Residential" buildings and "Commercial" buildings.



Transit Routes

Employees and family members of patients use the Via Transit system to get to the campus daily. This map shows the three main transit routes that intersect with the campus.

STRENGTH

Land Availability

- Large property.

Urban Location

- Facility is conveniently located near the center of San Antonio.

Residential Proximity

- Facility is located near residential zones which is convenient for staff members.

Existing Landscape

- Many trees and plant life are already in place.

Roads

- Roads are already in place.

Noise Levels

- Overall noise levels throughout the property are very low.

Existing Infrastructure

- Re-use of existing infrastructure.

WEAKNESS

Healthy and Accessible Food Options

- Healthy and accessible food options for staff.

Campus Layout

- Buildings are spaced very far from each other.
- Outdoor recreation spaces are located too far.

Perimeter Fence

- Large metal fence is aesthetically unpleasing.

Shaded Areas

- Lack of shade throughout the property, can be improved with:
 - Shaded pavilions + Trees

Wayfinding

- Hard to navigate through the property with the current signage.
- Facility buildings share the same color making it hard to identify them.

Wheelchair Accessibility

- Lack of wheelchair ramps/lifts.

Security

- Security levels are low.

Sidewalk & Road Quality

- Roads are in bad condition and many sidewalks are not in place throughout the site.

Old Buildings

Indoor Air Quality

- Unknown

Restroom Shortage

- Lack of restrooms throughout the facility.

O PPORTUNITY

Land Use

- Having a large property gives flexibility when designing a new facility.
- Future growth and bussiness oppurtunities

Urban Location

- Oppurtunity for collaboration with adjacent communities to enrich the facilities culture.

Pond

- Can be re-designed and used as an aesthetic feature.

Outdoor Activities

- Relocation of outdoor activities (basketball court, tennis court etc.) to a more convenient and usable space.

Road Reconfiguration

- Reconfigure roads to be more efficient.

Staff/Visitor/Patient Transportation

- Improvements to transportation within the facility.

T HREAT

Water Hazard

- Potential for patients to drown in the existing creek and pond.

Weather Exposure

- Direct exposure to heat and other weather elements.

Community Risk

- Potential for patients to escape and disturb the community.

Ligature

- Potential for patients to use items/environment to do self harm.



ARCHITECTURE: DESIGN SOLUTIONS

- Spring '18 Finalist: Serenity
- Spring'18 Finalist: Human Centered Care
- Spring '18 Finalist: Reflect a Reaction

DESIGN IDEA 1

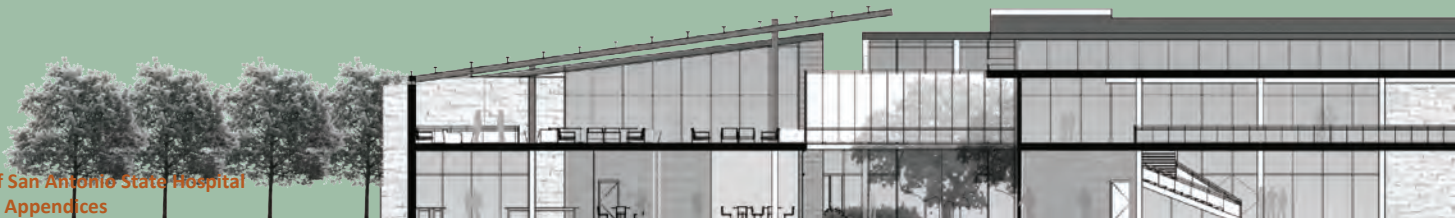
SERENITY

Christian Garcia
Rosalinda Frias

Third Year
Undergraduate

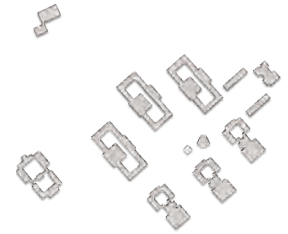


“Giving Patients a Total
Sense of Serenity through Local Artwork.

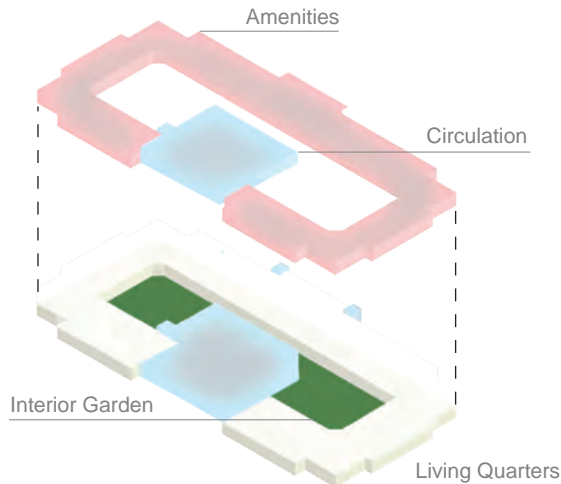
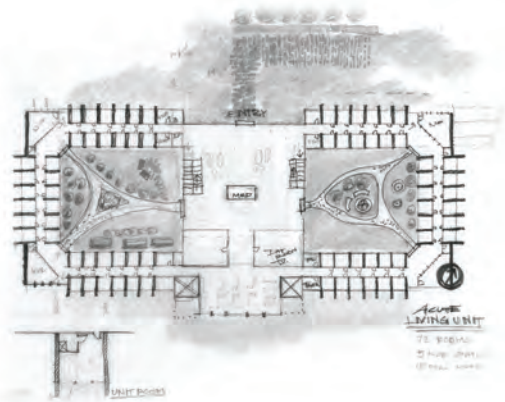


CAMPUS LAYOUT

Admin (1), Patient Services (2), Medical (3), Acute (4), Forensic (5-6), Residential (7), Geriatric (8), PICU (9), Chapel (10), Adolescent (11), Food Services (12), Maintenance (13).

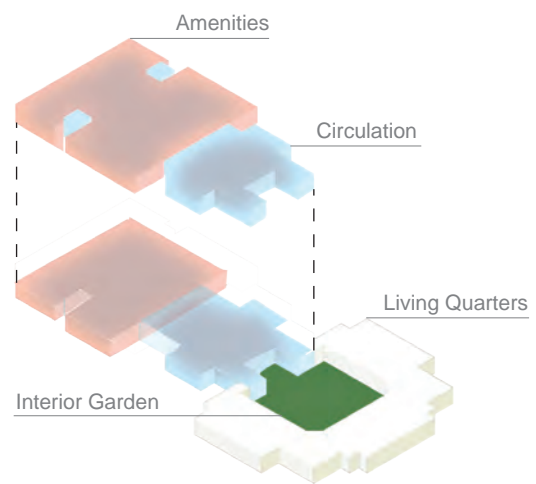
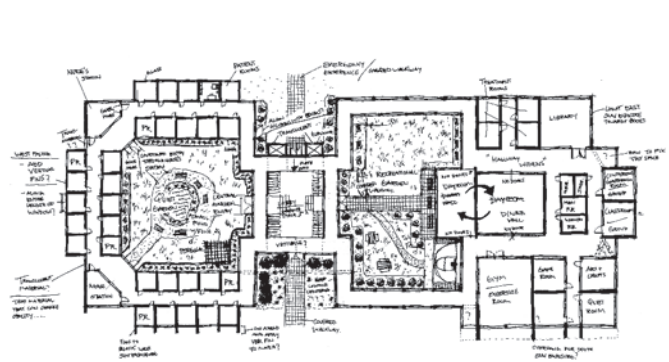


Short Term Building



The design of Serenity proposes an open campus that contains therapeutic nodes throughout the landscape. The layout of this campus was designed to suite the needs of different patient types, while keeping the majority together. The large, adequate environment allows the patients to fully immerse themselves in different activities, indoors and outdoors. This campus is intended to create a sense of place, seperate from that of a institutional environment.

LongTerm Building



Our proposed campus is divided by Short Term and Long Term living units. Both unit types were designed to house a certain number of patients. The goal of designing these units was to give the patient everything they need within their unit, eliminating the need for patients to travel across the large campus for daily services. Each living unit contains a private therapeutic garden, separate from the open campus landscape, making it easier for any patient type to experience a total sense of Serenity.

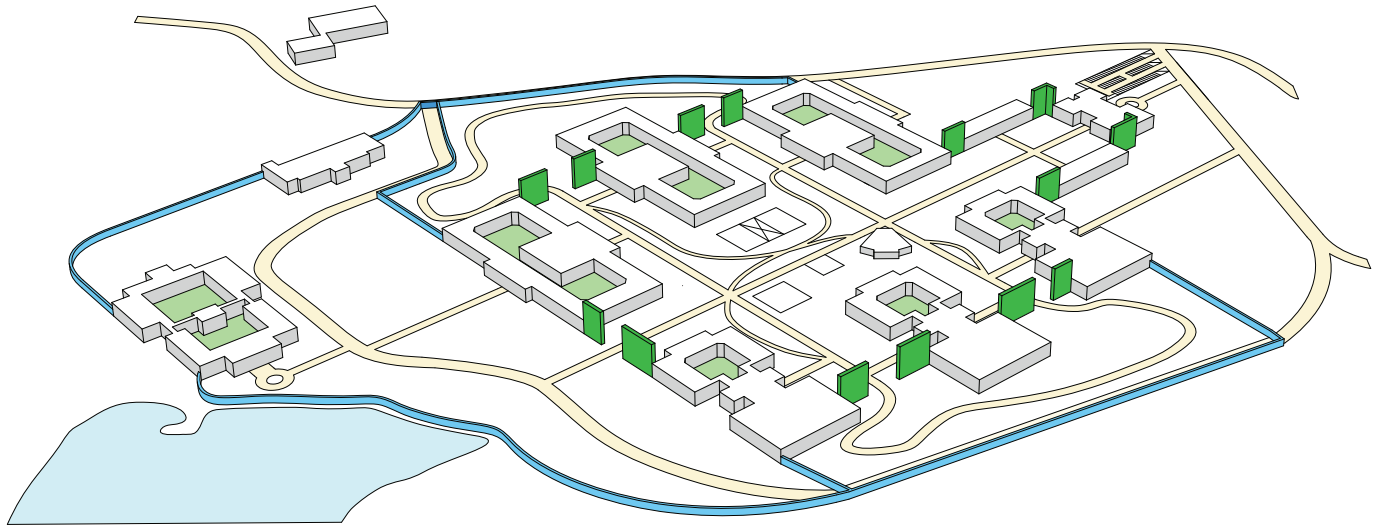
THERAPEUTIC ARTWORK

From the start, the design of Serenity posed a challenge. How do you give patients autonomy, without creating the sense of an enclosure? How can you secure the entire campus, while still allowing patients to have some freedoms?

For psychiatric patients, Art is a successful therapeutic treatment. Art can be used for self expression and to cope with emotions, with involving creative thinking, can reduce stress and anxiety. As part of the landscape and for security purposes, our design proposes Art Walls that double as gates that can enclose the campus, well before the actual property line. The Art Walls are intended for local Artists to illustrate, and engage the patients to participate.

Attached to the walls are removeable pannels that serve as the canvas for the Artwork. These panels are intended to be removed and placed at different locations throughout the campus, or taken outside the campus. This process allows the Art from SASH to be exhibited throughout San Antonio, spreading the word of SASH through the community.





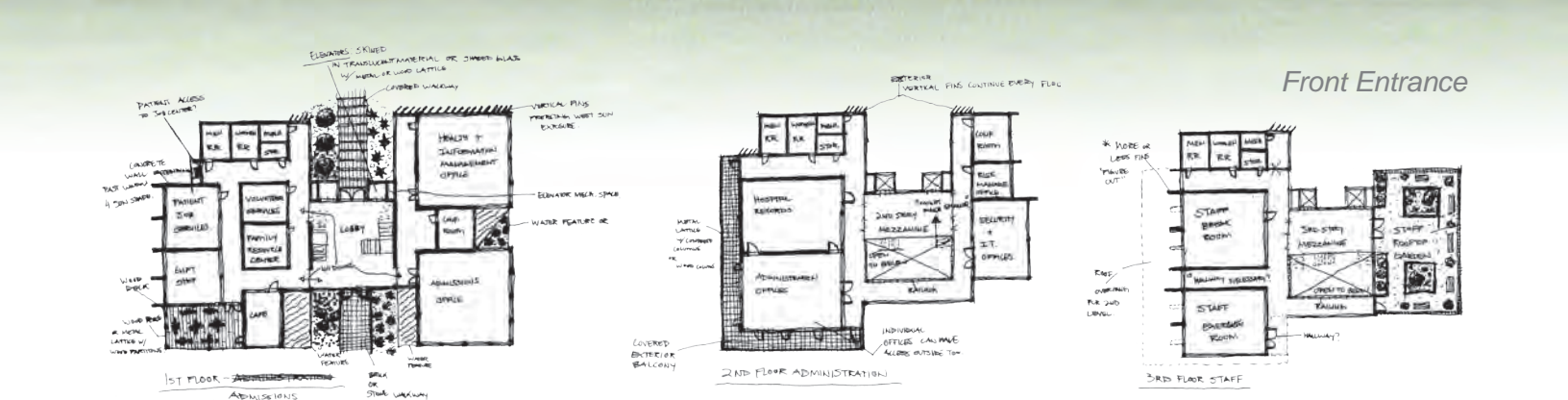
Art Wall Locations

The Art Walls allow the campus to be confined, or expanded, enlarging the therapeutic landscape.



Art Walls outside the Forensic Units.
Redesign of San Antonio State Hospital
Section VII: Appendices

Admin, Admissions, Staff Respite.



Redesign of San Antonio State Hospital

Section VII: Appendices

Third Floor: Staff Respite

- | | |
|--------------------|----------------------|
| 1. Exercise Center | 5. Storage |
| 2. Break Room | 6. Elevators |
| 3. Restrooms | 7. Rooftop Courtyard |
| 4. Mechanical | |

Second Floor: Administration

- | | |
|---------------------|--------------------|
| 1. Admin. Offices | 6. Elevators |
| 2. Hospital Records | 7. Security and IT |
| 3. Restrooms | 8. Conference Room |
| 4. Mechanical | 9. Risk Management |
| 5. Storage | |

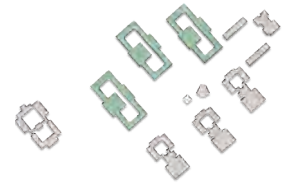
Ground Floor: Public Services

- | | |
|-----------------------|----------------------|
| 1. Lobby | 8. Mechanical |
| 2. Cafe | 9. Storage |
| 3. Gift Shop | 10. Elevators |
| 4. Job Services | 11. Admission Office |
| 5. Family Resources | 12. Conference Room |
| 6. Volunteer Services | 13. Health and Info. |
| 7. Restrooms | |



SHORT TERM LIVING UNIT

Acute and Forensic

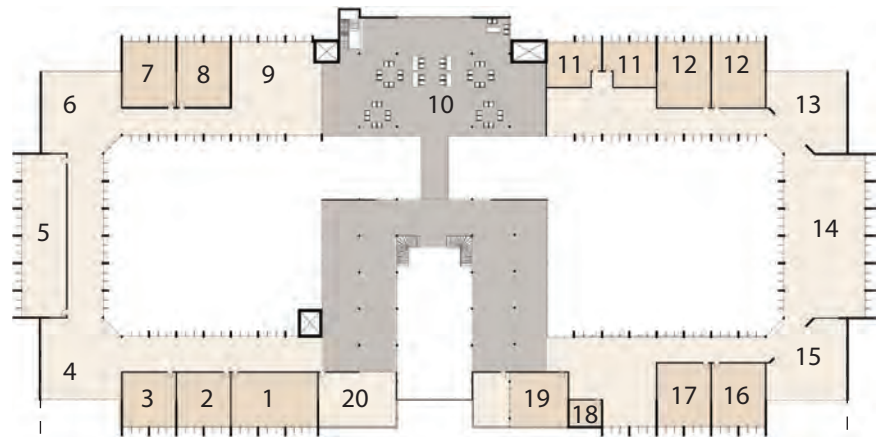


Acute Unit Therapeutic Garden



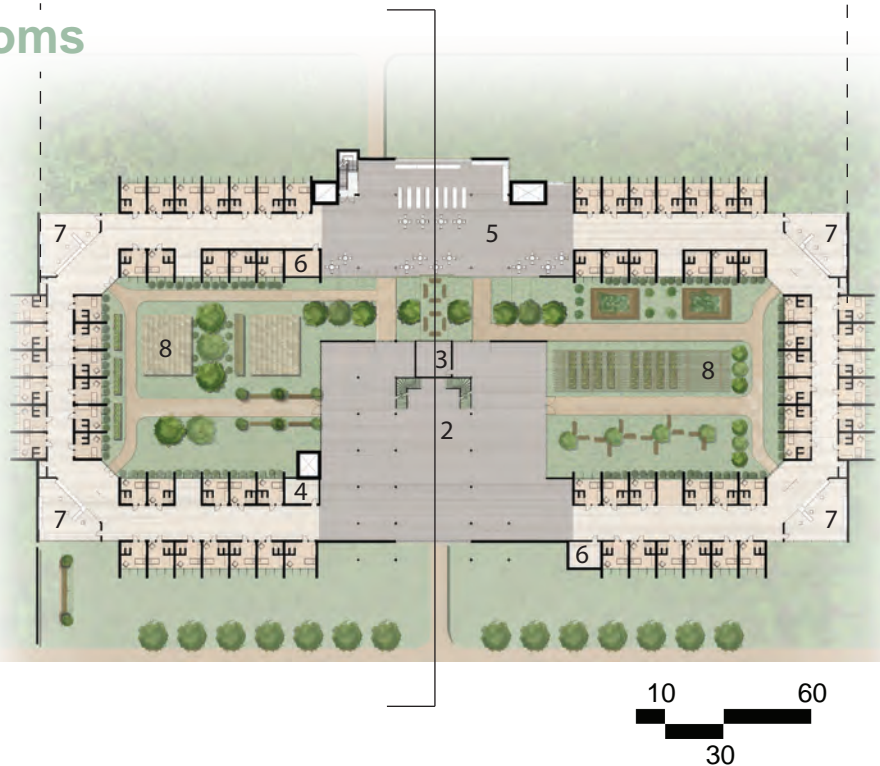
Second Floor: Amenities

- | | |
|-----------------------|----------------|
| 1. Group Therapy | 11. Restroom |
| 2. Conference Room | 12. Classrooms |
| 3. Computer Room | 13. Art Room |
| 4. Multi-Purpose Room | 14. Gallery |
| 5. Auditorium | 15. Library |
| 6. Dance Hall | 16. Yoga Room |
| 7. TV Room | 17. Meditation |
| 8. Game Room | 18. Storage |
| 9. Game Lounge | 19. Break Room |
| 10. Rooftop Courtyard | 20. Gym |



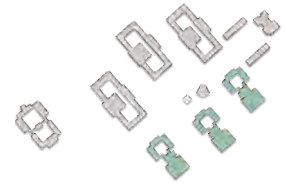
Ground Floor: Patient Rooms

1. Entry
2. Day Room
3. Medication Room
4. Multi-Purpose Room
5. Dining Hall
6. Treatment Room
7. Nurses Station
8. Therapeutic Garden



LONG TERM LIVING UNIT

Residential, Geriatric, and PICU.



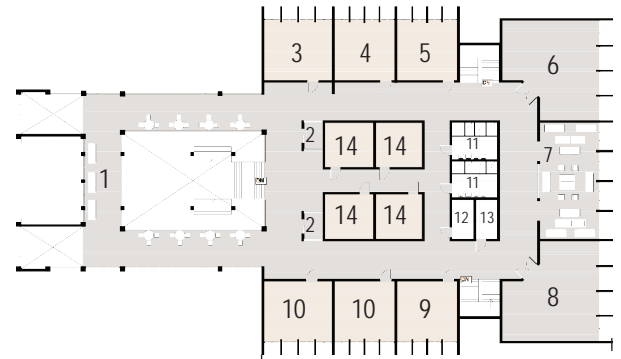
Geriatric Unit Entrance



Redesign of San Antonio State Hospital
Section VII: Appendices
Residential Unit Lobby

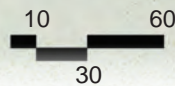
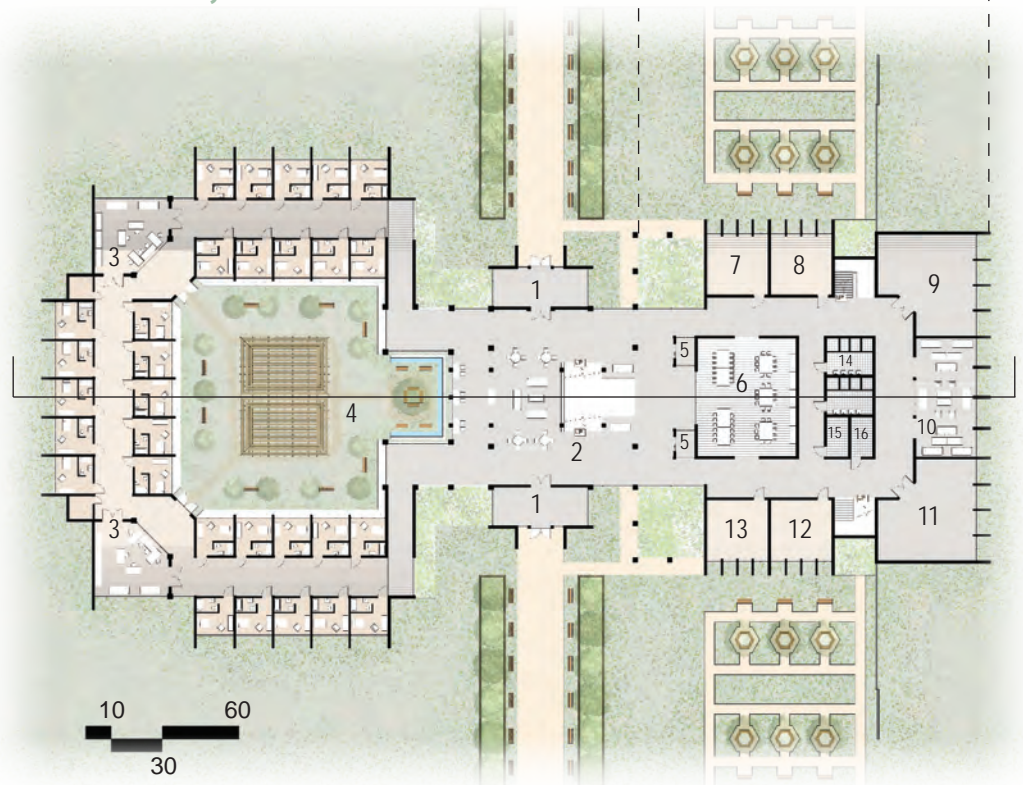
Second Floor: Calm Amenities

- | | |
|--------------------|---------------------|
| 1. Lounge | 8. Library |
| 2. Elevators | 9. Yoga Room |
| 3. Multi-Purpose | 10. Classrooms |
| 4. Conference Room | 11. Restrooms |
| 5. Computer Room | 12. Mechanical |
| 6. Art Room | 13. Storage |
| 7. Gallery | 14. Treatment Rooms |



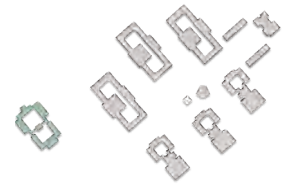
Ground Floor: Patient rooms, Recreation.

- | |
|-----------------------|
| 1. Entry |
| 2. Day Room / Lobby |
| 3. Nurses Station |
| 4. Therapeutic Garden |
| 5. Elevators |
| 6. Dining Hall |
| 7. Security Office |
| 8. Group Therapy |
| 9. Dance Room |
| 10. Lounge |
| 11. Gym |
| 12. TV Room |
| 13. Game Room |
| 14. Restroom |
| 15. Mechanical |
| 16. Storage |



ADOLESCENT LIVING UNIT

Seperate Unit For Adolescent Patients

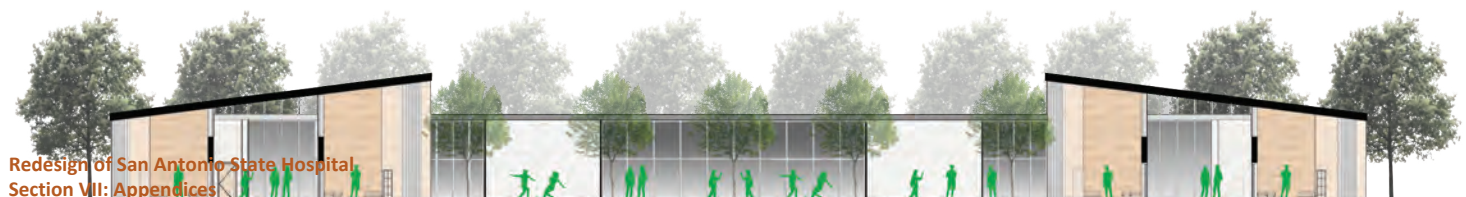
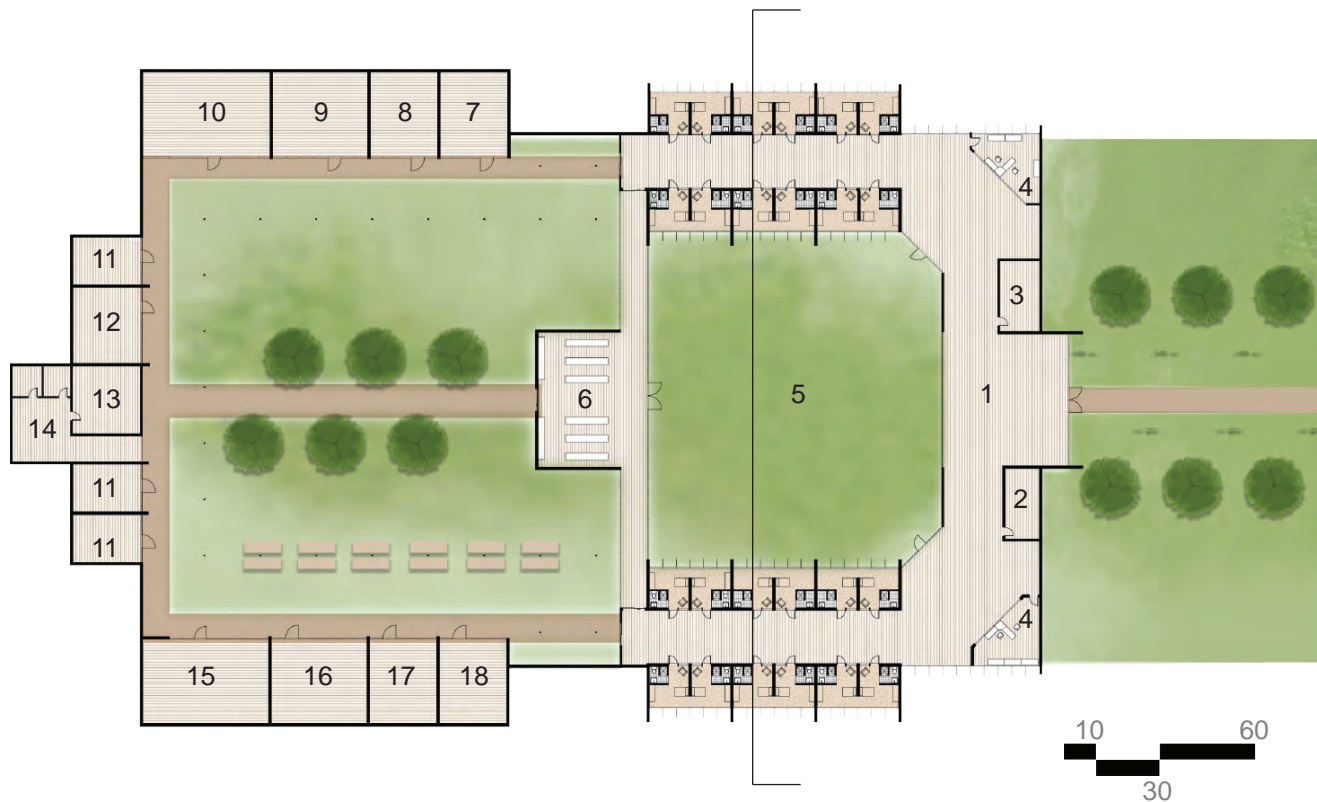


Our goal was to give the Adolescent patients a campus of their own. We designed the unit in such a way that the patients have 2, larger interior therapeutic gardens, along with a “therapy mall” connected by an outdoor walkway, in which contains all their amenities.

Above (Adolescent Recreational Garden).

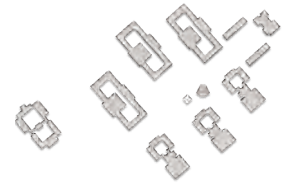
Ground Floor: Patient Rooms and Amenities

- | | | |
|----------------------|-------------------|--------------------|
| 1. Day Room | 7. Art Room | 13. Doctors Office |
| 2. Family Visitation | 8. Game Room | 14. Restroom |
| 3. Multi-Purpose | 9. Game Lounge | 15. Library |
| 4. Nurses Station | 10. Gym | 16. Quiet Lounge |
| 5. Quiet Garden | 11. Therapy Room | 17. Classrooms |
| 6. Dinning Hall | 12. Group Therapy | 18. TV Room |



SPIRITUAL CENTER

Place of Prayer.



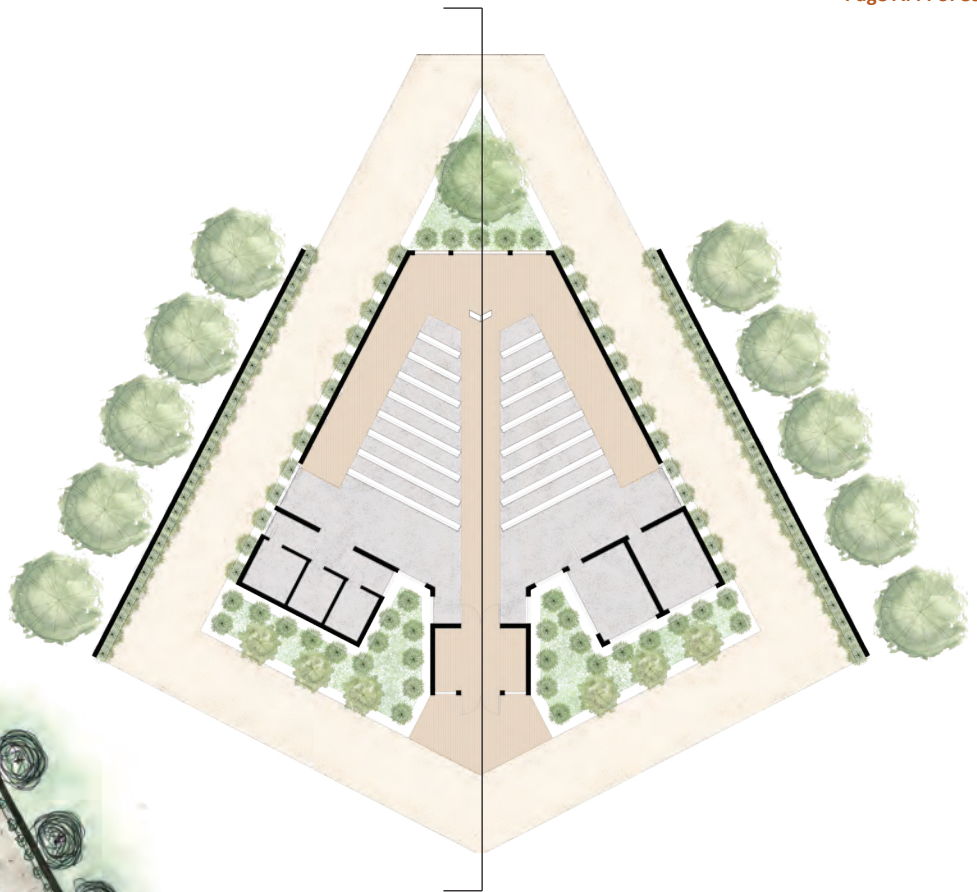
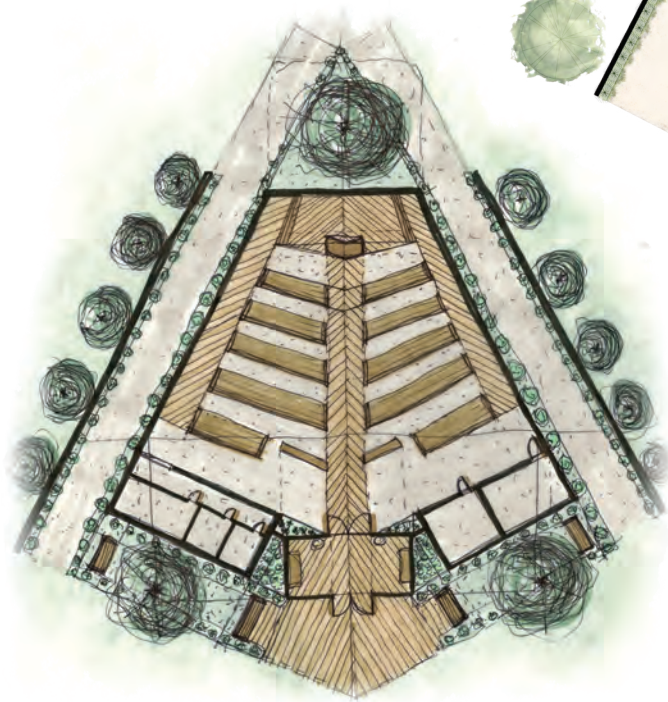
The Serenity Spiritual Center creates a sense of place, designated for the patients to come and reflect on their well being. In relation to its purpose, the exterior of the building is polished to the point of reflectance. Above

(Northern Facade)

Redesign of San Antonio State Hospital
Section VII: Appendices

Ground Floor: Chapel

1. Entry
2. Pews
3. Restroom
4. Storage
5. Mechanical
6. Multi-Purpose
7. Office



DESIGN IDEA 2

HUMAN CENTERED CARE

Joe Valadez
Katia Barrios

Third Year
Undergraduate

“Functionality Through Form”



CAMPUS LAYOUT

Administration (1), Welcome Center (2), Visitor Parking (3), Acute (4),
Geriatric (5), Residential (6), Adolescent (7), Forensic (8),
Therapy Mall (9), Medical Unit (10).



Service Roads

The Service Roads were designed to surround the campus, providing the staff or emergency personnel with easier access to the patient's units.



Interior Courtyards

The Campus has a strong emphasis on interior courtyards, which are created and secured by the buildings themselves.







FUNCTIONALITY THROUGH FORM

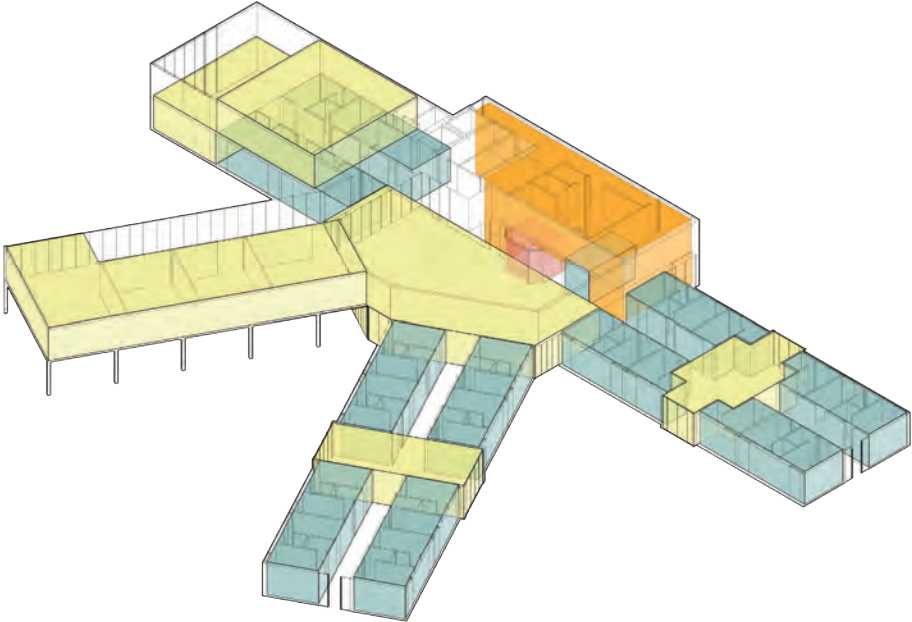
In response to San Antonio State Hospital's (SASH) proposal to replace their current outdated facilities with a "Patient-Centered Care" model, we proposed a "Human-Centered Care" physical and natural environment. This model not only responds to patient's health and well being, but also considers staff to be just as important.

After extensive research on Psychiatric healthcare, we incorporated our findings into the development of a new campus that utilizes nature as a therapeutic tool. We found that allowing more patient autonomy, paired with connections to nature aids the recovery process. We developed a modular unit that could be adapted to meet the needs of all patient types. The unit is designed to offer ample natural light, including a view of the outdoor environment in all patients' rooms. This form also allows for a clear line of sight from a single, centrally located nursing station to all patient areas.

Behind the nurses station is the "Staff Wall", which creates a separation of patient and staff space. By arranging the units with the staff wall facing the service road, our design provides emergency services easy access to each unit. The use of fences and gates could potentially create a "prison-like" setting, so our design proposes grouping the units together. This not only encloses the campus in a more "Human-Centered" manner, but also creates secure, outdoor courtyards for the patients to enjoy.



-  Nurses Station
-  Staff Wall
-  Common Area
-  Patient Rooms

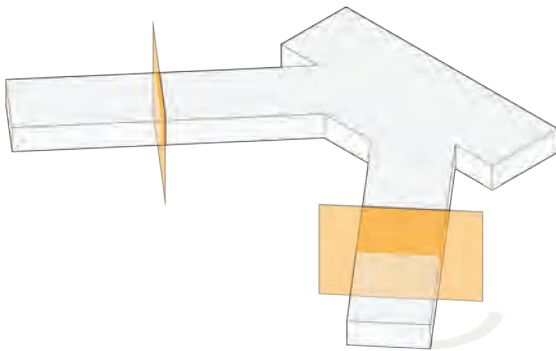


FORM DEVELOPMENT



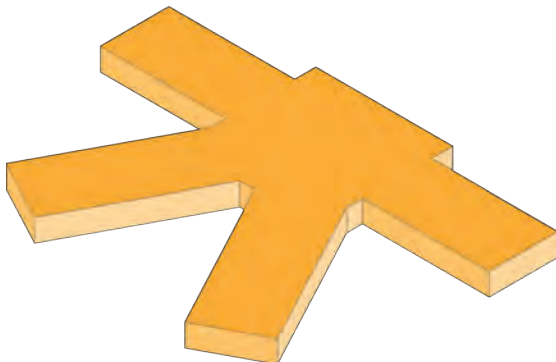
U - Shape

This Initial Form utilizes two main corridors, each being monitored by their own nursing stations. The nursing stations are connected by a staff wall, within the central space contain the patient amenities.



V - Shape

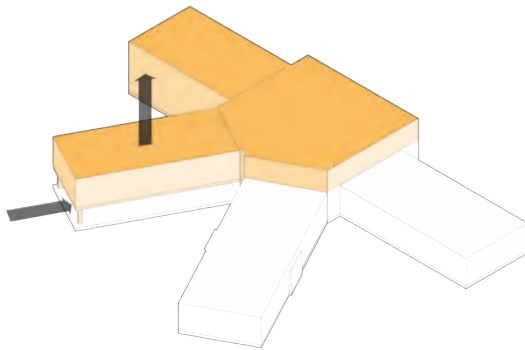
The Initial Form was altered for the use of one nursing station. This design resulted in creating long corridors along with implementing an unnecessarily wide footprint on the site.



K - Shape

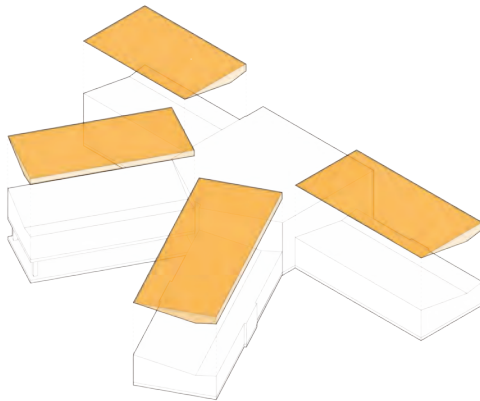
By splitting the V-Shape corridors in half and adding them to the sides, this design creates a form that has short corridors with complete sight-lines from the central nursing station.

K-SHAPE DEVELOPMENT



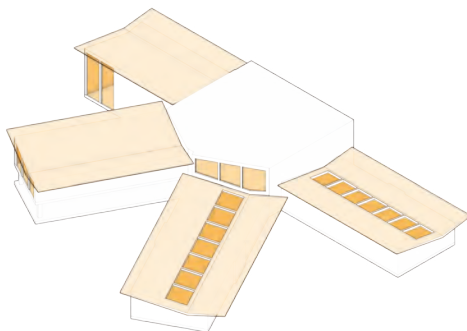
Entrance

The Entrance was created by raising a wing up to a second level, creating a covered area of entry, while providing a shaded space for patients to enjoy when outside.



Roof

Creating a Butterfly roof softens the overall size of the building, while creating the sense of a home like unit.



Natural Light

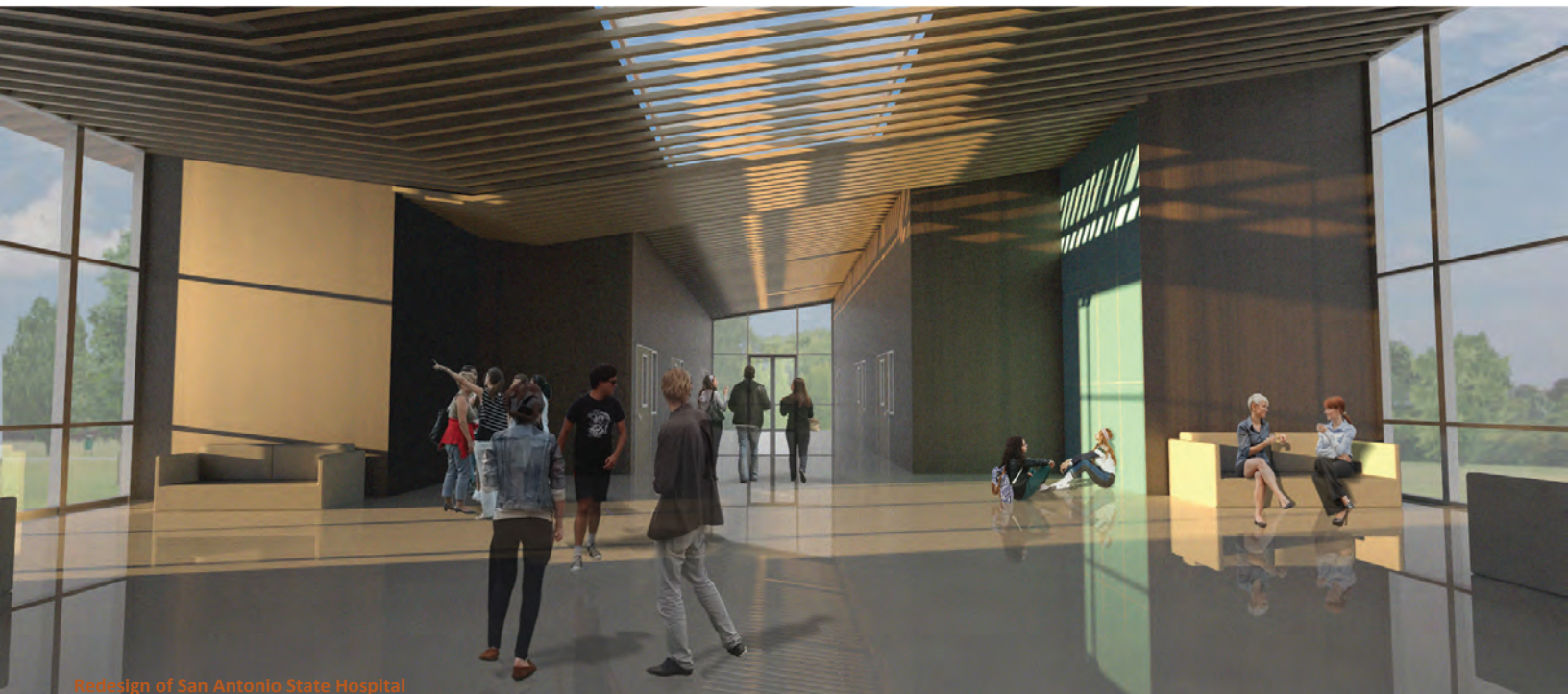
The butterfly roof utilizes “skylights” that bring natural light into the corridors. Larger windows are placed in common areas to help naturally illuminate high traffic areas.

K-SHAPE LIVING UNIT

Acute, Residential, PICU

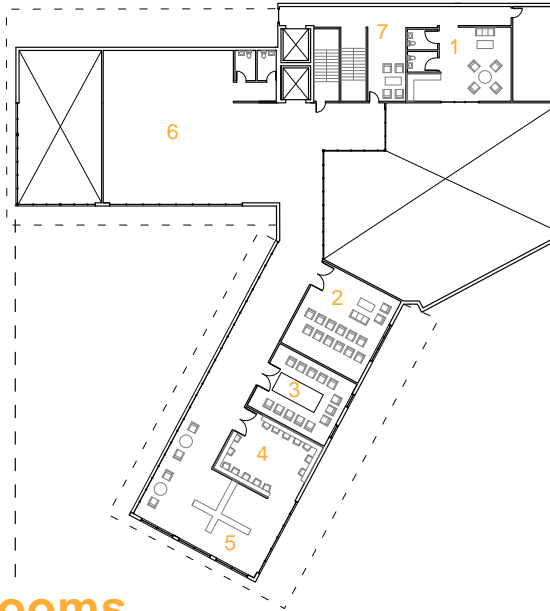


Patient Bedroom



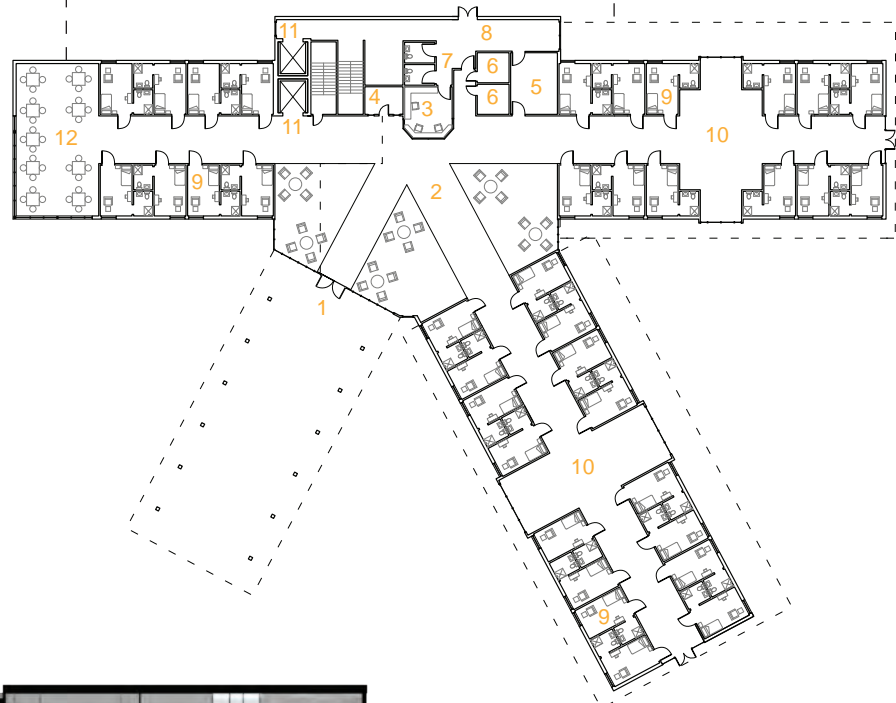
Second Floor: Additional Amenities

1. Staff Respite
2. TV Room
3. Group Therapy
4. Computer Room
5. Library
6. Multi-Purpose
7. Staff Hall



Ground Floor: Patient Rooms

1. Entrance
2. Common Area
3. Nurses Station
4. Medication Room
5. Doctors Office
6. Seclusion Room
7. Staff Bathroom
8. Staff Hall
9. Patient Bedroom
10. Studios
11. Elevators
12. Dining Hall





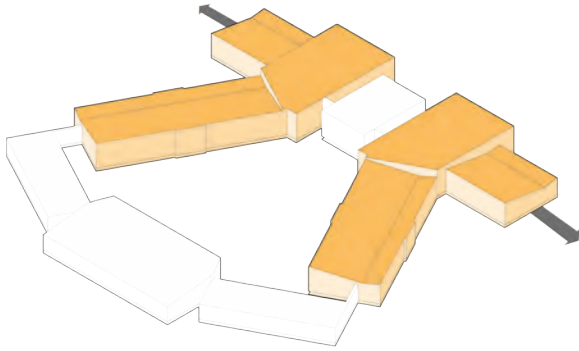
Patient Bedroom



Atrium in the Common Area

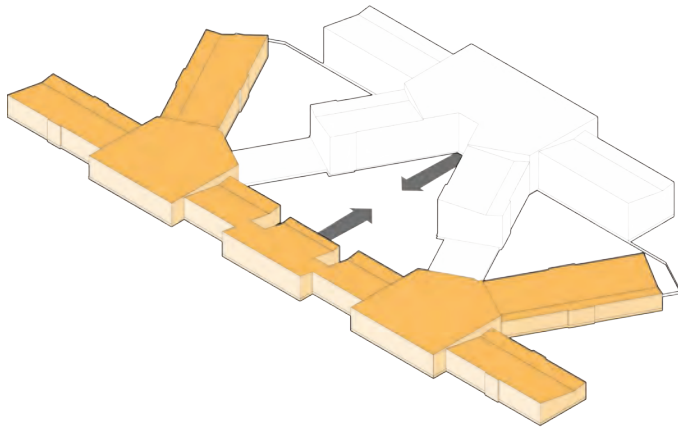


ADAPTING THE FORM



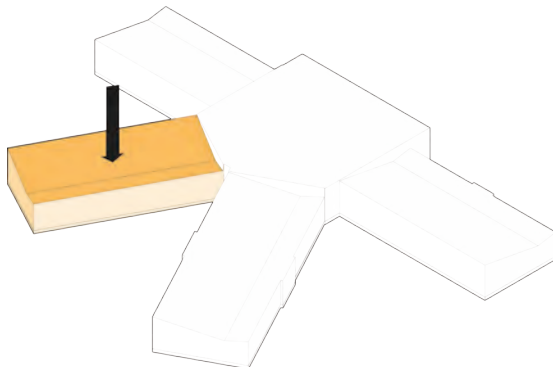
Adolescent Unit

The Adolescent Unit began with the standard "K-Shape" form. The form was then modified by being split in half, in order to create a separate wing for boys and girls.



Forensic Unit

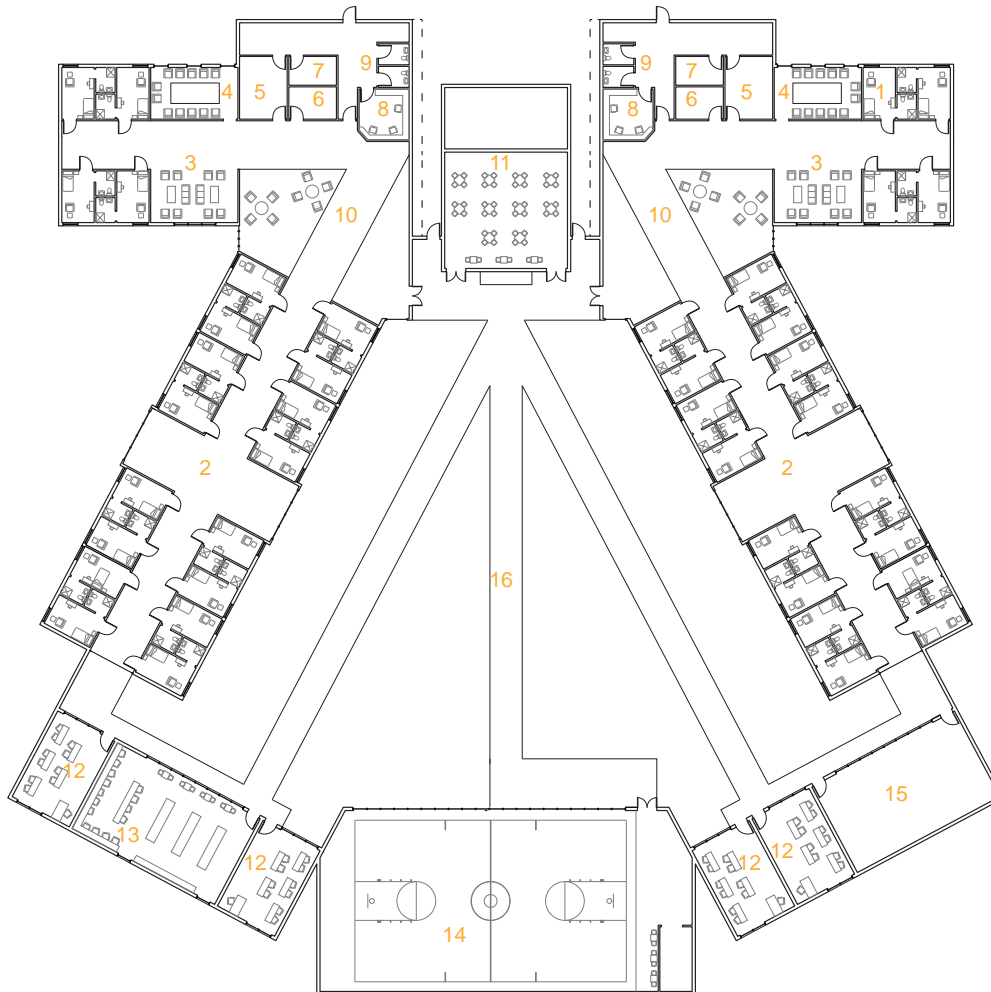
The Forensic patients are the hospital's largest demographic. With that in mind, we took 3 "K-Shape" forms and arranged them in such a way that creates an enclosed courtyard, separate from the main campus.



Geriatric Unit

The Geriatric unit uses the standard "K-Shape" form, although modified by bringing everything to a single level, ensuring that vertical circulation wouldn't be an issue.

ADOLESCENT UNIT



1. Patient Rooms
2. Studio (Common Space)
3. TV Room
4. Group Therapy
5. Doctors Office
6. Medication Room
7. Maintenance
8. Nurses Station
9. Staff Restroom
10. Day Room
11. Dining Hall
12. Classroom
13. Library/Computer Lab
14. Gym
15. Multi-Purpose
16. Enclosed Courtyard

FORENSIC UNIT



- | | | | |
|--------------------|--------------------|-------------------|------------------------|
| 1. Entrance | 7. Staff Bathroom | 13. Staff Respite | 19. Court Room |
| 2. Common Area | 8. Staff Hall | 14. TV Room | 20. Basketball Court |
| 3. Nurses Station | 9. Patient Bedroom | 15. Group Therapy | 21. Enclosed Courtyard |
| 4. Medication Room | 10. Studios | 16. Computer Room | |
| 5. Doctors Office | 11. Elevators | 17. Library | |
| 6. Seclusion Room | 12. Dining Hall | 18. Multi-Purpose | |

GERIATRIC UNIT

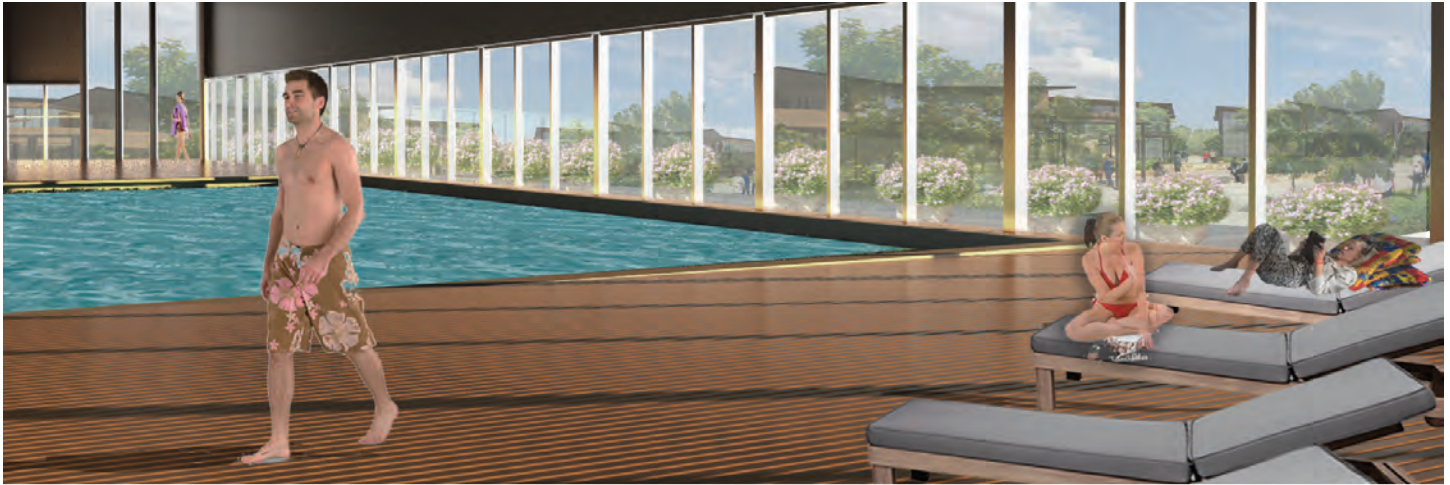


- | | | |
|------------------|-------------------------|----------------------|
| 1. Entrance | 6. Library | 11. Staff Restroom |
| 2. Studios | 7. Dining Hall | 12. Staff Break room |
| 3. TV Room | 8. Day Room/Common Area | 13. Medication Room |
| 4. Group Therapy | 9. Nurses Station | 14. Maintenance |
| 5. Computer Room | 10. Seclusion Room | |



THERAPY MALL

Family Visitation (1), Chapel (2), Fitness Center (3),
Pool (4), Studios (5), Basketball Court (6).



Interior Pool



DESIGN IDEA 3

REFLECT A REACTION

Robert Cabrera
Matthew Hinojosa

Third Year
Undergraduate



"A positive reaction in human health is the reflection of a well designed healing environment."



REFLECTING A REACTION

It is our hope that the South Texas population has access to a pioneering behavioral health program; one that inspires good architecture and confidence in individuals to pursue treatment. By designing a facility that ‘reflects’ the true nature of mental healthcare it is our expectation to activate a positive ‘reaction’ in treatment.

In response to Designing Healthy Places, we focused on planning and design development of an avant-garde psychiatric hospital to serve the South Texas Region. Research into evidence based practices highlighted the significance of a therapeutic and safe environment that adopts natural light and nature as healing agents. Our aim was to provide an architectural solution that embodied premium principles of mental health care and patient-centricity encapsulated many of the values research proves optimal to promote psychological wellness.

We designed the campus on axial alignments that collate building functions and subdivide patient types for safety and comprehension during an often frightening and confusing period of a patient’s life. We designed modular buildings in conjunction with color and art as wayfinding elements that enhance the building’s uniqueness and encourage pride and ownership of the units for patient and staff. Boredom is often considered as a major challenge for psychiatric patients. We designed multiple appropriately sized courtyards scaled to support a broad range of social activity. Set along the axis lines, the spectrum of these courtyards ranges from considerable social interaction to personal reflection in a small open-air setting.



Night-time render presenting the illuminated walkways of the complex, as well as the light boxes of the patient units.



Staffing Facility

Located at the entrance of the campus the staffing facility houses the administration offices, admissions building, security, and parking for employees and guests. The placement of this building offers easy navigation through the site and regulation of those who enter the grounds. It also provides privacy to the employees and doesn't interfere with patient recovery.

Therapy Mall

A centralized downtown area was necessary on the campus to provide an escape for patients who are limited in the areas they can access on the grounds. In order to create this space we gathered the essential functions that are vital to recovery in mental health. The program includes a welcome center, centralized dining facility, fitness center, pool, a street of wellness for doctors offices and a pharmacy, and the therapy plaza that focuses on patient success. The plaza sits at the heart of the mall and offers functions that promote success like an education center, data lounge, library, music therapy, rehabilitation, and indoor/outdoor therapy.

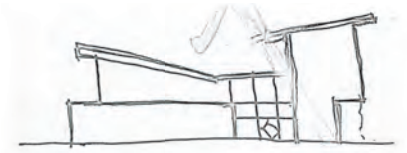
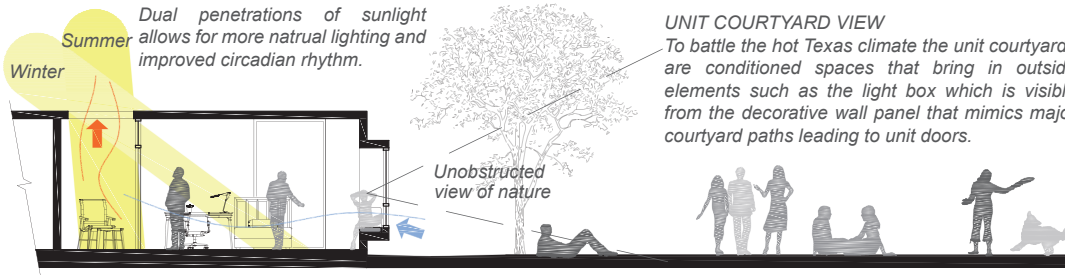
Patient Housing Units

On axis with the therapy mall is patient housing that is made up of a series on units that make up a large courtyard. Each unit consists of 18 bedrooms that can be single or shared and have auxillary functions such as a laundry room, seclusion room, group therapy, office, a medication room, and medication storage. These functions are placed at the narrowest point between two buildings so that patient privacy can be maintained; preventing an easy view into a bedroom. Each unit has an indoor unit courtyard surrounded by social areas for the residents and a nursing station that has immediate views to these patient gathering spaces and bedrooms.

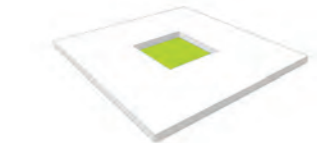
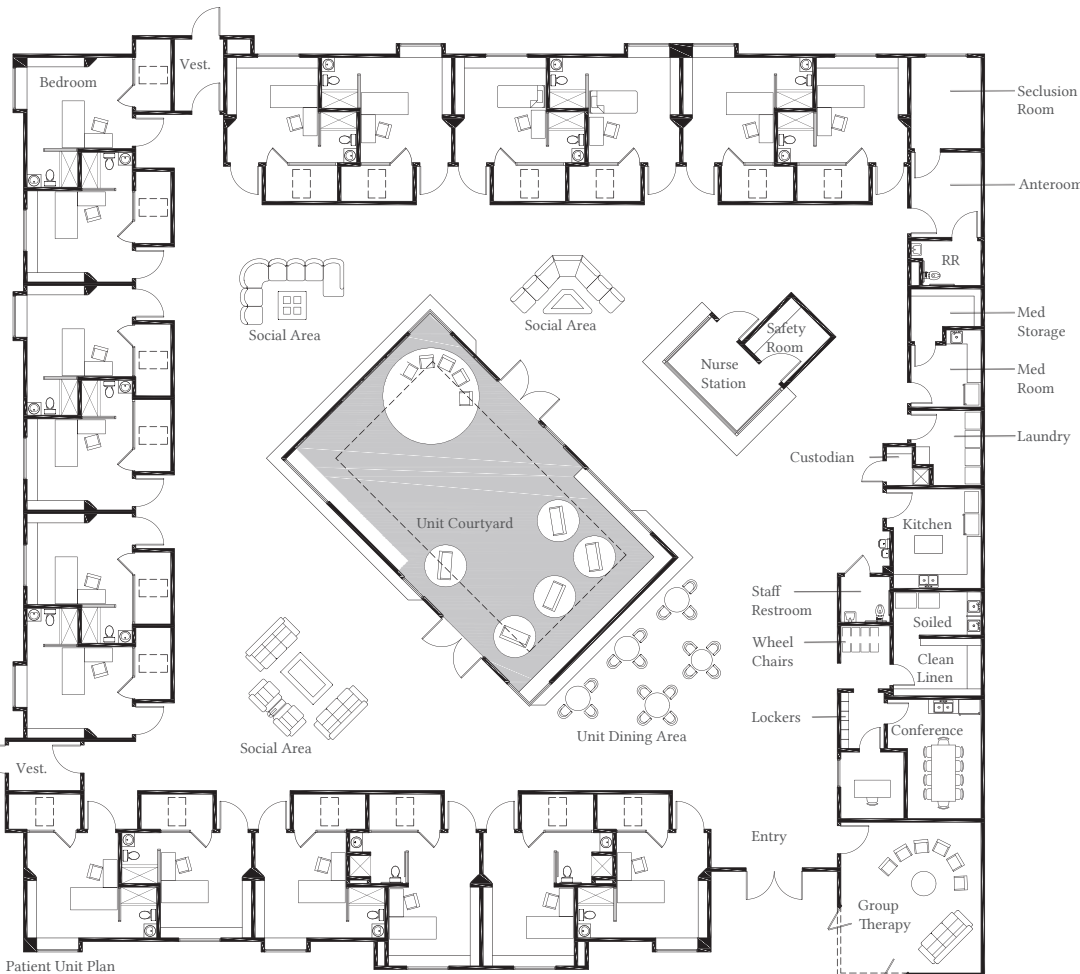


Daytime render of patient units with views of the residents and unique colors for each unit.
Redesign of San Antonio State Hospital
Section VII: Appendices

TYPICAL MODULAR PATIENT UNIT



Courtyard Approach
Landscape and Patient Centred Care



Axial Grid and Courtyard
Connection to wellness plaza
Modular units w/ Courtyard



Courtyard Thermal Comfort
Roof Lantern Feature



Volumetric Development
Landscape Development

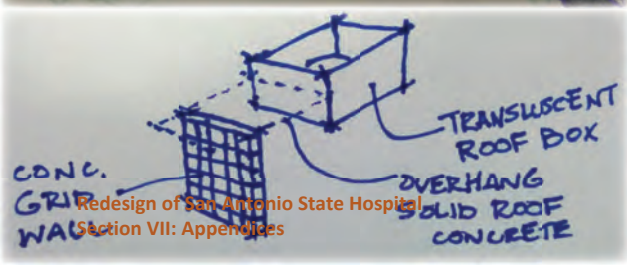
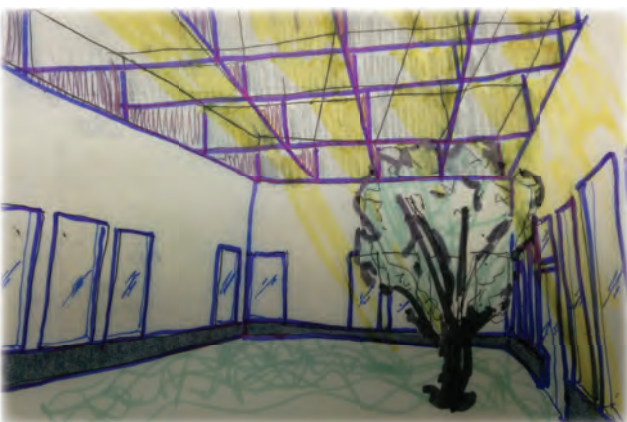


Colorful Wayfinding
Graspable Environment



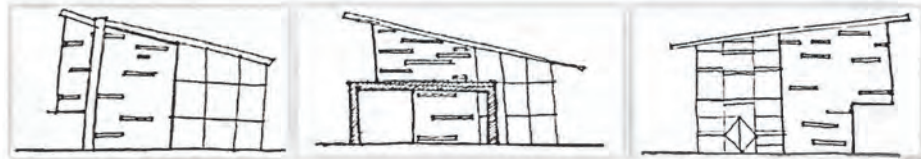
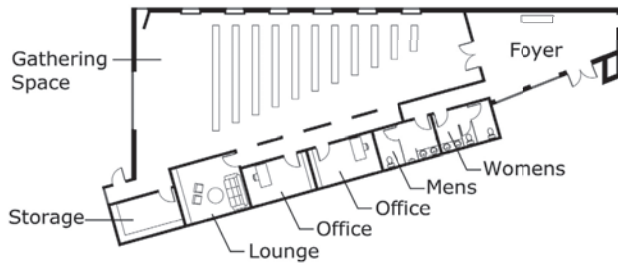


Each patient unit is distinguished by a unique pigment concrete color wall imprinted with a unique artistic work to serve as wayfinding strategies for patients and staff.



REFLECTION CENTER

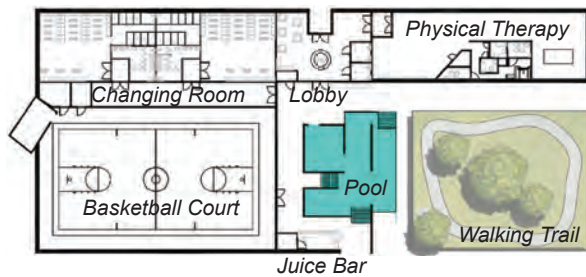
Mental wellness has proven to be dependent on a holistic approach that integrates far more proactive services than the traditional reactive illness-oriented model. The reflection center is optimized to promote patient empowerment, spirituality and reduce stress. The buildings' presence in the landscape as a breaking point in a gridded site layout convey its importance. Inside the focus is not placed on an even distribution of light, but the playfulness that reveals the space in different ways throughout the day. The experience of nature and sun are the driving forces that promote reflection in this space.



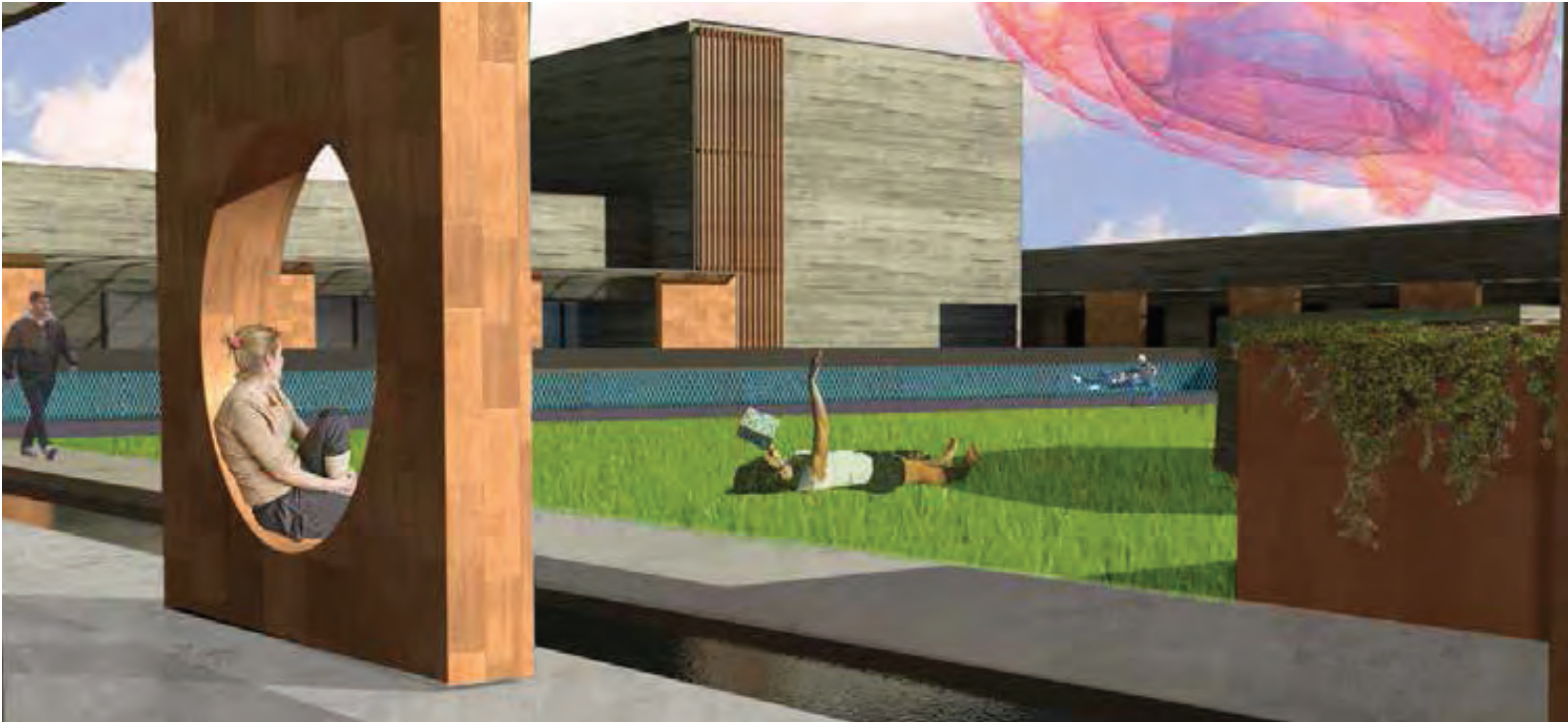
The reflection center is an essential stop before getting to the therapy mall
Redesign of San Antonio State Hospital
because of how essential it is for patients to get insight into their own mind and try
Section VII: Appendices
to overcome their illness.

RECREATION CENTER

To promote a spirit, mind, and body healing approach we recognize that the design of a fitness center is key to a mental health facility. Research shows that endorphins are released through exercise that increase happiness and support social interaction.



THERAPY MALL | WELLNESS PLAZA



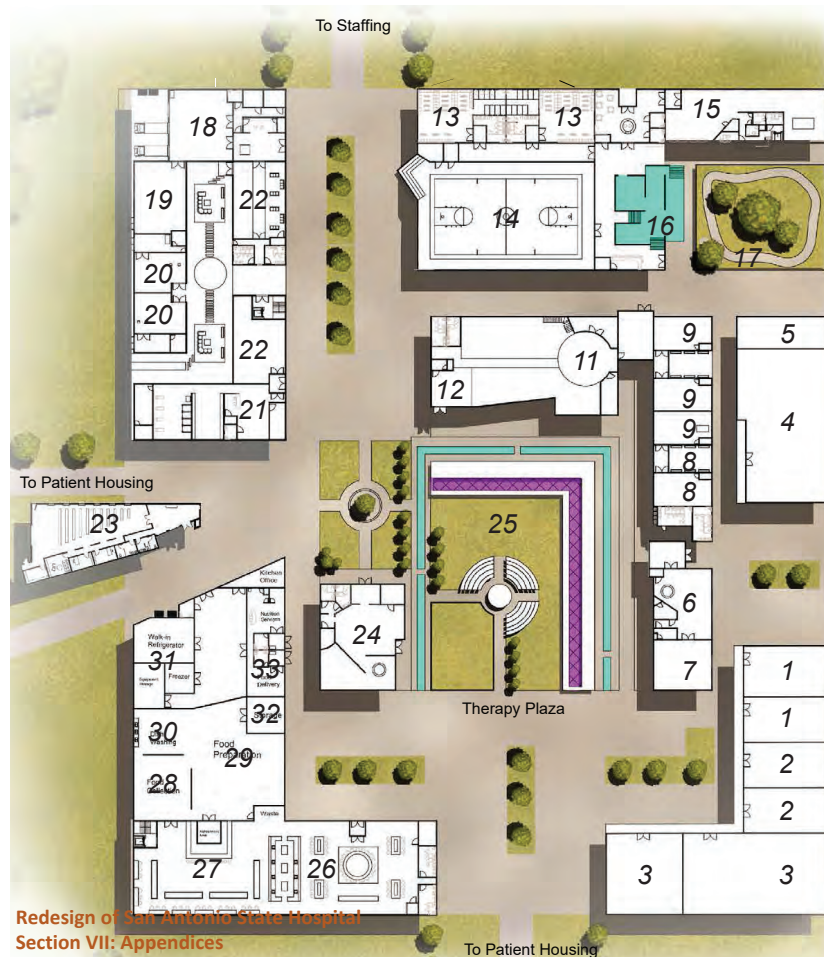
Art installation pieces, like the floating artpiece in these drawings, will be utilized in the Therapy Plaza to encourage patients to want to be in this space.

By attracting people into this area we hope patients will engage in the programmatic functions offered that are geared toward success and education.



THERAPY MALL

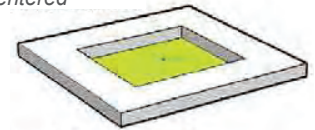
The creation of a downtown on the site allows the patients to have a space that they can visit on a daily basis. It is essential to give a landscape that promotes interaction with nature and the environment while creating autonomy, something we found in our research to be crucial in a mental health facility that implements a patient centered care model. In order to achieve this we designed our site using a layered courtyard scheme where security is enhanced through the creation of boundaries that limits the use of fencing that create an institutionalized environment. The wellness plaza is at the heart of the mall and connects the housing units. This is intended to provide a go to community setting, similar to that of regular public life, while actively engaging recovery and treatment that will allow success outside of the hospital.



Redesign of San Antonio State Hospital
Section VII: Appendices

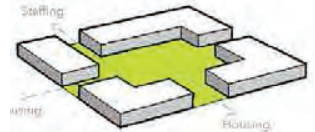
Courtyard Approach

Landscape and Patient Centered
Care



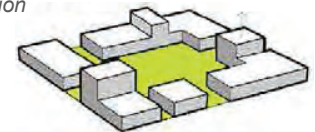
Access Through Courtyard

Connection To Housing



Volumetric Wayfinding

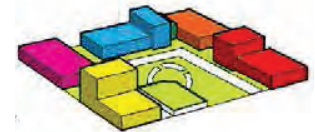
Guidance Through Elevation



Program Layout

Focus on Recovery

- Reflection Center
- Music Therapy
- Library
- Education Center
- Rehab Group
- Therapy



Creation of Community

Sense of Home



Medical

- Optometry 1
- Dentist 2
- Maintenance 3
- Pharmacy 4
- Storage 5
- Rehab 6
- Group Therapy 7

Education Center

- Adult Classroom 8
- Kids Classroom 9
- Data Lounge 10
- Library 11
- Cafe 12

Recreation Center

- Changing Room 13
- Basketball Court 14
- Physical Therapy 15
- Pool 16
- Walking Trail 17

Welcome Center

- Warehouses 18
- Donation 19
- Shops 20
- Salon 21
- Family Visitation 22
- Reflection Center 23
- Music Therapy 24
- Outdoor Therapy 25

Kitchen Center

- Kitchenette 26
- Dining Facility 27
- Food Collection 28
- Food Preparation 29
- Dish Washin 30
- Freezer/Refridgerator 31
- Storage 32
- Delivery Area 33



INTERIOR DESIGN: DESIGN SOLUTIONS

THIS STUDIO IS CURRENTLY IN SESSION AND THE STUDENTS' DESIGN DEVELOPMENT
WILL BE ILLUSTRATED HERE BY THE END OF FALL SEMESTER.

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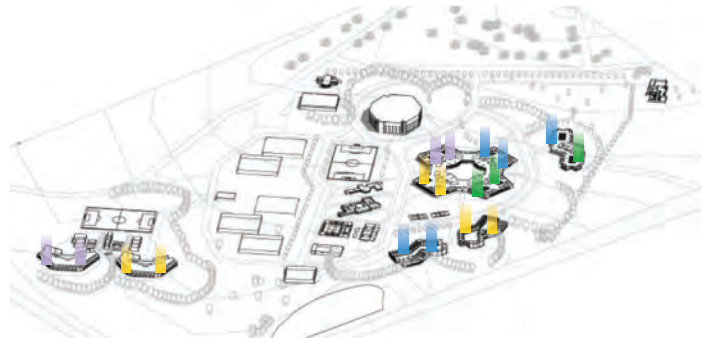
ADDITIONAL DESIGN IDEAS

01 Additional Design Idea

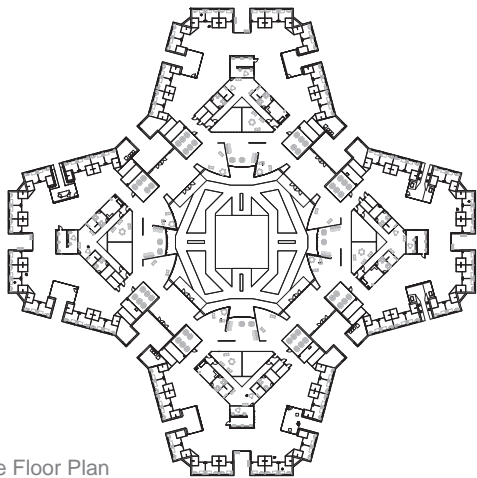
ENLIGHTENED THERAPY

Part of a Cohesive Whole.

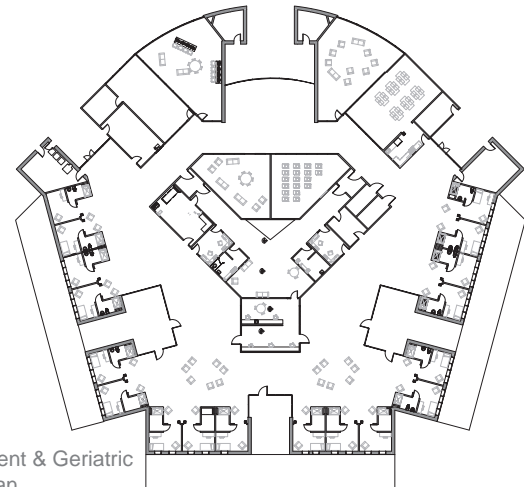
Each patient type dorm has a courtyard that not only brings the outside into the commons space, but is also geared toward creating a therapeutic environment with activities best suited for each patient type. This is achieved by combining design elements such as natural light, sound, color, texture, and smell. All together the courtyards try to embody a sense of being human in the world by connecting patients to the natural elements; water, sun/sky, earth, and wind.



Isometric Site Plan



Acute Floor Plan



Adolescent & Geriatric
Floor Plan



Sky Dorms - Adolescent, Longterm, & Acute

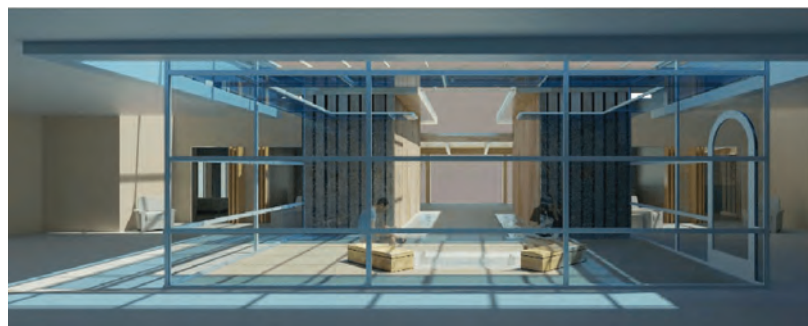


Relaxing Therapy Courtyard - Adolescent, Longterm, & Acute

Designers: Carlos Rodriguez-Ramirez & Christian Conley



Water Dorms - Geriatric, Longterm & Acute



Calming Therapy Courtyard - Geriatric, Longterm & Acute



Earth Dorms - Geriatric & Acute



Refreshing Therapy Courtyard - Geriatric & Acute



Energetic Dorms - Adolescent, Longterm, & Acute



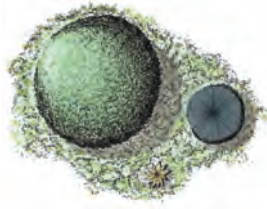
Creative Therapy Courtyard - Adolescent, Longterm, & Acute

02 Additional Design Idea

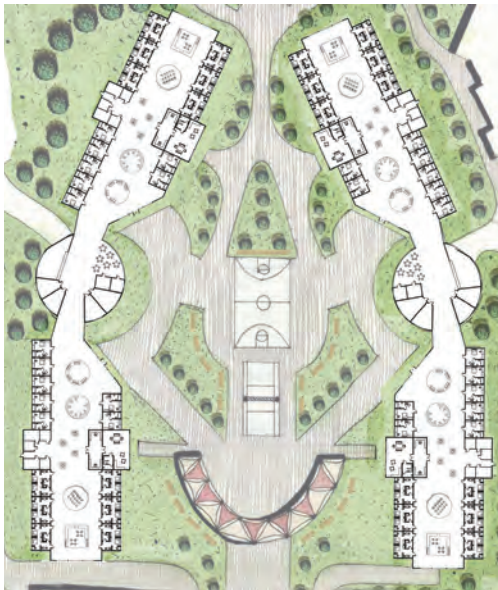
HOPE GARDEN HOSPITAL

Therapeutic Scenery

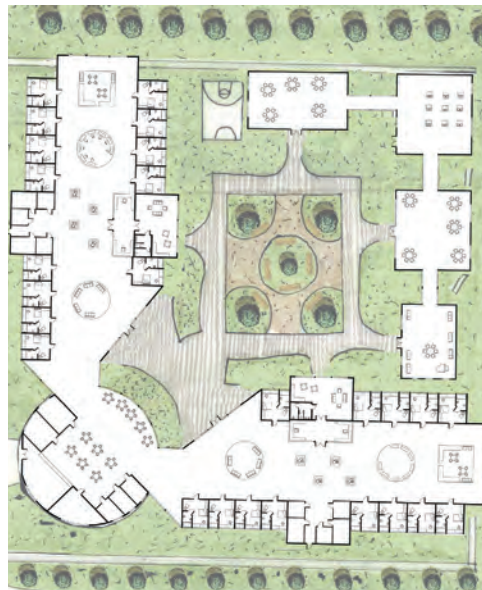
Previous research has proven that exposing patients to nature is one of the most important aspects to positively impact their mental health recovery process. Our design solution proposes a campus-like facility with great Attention to landscape where patients are separated According to their particular Health needs and security levels.



Campus Site Plan



Acute Units



Adolescent Unit



Forensic Units



Adolescent Unit



Designers: Zayra Rico & Eduardo Lopez



Entrance Building, front Facade

The **Circular Element** of each unit houses patient's dining rooms, staff and maintenance crews' entrances, as well as entry for emergency services. By having this similar circular feature in every unit, patients are able to become aware of their surroundings, and recognize the function of the building.



Recreation/Spiritual Center & Auditorium ramp



Single Patient Bedroom



Geriatric Courtyard



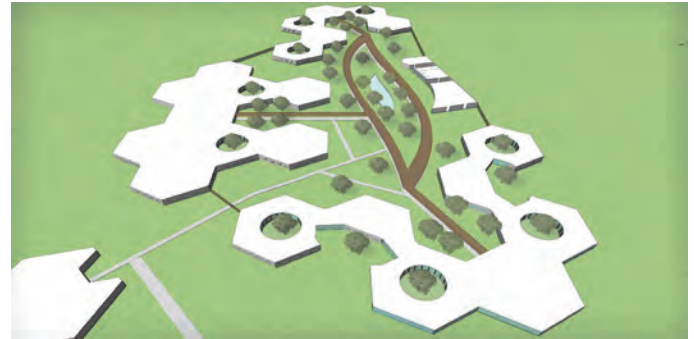
View from Nurse's station

03 Additional Design Idea

HEXAGONS FOR HEALING

A Modular Campus

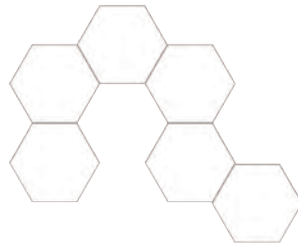
The design of this campus derived from the simplicity of the Hexagon. With six even sides, and parallel faces, this shape was the perfect candidate for SASH's program. This design provides ample spaces throughout the campus, while creating a unique environment through the use of a Modular layout.



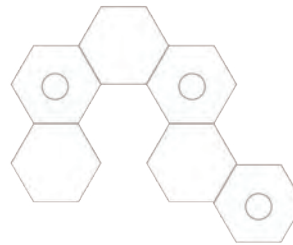
Isometric Site Plan



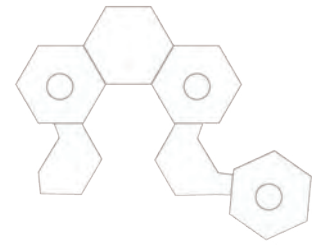
Single Hexagon for Lobby/Public Space.



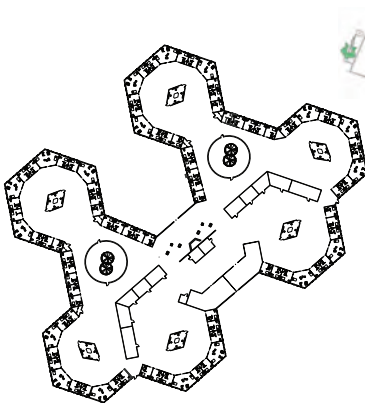
Add Hexagons in relation to Program.



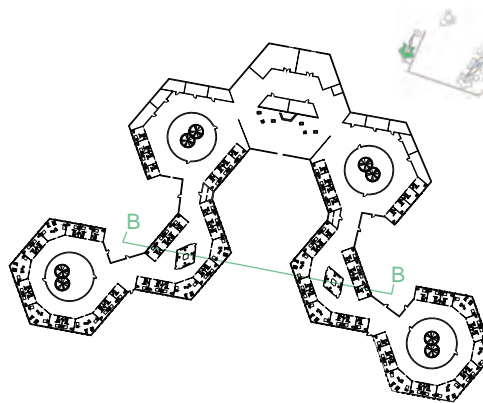
Introduction of Interior courtyards for Light and Biophilic design.



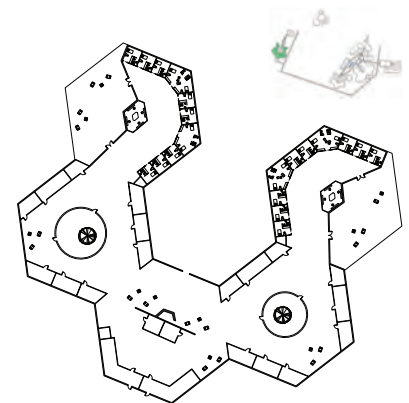
Modified walls refine the interior space and shape Exterior courtyards.



Forensic



Geriatric & Long Term



Adolescent

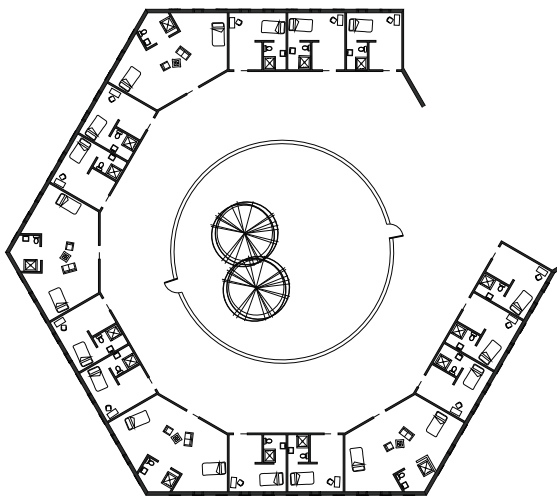
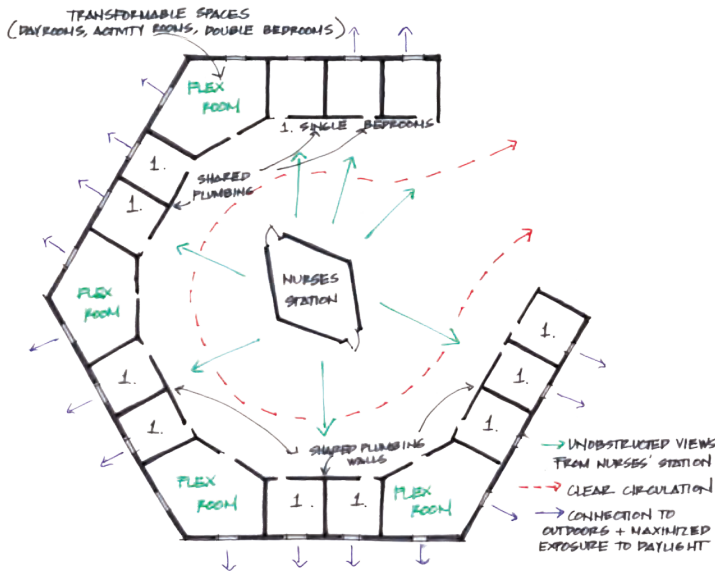


Designers: Christie Thompson & Andi Poore

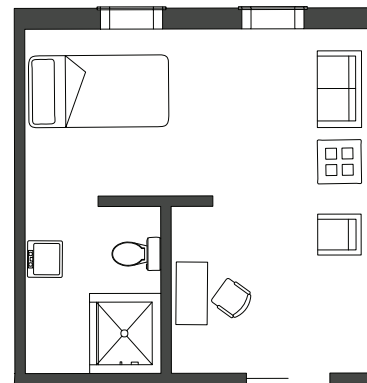
Shaping Sight-lines

We discovered that the Hexagon Shape was an ideal form for having ample sight-lines. The form allows the organization of “Pods”. These Pods are designed in multiple configurations.

For example a centrally located nurses station or interior courtyard, surrounded by double or single patient rooms. Within a Pod, a centrally located nurses station can monitor all the patient rooms, and their day room, allowing for a safer environment for all. Within a Pod containing a central interior courtyard, patients have the autonomy to enjoy a outdoor courtyard, without leaving their unit.



Unit with central Courtyard



Single Patient Room

NEXT PHASE

- SASH Semi-Structure Interview
- Behavioral Observation/Mapping

INTERVIEW QUESTIONS

STAFF

1. What is your name?
2. What is your position at the hospital?
3. How long have you worked at your current position?
4. What are your responsibilities?
5. What is your typical day like?
6. Does the design of this building afford staff's safety?
 - a. Yes-- What are the architectural conditions that make you feel safe?
 - b. No-- How do you think the building could have been designed differently?
7. Does the design of this hospital
 - a. Make your job easier in anyway?
 - b. Make it more difficult for you to tend your daily responsibilities?
8. Are there specific architectural features that contribute to your answer to question 7?
9. Is there a place designed specifically for staff to unwind and relax? (example of these places could be a music room, a meditation room, a place for exercise and yoga)
 - a. Yes-- What does these places offer and how often do you use them?
 - b. No-- Should these spaces be provided? If yes are there any types of activities you would like to have access to or would you prefer just an accessible breakroom per unit?
10. What do you think are the advantages of the design of this hospital?
11. If you could make any changes in the design of this hospital, what would you change and why?
12. What do you think is the most important way that architects can help to improve your daily experience?
13. Do you have direct interaction with patients?
 - a. No-- move to question 18
 - b. Yes-- All patients or specific demographic? What does that intel?
14. How and in what ways do you think the physical environment and design features can influence patients' health and wellbeing?
15. Based on your experience, does the design of the hospital provide opportunities for patients to be involved with their own recovery?
 - a. If yes, how?
 - b. If no, how do you think that could change?
16. Tell me about some of the design features of the hospital that addresses both individual and group needs of patients? (for example: allow for opportunities of various interaction levels, protects against social isolation while at the same time consider the sense of privacy for participants)
17. Do you think the spatial layout of this building provides opportunities for patients to:
 - a. Have spontaneous interactions with one another?
 - b. Be in control of how much and for how long they like to be involved in an activity?
 - c. Have access to space and control over where they go?

INTERVIEW QUESTIONS

PATIENTS

18. Does the design of this hospital provide patients with any opportunities for multisensory activities?

19. I will give you a word and I like you to tell me how it works at this hospital and if you would make any changes to its design:

- a. Egress and Ingress (patients and ambulance entrance, staff entrance to campus and building)
- b. Security (video cameras, locks, fence,...)
- c. Admission
- d. Pharmacy and drug dispensing
- e. Laundry
- f. Outdoor shading
- g. Colors

20. What do you think is the most important way that architects can help to improve patients' experience?

21. If you could make any changes to the design of this hospital, what would you change and why?

22. Is there anything that you like to add?

1. What is your name?

2. How old are you?

3. How much time do you spend in this building (how long have you been here)?

4. Can you tell me what your typical day is like?

5. How do you like your room?

6. Do you have a roommate?

- a. Yes-- How do you feel about having a roommates?
- b. No-- Would you like to have a roommate and why?

7. How do you spend your time in your room?

- a. Does the design of your room prevent you from any activity you like to do?

8. Where (which space or room) do you usually get together for group activities?

9. What are your favorite activities to do?

- a. Where is your favorite place in this building (on this campus)?
- b. What do you like most about this space?

10. How often do you interact with other patients? Is that during planned or spontaneous interactions?

11. If you could change anything about this building (campus) what would it be and how would you change it?

12. Is there anything else you like to address or ask me?

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Alejandra Colina

Victoria Flores

April Garcia

Chanler Kelly

Janthanee Khiewyoi

Elizabeth Lehmann

Daniela Lopez

Cindy Luevano



Appendix B: Current Admissions and Waitlist Processes and at San Antonio State Hospital

HHS's Inpatient Admissions Management

Understanding the SASH Wait List

HHS's Inpatient Management System



Overview of Inpatient Admissions Management

State Hospitals

Inpatient and Other Services Offered

ASH, EPPC, NTSH-WF, and TSH

- Adult, Child/Adolescent, Forensic Services, and IDD(ASH)

SASH

- Adult, Adolescent, Forensic, and Residential Adult Services

BSSH

- Adult, Forensic, and Residential Adult Services
- Acute and Rehabilitative Services for Veterans (via contract)

RGSC

- Adult, Forensic, and Residential IDD Services
- Outpatient Public Health Clinic

RSH

- Adult, Forensic, and Residential Adult Services
- Adult Maximum Security (males)

NTSH-Vernon

- Adult Maximum Security and
- Forensic Adolescent Services

KSH

- Transitional Adult Forensic Services (*specializing in treatment of persons found not guilty by reason of insanity*)

WCY

- Psychiatric Residential Adolescent Services





Inpatient Admissions Management

The agency manages 3 lists for pending admissions for civil and forensic inpatient services:

- 2 Forensic List -
 - Maximum Security Unit
 - Clearinghouse (non-MSU forensic)
- 1 Civil -
 - Non-forensic adults, adolescents, and children



Admissions Prioritization

1. Forensic and civil pending admissions are admitted on a first-come, first-served basis **unless** prioritization is deemed clinically necessary.
2. Clinical exceptions are reviewed and recommended by the receiving facility. Final approval for exceptions is provided by State Hospital System leadership.



TEXAS
Health and Human
Services

Forensic Admissions

Maximum Security & Clearinghouse

Maximum Security Unit (MSU) Admissions

Code of Criminal Procedure (CCP) commitments for violent offenses prescribed by statute

Persons found Incompetent to Stand Trial (IST) under CCP 46B or acquitted as Not Guilty by Reason of Insanity (NGRI) under CCP 46C


Admit to either:
North Texas State Hospital,
Vernon Campus, or
Rusk State Hospital (IST males
w/out diagnosis of ID/D)*

Violent Offenses Include

- Murder (Section 19.02)
- Capital murder (Section 19.03)
- Kidnapping (Section 20.03)
- Aggravated kidnapping (Section 20.04)
- Indecency with a child (Section 21.11)
- Sexual assault (Section 22.011)
- Aggravated assault (Section 22.02)
- Aggravated sexual assault (Section 22.021)
- Injury to a child, elderly, or disabled person (Section 22.04)
- Aggravated robbery (Section 29.03)
- Continuous sexual abuse of a young child or children (Section 21.02)
- Continuous trafficking of persons (Section 20A.03)



TEXAS
Health and Human
Services



TEXAS
Health and Human
Services

Forensic Admission Management

Clearing House


- Criminal Code commitments for non-violent offenses
- Primarily, persons found IST

Admit to a non-MSU Facilities
State Operated Facilities

Austin State Hospital	Rio Grande State Center
Big Spring State Hospital	Rusk State Hospital
El Paso Psychiatric Center	San Antonio State
Hospital	
Kerrville State Hospital	Terrell State Hospital
North Texas State Hospital, Wichita Falls	

*State Funded Facilities
Harris County Psychiatric Center
Montgomery County Hospital
Palestine Regional Medical Center

*Do not receive forensic admissions from outside State-operated hospital system



TEXAS
Health and Human
Services

Three ways Criminal Courts may submit forensic commitment information:

1. Email: ForensicAdmissions@hhsc.state.tx.us
2. Fax: 940-553-2504 or 940-553-2506
3. Phone: 940-552-4061

Based on the charge, the person will be added to either the Clearinghouse or MSU

Information Required to add forensic commitment to the Clearinghouse or MSU list

- Name
- DOB
- Gender
- Date of Commitment
- Date of Arrest
- Cause Number
- Charge
- Type of Commitment
- Committing County
- Copy of Order of Commitment



Forensic Admission

Additional Required Documentation (prior to admission)

- Indictment
- Supporting documents used to establish probable cause
- Expert reports related to competency or sanity
- Psychiatric, psychological, or social work reports
- Documents related to current or past mental condition
- Criminal History Record
- Attorney Contact information (state and defense)
 - Not Required to add a forensic commitment to the pending admissions list



Type of Forensic Admissions

Chapter 46B

- Found incompetent to stand trial (IST)
- 60 days commitments for offenses punishable as a misdemeanor
- 120 days commitments for offenses punishable as a felony
- If requested by the treating facility, the court may grant only one 60- day extension to the initial restoration period in connection with the specific charge.

Chapter 46C

- Found not guilty by reason of insanity(NGRI) and courts are maintaining jurisdiction
- Determination of inpatient, outpatient, or release
- Violent offenses referred to MSU not to exceed 30 days
- Court retains jurisdiction until the court terminates or the communitive period reaches the max provided by law for the offense to which the person was acquitted



Type of Forensic Admissions

Chapter 46B

- Found incompetent to stand trial (IST)
- 60 days commitments for offenses punishable as a misdemeanor
- 120 days commitments for offenses punishable as a felony
- If requested by the treating facility, the court may grant only one 60- day extension to the initial restoration period in connection with the specific charge.

Chapter 46C

- Found not guilty by reason of insanity(NGRI) and courts are maintaining jurisdiction
- Determination of inpatient, outpatient, or release
- Violent offenses referred to MSU not to exceed 30 days
- Court retains jurisdiction until the court terminates or the communitive period reaches the max provided by law for the offense to which the person was acquitted



Civil Admission Management

Inpatient Care Waitlist (ICW)

- Non-forensic pending admissions are managed by local mental health and behavioral health authorities via Clinical Management Behavioral Health Services (CMBHS)
- State Hospitals have viewing access only
- Patients on this list admit to either a Contracted Hospital or State Hospital
- State hospitals have internal waitlist that should coincide with CMBHS



State Hospitals Voluntary Admission

Voluntary Admission (H&S Section 572.001)

- Prospective patient must be at least 16 years of age to request admission
- Requires a signed, written request for admission*
- Requires capacity to consent
 - if no capacity to consent, the hospital may initiate an emergency detention or file for court-ordered MH inpatient services
- Parent, managing conservator, or non-CPS guardian can request admission for a minor who is under 18
- Minors in CPS conservatorship may be voluntarily admitted only if a physician states the minor is a person with mental illness or who demonstrates if a serious emotional distress or who presents a risk of serious harm to self or others if not immediately restrained or hospitalized

*Includes a statement that the prospective patient will remain in the hospital and consent to diagnosis and treatment until discharge or a request for discharge has been made



Types of Involuntary Civil Mental Health Commitments

- Emergency Detention (ED)
- Order of Protective Custody (OPC)
- Temporary Commitment (45 or 90 day)
- Extended Commitment (12 months)

Persons/professionals Involved

- Peace officers
- Admitting physicians
- Local mental health authorities (LMHA)
- Adults relatives and guardians
- Judges
- Attorneys



State Hospitals Court-Ordered Mental Health Services & Due Process

Court-Ordered Mental Health (MH) Services

- When a person becomes seriously mentally ill, temporary hospitalization at an inpatient psychiatric hospital **may** be the recommended treatment

Due Process*

- Due process of law is required
- Patients are entitled to a full trial, legal representation, and the right to cross-examine all witnesses

(Health and Safety Code, Title 7: Subtitle C: Texas Mental Health Code)

*Involuntary hospitalization is a significant infringement on a person's constitutional rights to the exercise his/her liberty



State Hospitals Emergency Detention

Emergency Detention (ED) (Chapter 573)

- Initiated by law enforcement/peace officer or guardian of *person* if prospective patient is 18 years of age or older
- Apprehending officer must have reason to believe that:
 - the person is mentally ill; **and**
 - because of mental illness there is **substantial risk** of **serious** and **imminent** harm to self or others unless he/she is immediately restrained
- Substantial risk of harm may be demonstrated by:
 - person's behavior; **or**
 - evidence of severe emotional distress and deterioration in the person's mental condition



State Hospitals Emergency Detention - Transport

Emergency Detention (ED) – Transport

- Peace officer is responsible for transport to either the nearest appropriate inpatient facility, or a facility deemed suitable by LMHA
- Guardian of *person* may transport a person 18 years of age or older to an inpatient facility *without* the assistance of a peace officer if guardian believes the ward is:
 - mentally ill; *and*
 - because of mental illness there is substantial risk of harm to the ward or others unless immediately restrained



State Hospitals Emergency Detention Cont.

Emergency Detention (ED) Cont.

- Limited to **48** hours*
- Requires preliminary examination by a physician
 - medical and psychiatric examination conducted in the presence of the prospective patient *or* via audio and televideo

* Except when that time period ends on a weekend, holiday, or before 4:00 PM on the succeeding business day



State Hospitals Order of Protective Custody

Order of Protective Custody (OPC) (H&S 574.021)

- Must be filed in county in which application for court-ordered inpatient MH services is pending
- Must be accompanied by a certificate of medical examination (CME)* no earlier than **3rd** day before day motion is filed
- Order issued if court determines**:
 - proposed patient is mentally ill; **and**
 - because of mental illness there is substantial risk of harm to self or other if not **immediately** restrained pending hearing

**Must be completed by a physician*

***Determination may be demonstrated by the proposed patient's behavior or by evidence of severe emotional distress and deterioration in mental condition to the extent he/she cannot remain at liberty*



State Hospitals Probable Cause Hearing

Probable Cause Hearing (H&S 574.025)

- **Purpose:** to determine if a proposed patient under an OPC presents a substantial risk of serious harm to self or others to the extent that he/she cannot be at liberty pending the hearing on court-ordered MH services
- Hearing must be held within **72** hours after proposed patient's detained under an OPC
- Hearing for court-ordered MH services must be held within **14** days of filing
 - continuance up to **30** days may be granted



State Hospitals Temporary and Extended MH Services

General Provisions Related to Hearing (H&S 574.031):

- Proposed patient is entitled to be present at hearing
 - patient or his/her attorney may waive this right
- Must be open to public **unless** patient or his/her attorney request a closed hearing
- Hearing for **temporary** services must be before a **judge** unless proposed patient or his/her attorney request a jury
- Hearing for **extended** services must be before a **jury** unless waived by the proposed patient or his/her attorney*
- Proposed patient must be **immediately** released if court denies application for court-ordered MH services

*Waiver of right to jury must be in writing **unless** patient or his/her attorney orally waive this right in the court's presence



State Hospitals Temporary Commitment

Temporary MH Commitment * (H&S 574.034)

- Treatment is typically authorized for no longer than **45** days (except that the judge may order a period to not exceed 90 days)
 - order may **not** specify a shorter period
- May **not** be issued for a proposed patient who is charged with a criminal offense that involved an act, attempt, or threat of serious bodily injury (SBI)

* Applies to both outpatient and inpatient commitments



State Hospitals Extended Commitment

Extended MH Commitment (H&S 574.035)

Treatment is authorized for not longer than **12** months

- order may **not** specify a shorter period

Requires:

- evidence the condition of the proposed patient will persist beyond **90** days; **and**
- that patient has received court-ordered inpatient MH services for at least **60** consecutive days in the preceding **12** months
- May **not** be issued for a proposed patient who is charged with a criminal offense that involved an act, attempt, or threat of SBI



State Hospitals Extended Commitment

Extended MH Commitment (H&S 574.035)

Treatment is authorized for not longer than **12** months

- order may **not** specify a shorter period

Requires:

- evidence the condition of the proposed patient will persist beyond **90** days; **and**
- that patient has received court-ordered inpatient MH services for at least **60** consecutive days in the preceding **12** months
- May **not** be issued for a proposed patient who is charged with a criminal offense that involved an act, attempt, or threat of SBI



References

21st Edition Texas Laws Relating to Mental Health

<http://hhs.texas.gov/services/mental-health-substance-use/state-hospitals>

Understanding the SASH Wait List

Each Local Mental Health Authority (LMHA) is responsible for managing a “Wait List” for patients who have been referred for admission to the San Antonio State Hospital. This process may vary considerably across different LMHAs. When a client is determined by local providers to need admission to SASH, the provider (or the agency for which the provider works) will contact the utilization management office of the LMHA who will place the patient on the Texas Health and Human Services (HHS) Clinical Management of Behavioral Health Services (CMBHS) centralized waitlist. The provider will also often have contact with SASH as well. The CMBHS wait list is not a rigid, “first come, first served” process. There is considerable back and forth between LMHA’s and providers in the community as to which patients get admitted; indeed, a patient may get admitted who was never on the CMBHS list. Table 1 below shows the clients admitted to SASH in fiscal year 2018 (September 1, 2017 to August 31, 2018).

Table 1. Admissions to San Antonio State Hospital by Prior Living Arrangement FY 2018

Prior Living Arrangement	Admissions#
Private Residence	274
Jail/Correctional Facility	196
Dependent in Family Home	101
Homeless/Lacking Permanent Residence	65
Personal Care/Group Home	25
Other State Hospital	13
Homeless Shelter	12
Respite	6
CPS Custody (Child Protective Services)	5
Nursing Home	5
Private Psychiatric Hospital	4
Supportive Housing	3
MH Facility	2
State Funded Comm. Psych. Hosp.	1
State Supported Living Center	1
Substance Abuse Center	1
Unknown/Not Collected/Not Available	1
TOTAL	715

The largest number of clients admitted to SASH in FY2018 were living in private residences at the time of their admission. In the Stakeholder interview process, mental health providers in Bexar County in particular were surprised by this data, as it was their impression in Bexar County that nearly all admission to SASH occurred among clients already in a free-standing psychiatric hospital, but this was rare according to Table

1. (It also possible that during data entry, the living arrangement of the patient just prior to the psychiatric hospital was used, thus the number admitted from hospitals is artificially low.)

For all the LMHA’s in the SASH catchment area, 1,674 persons were placed on the CMBHS wait list in FY 2018. They were on the wait list for an average of 4.9 days, with a range of 0 to 77 days. The modal (most common) wait was only 1 day. Clients were removed from the list either by being admitted to SASH or by improving clinically to point that they no longer require SASH services.

Table 2 on the next page shows the wait list clients by referring LMHA for FY2018. It is also broken down by the age of the client. The numbers appear to reflect

the population of the LMHA catchment area and there does not appear to be any major discrepancy in wait list times across the different LMHAs.

Table 2. Waiting List Statistics for Clients: San Antonio State Hospital, FY18

Provider/Age Type	Total WL Days	Total WL Clients	Avg. WL Days	Min. WL Days	Max. WL Days	Median WL Days	Mode WL Days
Behavioral Health Center of Nueces County*	627	61	10.28	0	52		
Adolescent	7	1	7.00	7	7	7	7
Adult	620	60	10.33	0	52	7.5	2
Bluebonnet Trails Community Services	132	10	13.20	2	33		
Adult	132	10	13.20	2	33	11.5	NA
Border Region Behavioral Health Center*	830	692	1.20	0	51		
Adolescent	10	134	0.07	0	6	0	0
Adult	820	542	1.51	0	51	0	0
Child	0	16	0.00	0	0	0	0
Camino Real Community Services	529	64	8.27	0	53		
Adolescent	27	2	13.50	7	20	13.5	2
Adult	502	62	8.10	0	53	5	2
Coastal Plains Community Center	450	29	15.52	1	77		
Adolescent	1	1	1.00	1	1	1	1
Adult	449	28	16.04	1	77	11	11
Gulf Bend Center	906	103	8.80	0	64		
Adolescent	8	1	8.00	8	8	8	8
Adult	898	102	8.80	0	64	4.5	1
Hill Country Mental Health & Developmental Disabilities Centers	1,387	225	6.16	0	51		
Adolescent	42	7	6.00	1	13	4	2
Adult	1,334	216	6.18	0	51	6	0
Child	11	2	5.50	1	10	5.5	NA
The Center for Health Care Services	3,149	333	9.46	0	58		
Adolescent	527	97	5.43	0	58	2	1
Adult	2,588	233	11.11	0	49	8	0
Child	34	3	11.33	5	22	7	NA
Tropical Texas Behavioral Health	179	157	1.14	0	24		
Adolescent	125	108	1.16	0	24	0	0
Adult	54	45	1.20	0	12	0	0
Child	0	4	0.00	0	0	0	0
Grand Total	8,189	1,674	4.90	0	77	1	0

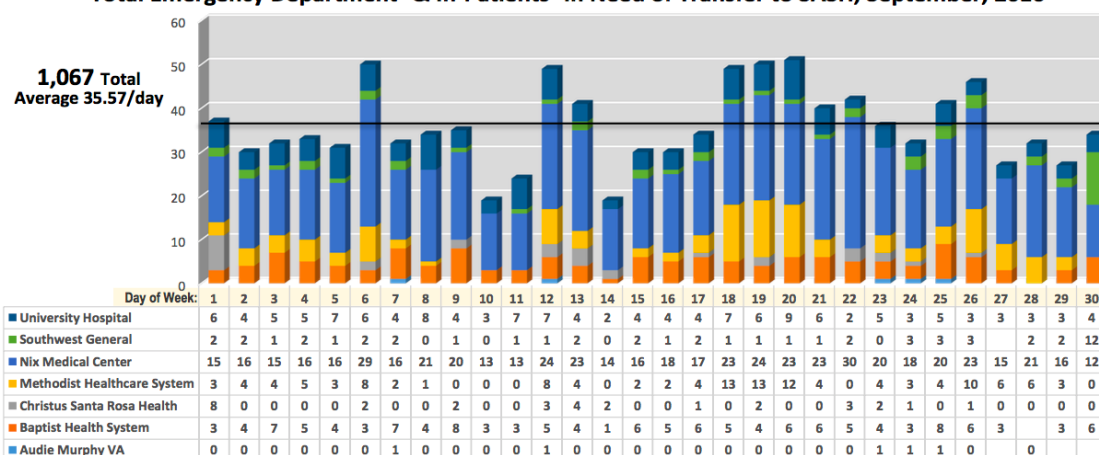
As noted in section II (Stakeholder concerns, Access to Care), there is an informal system by which a variety of stakeholders advocate for an admission of a given patient to SASH. While SASH has a maximum of 302 beds there are only about 70 beds available to serve civil patients for 61 counties. This means that it is extremely difficult to get a patient into SASH. It has become general knowledge that it is difficult to get a patient admitted to SASH, leading clinicians and families to forgo a formal process and instead work through an ad hoc process. As a result an enormous amount of effort of SASH clinical staff goes into screening phone calls from clinicians, clients and officials seeking an admission for a client. Surprisingly, clients will attempt to “walk-in” to SASH; sometimes families will literally drop a patient with serious mental illness off at the front gate. As a hospital, SASH fall under EMTALA laws and such patients must be offered a screening. SASH does not have the capacity to do a full medical screening, meaning a number of these patients must be sent to medical emergency rooms of local hospitals. Others are referred to back to their communities if they do not meet criteria for admission.

Another key issue is that the official CMBHS waitlist may not capture the true need for long term hospital care in the community. In September of 2016, the Southwest Texas Regional Advisory Council conducted a study by interviewing providers at local hospitals as to how many patients they thought would have benefited from a transfer to SASH. Figure 1 below shows Hospital Emergency Department and Inpatient Admissions from San Antonio, Texas for a 30-day period that needed transfer to SASH as the most appropriate level of care where a bed was not available.



**STRAC Regional
Emergency Department Operations Committee**

Total Emergency Department¹ & In-Patients² in Need of Transfer to SASH; September, 2016

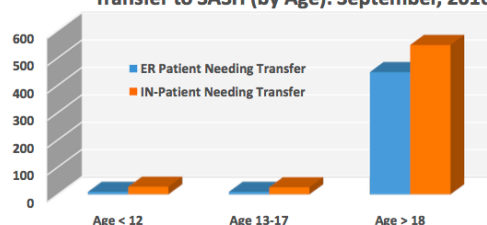


SASH - San Antonio State Hospital

Inclusion Criteria:

- 1) Emergency Department patients needing transfer to SASH for inpatient involuntary psychiatric admission who are acutely ill and/or violent, and may require a longer length of stay to stabilize.
- 2) Inpatients needing transfer to SASH for involuntary psychiatric admission who are acutely ill and/or violent, and who may require a longer length of stay to stabilize.

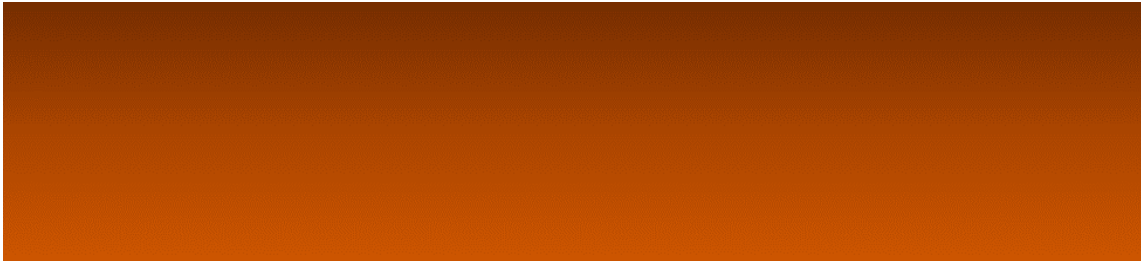
Emergency Department¹ & In-Patients² Needing Transfer to SASH (by Age): September, 2016



As noted in the report, “When individuals need inpatient care, they may have difficulty accessing a bed in a timely manner. State-operated facilities are frequently on diversion, and waitlists are on the rise. Forensic referrals have increased, outstripping the state's forensic capacity and encroaching on beds available for civil patients.” The planning process must ensure mechanisms exist to allow SASH to be able to discharge stable patients into outpatient care to create ongoing inpatient capacity for other acutely ill individuals. The coordination across the continuum of care is essential. Figure 1 provides credence to these notations in the report, as an

average of 35.7 patients per day would have been appropriate for transfer to SASH during a 30-day reporting period of hospitals located within San Antonio, Texas. Not all of these patients are entered onto the SASH waiting list, leading to differing perceptions regarding the backlog of patient awaiting admission.

It should not be concluded that *every* one of the patients identified by these providers in this study needed to be admitted to SASH. It does reflect the deep sense of the unmet need for treatment that exists for people with serious mental illness in our community.



Appendix C: Summaries of Executive Committee Meetings and Stakeholder Forums

Appendix C

SASH Executive Committee Meetings	2
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Monday, September 25, 2017 at San Antonio State Hospital.....	4
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Wednesday, November 15, 2017 at Methodist Healthcare Ministries.....	12
Monday, December 4, 2017 at Methodist Healthcare Ministries.....	14
Thursday, December 21, 2017 at Methodist Healthcare Ministries.....	16
Wednesday, January 31, 2018 at Methodist Healthcare Ministries.....	18
Monday, February 26, 2018 at Methodist Healthcare Ministries.....	20
Wednesday, March 07, 2018 at Methodist Healthcare Ministries.....	22
Tuesday, March 13, 2018 at Methodist Healthcare Ministries.....	28
Tuesday, May 8, 2018 at UTSA Downtown Campus.....	30
Friday, June 08, 2018 at Methodist Healthcare Ministries.....	32
Friday, June 13, 2018 at Methodist Healthcare Ministries.....	35
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Monday, June 4, 2018 at Methodist Healthcare Ministries.....	75
Tuesday, June 26, 2016 at Behavioral Health Center of Nueces County.....	80
Tuesday, July 10, 2018 at Gulf Bend Center.....	84
Thursday, July 12, 2018 at Methodist Healthcare Ministries.....	90
Tuesday, July 24, 2018 at Coastal Plain Community Center.....	94
Wednesday, August 1, 2018 at Border Region Behavioral Health Center.....	98
Tuesday, August 7, 2017 at Camino Real Community Services.....	103

SASH Executive Committee Meeting

Monday, September 18, 2017
8:30 a.m.
Methodist Healthcare Ministries
Conference Room 3
4507 Medical Dr. San Antonio, TX 78229

ATTENDANCE

George Hernandez, Sally Taylor, Mike Lozito, Gilbert Gonzales, JeLynne Burley, Allison Greer, Steve Pliszka, Gilbert Loreda, Fred Hines, Chris Bryan, Chris Yanas

-
- | | |
|-----------------------|---|
| Beyond SASH | <ul style="list-style-type: none"> • What other MH aspects can we impact through SASH funding? <ul style="list-style-type: none"> ○ Possibility of creating infrastructure in the DT area <ul style="list-style-type: none"> ▪ Walk in ▪ Crisis center ▪ PES services ○ Jail Campus? Align with city working to become a one-stop shop ○ Concern about stigma it will bring to mental health and criminal justice ○ Concern of helping people not in Bexar county, do other counties need local resources ○ Propose alternative locations to place the child unit elsewhere |
| Rural Counties | <ul style="list-style-type: none"> • Need to survey rural counties for needs assessment <ul style="list-style-type: none"> ○ Catchment areas of SASH • CHCS will lead coordination of meeting or conference call with rural areas on asset mapping • UT Health and Clarity will develop inventory document on survey questions to rural areas • Chris Bryan can call Texas Council about existing survey documents |
| SASH Needs | <ul style="list-style-type: none"> • Look into patient population – how many are IDD, forensic, civil? • SASH needs for kids – had trouble with staffing in past • Staffing needs – work with nursing schools? <ul style="list-style-type: none"> ○ Need RN supervisor (with psych specialty) and can staff more LVNs • Gather information on: the total number of psychiatric beds available in the SASH catchment area, the type of step-down services offered, and the average length of stay for different patient populations (namely, children). • Need to set up meet with Bob to have questions answered <ul style="list-style-type: none"> ○ Optional tour for those who wish to see campus |
| Pre-planning | <ul style="list-style-type: none"> • What other companies/services did Texas use in pre-planning? • Best practice delivery systems in other states or cities? • Architecture plans – see if there are any best practices and work on a space needs component • Keep in mind renovation \$\$, not included in proposal • Identify what type of expertise we may need to prepare this report and implement this plan. • Identify support services (e.g. UHS' laundry co-op) that can be integrated into the proposal. • Identify new sources of funding since the services will be funded locally. |
| To-Do | <ul style="list-style-type: none"> • Set up meeting with SASH (Bob Arizpe) – Chris Yanas, MHM • Set up conference call with Rural Centers – JeLynne Burley, CHCS • Contact Texas Councils – Chris Bryan, Clarity • Develop questions for Judges – Sally Taylor (UHS) and Gilbert Gonzales (Bexar County) • Develop questions for Rural Centers – Steve Pliszka (UTHSA) and Clarity • Look into other companies/services for pre-planning – Chris Yanas, MHM • Best practices for delivery system – Chris Yanas, MHM • Look into nursing workforce for SASH – Chris Yanas, MHM • Coordinate updates with Speaker's Office and Senate – Chris Yanas, MHM |

SASH EXECUTIVE COMMITTEE MEETING

Monday, September 25, 2017

9:00 AM – 11:00 AM

San Antonio State Hospital
6711 South New Braunfels,
Suite 100, San Antonio, TX

ATTENDANCE

George Hernandez, Dr. Sally Taylor, Gilbert Lored, Toni LoBasso, Chris Yanas, Allison Greer, Dr. Steve Pliszka, Fred Hines, Chris Bryan, Carol Carver, Bob Arizpe, Dr. David Gonzalez, Mike Lozito, Gilbert Gonzales

CAPACITY/BEDS	<ul style="list-style-type: none"> SASH is allocated 302 beds: 96 acute care beds (with 16 located in Laredo), 30 adolescent beds (~22 beds filled), 112 forensic beds (~140 beds typically filled), 24 geriatric beds (~23 beds filled) and 40 residential beds (~30 beds filled). The average length of stay is 43 days with about 20% having shorter LOS and 20% having longer LOS. Some patients have been at SASH 15 years. In the acute care unit nearly 50% of patients are there longer than a year. There is an onsite pharmacy and patients leave with medications in hand. SASH receives calls from county jails for evaluations, often due to lack of arrangements between county jails and LMHAs; find that these agreements vary county to county. SASH is not equipped to handle the IDD population. SASH has 30 beds for adolescents. Many of the children are CPS children and due to CPS not placing the children with families in time, many children miss the proper discharge window. The staffing requirements for adolescents are high, consequently SASH cannot serve more teens without more RNs. The current census is 9-12 children.
WORKFORCE	<ul style="list-style-type: none"> SASH has the following positions available: 84 RNs (12 positions currently open), 62 LVNs (almost all filled), and 313 PNAs (about 20 vacant positions). RN turnover is due to low salaries (~\$26/hr. – about \$10 below market rate), cases of patient aggression and a poor nurse referral system. There is no standard RN to patient ratio for the state (currently SASH has 1 RN: 40 acute patients). At night there is 1 RN, 1 LVN and 3 PNAs in the acute care unit for 40 patients. Majority of nurses are over 50 years of age. SASH does provide loan forgiveness for LVNs who choose to pursue RN education. Has 10 psychiatrists (1 child psychiatrist). There are 3 psychiatrists on call per night. Has 19 security guards (at any one time only 1 is on duty); however, these guards are not certified and are not peace officers.
ADDITIONAL REMARKS:	<ul style="list-style-type: none"> Given nursing staff shortage and facility location, the additional 40 beds being proposed for SASH should not be a max-security forensic unit; an extended acute care unit is recommended, which could be fully staffed and is needed. Releasing patients is difficult since most patients do not have government issued-IDs and step-down service organizations require IDs to provide services. Bob said that that the community needs more crisis stabilization units as opposed to more acute care beds. Laundry services are coordinated regionally in Kerrville; SASH and the SSLC provide food services for 600+patients a day. Rusk Hospital may not be rebuilt, rather expanded to accommodate 60-90 beds in Kerrville. Use of pre-planning money is recommended to fund a report on the needs of SASH, available local step-down services and the ideal front-end vision. Beds allocated in SASH 54 county service area by formula – 8 beds/100,000 population

NEXT STEPS	<ul style="list-style-type: none">• <u>Updates:</u> CHCS will be meeting with rural LMHAs this week;• Dr. Pliszka has developed questions for hospitals;• Dr. Taylor and Gilbert Gonzales have developed questions for judges• Chris Bryan waiting for response from Lee (Texas Council).• Committee will have bimonthly meetings (Next meeting on Oct. 11th from 11:30-1:00 @ MHM)• A nursing workforce subcommittee meeting will be organized by Chris Y.• Chris Y. - list of contractors used in previous state hospital plans developed and shared via email• Bob will share with this committee the June report he shared with HHSC.
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SASH Executive Committee Meeting

Wednesday, October 11, 2017
11:30 a.m.
Methodist Healthcare Ministries
Corporate Boardroom
4507 Medical Dr. San Antonio, TX 78229

ATTENDANCE

George Hernandez, Sally Taylor, Gilbert Gonzales, JeLynne Burley, Allison Greer, Steve Pliszka, Gilbert Lored, Fred Hines, Chris Bryan, Chris Yanas

SASH Steering Committee	<p>Need to add:</p> <ul style="list-style-type: none"> • Law enforcement – Sheriff’s Office and possibly SAPD • MH Stakeholder Org - NAMI SA • Bob Arizpe and SASH Clinical Director • Architectural consultant • Local legislators – Sen. Menendez’s staff and Carmen Tilton (Sen. Uresti) • George (UHS) will look into other hospital districts
Pre-Planning Budget	<p>Revisions</p> <ul style="list-style-type: none"> • Specify children and adults in Clinical Programing: gaps in service 1 and 2 • Clinical Programming: gaps in service 3 cost \$150,000 • Consultants: Architectural planning line item: <ul style="list-style-type: none"> ○ Delete UT school of Architecture ○ Change cost to \$80,000 • Expert Facilitator line item – expand on comments to include extended retreat and facilitated plan development <p>Planning Year 2 activities will change – placeholder for now</p>
Proposal Document	<ul style="list-style-type: none"> • Include information on need for staffing recruitment, including addressing the need to pay market rates • Replace Behavioral Health Policy and Behavioral Health Clinical Operations sections to address 15 points of strategic plan (Dr. Taylor’s summary) • Dr. Pliszka will integrate responses from judicial questionnaire into proposal
Statement of Work concerns	<ul style="list-style-type: none"> • Page 1 Section IA: continuum of inpatient and outpatient services on campus <ul style="list-style-type: none"> ○ ASH is looking to push services out to community ○ Mike Maples recommended looking at services on campus <ul style="list-style-type: none"> ▪ There may be concern from LMHA due to geographic location ○ Consider telemedicine opportunities? Company must have a physical facility for services • Page 2 Section IIE: develop plan to maximize resources <ul style="list-style-type: none"> ○ There may be a need to look into public-private partnerships
Conclusions	<ul style="list-style-type: none"> • Dr. Pliszka will make revisions to budget document and proposal by Monday morning <ul style="list-style-type: none"> ○ Will also ask Joy (HHSC) for clarification on Statement of Work concerns and target date • Try to submit by next week, before October 24th • Statement of Work will be shared to all LMHAs by JeLynne

SASH Executive Committee Meeting

Wednesday, October 25, 2017

11:30 a.m.

Methodist Healthcare Ministries

Conference Room 3

4507 Medical Dr. San Antonio, TX 78229

ATTENDANCE

George Hernandez, Sally Taylor, Mike Lozito, JeLynne Burley, Allison Greer, Steve Pliszka, Gilbert Lored, Fred Hines, Chris Bryan, Chris Yanas, Bob Arizpe, David Gonzalez, Doug Beach, Bart Vasquez, Cynthia Cabral, Carmen Tilton, Velma Munoz, Jeff Tunnell

Opening Remarks	<ul style="list-style-type: none"> SP will try to set up a call with Joy (HHSC) and Executive Committee on further recommendations and comments about proposal; hopefully for next meeting 11/6
Proposal Edits	<ul style="list-style-type: none"> Introduction <ul style="list-style-type: none"> Sally: SASH is a mixture of tertiary and acute care Sally and Chris Y. included a comment on challenges with recruitment of staff SASH Today <ul style="list-style-type: none"> George H.: Is the number for CHCS on the map patients or visits, is it unduplicated? <ul style="list-style-type: none"> JeLynne will look into Center for Health Care Services and SP can look at original source of map to see if there is any context The committee can also replace the map with a better illustration Table 1. Admissions to SASH from LMHAs <ul style="list-style-type: none"> There should be a comment on how SASH could serve more patients if we had unlimited access Sally will send study from STRAC about waiting list and mention how it doesn't reflect Austin's official list Bob will include comments about diversion and waitlist Sally added technical comment on how the comment will identify gaps in needs and services Partners <ul style="list-style-type: none"> Sally will edit University Health System to be more behavioral health focused Chris Y. will edit Methodist Healthcare Ministries to reflect 10 hospitals in the region Delete "several satellite locations" from Clarity Child Guidance Center Edit "Bexar County" to "our community" in Center for Health Care Services (first sentence) Include information about STCC under STRAC Formatting edits in NAMI (font switches to 12pt in last sentence) Doug will send list of NAMI affiliates in region to include Planning <ul style="list-style-type: none"> Sally: Should we include ACOG for IDD Authority? <ul style="list-style-type: none"> George H.: ACOG should be brought into meetings as needed Table 3. Executive Committee <ul style="list-style-type: none"> SASH – David Gonzalez, MD Medical Director of SASH Rural LMHA – Carmen will look into clarification from HHSC about using rural vs. non-urban terminology <ul style="list-style-type: none"> Legislature uses Rural, but HHSC uses non-urban (to include suburban areas) Carmen states that HHSC uses rural terminology Bexar County – Gilbert Gonzales, Director / Bexar County Department of Behavioral and Mental Health SAPD – Bartholomew Vasquez, San Antonio Police Department Mental Health Detail Supervisor Bexar County Sheriff's Office – Lt. Raul Garza <ul style="list-style-type: none"> Mike Lozito will look up title Should architectural people be included now or later? <ul style="list-style-type: none"> Will defer question to Joy

- Schematic Plan – first layout of system of care
 - Look into continuum of care and identify relationship
- Access to Appropriate Behavioral Health Services
 - Change “super-utilizers” to complex care needs because the state is trying to get away with term
 - JeLynne will make edits about including HB 13 and SB 292, mentioning how rural counties will apply for funding in FY 19
- Continuity of Care for Individuals Exiting County and Local Jails
 - Edit “Bexar County Behavioral and Mental Health Department focuses on jail diversion, release and **re-entry** efforts”
 - Mike will add comments on how the county will coordinating with the VA for veteran support
- Use of Peer Services
 - NAMI does not provide training, but they provide education and support of peers
 - Mention Haven for Hope’s peer navigator program support
- Behavioral Health Services for Individuals with Intellectual Disability
 - Change title to **Intellectual and Developmental Disabilities**
- Consumer Transportation and Access to Treatment
 - Delete “...even physical health care access is dwindling” (first sentence)
 - Delete “Closing of rural hospitals means fewer emergency rooms and fewer hospitalist physicians to treat those in most acute care” because it weakens section
- Access to Housing
 - Edit to include “With Haven for Hope **and others** as partners, we will examine child and adolescent services”
 - Mike, Bob, and Velma will add language on housing efforts
- Behavioral Health Workforce Shortage
 - Biggest problem is nursing shortage
 - Chris Y. included information about researching the region before coming up with conclusions
 - George H. wants to look into doing annual market studies to stay competitive
- Services for Special Populations
 - Edit to include “...physical disabilities and those with **Intellectual and Developmental Disabilities**”
 - Mention how the committee will keep an eye on progress interim studies
- Shared and Usable Data
 - Rename Healthcare Access San Antonio to HASA because they just acquired areas in North Texas

Next Steps

- Sally
 - Language on STRAC study for waiting list (Table 1)
 - Edit UHS information to be more BH focused
- JeLynne
 - Clarification on CHCS number of people served on Figure 1
 - Language on HB 13 and SB 292
- Mike
 - Language on county collaboration with VA
 - Language on housing access
 - Look up Sheriff’s office rep. and title
- Bob
 - Language on housing access
 - Language on diversion and waitlist for SASH (table 1)
- Velma
 - Language on housing access
- Carmen

- Edits and comments
- Chris Y.
 - Work on final edits to send to Dr. Pliszka
- Dr. Pliszka
 - Connecting with Joy (HHSC) for conference call

Next Meeting Monday, November 6th, 2017 at 11:30am
Methodist Healthcare Ministries

SASH Executive Committee Meeting

Monday, November 6, 2017

11:30 AM – 1:00 PM

MHM Conference Room 3

Conversation with HHSC

Mike Maples

- Keep in mind that the idea is not about a new building, but rather a system of care
- The population for SASH is not changing, it is inpatient forensic and civil individuals
- The proposal should identify partners to fill the gaps within inpatient care
 - What are some issues that can be addressed through community partnerships?
 - The design of the hospital should fit in with the partnerships
 - Should be portrayed through construction documents

Q&A

- Would part of the construction money be used for building off campus?
 - *Mike:* It is a little out-of-scope; the plan is to use the money to rebuild within capacity
- When should we have our proposal in?
 - *Mike:* We are waiting on LBB approval of the plan and funds. I encourage that documents should wrap up soon. Once LBB approves the funds, we want to be able to just sign a contract and start the flow of money ASAP
- *Rachel:* There are some comments that I have on the proposal. I can send written comments as well
 - The proposal is missing some aspects that are reflected in the statement of work
 - You need to be specific on who is responsible for each part in the planning aspect – how every organization is involved in the design of SASH
 - For design wise, we would like hospital design expertise in healthcare innovation
 - *Mike:* Use the UT study from RUSK as a “best practice” guideline for design; that is our main standardization and there will be some local tailoring
 - An architect doesn’t need to be identified, the idea is for you to be ready for an architect at the end of preplanning
- Recruitment of Staff? How is the state planning on handling it?
 - *Mike:* The design of the new hospital should reflect a place where people want to work – you should engage with stakeholders on what they want
 - We are continuing to work with legislators, and you should do the same, to create proposals for a competitive recruitment of workforce, but there is no need to spend planning money on it

Comments

- George Hernandez: We need to make a point about workforce, but change the wording so it doesn’t have the “workforce shortage” verbage
- Chris Bryan: I didn’t know that the plan was for all construction dollars to be on campus, the campus won’t cover all the counties
 - Carmen Tilton: I have the same concern. In addition, another concern is the UT study being the main guideline – the State doesn’t have a high tolerance for spending money on the same system throughout the state if it is a local collaborative

- Proposal Edits**
- Vision
 - Systems-Based Continuum of Care: ST added “always” to “SASH should not always be the first line of treatment...” because it is the first line for forensic treatment
 - SASH Today
 - Jeff has a map of SASH’s primary and secondary catchment area broken down by counties – can forward it
 - Wait list for SASH – 13 is the official list for all of catchment area, but unofficially it is more
 - Dr. P will change wording to incorporate study
 - Partners
 - Methodist Healthcare Ministries – “Bexar County” needs to be deleted in 4th line
 - STRAC – CY will take language from SB 292 for STCC project
 - Table 3: Need to add names for Bexar County Sheriff’s Office
 - Strategic Plan
 - 6 & 10 titles are very similar
 - GH: if the strategic plan has transportation, we need to include some information about transportation
 - CY: MHM has a Real Project on BH transportation in some counties of the catchment area, will include information in proposal
 - Dr. P will revise 13: Behavioral Health Workforce Shortage
 - Table 4
 - Need to be more specific on responsible individuals
 - Dr. P will wait for conference call with Rachel before proceeding
 - Dr. T: need to look for when to bring in additional stakeholders
 - GH will reach out to UTSA School of Architecture for consultation

Send any draft edits to Chris Yanas, who will finalize before next meeting. The plan is to finalize pages 1-10 so the next meeting can focus on the preplanning timeline and responsibilities.

- Next Steps**
- Dr. Pliszka
 - Set up conference call with Rachel (HHSC)
 - Change wording on workforce shortage
 - Revise sentence of wait list (table 1)
 - Add names and titles from Sheriff’s office
 - JeLynne
 - Clarification on CHCS number of people served on figure 1
 - Mike
 - Language on county collaboration with VA
 - Carmen
 - Follow up with HHSC about phone call
 - Chris Y
 - Work on final edits

Next Meeting
Wednesday, November 15th 2017
11:30 a.m. – 1:00 p.m.
Methodist Healthcare Ministries
Corporate Boardroom

SASH Executive Committee Meeting

Wednesday, November 15, 2017

11:30 a.m.

Methodist Healthcare Ministries

Corporate Boardroom

4507 Medical Dr. San Antonio, TX 78229

ATTENDANCE

George Hernandez, Sally Taylor, Mike Lozito, Allison Greer, Steve Pliszka, Fred Hines, Chris Bryan, Chris Yanas, David Gonzalez, Doug Beach, Javier Salazar, Don Tijerina, James Serrato, Rachel Samsel, Bob Arizpe, Cynthia Cabral

Proposal Edits

SASH Today

- Changed photo for clarification
- Need to include text on diversion and waitlists, including STRAC study
- Change language to include 13-26 patients on waitlist to get admitted
- Include number of beds for specialty populations

Partners

- Need to add Jeff's comments on LMHAs
- Grammatical error: 55 counties instead of 54 counties under Rural LMHAs
- STCC language was included

Planning

- Rachel: for table 3, it would be best to include roles of specific organizations; helps create memorandum of understanding

Access to Appropriate Behavioral Health Services

- Need to update language on SB 292 and HB 13 projects

Consumer Transportation and Access to Treatment

- Edits for transition between 1st and 2nd paragraph

Behavioral Health Workforce Shortage

- Dr. Pliszka will edit paragraph about nursing workforce
 - Rachel: there is a legislative report due Aug 2018 on nursing retention for state hospitals; legislators and staffers are aware so there does not have to be a big push on nursing shortage. Keep in mind that a new facility will be an attraction to the younger generation

Preplanning Focus

- Rachel: when we wrote the request for funds, we make it flexible so you can start the planning aspect early (after a request of funds from LBB). This proposal should only focus on preplanning. Think outside the box to provide a modern approach to psychiatric care – best practices on individual rooms. Look into optimal care models.
- Dr. Pliszka: Do we need to do a needs study for our catchment area?
 - Rachel: It depends on the amount of data you already have. How much more work will need to be done for the needs study? Keep in mind that the money will be used to build the same number of beds, we are not increasing footprint. The types of beds can change (280 beds and 20 swing beds)
 - Community funds are not included in the SASH funding, so you are not able to use a satellite campus as part of the funds.
 - HB 13 and SB 292 are in review and evaluations now, but Rachel is unsure when the funds will be distributed.
- The preplanning period will look into best practices, but it does not need to be concrete for the proposal. The planning document will include a best practice system of care. If it changes, we can modify and have conversations.

Next Steps

- Dr. Pliszka
 - Work on draft – will try to send by Wednesday
- JeLynne

- HB 13 and SB 292 language
- Bob
 - Language on diversion and waitlist, include STRAC's study.
 - Look into number of beds for specialty populations
- Jeff
 - Language on rural LMHAs
- Chris Y
 - Work on final edits
- Everyone:
 - Send in organization's responsibilities

Next Meeting Monday, December 4th, 2017
11:30 am – 1:00 pm
Methodist Healthcare Ministries – 3rd floor Boardroom
4507 Medical Dr. San Antonio TX 78229

SASH Executive Committee Meeting

Monday, December 4, 2017
11:30 a.m.
Methodist Healthcare Ministries
CR3
4507 Medical Dr. San Antonio, TX 78229

ATTENDANCE

Doug Beach, Edward Gonzales, Bart Vasquez, Tony LoBasso, Chris Bryan, Fred Hines, James Serrato, Velma Muniz, Rebecca Helterbrand, Steve Pliszka, Jelynn Burley, Sally Taylor, Rachel Samsel, David Gonzalez, David Miramontes, Allison Greer, Carmen Tilton, Chris Yanas, Jeff Tunnell, Sedef Doganer, George Hernandez, Don Tijerina, Christina Phamvu, Sebastien Laroche, Bob Arizpe

Proposal Edits	<p>SASH Today</p> <ul style="list-style-type: none"> • Map – need to add CHCS updated numbers • Add STRAC data <p>Partners</p> <ul style="list-style-type: none"> • Need to add Jeff’s comments on LMHAs • Grammatical error: 55 counties instead of 54 counties under Rural LMHAs • STCC language was included <p>Access to Appropriate Behavioral Health Services</p> <ul style="list-style-type: none"> • Need to update language on SB 292 and HB 13 projects • TCC can be incorporated into table with rural LMHAs with projects <p>Consumer Transportation and Access to Treatment</p> <ul style="list-style-type: none"> • Edits for transition between 1st and 2nd paragraph
Other Items	<p>Timeline</p> <ul style="list-style-type: none"> • Rachel: We have the expectation of staying true to the timeline, and delay in approval would shift timeline accordingly <ul style="list-style-type: none"> ◦ Flexibility to move A&E up after initial LBB approval of funds ◦ Dr. Pliszka: The timeline will be constantly revising if the funds are not issued soon ◦ Rachel: We have no idea when the funds are available, but we are working on the first draft of the contract • David (EMS): Is there money and time allocated for surprises? <ul style="list-style-type: none"> ◦ Gilbert G: There will be money once funds are issued, but funds aren’t available yet • UTSA architecture will need input from the community; ideally would want Jan-Apr timeline <p>IDD individuals</p> <ul style="list-style-type: none"> • State hospitals only provide IDD if there is a co-occurring MH • SASH is not set up for severe IDD <ul style="list-style-type: none"> ◦ Max security state hospitals are the only programs addressing specialized individuals in the state hospital system <p>Renovation Funds – 40 civil beds</p> <ul style="list-style-type: none"> • HHSC is already meeting with architecture – that is a different set of funds (different approval, deferred maintenance) <ul style="list-style-type: none"> ◦ Most likely intermediate care for adults ◦ There is an underutilization of adolescent beds in all hospitals • There is no funding for the Laredo SASH campus <ul style="list-style-type: none"> ◦ Relatively new <p>SASH Catchment Area</p> <ul style="list-style-type: none"> • SASH serves 29 counties for adults and an additional 26 for adolescents (starting at age 13)
Next Steps	<ul style="list-style-type: none"> • Dr. Pliszka

- Work on draft
- Allison
 - HB 13 and SB 292 language
- Bob
 - Language on diversion and waitlist, include STRAC's study.
- Jeff
 - Language on rural LMHAs
- Chris Y
 - Work on final edits
- Everyone:
 - Update organization's responsibilities

Plan is to nail action plan by next meeting

Next Meeting

Wednesday, December 20, 2017
11:30 am – 1:00 pm
Methodist Healthcare Ministries – Conference Room 3
4507 Medical Dr. San Antonio TX 78229

SASH Executive Committee Meeting

Thursday, December 21, 2017
11:30 a.m.
Methodist Healthcare Ministries
CR3
4507 Medical Dr. San Antonio, TX 78229

ATTENDANCE

Doug Beach, Bart Vasquez, Tony LoBasso, Chris Bryan, Velma Muniz, Steve Pliszka, JeLynne Burley, Sally Taylor, David Gonzalez, Allison Greer, Jeff Tunnell, Sedef Doganer, Don Tijerina, Christina Phamvu, Sebastien Laroche, Bob Arizpe, Mike Lozito, Sarah Hogan, Molly Biglari, Eric Epley

Announcements	<ul style="list-style-type: none"> LBB released funds for SASH
Budget	<ul style="list-style-type: none"> Will need to redistribute funds to STRAC for study Architectural planning split in two (initial - \$100,000 and secondary (\$200,000)
Timeline	<ul style="list-style-type: none"> Architectural planning will start in Jan Feb, March will have town hall meetings and create a white paper <ul style="list-style-type: none"> Jeff brought up moving SWOT analysis to be parallel with town hall meetings because the SWOT analysis will benefit from stakeholder meetings – everyone agreed Final architectural design Retreat and final planning document due in 1 year
Proposal Edits	<p>SASH Today</p> <ul style="list-style-type: none"> Plan to strike map Need numbers from CHCS for # individuals and year <p>Planning</p> <ul style="list-style-type: none"> Add Haven for Hope on table of Executive Committee <p>Access to Appropriate Behavioral Health Services</p> <ul style="list-style-type: none"> Alison can inset table for Bexar County for HB 13 and SB 292 <ul style="list-style-type: none"> Chris Y (MHM) will handle rural areas <p>Access to Timely Treatment Services</p> <ul style="list-style-type: none"> Dr. Pliszka will edit language about 35.7 patients – include per day <ul style="list-style-type: none"> SASH official waiting list is 7 patients as of today STRAC data was included – good placement within proposal <p>Use of Peer Services</p> <ul style="list-style-type: none"> Haven for Hope will elaborate <p>Behavioral Health Services for Individuals with Intellectual and Developmental Disabilities</p> <ul style="list-style-type: none"> Can we be more specific on the # of days a patient with IDD stays in the emergency room? <ul style="list-style-type: none"> Dr. Taylor can look into records, but might have data ACOG might have some data, but won't cover all of catchment area Tony (MHM) can look into MHM study for super-utilizers Dr. Pliszka will change language to be more specific
Other Comments	<ul style="list-style-type: none"> There is still confusion whether funds can be used outside of SASH Campus <ul style="list-style-type: none"> Send in proposal and use stakeholder meetings and SWOT analysis data to make our case of using funds for outside SASH area to HHSC after proposal is approved Plan is to use master design for RUSK with local specific changes Dr. Pliszka will plan to have final draft by end of next week

Action Items	STRAC <ul style="list-style-type: none">• Give amount for STRAC Study for budget
	CHCS <ul style="list-style-type: none">• Clarification on # individuals seen per year• Alison – SB 292 and HB 13 table for Bexar County
	MHM <ul style="list-style-type: none">• Chris – HB 13 and SB 292 data on other counties• Tony – look at MHM study on super utilizers for number of days in ER
	UHS <ul style="list-style-type: none">• Sally – look at records for # days a patient stays in the ER
	UTHSCSA <ul style="list-style-type: none">• Dr. Pliszka<ul style="list-style-type: none">○ Edits on Access to Timely Treatment Services○ Edits on BH Services for IDD Patients○ Include Haven for Hope and contact person in table○ Final edits
	Haven for Hope <ul style="list-style-type: none">• Elaborate on use of peer services

SASH Executive Committee Meeting

Wednesday, January 31, 2018
11:30 a.m.
Methodist Healthcare Ministries
CR3
4507 Medical Dr. San Antonio, TX 78229

ATTENDANCE

Doug Beach, Bart Vasquez, Chris Bryan, Steve Pliszka, JeLynne Burley, Sally Taylor, Allison Greer, Jeff Tunnell, Sedef Doganer, Christina Phamvu, Sebastien Laroche, Sarah Hogan, Molly Biglari, Eric Epley, Joseph Blader, Chris Yanas, Edward Gonzales, David Miramontes, Gilbert Gonzalez, Cynthia Cabral, Carmen Tilton, Mike Ruggieri, Don Tijerina, Alwyn Mathew

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| Announcements | <ul style="list-style-type: none"> • Dr. Pliszka: We are working with HHSC, should be ready to subcontract by next week • UTSA is working on revising their proposal • SASH Tour provided for UTSA School of Architecture and MHM – first hour was in conference room talking about design needs and facilities and then took a tour of a building that they are fixing to reopen |
| Architectural Planning | <ul style="list-style-type: none"> • Will bring in consultants and expertise (work with UT Health and UH on suggestions for architecture firms- Possibly SG2?) • Doug Beach – should we possibly have a subcommittee of the steering committee on architectural needs? Volunteer to host and run sub-committee <ul style="list-style-type: none"> ○ UTSA agrees and will be involved ○ MHM will be involved • Dr. Taylor – Is the expectation to take the Rusk design and tweak it? Yes <ul style="list-style-type: none"> ○ We need to be familiar with the Rusk design ○ Ask UT Austin to present on Rusk Design • JeLynne – we should have a conversation on other services on campus. Ex: buildings that cannot be used for psych care may be converted to housing or training <ul style="list-style-type: none"> ○ Molly: Haven wants to be part of that conversation • Dr. Blader will send Rusk plan around |
| Stakeholder Meetings | <ul style="list-style-type: none"> • MHM can host meetings in Bexar County and other counties, maybe in the evening? <ul style="list-style-type: none"> ○ Have a key person where stakeholders can connect for feedback and information • MHM will develop a template for the different meetings and other people can contribute to details (meeting details, types of stakeholders, themes) <ul style="list-style-type: none"> ○ CHCS/Haven for Hope and Partners ○ SASH clinical Staff ○ Bexar County Law Enforcement ○ Advocacy/Consumer Groups ○ Bexar County Child and Mental Health Issues ○ Bexar County Psych/Medical/EMS ○ Rural LMHAs – comprehensive <ul style="list-style-type: none"> ▪ Hill County ▪ Tropical ▪ Victoria • MHM and UT Health will compile information for report • MHM will compile list of recommended facilitators |

- SWOT Analysis**
 - Dr. Taylor – we should have an initial meeting with all SWOT analysis to ensure we aren't doing the same work twice
 - Do we need to contract with a third-party?
 - Carmen -feel free to use the SWOT analysis information for your needs, including HB 13 and SB 292
 - SWOT analysis and stakeholder meetings will be concurrent
- Funding**
 - State will pay by reimbursement
 - Subcontractors will send invoice with detail of services to UT Health; they will submit to state
- Next Steps**
 - Dr. Pliszka
 - Will contact George Hernandez for recommendations for architectural consultants
 - Set up presentation by UT School of Architecture
 - Set up meeting for Architecture subcommittee: Doug Beach, Dr. Pliszka, Chris Yanas, Sedef Doganer
 - Chris Yanas
 - Send out recommendations for facilitators
 - Develop stakeholder meeting template
 - Assist with group meeting for SWOT analysis
 - Dr. Blader
 - Send out Rusk Plan

SASH Executive Committee Meeting

Monday, February 26, 2018
11:30 a.m.
Methodist Healthcare Ministries
Boardroom
4507 Medical Dr. San Antonio, TX 78229

ATTENDANCE

Doug Beach, Bart Vasquez, Chris Bryan, Steve Pliszka, Sally Taylor, Jeff Tunnell, Sedef Doganer, Neda Norouzi, Christina Phamvu, Sebastien Laroche, Molly Biglari, Joseph Blader, Chris Yanas, Gilbert Gonzales, Cynthia Cabral, Don Tijerina, Alwyn Mathew, Bob Arizpe, Amanda Mathias, George Hernandez, James Kazen, Tony LoBasso, Raymundo Rivera, Reuben Pinkson, Dean Almy, Ruben Acevedo, Velma Muniz, Michael Charlton, Rosanne Fohn

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| <p>Rusk State Plan Presentation
Dean Almy
Center for Sustainable Development</p> | <ul style="list-style-type: none"> • Rusk Plan is an urban design-based project • DSHS wanted Rusk plan to be prototype for everyone to use in the state for state hospital planning • Looked at research & best practices <ul style="list-style-type: none"> ○ Looking at state hospitals (Worcester Recovery Center, MA) and around the world (most in Scandinavia) ○ Flexibility in Criminal and Civil • Design aspect <ul style="list-style-type: none"> ○ Emphasis on nature and mental health – fundamentals ○ Talked to different stakeholders, Rusk Staff, hospitals, architectures, community ○ Matching design with state fund regime (designed to meet economic staffing needs) ○ Pt's room <ul style="list-style-type: none"> ▪ Best practices are single rooms, but hard to do with low staff ▪ Duplex rooms offered best flexibility ▪ Rusk wanted community showers ▪ <i>Dr. Arizpe: SASH had concerns with single rooms as well d/t staffing constraints</i> ○ Unit (15,000 sq. ft. per unit) <ul style="list-style-type: none"> ▪ Patent vs. staff entry ▪ 20 patients per nurse station ▪ Active vs. passive surveillance <ul style="list-style-type: none"> • Wanted more passive surveillance • Strategically placed nurses station to have view of both corridors, day space, and courtyard ▪ day space area is less regulated, more social people can move into courtyard ▪ units can have supportive treatment space (treatment rooms, laundry) ○ Quad Scale (60,000 sq. ft. per quad) <ul style="list-style-type: none"> ▪ Accumulate additional facilities ▪ 4 units = 1 quad ▪ Includes kitchen, dining, medication room ▪ Shared active outdoor space (basketball court) ▪ Design allows 1 guard per quad ○ Landscape Scale <ul style="list-style-type: none"> ▪ Use of big tree for shade ▪ Plants that thrive in Texas environment, easy to maintain ○ Therapy mall <ul style="list-style-type: none"> ▪ Includes administrative support ▪ Patient processing ▪ Visitations ○ Medical clinic – not meant to be emergency room or critical care, basic medical care |
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	<ul style="list-style-type: none">• George Hernandez: Are the plans scalable for best practices? The target design plan is beyond the best practice being proposed
Architecture Update	<ul style="list-style-type: none">• UTSA School of Architecture<ul style="list-style-type: none">○ 16 students; 8 groups of 2 students○ Met with SASH twice to understand their needs○ Did extensive research, based off Rusk Plan○ Getting into more details of plan, including color and textile details○ Goal to have final design plan by early to mid-April○ Everyone is welcome to see initial designs on Monday, March 5th – will send meeting details out• UT Health SA Facilities<ul style="list-style-type: none">○ Jim: we are really good at cutting down time between conceptual to construction○ As soon as initial MOU with DSHS is done, we can send out RFQ for qualifications<ul style="list-style-type: none">▪ Review and send 2 or 3 for proposals and interviews<ul style="list-style-type: none">• Interview group will consist of engineers, architecture, clinical staff, stakeholders
Stakeholder Meetings	<ul style="list-style-type: none">• HMA and Meadows are in the process of sending in their proposals• Will hopefully have to you by late this afternoon or early tomorrow morning• Asked Hogg Foundation, but facilitation is not in their scope of work• Facilitation will include SWOT, Stakeholder meetings, and retreat to help Dr. Blader gather data for white paper• Proposal presentations by HMA and Meadows will be at next meeting
Next Meeting	Wednesday, March 7 th 2018 11:00 am – 2:00 pm MHM Boardroom

SASH Executive Committee Meeting

Wednesday, March 07, 2018
11:00 a.m.
Methodist Healthcare Ministries
Boardroom
4507 Medical Dr. San Antonio, TX 78229

ATTENDANCE

Scott Ackersan (HMA), Doug Beach, Joseph Blader, Chris Bryan, Edward Gonzales, Gilbert Gonzales, David Gonzalez, Allison Greer, George Hernandez, Fred Hines, Sarah Hogan, Sebastien Laroche, Tony LoBasso, Mike Lozito, Bren Manaugh (HMA), Marco Mar, Amanda Mathias, David Miramontes, Velma Muniz, John Petrila (Meadows), Christina Phamvu, Steven Pliszka, Sally Taylor, Amanda Ternan (HMA), Jeff Tunnell, Chris Yanas, Arnold Menchaca

**Health
Management
Associates
Proposal
Presentation**
Bren Manaugh,
Amanda Ternan,
Scott Ackerson

- Background
 - Bren – expertise in behavioral health, correctional health and jail diversion, and integrated care; specializes in staff and partner engagement, systems design and clinical quality improvement; business and clinical expertise
 - Amanda Ternan – background in data analytics; specialized in data management tools including strategic planning and stakeholder forums; prior project management consultant with Center for Health Care Services and Texas 1115 DSRIP waivers
 - Scott Ackerson – experience in community organization, program development and community engagement dealing with behavioral health and homeless services; expertise in integrated and collaborative systems of care; consultant with Haven for Hope for strategic housing plan; expertise in child welfare services
- HMA
 - HMA is a leading independent, national healthcare research and consulting firm providing technical and analytical services, specifically in publicly-funded health programs
 - 200 consultants in 22 offices throughout the country
- Relevant experience
 - Texas HHSC – strategic planning for delivery system for high utilizers
 - SAMHSA – comprehensive treatment planning restructuring with stakeholder engagement and TA
 - Haven for Hope – Ongoing consultation and TA
 - Date of Delaware – Behavioral Health and Primary Care Integration Service Delivery System Transformation
 - Hospital Association of Southern California – Stakeholder and environmental analysis and recommendations
 - Texas Department of Agriculture – State office of Rural Health Program Planning and needs assessment including SWOT analysis and stakeholder engagement
 - Columbus, Ohio Celebrate 1, Infant Mortality Strategy – community assessment and stakeholder engagement
 - Rapid City, SD – creating comprehensive system of care for people experiencing homelessness
- Process
 - Starts with partnering with clients and listening to their needs to best plan for the project, using best practice methodologies
 - Work closely with the client to document and assess throughout the project to avoid unforeseen risks and manage requirements
 - Track project timelines and commitments to the client to ensure optimal completion of the project components
- Approach for the Facilitation of the SASH Redesign Planning Process
 - Detailed project goals and related objectives
 - Project roles and responsibilities for MHM / the Executive Committee and HMA

- The project's main stakeholders
 - The project's critical success factors (elements necessary for the project to achieve its goals)
 - Project timeline and major milestones
 - A list of constraints, risks, and potential mitigation strategies
- SWOT Analysis
 - The structure is in the proposal
 - HMA's SWOT analysis will be more in depth due to the understanding of the community and historical needs and issues in the community
- Plan and facilitate stakeholder meetings in the SASH service area – specifically the 7 LMHA footprint regions
- Compile the information from stakeholder meetings and SWOT analyses to inform the SASH redesign plan and report
- Facilitate a retreat for the Executive Committee with objective of integrating data to inform development of the written plan and budget for full planning funds
 - HMA will make the data meaningful so the paper will be grounded by factual data and robust stakeholder input
 - Align the viewpoints of the committee

Questions

- *Gilbert Gonzales: Will you provide Spanish translation?*
 - *We will ensure people have a voice, including a Spanish translator*
 - *Will also interact with the community for other needs*
- *Steven Pliszka: How will you deal with a relatively large public area?*
 - *We will look at who we are inviting, guided by the committee*
 - *Accommodate for 100% participation, assuming they will not all show up*
 - *Communication of event through messaging and engagement & outreach, guided by the committee*
- *Doug Beach: Will you include peers in the process? If so, how?*
 - *We will engage peers through engagement and outreach in the communities*
 - *We will also include patients and family members through organizations, peer-run programs, clubhouses – hopefully with help from the committee*
 - *Scott: We worked with Haven for Hope in adding peers to their workforce, they started out with 0% and now 50% of their workforce is peers*
- *Joseph Blader: How will you engage people at SASH?*
 - *We will be developing forums, hopefully using the executive committee for resources*
 - *Collaborative process*
 - *we will ask for recommendations of key contact points – looking for champions who are able to reach out to more important people*
- *George Hernandez: Do you look at best practices?*
 - *HMA has a great understanding of the national landscape where we can see best practices and evidence-based practices emerging; we have 200 colleagues who are experts with state inpatient hospitals (ex: Virginia) and will tap into those resources from our colleagues once we get a better understanding of the project*
- *Fred Hines: I didn't see a list of inpatient or child & adolescent work on the website.*
 - *The website doesn't represent every area of clients or expertise – but it is a wide landscape*
 - *We do have a history of inpatient and child expertise and can provide additional information if needed*
 - *In addition, Bren has served at the Children's Crisis Center as a therapist and has*

developed an understanding of the needs and issues around this area

- *Doug Beach: Should we know people from the other locations who will be on our team?*
 - *Our intention is to understand the goals and then reach out to colleagues to help*
 - *If you need the bios of other team members, we can accommodate*
- *Mike Lozito: There is a possibility to repurpose some of the old buildings. How would you incorporate that into the SWOT analysis and stakeholder meetings?*
 - *It would be a collaborative process with the committee's input and direction*
 - *The goal is to use the SOWT to build a strategic plan*
- *Sally Taylor: Do you have integrated inpatient experience? In addition, do you have any relationships with the legislature?*
 - *We have colleagues in Austin that are policy experts and engaged in the state level*
 - *We do have the opportunity to look for subject matter experts within HMA, we want to match the right skill set with the committee*
- *Joseph Blader: How will you make sure the SWOT and stakeholder plan will be diverse?*
 - *We will compile the report and use the actionable report to develop an overall plan*
 - *It is hard to capture specific groups in the RFP, but we are very flexible and great and listening to what the committee wants*
- *George Hernandez: Does your budget include HMA expertise in other areas?*
 - *Yes*
- *Chris Bryan: We have been unclear on legislative intent vs HHSC interpretation. How would you help us on that?*
 - *We would do background research and intelligence gathering from our colleagues in Austin*
- *Chris Bryan: Are you involved in other state hospitals?*
 - *No*
- *Jeff Tunnell: How are you envisioning the stakeholder forums outside of San Antonio? Would it be a roundtable, a panel, etc?*
 - *We will provide clear and specific information on goals and mission; managing process to stay on track*
 - *In addition, we have provided a list of questions beforehand of areas to think about before meeting*

Discussion

- *Sally Taylor: It seems that HMA will rely heavily on MHM, is that okay?*
 - *Chris Yanas: Their budget does not include the venue or food cost, so MHM will need to access the planning budget to cover these costs*
- *Doug Beach: We need extensive information on every one of the team, including subject matter experts*
- *George Hernandez: I like how they are located in San Antonio, but their proposal could have been more detailed*
- *Chris Bryan: I like how they were specific in their expertise in project management and data*
- *Gilbert Gonzales: We need someone with a legislative connection due to the forecast of the upcoming legislative session*

Meadows

Presentation John
Petrila, Amanda
Mathias

- Mental health has transformed in the last 30 years; we have a better understanding of mental illness and their affects
- History
 - MMHPI has been around for 4 years, philanthropically funded
 - Vision: we envision Texas to be the national leader in treating people with mental health needs
 - Mission Statement: To provide independent, non-partisan, and trusted policy and program guidance that creates systemic changes so all Texans can obtain effective, efficient behavioral health care when and where they need it
 - Bridge with state policy and local systems
 - Learn from different communities
- We work with communities across Texas
 - Redesigning local mental health systems
 - Informed by best practices and data
 - Involving key stakeholders
 - With a focus on integrated care
- We have several local system efforts including:
 - HB 13 and SB 292 assistance throughout the state, including CHCS
 - Working with Bexar County Judicial Services for the waitlist
- What usually happens when a state redesigns a state hospital?
 - It looks but, but it is not well suited for treatment, takes only forensic patients, is redesigned by state officials, and does not change existing use
 - Texas is special where the Legislature wants local communities to redesign their own state hospital
 - Multi-purpose campuses
 - Tied to universities
 - In a redesigned and integrated service system
- MMHPI SASH Redesign Proposal
 - We will engage the community, SWOT analysis (using county-specific data), and facilitate the retreat and framing the white paper
- Engaging the Community
 - Work with each LMHA to identify, convene and interview key stakeholder
 - Interview additional stakeholders as identified by Planning Group
 - 2 people will be assigned to help schedule these interviews
 - Patients and staff are supported
 - Tailor interventions to the SASH community
 - Report to Planning Group
 - Weeks 1-2: scheduling
 - Weeks 3-6: interviews depending on scheduling
 - *Joseph Blader: what is your background at the state facility redesign?*
 - *MMHPI has 4 years of state hospital – legal and policy assistance*
 - *We have not been to San Antonio State Hospital, but working closely with ASH and other projects in the state*
 - *Sally Taylor: How will you design the SWOT analysis?*
 - *Amanda: We look at pathways in and pathways out; looking at barriers and continuity of care*

- SWOT Analysis
 - The SWOT will include results from stakeholder engagement and interviews, as well as an analysis of the prevalence of mental illness and serious emotional disorders within the SASH catchment areas, including social determinants
 - Weeks 1-2: data analysis begins
 - Weeks 5-9: analyses from stakeholder engagement
 - Examples of SWOT
 - Strengths: pilot programs; STRAC; Haven for Hope
 - Weaknesses: Service gaps, collateral issues
 - Opportunities: TAV health, criminal justice initiatives
 - Threats: changes (DSRIP)
 - *George: I don't see how DSRIP can be a threat. A threat would be the lack of unity between different areas of the state on their DSRIP projects*
 - Examples of prevalence data and inpatient psychiatric beds (for ASH)
- Planning Group Retreat and Plan
 - MMHPI will organize, facilitate, and report on a day-long retreat of the Stakeholder workgroup, as well as additional invitees as selected by the Stakeholders
 - The retreat will be held closer to the end of the project
 - Will result in white paper outline for next phase planning
 - Weeks 7-conclusion
- MMHPI Team
 - Leads: John Petrila and Amanda Mathias
 - Members: Tim Dittmer, Sam Shore, BJ Wagner, Ron Stretcher, Michele Guzman, Tegan Henke (bios in packet)
- Examples of timeline, work plan, and work plan by week

Questions

- *Joseph Blader: Where will you get data on the ED visits?*
 - *We have knowledge of coding and analyzing data on the THIC database and have worked extensively with THA's data analyst*
- *Joseph Blader: How will you conduct interviews at different sites? How do you know you have the right people at sessions? Will you get input from patients or peers?*
 - *We are using the guide in your proposal, but we will take guidance from the committee*
 - *For peers, we used organizations to reach out to other organizations (peer services) and NAMI was able to provide resources as well*
 - *We will plan for onsite interviews and who phone interviews for the people we missed*
 - *We already have a list of stakeholders in some counties*
- *George Hernandez: Who will be in charge of evidence-based practices?*
 - *Amanda and Tegan*
 - *We already have a big portfolio of best practices out there*
- *Chris Bryan: How will you help us with legislative intent vs. HHSC interpretation?*
 - *we have relationships with people who sponsored the funding and will be able to help clarify some information*
 - *I think the gap with HHSC is due to cautious interpretation for legislative will*
 - *It is a political task, but we have the relationships at the capitol*
- *Chris Bryan: Meadows hasn't prioritized SASH at a state level in the past, why?*
 - *Our role was not the prioritize particular areas, but shape policies in Austin*
 - *We would have the same criticism in Dallas, but we were there to help communities when needed*

Discussion	<ul style="list-style-type: none">• We have \$340,000 budgeted for SWOT, stakeholder, and retreat, but we need to set money aside for food, venue cost, and others• Steven Pliszka: Meadows does have access to data• Joseph Blader: in addition, they are engaged in content area• David Miramontes: Their role should be more data driver rather than interpreting the data, which is our job• Chris Bryan: There is no history of support from Meadows at state level for SASH funding; there is concern of how the final proposal will get translated in the legislature; we will need to go back to the Legislature and fight for construction funds in 2019• Mike Lozito: Can we contract with both? Meadows for SWOT and HMA for stakeholder engagement? – concern for lack of time• Doug Beach: The best group at the UTSA Architecture presentations was their idea to look at it conceptually first, which is what Meadows did today in their presentation. They already know about the state hospitals and their data• George Hernandez: Meadows does have a stronger proposal; and we have to set aside what happened in Austin• There is concern for competition with ASH at state level when asking for money, who will Meadows prioritize?<ul style="list-style-type: none">○ <i>George Hernandez: We can put in a conflict of interest clause</i>
Next Steps	<ul style="list-style-type: none">• Chris Yanas will send out possible dates for a future meeting to finalize the selection of SASH project consultants

SASH Executive Committee Meeting

Tuesday, March 13, 2018

11:30 a.m.

Methodist Healthcare Ministries

Conference Room 3

4507 Medical Dr. San Antonio, TX 78229

ATTENDANCE

Doug Beach, Joseph Blader, Chris Bryan, Allison Greer, George Hernandez, Sarah Hogan, Sebastien Laroche, Tony LoBasso, Velma Muniz, Christina Phamvu, Steven Pliszka, Sally Taylor, Jeff Tunnell, Chris Yanas, Arnold Menchaca, Molly Biglari, Cynthia Cabral, Raul Garza, Gilbert Gonzales, JeLynne LeBlanc-Burley, Alwyn Mathew, Johana Rodriguez, Bart Vasquez, Allen Pittman, Sedef Doganer, Rachel Samsel, Amanda Flores, Lauren Lacefield-Lewis, John Robert, Renu Razdan

Update on where we are

- In the process of selecting a facilitator for the stakeholder meetings, SWOT analysis, and retreat
- At the same time, we are starting the construction phase with UTSA School of Architecture design and starting process for hiring an architecture firm
- Last week, we heard presentations from Meadows and HMA on their proposal
 - Meadows was in depth and we like how they had access to data, but there is a cost issue
 - HMA provided more details in the addendum (provided)

Discussion on proposals

- While the Meadows proposal was detailed and thorough, will there be any problems from HHSC? Can we put in the contract that the data collected will be ours, not Meadows?
 - *HHSC: Ultimately, HHSC owns the data. We have engaged with Meadows on several programs, but we will still need to run through the proposal and contract to make sure everything is okay. Once we get the recommendation from the steering committee, I will run it by leadership and we will let you know if there are any concerns.*
- Who signs the contract? The local entity or HHSC?
 - *HHSC: you will sign the contract, but HHSC leadership will need to ensure that we are good with the proposal*
- Concern with Meadows proposal amount and if they will be flexible
- How do the proposal amounts compare with ASH and other efforts?
 - *HHSC: The amounts should be based off your budget plan. You are allocated \$1 million and how much you decide to allocate to the facilitator is up to you. I would suggest asking for detailed budgets between both contracts*
- Tony: MHM usually bills on a work statement, but we need a more detailed budget. We have a template for grantees that provide information on everything we need, but we also welcome their own too. We can pass that along to the organizations
- Meadows provided a vague budget of:
 - \$175,000: stakeholder meetings
 - \$80,000: SWOT analysis
 - \$30,000: retreat
- Is it possible to ask Meadows to come down and present their budget, possible negotiation?
 - Look at detailed budget and areas to save
 - Is there a need for 5 people to go to regional meetings or can we negotiate to 2 people?
- HHSC funds cannot pay for food. Rachel (HHSC) can provide information on allowable cost using GR funds
- How does HHSC factor in travel pay?
 - *HHSC: We don't get too involved with a subcontractor. If the contract is acceptable to you guys, then you guys will be the ones negotiating travel pay.*

Final Thoughts:

- Chris Y. and Dr. Pliszka will draft a written email requesting a detailed budget (using the template from MHM) and a detailed outline of their product (with deliverables) by **Wednesday, March 21, 2018**
- MHM will also include contract guidelines that explain reimbursable rates (hotel, food, etc.)
- Once the budgets are sent in, we will meet **Friday, March 23, 2018** to go over detailed budgets and start the negotiating process with both organizations

HHSC Updates

- We are working on a letter to LBB to request additional money for construction
- We are in the process of completing town hall meetings for staff members of the hospital on construction needs
 - Producing feedback and FAQ sheets
 - 2 more town hall meetings
 - Will share information with us

Update on UT Health – Architecture Firm

- We need approval from the Chancellor (formality) and then we will start getting together an RFQ
- Our facilities team is out on spring break, but will hopefully get dates by next week so the architecture sub-committee can meet with them to get started on the RFQ process

Next Steps

- Tony L and Chris Y will work together on getting contract guidelines and template budget for the organizations
- Chris Y and Steven P. will work on a draft email to send to HMA and Meadows requesting information
- Chris Y. and Sally T. will confirm room location for next meeting
- **Next Meeting: March 23rd, 2018 at 11:30 Location TBA**

SASH Executive Committee Meeting

Tuesday, May 8th, 2018

11:30 am

UTSA Downtown Campus

Monterey Building 4.420

301 S. Frio St, San Antonio, TX 78207

ATTENDANCE

Robert Arizpe, Doug Beach, Molly Biglari, Joseph Blader, Chris Bryan, Sedef Doganer, Raul Garza, Gilbert Gonzales, Allison Greer, Fred Hines, Sarah Hogan, Sebastien Laroche, Jelynn LeBlanc-Burley, Gilbert Loreda, Arnold Menchaca, David Miramontes, Christina Phamvu, Steven Pliszka, Sally Taylor, Chris Yanas, Garret Mortin (HHSC), Davis Pan (CHCS), Amanda Mathias (MMHPI), John Petrila (MMHPI), Sam Shore (MMHPI), John Robert (HHSC), Carol Skacal (HHSC), Allen Pittman (HHSC), Renu Razdan (HHSC), Rachel Samsel (HHSC), Ruben Acevedo (SASH), Juan Medrano (SASH)

Update on Architecture Plans

Dr. Steven
Pliszka, UTHSA

- We are hopeful to issue contract with MMHPI this week
- Even though the contract states that UTHSA will receive the data, everyone in the Executive Committee will review the data; it will be an open discussion
- The Board of Regents of the UT system will be considering how they coordinate efforts with the State Hospitals
 - Dr. Pliszka will meet with Mike Black, Senior Executive Vice President and COO UTHSA and then we will start the RFQ for an architecture firm (parallel with the stakeholder meetings and SWOT analysis)
- The architecture committee consists of:
 - Molly Biglari
 - Dr. Pliszka
 - Sally Taylor
 - Joseph Blader
 - Doug Beach
 - Chris Yanas
 - Clarity representative
 - David Miramontes (will invite the Fire Marshall)
 - HHSC Maintenance representative
 - Bob Arizpe
 - *Please let us know if you would like to be included*

Update on Data Collection, Stakeholder Meetings

MMHPI – John
Petrila, Amanda
Mathias, Sam
Shore

- The timeline is more relaxed, so we will have time to prepare meetings
- We are starting the SWOT analysis on Bexar County due to the amount of access of data that we already have
- We are also working on gathering data at a county level for all the LMHAs in the catchment area
 - 3 years of data, from March 2015 – March 2018
 - Three main areas of focus: civil, voluntary and forensic patients
 - *Dr. Arizpe: Voluntary beds are a small population, so SASH groups voluntary patients with civil patients*
 - The data shows there is a decrease in civil admissions and an increase in forensic admissions
 - *In order to get the whole picture, we need to consider the variables: the decrease in civil beds may be due to the number of offline beds due to staffing or the length of stay increasing due to less short turnaround patients*
 - *We need to look at the average census and length of stay at the hospital*
 - THCIC Data to look at discharge information
 - *We have to be careful with the data because it may show as a discharge, but there may have been a re-admission or a step-up or step down in programs;*

we need to keep track of level of care and some providers have to do that manually

- *What information do we have on co-morbidities?*
 - THCIC can look at diagnosis, but we will have to look into looking at co-morbidities (help on diagnosis codes)
- We are also looking at detox data
 - MMHPI will put in a request for SASH specific data
- *How is our time schedule compared to ASH?*
 - ASH and SASH are on a similar time schedule
- HHSC is reassessing the hospital's catchment area
 - However, the catchment area is not a hard boundary line – we are working as a system instead of individual hospitals
 - We can send out the new catchment area as soon as we finish the public document
- Stakeholder Engagement
 - LMHAS want to have face-to-face or phone call with MMHPI before giving out distribution list
 - We have 6 open-ended questions that we are going to standardize

**Legislative
Policy
Subcommittee**
Chris Yanas,
MHM

- The Legislative Policy Subcommittee consists of GR people:
 - Chris Bryan
 - Eric Epley
 - Allison Greer
 - Gilbert Loreda
 - Gilbert Gonzales
 - Andrew Smith (UHS)
- We are setting up a May 30th Lunch & Learn at the MHM boardroom

Next Meeting

- Wednesday June 6th at 11:30 am at Methodist Healthcare Ministries (4507 Medical Dr.)

SASH Executive Committee Meeting

Friday, June 08, 2018

11:30 am

Methodist Healthcare Ministries
Boardroom
4507 Medical Dr

ATTENDANCE

Robert Arizpe, Doug Beach, Molly Biglari, Joseph Blader, Chris Bryan, Jacqueline Cantu Sedef Doganer, Gilbert Gonzales, David Gonzalez, Sebastien Laroche, Jelynn LeBlanc-Burley, Gilbert Lored, David Pan, Christina Phamvu, Steven Pliszka, Sally Taylor, Jeff Tunnell, Chris Yanas, Amanda Mathias (MMHPI Allen Pittman (HHSC), Rachel Samsel (HHSC), Amanda Flores (HHSC), Vincent Creazzo (SASH)

Update on State Contract and Planning Budget Dr. Pliszka

- We made some edits to the budget to comply with HHSC and UT Health's contract terms
- The original budget:
 - \$360,000 to UT Health
 - \$340,000 to Stakeholders
 - \$300,000 for Architecture
- Revised budget:
 - \$350,000 to UT Health
 - \$267,073 to Stakeholders
 - \$240,835 to Meadows Mental Health Policy Institute
 - \$26,238 to Methodist Healthcare Ministries
 - Savings to be added to the Architecture budget; will total \$382,927 for Architecture
- UT Health Budget
 - \$220,195 for personnel and salaries
 - \$130,435 for indirect charges
 - Totals to \$350,630 for UT Health Budget

Update on Architecture Plans Dr. Pliszka

- Dr. Pliszka had a meeting with UT System 2 weeks ago – full support of UT system's involvement with state hospital reconstruction
 - UT System's Office of Facilities, Planning and Construction will be involved with UT Health on architecture work; Jim Kazen (UT Health) will serve as the liaison
- Dr. Pliszka will meet with Jim Kazen on Monday (June 11) to prepare architectural RFQ
 - Will have more information next meeting on details of RFQ and bid process
- Doug Beach had a question about the work and funding of architectural designs from UTSA School of Architecture
 - The \$100,000 allocated to UTSA School of Architecture is for the student designs from this semester and their ongoing work next semester

Update and Group Discussion on SASH Stakeholder Meetings Amanda Mathias

- We are coordinating with LMHAs to interview key stakeholders
 - Worked with Jelynn and CHCS for the Bexar Stakeholder meeting on June 4th
 - Working with Terry Crocker (Tropical Behavioral Health) to contact key stakeholders
 - Had a conversation with Chief Rodriguez (McAllen) and he had some great points on SASH design process and community input from a law enforcement point of view
 - Working with Jeff Tunnell (Gulf Bend) to set up a stakeholder meeting in Victoria area
 - Continued outreach efforts to:
 - Coastal Plains Community Center
 - MHMR Center of Nueces County (Mike Davis)
 - Border Region Behavioral Health Center
 - Camino Real Community Services
 - Jelynn Burley mentioned that the Texas Council meeting is next week in Dallas and all the executives of the LMHAs will be attending. She is willing to reach out to the LMHAs to coordinate stakeholders

-
- Amanda will work with Jelynn to help coordinate efforts with LMHAs
 - Overarching themes from the June 4th meeting
 - Many community stakeholders had concerns about access to services
 - Many community partners also mentioned workforce issues at SASH lead to lack of access to services
 - Salaries / shortage of staff
 - We asked if adolescents should be served at SASH; community partners stated satellite campuses were better for adolescents due to families having trouble finding transportation
 - Law enforcement brought up design / structural needs: secure entry and exit points, weapon boxes
 - Providers mentioned need for technology to communicate to partners and patients
 - There are no policies or processes for continuation of care
 - Many stakeholders expressed the need for some sort of step - down or transition services on campus
 - Stakeholders recommended ACT or ACT-like teams to provide wrap around services for individuals leaving SASH
 - Programs to coordinate police
 - Chief Rodriguez (McAllen) stated that McAllen lost 3 people this year because it is hard to follow patients after they leave
 - Stakeholders addressed respite for families, especially with adolescents
 - Parents will call police when they need a break
 - Parent education
 - Rural community stakeholders addressed the lack of crisis services in their area
 - We are setting up stakeholder meetings for:
 - Dr. David Miramontes for ED/EMS personnel
 - Dr. Sally Taylor asked if we have data from SASH about people they see with co-morbidities and special populations
 - Doug Beach/NAMI and families who have been through the SASH system
 - Bob Arizpe and SASH employees on needs and data
 - Doug Beach w/question: where will the information of community needs go? Our scope is to design the process, but the stakeholders address concerns about their community needs
 - The committee will address the community needs and information in the white paper
 - It will include recommendations to SASH and the mental health system as a whole, including communities
 - Construction funds may be used for services outside of campus, depending on cost of construction and FTE (the services can't take away from the FTE at SASH)
 - There were varied responses on whether acute patients should be treated at SASH
 - Sally Taylor mentioned that there are different levels of acuity
 - Bob Arizpe asked if there were any comments on forensic patients
 - Most of the conversation talked about gaining or protecting Civil beds
 - The long jail times for maximum security beds were addressed
 - Kerrville and Rusk State Hospital are increasing the number of maximum security beds, which may alleviate the SASH community
 - Dr. Edward Gonzalez stated that the large majority of their beds will be forensic and the structural design should accommodate for forensic patients
 - Competency and training classes
 - How to design to make the process more efficient; it takes more staff to walk to a patient than it would for a patient to walk to the training room themselves
 - Executive Committee members asked about the number of forensic and civil beds at SASH

- 60% of beds are forensic and 40% are civil and the trend seems to continue in the next couple of years
 - SASH has 302 beds total, 116 forensic (186 civil)
 - However, forensic patients may be put in civil beds and civil patients may be placed in forensic beds, depending on the need
 - SASH plans to put acute patients that do not specifically fit in a certain unit into the newly renovated 40 bed unit to open up 40 more beds in the units
 - Dr. Edward Gonzalez stated that if the community wants to increase PICU (psychiatric Intensive Care Unit) beds, then SASH would need an increase in staff
 - Need to find a balance for staff and number of PICU beds
 - SASH has 20 adolescent beds (ages 13 to 17) and they have had an average of 16 adolescent patients at a time in the last 4 years
 - SASH cannot physically separate children and adolescents, so they do not offer child services at this time
 - Community stakeholders mentioned that there is a yearlong wait at Waco
 - Rachel Samsel (HHSC) stated that Waco does not have a long wait list, but there are certain requirements for admission; it may be perception that there is a long wait list, due to the requirements
 - Doug Beach mentioned that the community input would allow us to advocate for policy changes for communities to address their needs
 - Chris Bryan mentioned that if we put together a strategic plan of SASH that includes the community needs, we will have a roadmap for other potential grants and policy initiatives from the Legislature to provide these services
 - Jeff Tunnell recommended that the report and data should include how the state has spent money to relieve the SASH waitlist
- Data Analysis**
Amanda
Mathias
- We have sent in an HHSC request for hospital usage data
 - Jelynn Burley mentioned working with a subcommittee on the Mayors Housing Task Force and they have started using the term “service-enriched housing”
 - She recommended that the committee begin to use “service-enriched” terms in the plan and when talking to communities
 - Joseph Blader mentioned that THCIC data does not contain prevalence of co-morbidities. Is there anywhere to find that information for SASH?
 - Amanda Flores (HHSC) will talk to the quality team and look at the data to see what they can pull for us
 - Members of the committee mentioned the need for data on utilization for the contracted beds and DFPS contracted beds
 - Chris Bryan educated members of the committee on the process of CPS beds and lack of coordination for placement, especially with the move towards managed care
 - Joseph Blader had questions about the amount of foster care or CPS children are seen at SASH
 - Clarity has data from their site on readmission for children in StarKids
 - Dr. Sally Taylor recommended the state and hospital(s) data should be connected through STRAC to show the number of DFPS kids seen at SASH or in the community
 - Joseph Blader asked about rehospitalization data from SASH
 - Dr. Edward Gonzalez thinks that there is a new State Utilization Committee that may be looking into it
 - Amanda Flores will be able to help us find that information
- Next Meeting**
- Friday July 13th, 2018 at 11:30
 - MHM, 3rd Floor Boardroom

SASH Executive Committee Meeting

Friday, June 13, 2018

11:30 am

Methodist Healthcare Ministries
Boardroom
4507 Medical Dr, San Antonio, TX

ATTENDANCE

Robert Arizpe, Doug Beach, Molly Biglari, Joseph Blader, Cynthia Cabral, Jacqueline Cantu, Raul Garza, Allison Greer, George Hernandez, Fred Hines, Sarah Hogan, Sebastien Laroche, Jelynn LeBlanc-Burley, Tony LoBasso, Gilbert Loreda, Mike Lozito, Amanda Mathias (MMHPI), Alwyn Mathew, David Miramontes, Neda Norouzi (UTSA), Christina Phamvu, Steven Pliszka, Joanne Sundin (Baptist Health System), Sally Taylor, Chris Yanas, Vincent Creazzo (SASH), Jim Kazen (UTHSA), Tiffany Juarez (SASH), Jessica Miller (Baptist Health System), By phone: Allen Pittman, Rachel Samsel

Architectural Design

Jim Kazen and Steven Pliszka

- Steven Pliszka (UTHSA): We have sent out the call for RFQs for architecture design companies
- Jim Kazen (UTHSA): We had a pre-submittal conference in June and about 10 architectural firms attended
 - UT Health is going through the vetting process and we will work with the Executive Committee to narrow the list of firms to 3
 - We will be asking members of the Architecture Subcommittee to join us in interviews
 - There is a tight timeline to the Legislature for accurate funding of the building, so we will be moving quickly
- Steven Pliszka (UTHSA): I will send out an email next week to the Architecture Subcommittee about the interview process and updates

Stakeholder Meetings

Amanda Mathias

- We have had several stakeholder meetings and some great feedback from each meeting (Nueces County, Gulf Bend, ED Operations, CHCS Crisis Stabilization Unit, NAMI Peers)
- We have tried to reach out to 3 LMHAs, but have not received a call-back; Chris Yanas will reach out through MHM's funded partner connections
- Allison Greer sent out a request for bed data to all the LMHAs and we will use this data in the SWOT analysis
- A former SASH patient (now peer specialist) from the NAMI stakeholder meeting has offered to pull together other peers that have been through SASH for additional information. We will work with her and NAMI to set up the meeting
 - NAMI members had great things to say about the treatment they received at SASH

Law Enforcement Navigation of Behavioral Health Patients

Dr. David Miramontes

- In Texas, patients are emergency detained by police officers and judges only
- We created the "easy button," which allows law enforcement officers (LEOs) to transport to the closest ER
 - Medically stable psych patients can clog up the ERs while awaiting a transfer
 - Why can't LEOs take stable psych patients to freestanding psychiatric hospitals?
 - Barriers include financing and insurance
- What is an Emergency Detention?
 - Health Safety Code Title 7 Ch. 573
 - Sec. 573.001 Apprehension by peace officer without a warrant
 - Reason to believe a person has a mental illness **and**
 - Substantial risk of serious harm unless immediately restrained **and**
 - Not sufficient time to obtain a warrant
 - "substantial risk of serious harm" is demonstrated by
 - The person's behavior
 - Reports from others can be allowed

-
- Evidence of emotional distress and deterioration in the person's mental condition to the extent person cannot remain at liberty
 - Officers must transport
 - To inpatient mental health facility
 - Or approved mental health facility by the county mental health authority
 - To EMS with a MOA
 - Jail or detention facility (but kept separate from other people)
 - *It doesn't mention emergency rooms*
 - Officers may seize firearms
 - Good for 48 hours (not including weekends)
 - Mental health warrant from a judge
 - Family, friends or others can petition the court if
 - There is evidence the person has a mental illness
 - They believe there is substantial risk of harm to self or others
 - Must specify the risk of harm in detail
 - Must document behaviors, acts, or threats
 - Must state risk of harm is imminent
 - A physician may also file for MHW if the patient is in their care (fax)
 - Probate Court issues MHW
 - The clerk will file the order
 - Warrant is sent to Bexar County Sheriff
 - BCSO Mental Health officers will evaluate and detain
 - Patient is transported to inpatient psychiatric facility
 - Order is good for 48 hours (not including weekends or court holidays)
 - What we had:
 - We need a system and a way to communicate who had open beds
 - We needed to send the BH patients to the right place on the first transport
 - How do we reasonably "medically clear" patients?
 - How can we track and make sure we are doing the right thing?
 - We developed a system
 - Letter of agreement with partners
 - MEDCOM's navigation process
 - LEOs are trained to call EMS only when needed
 - LEOs call MEDCOM to coordinate and load balance psych hospital transports.
 - MEDCOM navigation system
 - Separated into categories (age groups, gender, etc.)
 - Diversion means that the hospital is at capacity
 - Diversion override is for the zone
 - Long term diversion
 - LEOs MEDCOM emergency detention protocol includes screening for medical conditions that may require emergency department medical evaluation
 - Patients may not be released for MEDCOM Law Enforcement navigation to a free standing psychiatric hospital if they have
 - Lacerations, significant abrasions, wounds or trauma
 - Any history of ingestion/ OD
 - Significant intoxications, agitation, delirium or aggressive behavior such that they cannot walk or participate in psychiatric interview
 - Any peg tubes, implanted ports, lines or medical problems that are not under control
 - Program Growth

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- Program launched in October 2017 with only 2 SAPD shifts and restricted to downtown districts **39 transports to psych facilities**
 - Expanded to all San Antonio districts by November and launched Bexar county MH unit **297 transports**
 - December **563 transports**
 - January **603 transports**
 - Law Enforcement Navigation (Oct 2017 – May 2018)
 - LEO navigated by MEDCOM = 55%
 - In hospital, ED = 29%
 - Self-Navigation = 5%
 - LEO to Magistrate 2%
 - LEO to general hospital = 1%
 - EMS to general hospital = 8%
 - 71% transported navigated in the fields
 - 29% transported navigated in the hospital
 - Does not include hospital ED data from Bexar County Hospital District Police (working on obtaining the data)
 - MEDCOM Navigations
 - Increased navigations on Mondays, Thursdays, and Fridays
 - Navigations are increase in the evenings
 - Also follows nurse shifts increase and schedules
 - May 2018 had 739 navigations
 - Prue area (11%)
 - North area (14%)
 - East (12%)
 - BCSO (10%)
 - South (15%)
 - Central (18%)
 - West (16%)
 - Other (4%)
 - May 2018 navigations by demographics
 - Children less than 12 years old
 - 40% female
 - 60% male
 - Adolescents (12-17)
 - 57% female
 - 43% male
 - Ages 18–64
 - 35% female
 - 65% male
 - May 2018 in hospital detentions
 - 12% Christus
 - 9% SWG
 - 14% NIX
 - 36% Baptist
 - 29% Methodist
 - Performance Improvement Process
 - We have a performance improvement committee with representation from:
 - STCC
 - MEDCOM
 - Psych facilities

	<ul style="list-style-type: none"> ▪ LEO ▪ OMD / SAFD ○ Secondary transfers are red flags because it means our triage system didn't work ○ Our workgroups are confidential and cannot attend by phone call to keep confidentiality • The future and beyond for emergency detentions <ul style="list-style-type: none"> ○ TAV Health is looking to tag patients and analyze social determinants of health ○ ISD law enforcement ○ Further training ○ Gathering and processing data <ul style="list-style-type: none"> ▪ Decreased wall times – the time the paramedic enters the hospital to the time there is an available bed ▪ Decreased boarding times – the length of stay in the ER ▪ Right patient to the right hospital ○ We are working on in-hospital navigation ○ Also working on pairing law enforcement with telepsychiatry ○ A big gap is admission pregnant women with behavioral health issues <ul style="list-style-type: none"> ▪ Women will have to stay in the hospital for 3 months because of lack of availability ▪ Challenging placement
Recommendations of funding Steven Pliszka	<ul style="list-style-type: none"> • During the next meeting, we will go into further details on making recommendations of funding <ul style="list-style-type: none"> ○ Should the funding be used all for the SASH campus or build off-campus ○ We can't reduce the beds or staff at SASH ○ Should we look into long-term housing and assisted living? ○ Should we look at a downtown structure for integration of the crisis stabilization unit? • Sally Taylor: During the stakeholder meetings, many stakeholders mentioned satellite campuses, especially for adolescents • Tiffany Juarez– satellite campuses are difficult to operate <ul style="list-style-type: none"> ○ The judges and the community need to understand the system ○ Dr. Arizpe: There is also a difficulty with securing staff;
Next Meeting	Chris Yanas will follow up with SASH Committee with suggested dates for next meeting in the month of July.

SASH Executive Committee Meeting

Tuesday, July 31st, 2018
11:30 a.m.
Methodist Healthcare
Ministries - Boardroom

Attendance:

Robert Arizpe, Molly Biglari, Chris Bryan, Cynthia Cabral, Jacqueline Cantu, Raul Garza, Gilbert Gonzales, David Gonzalez, Allison Greer, George Hernandez, Fred Hines, Sarah Hogan, Tiffany Juarez, Sebastien Laroche, Jelynn LeBlanc-Burley, Tony LoBasso, Mike Lozito, Amanda Mathias, Jessica Miller, David Miramontes, David Pan, Christina Phamvu, Steven Pliszka, Joanne Sundin, Sally Taylor, Jeff Tunnell, Bart Vasquez, Chris Yanas, Vincent Creazzo (SASH), Neda Norouzi (UTSA), Jim Kazen (UTHSA), Amanda Flores (HHSC). By Phone: Doug Beach, Rachel Samsel

SASH Diversion Bob Arizpe

- As of July 31st, SASH has stopped admission for adults, but will continue to take adolescents for short-term visits.
- SASH will be closing 36 bed units, leaving 72 beds available for adults services.
- If everything goes perfectly, we will be able to open back up in 2-3 months (by October or November)
- Impact of patient flow
 - Four full treatment teams working with patients will be able to respond more quickly and more individualized treatment
- Sally Taylor: What is the outlook at this next session on workforce shortage?
 - Amanda Flores: that has been a priority for HHSC for several sessions; we are close to talking to the public on our recommendations. We meet with Dr. Pliszka monthly - hopefully we will be able to talk to them about legislative initiatives next month and he will be able to relay the information back to the team.
- Chris Bryan: In our data piece, can we put in how many times over the past three sessions there's been a call for diversion related to workforce?
 - There will be more information for HHSC to utilize.
- Chris Yanas: is it a shortage of nurses in Bexar area or is it the issue of salary?
 - Bob Arizpe: We are having trouble recruiting medical assistants, psychiatric nursing assistants, but it is primarily RNs
 - Our salaries are not competitive, but there is also a state and national shortage
 - SASH can't compete with sign-on bonuses and market salaries
- Jeff Tunnell: I know HHSC has \$120 million biannually to support inpatient services at other hospitals. Are they going to up the amount next session?
 - Amanda Flores: once we have a confirmed list of what HHSC can talk about publicly, we will have more details

Architecture Firm Proposals Jim Kazen

- Ten firms have submitted their qualifications and we are spending time going through each packet and checking references
- We will be convening on the 8th of August to shorten the list to four firms, all of whom I will interview
 - Anyone who wants to be included in the interview process, contact me or Dr. Pliszka
 - We will interview the major firms and all the major subcontractors
 - We will include HHSC in the interview process

Stakeholder Meeting Amanda Mathias and Chris Yanas

- Amanda Mathias: We have met with or scheduled to meet with all of the LMHAs in the SASH catchment area
 - Already pulling information from interviews to put into SWOT analysis

- Amanda Mathias expresses gratitude for the MHM team on how much time and effort they have put into the project and the stakeholder meetings.
- We should think about times where we should get together for the retreat
 - Week of September 10 (except the 14th)
 - September 20th or 21st
 - MHM will send out a doodle poll
- We would put together the SWOT and report and we will present it to you at the retreat for your report
- Chris Yanas: We have been meeting with LMHAs and there are a lot of very committed people. There are themes of the same issues impacting all of LMHAs, including not having access to SASH and not having the local resources to care for these complex patients. The patients are in the hospital ERs for hours but are not getting mental health care. Just like Bexar, they are doing their best to develop local solutions to take care of their own.
- Amanda Mathias: When anyone talks about the care in SASH, it is phenomenal care and the staff is amazing. The folks that work there are doing everything they can to get people admitted from rural communities
 - It has been inspiring to hear about how these communities work together to create their local solutions

Flow of Patients
Steven Pliszka

- People in crisis are coming in two major areas: either self-referred or through law enforcement
- They fall into 3 main buckets: crisis center (downtown), many are rotated between free standing psychiatric hospitals, and ERs
 - Out of this grouping, a small number of patients get into SASH through civil commitment
 - The others when discharged, are moved to a variety of different services
 - The question at that point is if they make a successful connection with services? If they don't, they repeat the same cycle
 - Most the people from Bexar County that go into SASH have been coming from hospitals
 - At Baptist, they do not go from the crisis center to the ER
 - There are 342 beds in SASH, there are 737 people cycling through the LE system
- Law enforcement navigation is a small flow of people going through the system
 - In May, 739 LE navigated patients
 - About 167 went to general ERs or to the magistrate
 - 569 went to free standing psychiatric hospitals
 - The 569 patients that went to free standing psychiatric hospitals aren't the only patients that the hospitals are seeing; walk-ins would add to the LE to get the total admissions.
 - how many go to SASH?
 - Others are discharged or in the hospital waiting to go to SASH
 - LE sent 170 to crisis centers
 - Crisis center received 232 from other sources
 - About 300 of the folks were placed in observation
 - 45 of the patients were hospitals and 0 were sent to SASH
 - The majority being sent to community services
 - The question is if the patient goes to community services or do they cycle back into the system?
- George Hernandez: is Christus Santa Rosa not included?
 - They don't have anywhere to house the patient
- David Gonzalez: most of our patients from Bexar come from the hospitals.

**Group Discussion
on possible
satellite campus
options**

- It is rare to receive a patient from a medical ER to the crisis center to SASH
- There are 342 beds at SASH, from LE navigation alone, there are 739 people in the system and that doesn't include everyone else who is in crisis. We can assume there are about 1400 people that need SASH, but there are only 342 beds.
- We need more information on how the process works outside of Bexar and I'm hoping to get that information through Meadows' work.
- If we are going to impact the system, the way we are organizing the crisis services will need to a separate process from SASH, but there needs to be coordination.
 - Do we want a new building downtown to bring these services together?
 - When I was meeting with the crisis team, the buildings are not in the best shape
 - The building was an insurance office and has been converted
 - A new building could be expanded to include other services to make a "one stop shop" and coordinate medical record system to make it more efficient
 - If some of the construction funds can be used for that and we get some matching funds from the community, we can reduce the footprint at SASH
- Jelynn: How do we deal with crisis from outside the Bexar Community?
 - The places that don't have psych services sit in the ER and the others go to hospital contracted beds
 - They also come into the Bexar County and STRAC is working to maneuver the data to figure out the volume
 - Amanda Mathias: we have been told that the police will get called from the ER to transport patient to a psych bed
- George Hernandez: We don't have the resources to build two facilities in Bexar County. The first priority is SASH. If we have money left over, we should look in the rural areas to relieve their burden
 - That will require as much money as what we have here. I think we need a subgroup on how to fund that area
- Amanda Mathias: The communities are asking how UT Health San Antonio will be involved with that process?
- Amanda Flores: One of the directives that Dr. Pliszka has gotten from HHSC leadership is that he would explore any potential satellite sites within Bexar County only, because the State cannot lay off staff or move staff.
- Sally Taylor: When I have been reading the notes from the LMHA stakeholder meetings, it seems best to make a PES or CSU with 5 or 6 beds in the rural areas.
 - Amanda Flores: HHSC may have that in mind. They are talking about what to do in those areas on how to contract, but it is not tied to the rider on SASH construction
 - We can propose several solutions that aren't tied to construction. If the proposal talks about contract beds or telepsychiatry, it can be solution.
- Jeff Tunnell: Within your chart, outside Bexar County, there is a whole piece missing.
 - Dr. Pliszka: Once we get the information from the MMHPI, we can add the missing piece
 - Jeff Tunnell expressed concern to Committee members about building a satellite location in San Antonio and reconstructing SASH at the same level. Rural county jails and ERs are housing patients and dealing with the community because SASH is not a primary location for rural counties. There is frustration within the rural counties to fully address the needs of the other catchment counties when it comes to SASH.
- Chris Bryan: San Antonio or someone in our area should fill the vacant spots on the Behavioral Health Advisory Committee to get involved and provide input to the state agency.

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- Jelynn: Once we know more about the rural communities, we need to map that. I'm wondering if we should also put the navigations that come out of the new justice intake process and the crisis stabilization unit in our report or analysis.
 - Mike Lozito: There is only so many dollars designated to do what we need to do, which is the rebuild of SASH. It would be creative to look at other funding streams
 - George Hernandez: there are other solutions that may not require state guidance. The problem is bigger than the funds that have been allocated by the state
 - Sally Taylor; STRAC did a study and it was hard to capture the population that couldn't get into SASH. We tried to capture what we couldn't access.
 - Chris Bryan: The rural LMHAs asked us to look at the number of people that needed access but couldn't access SASH.
 - Jelynn: In your diagram, do we know what the other community programs are?
 - Dr. Pliszka: We would have to break it down, but we can get a list
 - Sally Taylor: Of the 739 law enforcement navigations, only 729 were navigated once. These are new people going through the system, not the same people navigating through the system again.
 - Dr. Pliszka: People may navigate within several months; this data just captures one month. We can look at the data. But there are also a lot of new people coming into the system.
 - Jeff Tunnel: I pulled some numbers from our 7 counties. We have 153 patients that needed inpatient hospitals, only 36 were able to get into SASH; average LOS at SASH was 15.7 days and patients stayed in the ER for 2 days before placement into SASH
 - 117 went to psych hospitals that were at least 2 hours away and would stay about 7.7 days.
 - Patients would wait 18 hours in the ER before placement in a private psychiatric hospital.
 - there is a big volume of patients needing to go into SASH, but there are only a few that are getting access to SASH
 - Dr. Pliszka: Another way to look at it is local funding through big rural counties and Bexar county with communication and coordination, but it cannot be done with SASH money
 - Amanda Flores: We can't use state dollars to buy land; it needs to stay in Bexar County, no reduction or movement of staff
 - Constraints were provided because the funding is conservative to rebuild a 300-bed hospital. When you start looking at satellites, the costs increase.
 - Chris Bryan: If we put in a strategic plan that includes satellites, we can show the cost-savings.
 - If we start talking about satellites that aren't involved with the construction rider, you might lose out on money needed to reconstruct the hospital.
 - Jeff Tunnell: The rural sheriffs association have voiced to me that putting money and not getting more beds is a lost conversation.
 - Amanda Flores: There are new beds coming into the system. SASH does not work in isolation. There are two conversations – rider that deals with state hospital construction and state supported funding
 - Dr. Pliszka: Part of the report should show that adding 10 beds to SASH won't solve the problem. You need to deal with the people going through the system and need local buy-in.
 - Amanda Mathias: All these communities are doing everything they can to support their patients with what they have. We need to learn how to build systems in these communities, so they don't have to utilize SASH. They need help in their communities who need this level of treatment

- Sally Taylor: Until we have the right access at the right time, the forensic population will increase. Forensic patients have longer bed stays.
 - Rachel Samsel (by phone): We are at the pivotal point in the state's mental health delivery system. There are a lot of things coming up that will impact the civil and forensic population. Keep that in mind as we are looking to establishing competency restoration programs and other programs that may help the rural communities. As soon as we have OCR in the communities, people may not have to travel to SASH. The committee should look to the future of the mental health system and not just on how it looks now.
 - Sally Taylor: I don't know what is coming online.
 - Amanda Flores: that is what HHSC is working on doing a better job, on letting you know of the other things going on.
 - Fred Hines: What happens if we are building a 300-bed facility and these new things start popping up and we only needed a 150-bed unit
 - Amanda: Even if we have OCR, we will still utilize the beds
 - Tiffany: We will utilize the beds due to population increases. I don't think we will need a decrease in beds for a while.
 - Jelynn: Can you tell us about HB 13?
 - Amanda Flores: They are working on the contracts and grants. It is still ongoing procurement, so we can't release details. As soon as they finalize those, they will be able to provide more details. The communities and grantees may be able to provide more details.
 - Rachel: the first few contracts have gone up and they are working on the others. We can follow up and see if there is a better update we can provide.
 - Role of the UT Health San Antonio and clinical aspect of the hospitals
 - I will have a conversation with Commissioner Mike Maples and Dr. David Lakey. I am approaching this as a standpoint of neutrally beneficial.
 - I have had conversations with Dr. Gonzalez and Bob Arizpe to get a high-level view.
 - UT Health San Antonio will need to look at the numbers and make sure the costs aren't offloaded to the medical school
 - I will not be making the final decision; I will recommend our decision to the new UT Health San Antonio dean and Dr. Henrich
 - I will keep you updated on that discussion
- Role of UT Health San Antonio and clinical aspect of the hospitals**
Steven Pliszka
- Next Meeting**
- Tuesday, August 14 at 11:30 a.m.

SASH Executive Committee Meeting

Tuesday, August 14, 2018
11:30 a.m.
Methodist Healthcare
Ministries - Boardroom

Attendance:

Robert Arizpe (SASH), Doug Beach (NAMI SA), Molly Biglari (Haven for Hope), Joseph Blader (UTHealth SA), Chris Bryan (Clarity), Vincent Creazzo (SASH), Sedef Doganer (UTSA), Gilbert Gonzales (Bexar County), Allison Greer (CHCS), George Hernandez (UHS), Sarah Hogan (STRAC), Jim Kazen (UTHealth SA), Tony LoBasso (MHM), Amanda Mathias (MMHPI), Velma Muniz (Bexar County), Neda Norouzi (UTSA), David Pan (CHCS), John Petrila (MMHPI), Christina Phamvu (MHM), Allen Pittman (HHSC), Steven Pliszka (UTHealth SA), Sally Taylor (UHS), Jeff Tunnell (Gulf Bend Center), Chris Yanas (MHM),

SASH Diversion Bob Arizpe

- We were able to discharge some of our patients and will now be able to take civil, forensic and adolescents (male only) into SASH. I will send a formal statement this afternoon.

UHS Renovations Steven Pliszka

- Dr. Pliszka (UTHealth SA): UHS has a 14-bed unit that needs to be renovated for anti-ligature structures. The unit will temporarily move over to the Nix for 2-3 months. It has not been approved by the UHS Board, but we are expecting that it will. We are in the process of working on the flow of patients. Other hospitals are going through the same types of renovations at this time to ensure compliance.

Architecture Consultants Jim Kazen (UTHealth SA)

- We have narrowed the list of contractors from 10 companies to 5 companies. The finalists are:
 - Shepley Bulfinch and Marmon Mok
 - Perkins & Will Global
 - Munoz and Company
 - HKS
 - Alamo Architects
- We will be interviewing the organizations and their whole team (including behavioral and engineering consultants) on September 6th from 7:45 am – 5:00 pm at the UT Health SA Campus – Presidents Conference Room.
- SASH Executive Committee members and HHSC staff are invited to join the interview
 - An invitation will send out to those who would like to be included

Stakeholder Meetings Amanda Mathias (MMHPI), Chris Yanas (MHM)

- As of last week, we have completed meeting with all of the LMHAs in the catchment area.
- The last meeting was with Camino Real, our closest LMHA outside the Bexar region, and they stated that they are having the same issues along with the other LMHAs related to access to SASH. They are unique because they have a crisis stabilization unit at the center, along with another location in Eagle Pass.
 - The center is looking at extended ops.
 - The LMHA has a dedicated team that is trying to use what little resources they have to combat the rising mental health population.
 - Another interesting statement from Camino Real is that they weren't able to apply for the community collaborative grants because they could not secure the local matching funds in their community.
- Chris Yanas (MHM): There were about 15 people at Camino Real, including law enforcement officials. They talked about their two crisis centers that were built with funding from the 1115 Medicaid Waiver. In addition, they asked for assistance in providing or funding access to substance use and detox facilities. They understand the staffing issues and diversions at SASH, and believe the State should increase salaries to retain staff.

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- *Sally Taylor (UHS): How big are the crisis centers and who can access the centers?*
 - Each center is a 16-bed unit and anyone in the catchment area can access it. They stated that they receive people from other counties, including Bexar County.
- Retreat Agenda Proposal**
Amanda Mathias (MMHPI)
- Who would we like to invite to the retreat?
 - After meeting with Chris Yanas (MHM), Dr. Pliszka (UT Health) and Dr. Blader (UT Health), we propose that the attendees include the SASH executive committee and executive directors (or 1 representative) from the LMHAs.
 - The retreat will be held on Thursday September 13th, 9am – 3pm
 - We may not need the full six hours, but we would like to block out the whole day to make sure we have enough time for discussion and feedback
 - MHM is looking at St. George Maronite Center for retreat location
 - MMHPI Presentation Plan
 - Data
 - System: Bexar and Rural
 - SWOT findings
 - Focus on SASH and the system
 - Feedback on agenda
 - Proposed Agenda:
 - 8:30 am – breakfast
 - 9:00 - welcome and introductions
 - 9:15 - MMHPI presentations
 - 10:00 – Questions
 - 10:30 - Break
 - 10:45 – breakout group discussions and report out (special populations and waitlist issues)
 - 12:00 – lunch
 - 12:30 – further discussion about off campus locations (Dr. Pliszka)
 - 1:30 – architecture building discussions
 - 2:30 – Wrap up and adjourn
 - *Doug Beach (NAMI SA): At the retreat, will we hear about any proposals for the role of UT Health San Antonio?*
 - Dr. Pliszka will be having a meeting with HHSC and Dr. Henrich on the following Monday to discuss plans, so there will not be a lot of detail about this issue at the retreat. This retreat will focus on the structural phase. We should set up another meeting in October to discuss the operational phase.
 - *Dr. Blader (UTHealth SA): We need to deep dive into the construction; maybe we should extend an invite to the people from the consumer meeting.*
 - Doug Beach (NAMI SA): I agree with inviting former patients to the meeting. We have a lot of expertise in the clinical aspect, but it would be great to have more input from the patients who will utilize SASH. If the committee decides to invite consumers, I can reach out to families and see who would like to join.
 - Chris Yanas (MHM): We caution opening up this meeting to stakeholders – we value their input, however that was the reason we held 1:1 sessions with as many groups as possible. The larger the group, the harder it will be to focus and assess the data and recommendations we’ll be hearing, and hopefully taking action on.
 - Dr. Blader (UTHealth SA): The issue of who is going to manage the campus is currently not on the agenda
 - *Sally Taylor (UHS): The theme of staffing keeps coming up over and over again. Will we have any idea on how that will be addressed in the next session?*
 - Gilbert Gonzales: It is a major obstacle

	<ul style="list-style-type: none"> Chris Yanas: At the last Judicial Commission on Mental Health meeting, Mike Maples discussed the state hospitals and the staffing issue. He said that there is a committee currently working on the issue. There is a good probability that funding for workforce will be included in HHSC's LAR (Legislative Action Request), but no details at this time. We can follow up with Commissioner Maples and Allen Pittman for more details.
Forensic Issues	<ul style="list-style-type: none"> Bob Arizpe (SASH): We are one of the few campuses that house forensic and civil patients on separate units. We are allowed to mix the patients and we have mixed them in the past if there are not a lot of patients on the unit. When we are looking at the design, it may be counterintuitive to separate forensic and civil patients because history shows that forensic patients are less aggressive than civil patients. Adolescents and geriatric patients are the only population that need separation. The three designs from UTSA integrated forensic and civil patients. We could also look at other services on campus, including a mock court room. Right now, the mock court room is off campus and we need staff members to escort the patients. Any design that will minimize the need for a staff escort will help us.
Additional Discussion on Satellite Campuses Steven Pliszka	<ul style="list-style-type: none"> Points for the discussion: <ul style="list-style-type: none"> There is a placeholder for \$270 million will be needed to replace the beds, but It is unlikely this amount of money will fund both SASH and a satellite Rebuilding the 300 beds with no change to the system doesn't get us anywhere with the current staffing issues A satellite would need to be regionally financed – such as a “match” to the SASH funding to help with costs Regional Issues: <ul style="list-style-type: none"> There are about ~1000 crisis incidents in Bexar County and maybe another ~1000 incidents from LMHAs (need more accurate data) in May 2018 – 78 people were admitted to SASH <ul style="list-style-type: none"> Bob Arizpe (SASH): staffing has affected these numbers, which is why it is low in May. If we had our full staff, our admission number would be closer to 120. there is no one-stop shopping for people with mental health crisis Other counties are bringing mental health crises to Bexar County – even from counties outside the SASH catchment area – formally and informally we need a regional strategy The proposed Regional Crisis Center located at the downtown CHCS Crisis Care Center would serve as a regional outpost <ul style="list-style-type: none"> Telepsychiatry would provide medication, recommendations and consultations Difficult cases are moved into the regional center, the money would follow the person to the regional center – there will be some increased costs if the patient is sent without coordination The Regional Crisis Center would allow us to use additional space without the need to purchase land <ul style="list-style-type: none"> The first floor would house police and law enforcement, medical clearance unit, ambulatory adult, and ambulatory child Patients would head to other floors for other services <ul style="list-style-type: none"> 2nd floor – sobering 3rd floor – crisis beds 4th floor – detox 5th floor – outpatient (OATS, Primary Care)

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- *George Hernandez (UHS): The unit is in the central business district, which is already congested. There is no problem with access to land at SASH; , maybe this regional outpost would be helpful at SASH. In addition, one shop stops can create some problems. At UHS, we aren't able to house adolescents and adults in the same area because our first priority is keeping the children safe.*
 - Chris Bryan (Clarity): The big issue with children is keeping them close to the community. How does the satellite campus in downtown San Antonio help keep children closer to the family?
 - Jeff Tunnell (Gulf Bend Center): In the rural areas, we have transportation issues. The concept of Bexar being a central resource location will not help the rural areas. If we had a regional campus closer to the rural communities, it would help. I would rather send a patient to Seguin (1 hour away) than San Antonio (2 hours away)
 - Dr. Pliszka (UTHealth SA): We aren't taking away services. The LMHA would be able to pay for services at the regional crisis center if there is an overflow of patients in their area.
 - Sally Taylor (UHS): STRAC is trying to get the current data on the number of patients brought in to Bexar County on emergency detention. Would we be able to utilize the regional PES with this model?
 - Jeff Tunnell (Gulf Bend Center): Law enforcement will bring our patients to the hospital, but who will pick up the patient after their treatment? Our patients are put on a bus after discharge and have to wait for a transfer to Victoria. Sometimes they don't make it back.
 - Sally Taylor (UHS): I like the concept of a regional crisis center, but we need to take into account the rural areas and specialty populations, including adolescents and IDD patients.
 - Jeff Tunnell (Gulf Bend Center): there are other models out there, including ones in the Panhandle and Texas Tech. There are other opportunities in the rural area to leverage state dollars with the state hospital funding to pay for our population. *I will send Dr. Pliszka and Amanda more details about the models.*
 - Allen Pittman (HHSC): The criteria for satellite campuses are:
 - No additional funding needed for land
 - Located in Bexar County
 - No reduction of beds or staff on SASH Campus
 - George Hernandez: Has SASH looked into putting an ambulatory unit on the hospital, modeling it after the Houston psychiatric hospital where they provide inpatient and outpatient services?
 - Dr. Pliszka (UTHealth SA): the state pays for the building in Houston and provides money to the school to manage the hospital. We are discussing this among several options, but we don't have any concrete details.
 - Sally Taylor (UHS): A big gap in the community is that there is no quick way for patients to be seen to get meds.
 - Chris Yanas (MHM): One of the things we heard across the board is the transportation issue. The families aren't able to be included in the care, or sometimes the discharge plans, due to the lack of transportation. We've been told that on many occasions, LMHA staff has to drive the patient back to the community.
 - George Hernandez (UHS): Would we be able to ask the state if they are looking at a smaller catchment area? It may be helpful because we can provide better care.
 - Sally Taylor (UHS): The regional PES model is looking at smaller regions. Our trauma region is only 24 counties and that is our largest region area. We also have other means of transportation for our patients (including helicopters)

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- Next Meeting**
- Architecture interviews – September 6 at UT Health SA (Presidents Conference Room)
 - Retreat – September 13; location to be determined.
 - Next Meeting: no further meetings until the retreat
 - Dr. Pliszka (UT Health SA): We will send a phone invite for further information about the retreat planning
 - Dr. Blader (UTHealth SA) and Chris Yanas (MHM) will reach out to SASH to set up a meeting to discuss data

SASH Executive Committee Meeting

Tuesday, September 25th, 2018

11:30 a.m.

Methodist Healthcare

Ministries - Boardroom

Attendance:

Bob Arizpe (SASH), Doug Beach (NAMI SA), Joseph Blader (UTHSA), Chris Bryan (Clarity), Vincent Creazzo (SASH), Mark Hendrix (BHCNC), Amanda Flores (HHSC), David Gonzalez (SASH), Allison Greer (CHCS), Fred Hines (Clarity), Sarah Hogan (STRAC), Jim Kazen (UTHSA), David Miramontes (SAFD), Velma Muniz (Bexar County), Christina Phamvu (MHM), Steven Pliszka (UTHSA), Ross Robinson (Hill Country), Sally Taylor (UHS), Chris Yanas (MHM), Sheree Hess (Hill Country), Tim Bray (HHSC). By phone: Debra Saenz (Continuity of Care - Coastal Plains), John Petrila (MMHPI), Amanda Mathias (MMHPI), Trina Ita (HHSC), Robert Dole (HHSC), Rachel Samsel (HHSC)

Update on Architecture Planning Process

Jim Kazen, UT
Health SA

- We have selected HKS as our architecture firm. They firm is based out of Dallas (600 employees in Dallas). They will be working with Architecture+ and Frank Pitts, who is well known for behavioral health redesign. The lawyers from UTHSA and HKS have approved the architecture contract.
- Last week, we sent out RFQ for a contractor, who is key in assisting the architects in current pricing (deadline is December 31st)
- On Oct 1 – Some individuals will meet with Dr. Pitts to provide input on scheduling (1:30 pm – 1st floor, UT Health San Antonio). Invitation to selected members will be forwarded.
 - Chris Yanas
 - Doug Beach
 - Jeff Tunnell
 - Bob Arizpe/Dr. David Gonzalez
 - Ross Robinson

Update on SASH Project

Discussion with UT System

Dr. Pliszka, UT
Health SA

- I met with Tim Bray (HHSC), Dr. Lakey (UT System), and other UT Health representatives to talk about future plans for collaboration with the UT Health System and SASH.
- There was a general consensus to further explore our options, but no concrete plan
- The next step is for me to have a good understanding of the clinical operations and continue discussion on what we want to look for in a successful partnership. I am not the expert on SASH, so I will need to seek guidance on expertise in this area. I know the committee has expressed ideas on future clinical operations and I look forward to receiving input on these ideas in the future. I think that this conversation should be tabled until after the hospital is built so we aren't sidetracked in our charge by the Legislature. I will continue to keep you informed on our next steps.
- I am planning on spending an entire day at SASH on Oct. 9 to see the flow of the patients (from morning to afternoon) and see where UT Health can contribute. This will be the first of many visits over the next couple of months to study the operations at a fine-grain level.
- *Chris Yanas (MHM): Is Dr. Lakey asking Dell Medical School to wait until the ASH hospital is built before having the conversation on its role in hospital operations?*
 - *Dr. Pliszka (UTHSA): I think we are further along than they are. From last I heard, Dell Medical School has not agreed to fully manage ASH.*
 - *Tim Bray (HHSC): We have not had the same conversation with leadership with Dell Medical School as we have with UT Health SA.*

Recap of SASH Stakeholder Retreat

John Petrila,
MMHPI

- Dr. Pliszka (UTHSA): During the retreat, we made recommendations to reform the mental health system. In addition, Ross (Hill Country) talked about the need for more regional services and we endorsed that idea.

	<ul style="list-style-type: none"> ○ Our consensus is that the 300+ beds should remain on campus. In the white paper, we would strongly recommend additional funding for the creation of additional regional psychiatric services or other local services to allow the outlying counties to deal with problems locally. ○ Ross Robinson (Hill Country): Such a request would be consistent with Rider 147. • John Petrila (MMHPI): There was a clear consensus at the retreat (designed to report on stakeholder engagement) that there are huge gaps in acute care emergency capacity in SASH catchment area. That combined with other environmental issues, there is a need over time to develop some acute regional capacity, but not at the expense of fewer construction of beds at SASH. To make sure that beds don't fill up over time, we need to look at regional capacity. Mike Maples was clear that the report could include strategies that would affect the use of SASH. • Trina Ita (HHSC): I want to make sure I understand that you are asking for additional funds to expand acute services that are not the same expansion of CSUs through HHSC. • Ross Robinson (Hill Country): We were talking about the Sun Rise Canyon Model for the regional acute approach. • Dr. Pliszka (UTHSA): Dr. Blader will be the chief writer of the white paper. We would like to select a White Paper Review Subcommittee to review drafts. <ul style="list-style-type: none"> ○ Chris Yanas ○ Ross Robinson ○ Chris Bryan ○ Sally Taylor • Dr. Pliszka (UTHSA): Dr. Henrich would like to see a draft with the major ideas and clinical operations by November, so I think it would be best to set some milestones. Does everyone agree to have some main bullet points by October 15th? • Ross Robinson (Hill Country): We would like the committee to focus on IDD patients. They are terribly served in the inpatient hospitals, private and state hospitals. • Sally Taylor (UHS): I would agree with that. There is also a major gap in services for IDD / MH dual diagnosis in the outpatient setting as well. • <i>Chris Yanas (MHM): Is there additional work currently being done at HHSC to address the IDD population?</i> <ul style="list-style-type: none"> ○ Trina (HHSC): That is under the oversight of Hailey Turner. There is a 5-year behavioral health plan and right now they are working on updating the strategic plan to better serve the IDD population. I don't have details, but I believe that there is some request in the LAR to address the IDD population. As far as on the facility side, Amanda or Tim would be able to speak to that. ○ Tim Bray (HHSC): We have included expansion of services with SSLCs and community services with our LAR. That would impact this group as well. • Dr. Pliszka (UTHSA): We should invite IDD representatives and forensic representatives to guide our discussion at the next meeting so we are able to learn more about the gaps in services. • Tim Bray (HHSC): We are looking to increase access to forensic services for IDD population (on SSLCs) in our exceptional items.
HHSC State Hospital Salary Report	<ul style="list-style-type: none"> • Chris Yanas (MHM): In the appendices of the report, you will see how SASH compares to the other state hospitals related to workforce shortages. It didn't drill down to the main issues that Bob has talked about in the past, but you see that there is a problem across the board, except for areas that have recently received additional funding. • Amanda Flores (HHSC): Rachel Samsel (HHSC) was the primary author of the report, but it goes over broadly what we have done to increase retention and recruitment. The appendices provide a position by position detail with turnover rates and data by hospital. It has some recommendations as well.

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- Rachel Samsel (HHSC): The focus of the report was to highlight issues related to recruitment and retention and salaries and provide recommendations on workforce issues. We highlighted some issues and talked about those same issues multiple times with this group. We wanted to highlight the differences in market rates across the hospital system in areas that we have recruitment issues. Some of the historical pieces that the Legislature has done to address these issues are mentioned in the report. If you want more information on past details, we can provide you with that information.
 - Sally Taylor (UHS): There is a typo in A-5 that shows SASH is above the market rate when the lower SASH salary reflects that it should be noted we are market rate.
 - Dr. Gonzalez (SASH): our main concern is PNAs, which is captured in the report. We have been doing better with provider workforce.
 - Tim Bray (SASH): We are starting to capture other mental health professionals shortages in our facilities, including social workers, but the data is not in the report because it is still new.
 - Chris Bryan (Clarity): It would be hard to make the argument for a nursing difference of \$6,000, so I think we need to drill down on the reason why it is hard to retain nurses.
 - Fred Hines (Clarity): The market salary looks more like a scale, rather than the market.
 - Dr. Gonzalez (SASH): We pay a psychiatrist around \$207,000, which is significantly low in the market. It is difficult to compare private sector and state employees.
 - Dr. Blader (UTHSA): With respect to RNs, PNAs, and LVNs, do you have data on how many people leave SASH to go to the private inpatient psychiatric hospital or another factor?
 - Amanda Flores (HHSC): We have employees fill out an exit survey, so we can provide you with information that may pertain to what you are looking for.
 - Dr. Gonzalez (SASH): Coming from the private sector, we see the same PNAs and nurses in the private sector in the same field. Staff are staying in the psychiatric field, but they are moving somewhere that has better pay.
 - Sally Taylor (UHS): Are there any other educational benefits available through the state?
 - Bob Arizpe (SASH): We don't have educational benefits for PNAs, but we do for LVNs. However, an issue is that we don't have enough staff to let them take time off for educational leave.
 - Dr. Gonzalez (SASH): A huge recruitment is the student loan repayment. Nurses and providers will get their loans paid off. It may not be as advertised as nurses as it is for providers.
 - Tim Bray (HHSC): It is not a big program for nurses as it is for providers. We had conversations with the Legislature on expanding these programs, but there is no movement. We have asked for targeted increases for nurses.
 - Chris Yanas (MHM): I have talked to MMHPI about doing some additional research specifically for SASH salaries, recruitment and retention. Is there any input from committee members to support these efforts or are we good with HHSC's report?
 - Chris Bryan (Clarity): MMHPI might be able to look at salaries and gaps in workforce in our catchment area. We don't have a handle on what the workforce looks like in our area.
 - Ross Robinson (Hill Country): Especially when you talk about kids, you need to look at the lack of child psychiatrists.
 - Fred Hines (Clarity): We also need to look at national figures because we recruit outside of Texas.
 - Amanda Flores (HHSC): Some of the national information may be available through DSHS and their workforce group.
 - Dr. Blader (UTHSA): is it possible to get that information separated by experience?
 - Amanda Flores (HHSC): I can give you the contact information, but I'm not sure what information they have.

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- Dr. Gonzalez (SASH): From experience, the only place that has given me compensation for experience is the private sector.
 - Tim Bray (HHSC): We revised North Texas State Hospital staffs' compensation plan based on experience. You come in with 0-2 years, you get this market rate. If you have 3-5 years, you have market + 3.5%, 5-10 years, you have market + 7%. For staff with 10+ years of experience, you will receive market plus 10%. We built in automatic pay raises 3.5% every two years. So far, it has been received positively, retention and attracting new nurses to the hospital has been positive. In thinking of that model, we would love to explore that across our clinical operations.
 - Mark Hendrix (BHCNC): Do you know if the state job is their sole job? We are seeing that providers have multiple jobs to secure market pay.
 - Dr. Gonzalez (SASH): There are a variety of us that work outside the hospital to make up the difference in state salaries.
 - Mark Hendrix (BHCNC): The average salary for our psychiatrists is around \$500,000

Next Meeting

- Dr. Pliszka (UTHSA): Next meeting should focus on IDD and forensic representatives. I think we should hold off on the date until we find out when they are available, hopefully within the next 2 weeks.

SASH Executive Committee Meeting

Wednesday, October 17th, 2018

11:30 a.m.

Methodist Healthcare

Ministries - Boardroom

Attendance:

Bob Arizpe (SASH), Doug Beach (NAMI SA), Molly Biglari (Haven for Hope), Joseph Blader (UTHSA), Chris Bryan (Clarity), Vincent Creazzo (SASH), Matthew Faubion (Kerrville State Hospital), Amanda Flores (HHSC), Emma Garcia (Camino Real), Gilbert Gonzales (Bexar County), Allison Greer (CHCS), Sheree Hess (Hill County MHMR), Sarah Hogan (STRAC), Jim Kazen (UTHSA), Gilbert Loredó (UTHSA), Jelynn LeBlanc-Burley (JL), Christopher Lopez (HHSC), Kristina Martinez-Fields (UTHSA), David Pan (CHCS), Christina Phamvu (MHM), Steven Pliszka (UTHSA), Sally Taylor (UHS), Jeff Tunnell (Gulf Bend), Chris Yanas (MHM), Melissa Boulard (SASH), Jacob Ulczyaski (AACOG), Robert Dole (HHSC), Tim Bray (HHSC), Leo Trejo (Coastal Plains)

Update on Architecture Planning Process

Dr. Pliszka and

Jim Kazen

- Dr. Pliszka (UTHSA): HKS was chosen as the architecture firm. They will take a tour of SASH tomorrow afternoon and will meet with the architecture subcommittee and SASH patients/staff on Friday.
- Jim Kazen (UTHSA): UTHSA sent out an RFQ for general contractors, who will be able to tell us the feasibility of the design, including financial feasibility. We have narrowed the applicants to five companies:
 - Archer Western
 - Bartlett Cocke General Contractors
 - Flintco
 - Spaw Construction
 - Turner Construction
- Jim Kazen (UTHSA): On the 19th, we will further narrow the list down to three before we make our final decision.
- Dr. Pliszka (UTHSA): Last week on Tuesday, Dr. Blader and I spent the whole day at SASH looking at clinical information – it made clear to us the enormous challenges
- Dr. Pliszka (UTHSA): On October 30th, me and senior leadership from UTHSA will have an extensive conversation with UT Health Houston on their operation, various challenges, and opportunities.

Report on new SASH Bed Numbers

Bob Arizpe

- As of right now, SASH has 302 beds, but we will be downsizing our capacity to 268 beds. The impact will be minimal.
 - Loss of 4 acute civil beds (already have a unit offline due to staffing issues)
 - From 36-bed units to 34-bed units
 - Loss of 4 additional adolescents beds (already have 8 offline due to staffing issues)
 - From 20-bed unit to 16-bed unit
 - Loss of 10 residential beds
 - From 40-bed unit to 30-bed unit; our 40-bed unit was rarely at capacity so downsizing to 30-beds will virtually have us at capacity 100% of the time.
 - Loss of 14 forensic beds
 - Will move towards 34-bed units
 - Geriatric beds will be maintained
- We have a significant shortfall each year (about \$14 - \$16 million that has to be covered)
- Tim Bray: We are taking the opportunity to tie the capacity to the budget to create a more accurate representation of beds available. We took the budget for FY 19 as a starting point, looked at each hospital bed day rate and used that to calculate the number of beds we could support through the budget in the different hospitals. We have gotten closer to the number of people we are actually serving. Hopefully going forward, it will be more stable

- Changes were made at several hospitals
- *Dr. Blader: What is the implication on the new hospital?*
 - Dr. Pliszka: We will continue building for a 316-bed hospital, but SASH will be budgeted to operate on their capacity
 - Bob Arizpe: We are looking at the extra 40 beds (from the renovation project) being swing beds primarily for the civil population.
- *Chris Bryan: If we are looking at a systemic approach, our terms should be similar across the board. We should reconsider the term “acute.” If we get to a place where acute is being taken care of in the community, the state hospital would have a higher classification*

Competency 101

Christopher
Lopez, HHSC

- Forensic commitments fall into two categories
 - 46B: Incompetent to Stand Trial (IST)
 - 46C: Not Guilty by Reason of Insanity (NGRI)
 - Will have to go to a maximum security and then to another transition hospital
- Flowchart process for 46B and 46C commitments are complicated processes
 - When you are looking at the law right now, it states that the forensic commitments are regulated by DSHS, but there was a transition to HHSC in 2017 due to new laws. There is a new provision in law that will allow us to read the allow to keep up with the current practice. It is not uncommon that we will get commitment classifications that are out of date.
- Why does it take so long to get a defendant into a state hospital?
 - In 2006, there was a higher civil population (72%) to forensic population (28%)
 - 2016 was the turning point to when we saw a higher forensic population compared to the civil population.
- One of the reasons for the higher forensic population is due to a longer length of stay. The chart shows the average lengths of stay for civil and forensic commitments as of discharges last month. Some of the reasons for the longer lengths of stay for forensic patients include:
 - More complex patients
 - Civil commitments are served until the treating clinician decides that you can be served in a less restrictive setting, but forensic commitments will be served inpatient until the patient is competent to stand trial. After initial commitment, if the patient continues to meet commitment criteria, their stay is increased 1 year at a time.
- Current capacity at state hospitals
 - *Jeff Tunnell: The capacity has stayed the same, even though the population has grown*
 - Amanda Flores: The CannonDesign goes in depth about this consideration
 - Chris Lopez: We do not have enough resources for our population capacity
- What is competency?
 - A person is incompetent to stand trial if they do not have:
 - Sufficient present ability to consult with their lawyer with a reasonable degree of rational understanding; or
 - Does not have a rational as well as factual understanding of the proceedings against them
- Who does Chapter 46B apply to?
 - Incompetency proceedings apply to defendants charged with a crime punishable by confinement, but this is applicable to:
 - Trial on the merits of index offense
 - Motions to revoke probation / parole

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- Motion to adjudicate (deferred or pre-trial adjudication)
 - Forensic Commitment Process (IST)
 - Issues of competency may be raised by either part or the court on its own motion
 - If evidence of incompetency is not found, criminal proceedings resume
 - If evidence of incompetency is found, the court will order an examination by a qualified expert
 - Even if there is agreement that the defendant is incompetent, there must be an examination by a qualified expert
 - *Dr. Blader: Do you have data on the number of forensic commitment on misdemeanors vs. other criminal activity? We should include it in the report.*
 - Amanda Flores: We can get you that information
 - A patient is charged with class B misdemeanor. If we raise the issue of competency for these clients, we are looking at long-term treatment / commitment. The criminal justice system has to examine whether to utilize the state hospital for minimal charges. We can serve more civil patients in the same time as we serve a forensic patient, so the judicial system needs to carefully examine whether a patient needs to have a forensic commitment.
 - A patient is only required to go to maximum security for statutory offenses or use of a deadly weapon
 - *Sally Taylor: If we don't address the number of civil beds, we are feeding the forensic pipeline because our patients don't have access to treatment that will help them stabilize*
 - Amanda: We are working with LBB and the Governor on a pre-planning request for increasing capacity in the Panhandle and DFW area.
 - *Dr. Blader: It would be great if we see the change over time forensic vs. civil to be further broken down by the types of charges, in particular how often the alleged offenses are classes of felonies or misdemeanors*
 - Amanda: I will set up a meeting with you and our HHSC data team to look at our data and see what we can do to help
 - Dr. Faubion: The general population has grown significantly, and we assume that the crime rate is static, and the rate of incompetency referrals stay the same; that is not the issue. The number of felony competency referrals have grown significantly in the last couple of years
 - Notice and Report to Court
 - Treating facility must notify and provide report to the court:
 - When defendant is restored to competency
 - When defendant is determined unlikely to be restored within foreseeable future
 - Term of commitment is about to expire
 - Defendant is clinically ready to go to OCR or JBCR (theoretical because it is new); or
 - Defendant has "timed out" under maximum period of commitment (the max time that the person can be served forensically is the max sentence for their charge, with includes their arrest, the time waiting in jail, and the time in the hospital)
 - Court Determination of Competency after restoration commitment
 - the court take up the issue of a defendant's restoration to competency in a priority ahead of any matters
 - However, the criminal court on the initial case may take a while. While the patient is waiting in jail for the initial case, they are likely to relapse, and the cycle starts over again.

**Overview of
Forensic
Commitments**
Dr. Matthew
Faubion, Clinic
Director –
Kerrville State
Hospital

- Court Ordered Forensic Forced Medication
 - If you have a jail setting where the court order allows the jail physician to involuntary forced medication, inmates may be able to be treated in the jail system to reduce LOS. However, some jail physicians do not have the license to prescribe certain medication or some jail systems and judicial systems are not educated on the process.
 - Few prosecutors have availed themselves of any provisions to obtain these orders because the orders must be obtained via Probate court jurisdiction rather than the court with the underlying criminal matter
- Typical Forensic patient in Texas:
 - Male
 - 80% primary psychotic disorder
 - 75% have substance use comorbidity
 - Not competent to stand trial
 - 95% are 46B, but the 46C patients stay longer
 - 64% of state hospital beds are utilized by forensic patients
 - The forensic patients stay longer in the state hospital than the civil counterpart
 - 7 civil admissions per 1 forensic bed
- Restoration of Trial Competency in Texas
 - The judge decides whether the individual should be treated as an inpatient or as an outpatient IAW Article 46B of the Code of Criminal Procedure
 - Outpatient competency restoration is available in 14 areas of the state
 - Community safety is a primary concern
 - the standard is that if the judges think the patient is dangerous, they will be committed to inpatient services
- Inpatient restoration of competency
 - 80% of individuals restore to competency within 6 months
 - Treatment modality is most often antipsychotic medication
 - At Kerrville State Hospital: Having the court ordered medications is enough for competency restoration
 - Hospitals that must go through the probate court for involuntary medication slows down the process. Ideally, it would be great to have order for involuntary medication at admission into inpatient services
 - *Sally Taylor: At UHS, our probate court will say they don't have jurisdiction and transfer the case to a criminal court*
- Texas Sanity Statute
 - The term “mental disease or defect” does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct
 - Must be proven by preponderance of the evidence
 - Burden of proof on the defense
 - Average length of stay at Kerrville State Hospital is 1200 days due to insanity cases
 - Insanity cases drives the length of stay due to the community backlash at the judges for letting people out in the community if they are deemed “unsafe”
 - While we have a statutory mandate to communicate, the court is in control and safety overrides a lot of the mandates
- NGRI Process
 - In maximum security, patients are presented to the board within 42 days, so they often don't pass the board the first time when presented because they are not in treatment long enough

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- Once the patient gets approval from the board to be released from maximum security, they move to a transitional facility and start competency restoration
 - The process shows how one patient can tie up a bed at the hospital
 - There needs to be change in statute that does not require an inmate that is out on bond to go to a maximum-security unit
 - Mitigation of violence risk
 - At Kerrville, we created a community reintegration program that last 6 months and we have about 24 people in the program at a time. We teach patients how to get an apartment, how to get a job and other practical skills
 - Patients also participate in wellness-oriented community activities
 - About 80% of the time, court agrees with release, but 20% of court cases do not agree with release and the patient has to wait another year to be considered for release
 - Challenges in Community Reintegration or Forensic Mental Health Patient
 - There is no uniform approach to the forensic patient when they are transitioned out of the hospital
 - Housing options vary across the state
 - Proximity to family vs. proximity to service delivery
 - Wishlist
 - We need additional levels of care that are not inpatient (ex: intermediate care, transitional services)
 - We need dedicated services in the community for forensic patient – intermediate level of care
 - When we notify the court that the patient is not restorable, we need the ability to send patient somewhere secure that will not put the community at risk but provide resources and services needed for the patient
 - We need to be careful about building beds that we cannot staff
 - We need to streamline flow of system for forensic patients to cut down length of stay
 - We need to share resources across the system to increase flow through the system and increase quality of care for the patients
 - Academic collaborations
 - *Doug Beach: What is the level of receptivity to the Judicial Commission on Mental Health?*
 - I think there are issues that have to be dealt with on ownership. We need to come up with more collaborative ways to look at continuum of care
 - Amanda Flores: we are having conversations with internal and community partners.
 - *Dr. Blader: Have you identified any model programs that fit the bill of transition programs for the forensic patients?*
 - We have a proposal in the handouts, but we have not seen an established program due to complexity and lack of access to resources, especially housing
 - We can look towards a regional delivery system with academic partnerships

Announcements

- Dr. Pliszka: we are starting to work on the white paper, part 1 focuses on physical structure and part 2 is the larger reforms to the mental health system (SASH Plus)
 - I will send a rough outline tomorrow so we can have comments and conversation. We want to have a flushed down draft by November so the paper can be ready by December.

SASH Executive Committee Meeting

Tuesday, November 20th, 2018
11:30 a.m.
Methodist Healthcare
Ministries - Boardroom

Attendance:

Doug Beach (NAMI SA), Molly Biglari (Haven for Hope), Joseph Blader (UTHSA), Chris Bryan (Clarity), Amanda Flores (HHSC), Gilbert Gonzales (Bexar County), Allison Greer (CHCS), George Hernandez (UHS), Sheree Hess (Hill Country), Sarah Hogan (STRAC), Gilbert Loreda (UTHSA), , Jelynn Burley (CHCS), Tony LoBasso (MHM), Mike Lozito (Bexar County), Amanda Mathias (MMHPI), Neda Norouzi (UTSA), Steven Pliszka (UTHSA), Ross Robinson (Hill Country), Maria Sanchez (Border Region), Sally Taylor (UHS), Jeff Tunnell (Gulf Bend), Bart Vasquez (SAPD), Zahra Barsi (MHM), Sebastien Laroche (MHM) Christina Phamvu (MHM), Chris Yanas (MHM); By Phone: Rachel Samsel (HHSC), Andrea Richardson (Bluebonnet Trails), Sam Shore (MMHPI)

Architecture Subcommittee Dr. Pliszka

- The Joint Commission was at SASH last week so the architecture subcommittee meetings were cancelled. Bob Arizpe is currently working on recommendations from the Joint Commission.
- We are still planning on having the next meeting on November 29th and 30th.
- *Rachel Samsel (HHSC): Joint Commission has been ahead of schedule on their visits. They showed up to SASH five months early.*

Review and Discuss SASH Stakeholder Report Sam Shore and Amanda Mathias

- Quantitative Data – Sam Shore
 - We had three areas of focus on the quantitative side: prevalence, inpatient utilization in catchment area, and resources for purchasing bed days at San Antonio State Hospital for LMHAs
 - Prevalence:
 - For our prevalence data, the estimates are based on proven methodologies
 - We wanted to focus on specific subgroups because there is a broad mental health need for the catchment area, but the people that need inpatient services are a smaller subset than the entire population of people who have a mental disorder.
 - One subgroup that we focused on is the people who live in poverty (equal or below 200% FPL). These are people who do not have discretionary funds or insurance to take care of their healthcare needs and are more likely to need public services
 - Another subgroup includes the patients who have severe illnesses. We looked at adults with a serious mental illness and youth who have serious emotional disturbance.
 - On page 4 of the document, we provided estimates on prevalence on a county or LMHA level via an interactive Excel file.
 - Data for Adult Mental Illness:
 - The total adult population in the catchment area is 3.9 million, but the population with behavioral health needs is 920,000. There are about 180,000 estimated adults in the SASH catchment area that have SMI, with 110,000 of those living in poverty. We broke down the data even further to see those patients in poverty with complex needs for forensic services (2,000 people) and without forensic needs (2,000 people).
 - There are about 500 young adults each year in the catchment area that are having first episode psychosis and could use programs that

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- are designed to treat first episode psychosis.
 - Data for Youth Mental Illness
 - There are about 200,000 youth in the catchment area that have a behavioral health need and 40,000 of those youth have a serious emotional disturbance. Of the 40,000 youth with SED, 25,000 of them are in poverty; 2,000 of those youth are at risk for out-of-home or out-of-school placement and need intensive wraparound services.
 - There are about 200 cases of first episode psychosis each year. These youths would need specific interventions for treatment.
 - Inpatient Utilization and Capacity in the catchment area
 - We have data from about 29 hospitals in the catchment area on their utilization for psychiatric care. The data was taken from the Survey of Hospitals and the THCIC (Texas Health Care Information Collection). There are graphs in the appendix of the report that shows the utilization data on 26 of the hospitals and the type of population the hospital services over a three-year period (2015-2017).
 - The Survey of Hospitals asked facilities to report capacity. For utilization, we analyzed discharge records from the THCIC
 - On page 19-20, we looked at the number of bed days purchased by the LMHAs in the catchment area
 - For adults in 2017, there were almost 20,000 bed days purchased for \$11.3 million and 2018, there were almost 21,000 bed days purchased for about \$11.8 million
 - The data expenditures are a combined total of state and local dollars to buy the beds. Local communities are having to use their own dollars to supplement payment for these contract beds.
 - *Jeff Tunnell (Gulf Bend): When you prepared the information and looked at the raw data, did you have any surprises?*
 - I did not have any surprises. One difference between ASH and SASH is the level of poverty in some of the geographic area were lower than ASH
 - *Joseph Blader (UTHSA): Where did you get the estimates on poverty data?*
 - The poverty data came out of the American Community Survey
 - *Chris Bryan (Clarity): Do you have data on what hospitals are working with the LMHA on their bed days purchased? And how does that reflect in areas where there are some hospitals that are not interested in psychiatric care.*
 - The data from the LMHA did not break it down between the hospitals in the area. Not every facility is willing to take psychiatric patients. On the qualitative side, in some cases, people are having to send patients to another community because of the lack of available beds in their community.
 - *Amanda Flores (HHSC): Related to the ASH project, THA worked with ASH on a survey to the hospitals on the willingness for psychiatric area and obstacles for psychiatric care. The summary will be included in ASH's report and I will bring the data to this committee once the report is given to HHSC*
 - *Chris Bryan: Chris Yanas and I have a meeting with Senator Schwertner's staff next week that includes THA's Sarah Gonzales – can check on status of THA's hospital survey.*
 - Qualitative Data – Amanda Mathias
 - We were in contact with 163 stakeholders for the SASH catchment areas

- Some of the common themes revolved around standardized practices and workforce issues. We also looked at treatment for specific populations, including IDD populations and those with co-morbidities.
- Some of the weaknesses identified are the local capacity, lack of crisis systems in the area, workforce issues, and lack of credentialing standards.
- There are several opportunities for the SASH catchment area, including TAVHealth, law enforcement navigation through the STCC project, HB 13 and SB 292. We heard a lot about the use of DSRIP dollars for innovative projects, but we need to look at sustainability. Most of these innovative services are not reimbursable through Medicaid or insurance and there are concerns about loss of funding.
- *Joseph Blader (UTHSA): Can you identify one or two impactful programs or alternatives to avoid hospitalization on the front and improving quality of life on the backhand?*
 - One of the most impactful projects is the integrated care through the 1115 Waiver. Nueces County had to get rid of their integrated care program due to loss of funding and they immediately saw the patients cycling through the system area. The LMHAs who were able to keep their integrated care did see tremendous results related to severity of needs. In addition, the STCC project here in Bexar County is an example of a model for the catchment area and state. They have made a huge difference in the system and will continue to do so when it expands

**Review and
Discuss Draft
White Paper**
Dr. Pliszka

1. Replace SASH in current location with 302 bed capacity. State of the art design
 - *Gilbert Gonzales (Bexar County): We should break down the bed capacity by classification (forensic, civil, residential, etc.)*
2. Regional psychiatric emergency services (PES) ideas for services beyond extended observation units (EOS - up to 48 hours) and crisis stabilization units (CSU-up to 2 weeks) and short-term inpatient (30 days)
 - *Ross Robinson (Hill Country): In our facility, our short-term inpatient stays are defined up to 45 days;*
3. Enhanced Assisted (involuntary) Outpatient Treatment
 - Increase case management
 - Ability to ensure compliance with medication and other
 - *George Hernandez (UHS): Who will enforce the medication order? We are able to do it in a hospital setting because we are taking on the liability if the patient is a danger to others, but I'm not sure there will be consensus among the community on enforcing medications.*
 - *Sally Taylor (UHS): When on an outpatient commitment, patients have a treatment plan and if they cannot abide by the treatment plan, the outpatient commitment order can be modified to inpatient status. The problem we run into is that there is a lack of available beds for the patient to return to if the court order is modified.*
 - *Gilbert Loreda (UTHSA): We can work with Senator Menendez on this issue*
 - *Ross Robinson (Hill Country): I have concerns because it is counter-intuitive to compel someone for medication when care is supposed to be patient-centered. In addition, there may be concern from my staff, especially the peer support specialists.*
 - *Chris Yanas: there will be pushback from the Disabilities Rights groups on this.*

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- *Steven Pliszka (UTHSA): One of the reasons that our system is broken is due to the right to refuse treatment is taken too far, especially when the patient is delusional and does not believe that they lack competency*
 - *Ross Robinson (Hill Country): There are different issues if the patient is legally lacking competency or not. The patients that Dr. Pliszka sees may need a medication order, whereas not everyone with a mental illness will need enforcement of medication.*
 - *Steven Pliszka (UTHSA): We can combine this recommendation with recommendation 5 and make it more specific to certain populations.*
 - *Doug Beach (NAMI SA): I have seen so many good outcomes where the patient is engaged, but it is intensive. Once you establish trust, there are great outcomes. There are some cases where forced compliance is helpful, but we need to increase case management and intensive treatment models*
 - *Steven Pliszka (UTHSA): I can reword recommendation 3 and 5 based on these discussions*
 - Substance abuse screening
 - 4. Increased structure/supportive housing
 - Housing options for patients who are chronically psychotic and need secure facilities (Vermont model-commitment to Housing as part of ACT)
 - *Gilbert Gonzales (Bexar County): This gives us an opportunity to address step-down units and housing options at the SASH Campus*
 - *Mike Lozito (Bexar County): We should also look at ways to repurpose old buildings to other services that will improve the quality of life for patients on the SASH campus.*
 - 5. Increased number and support for guardians
 - Identify patients who lack capacity for making financial and medication decisions
 - Assign guardians when families are unable or unwilling to carry out this role
 - Manage patient funds (especially disability payments) such they are appropriately spent on food, housing and medical care
 - 6. Improvements in child mental health services
 - Endorse Texans Care for Children – HHSC recommendations for Child Mental Health page 5-7, especially enhanced residential care
 - Endorse some of Texan Care for Children Child Abuse prevention treatment
 - School based mental health programs, endorse Senator Nelson’s plans for telepsychiatry in schools
 - *Chris Bryan (Clarity): Some strategies for SASH include standardized admission processes for children. We need to determine where inpatient/partial contracted beds are, and if more specialized support, training, beds are needed in those areas, focusing on the SASH high discharge areas of Victoria, Webb and Hidalgo counties. In addition, here are some strategies for the region:*
 - *Work with the state to increase programs and mid-level services, such as crisis assessment, intensive outpatient and partial services for kids. How many of the school safety and community children’s mental health recommendations in the upcoming legislative session can be directly applied to the regional SASH strategy (ie, CPAP, community-based programs, grants, regional CPS strategies)*
 - *Can we do expansion or innovation in the YES waiver to relieve SASH in very specific high-needs areas? As we build a regional hub plan, family support, education and respite must be included, locally or through technology*

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- Ross Robinson (Hill Country): The YES waiver only allows reimbursement for respite services for licensed facilities, which is a burdensome process. We can work with you on this strategy
 - Chris Bryan (Clarity): In addition, care coordination needs to be a reimbursed service
 - Amanda Flores (HHSC): *We are working on a RFI (Request for Information) for the San Antonio and Austin catchment area communities for agencies who wish to have services on campus. We are hoping to post the RFI within the first 2 weeks of December. HHSC will be asking community members who would like to put services on campus for more details on the services provided and what requirements are needed (including land, building needs, etc.) We would not be able to provide funding, but we are able to offer land or buildings that agencies could renovate to put to use.*
 - Doug Beach (NAMI SA): *I have families asking if children should continue to be seen at SASH or should they be served closer in the communities?*
 - Chris Bryan (Clarity): We can talk about opportunities to increase training and services in these high discharge areas (Victoria, Webb, and Hidalgo counties).
 - Chris Bryan (Clarity): SASH only gets a small amount of STAR Health kids (IDD, foster care, medically complex), which is not reflective to our hospital admissions of STAR kids. I'm not too sure the reasoning for the low admission of these kids, but I can conduct further research.
 - Doug Beach (NAMI SA): *We need to get the kids into the community where they can be educated, and care can be coordinated*
 - Joseph Blader (UTHSA): *I would consider contracting with a charter school to run the school on campus. Youth still need school services as part of their treatment plan.*
 - Doug Beach (NAMI SA): *I was surprised to see the amount of educational schooling on campus.*
 - Chris Bryan (Clarity): The school districts are moving towards the minimum rule. We want kids to go to school for their coping mechanism, but due to funding – the psych hospitals are being moved towards the 4 hour per week school needs
7. Expansion of substance abuse treatment services
- Address substance abuse in pregnant women and new moms (Texans Care for Children pregnancy recommendations – attached)
 - The county and city decided to continue the Substance Abuse committee
 - Mike Lozito (Bexar County): *The city and county have decided to continue to Bexar County Joint Opioid Task Force. We will have someone with the county that will be working with substance use treatment. We have a criminal justice grant to cover some substance abuse treatment services for inpatient and outpatient*
 - Doug Beach (NAMI SA): *We should add another sub-recommendation on dual-diagnosis treatment*
 - Jelynn Burley (CHCS): *By 2021, all LMHAs are transitioning towards the CCBHC (Certified Community Behavioral Health Clinics) model - providing integrated care with behavioral health services, substance use services, and primary care*
8. Linking inpatient and outpatient services/improved communication
- Ensure all psychiatric patients have a medication management visit with a prescriber within 30 days of discharge (UTHSA TCC Management)
 - Jeff Tunnell (Gulf Bend): *Some of the best practices we work with on the*

state is a management visit within 7 days.

- *Chris Yanas: MHM offers free medications to individuals coming out of Bexar County jail – the pharmacy is near to the jail but still have released inmates who do not fill their prescriptions – lack of transportation, follow-through. We are trying to see if the meds can be dispensed inside the county compound.*

- Steven Pliszka (UTHSA): The theme is to reduce the gap in medication

- Establish a standard of care that psychiatric prescriber may accept a discharge summary from a psychiatric hospital as the basis for continuing medication even if they have done a full evaluation of their own
- Better tracking of the clinical course of patients as they move through the mental health care system, identification of high utilizers and assignment to intensive case management
- Shared medical records between pharmacies, state hospitals, LMHA's and private hospitals, accessible to front line clinicians
 - *Chris Bryan (Clarity): I am having a meeting with several folks on the E-Health Advisory Committee on legislative priorities. I am going to talk about involving state hospitals, LMHAs and private hospitals on the HIE expansion*

9. Role of UTHSA at SASH (TBD)

- Houston evolved in a unique way because they did not have a state hospital to begin with. The psychiatric center is half-owned by Harris County and has acute beds for commercial patients that generates a revenue, which allows them to pay market salaries and operation. I'm skeptical that the model will be applicable to SASH
- We need to have continued dialogue with HHSC and the community on different types of models

10. Legal changes recommended

- Allow compel medication order at the same time at OPC
 - *Sally Taylor (UHS): I am told from judges that compelling medication has more legal ramifications than an OPC, which means that the patient must meet in person with a judge before issuing a medication order.*
- Limit on amount of time a person deemed IST can be held in hospital in no longer meets civil commitment criteria
- Immunity for clinicians who accept seriously ill patient from hospital for aftercare in a timely manner
 - *Steven Pliszka (UTHSA): I think that this fear of liability inhibits providers from providing services after hospitalization just so patients are able to have a refill on their medication. I don't know if we can change this through legal recommendations or education to providers on this subject.*
- Compel medication orders for AOT
- Commitment to substance abuse treatment services
 - *Sheree Hess (Hill Country): We would like this recommendation to include the CSUs as well*
 - *Ross Robinson (Hill Country): We should amend facilities licensure requirements for substance abuse treatment services. Right now, you cannot provide outpatient SUD treatment unless you are a licensed facility, which is burdensome for rural communities. In order to be licensed, there are lots of standards to follow and organizations would need to pay a hefty*

licensing fee. Since I am in a rural community, I would need a separate entity for substance abuse treatment instead of using individual license under the provider. If our LCDC and qualified mental health professionals go into the community with dual diagnosis, they cannot provide substance abuse counseling because they are not operating from a licensed facility. It is a TAC requirement and we are asking for a statutory change

- *Sheree Hess: allow electronic application for EDs by LMHAs as well as physicians; Texas Health & Safety Code 573.012*
- Steven Pliszka (UTHSA): I will rewrite recommendations based on the comments

Next Steps

- Steven Pliszka will revise recommendations based on comments. If any members have additional information or edits that they would like to include, please email Dr. Pliszka this week or early next week.
- Chris Yanas (MHM) will send out a meeting request for week of December 3rd.
- Doug Beach – need to include discussions on the geriatric and IDD populations at the next meeting.
- Chris Yanas: also need to revisit HHSC study on staff recruitment and retention and include recommendation for competitive state hospital staff salaries and benefits

SASH Executive Committee Meeting

<i>December 4, 2018</i>	ATTENDANCE
Methodist Healthcare Ministries Corporate Boardroom 4507 Medical Drive San Antonio, Texas	Steven Pliszka, Doug Beach, Joseph Blader, Chris Bryan, Amanda Flores, Emma Garcia, Gilbert Gonzales, Sheree Hess, Fred Hines, Kristina Martinez, Velma Muniz, David Pan, Ross Robinson, Sally Taylor, Jeff Tunnell, Chris Yanas, Sebastien Laroche, Zahra Barsi, Amanda Flores (by phone)

Architecture Subcommittee (Dr. Pliszka)	<p>The architecture subcommittee reviewed potential site locations for the construction of the new SASH hospital.</p> <ul style="list-style-type: none"> The subcommittee is leaning towards “Site Plan D” which is located near the access roads and leaves the current SASH buildings in place (which could be repurposed in the future - barring any asbestos and building foundation issues). The subcommittee reviewed the advantages and disadvantages of building a single story vs. multi-story facility (e.g. carbon foot print, elevators, ability to move patients, etc.). <ul style="list-style-type: none"> Per HHSC recommendation, HKS will be contacting a HHSC multi-story facility in El Paso to identify the specific challenges that the facility faces in the delivery of care due to being multi-story. HKS will report back to the subcommittee in December. The subcommittee is working with OT and PT staff at SASH to identify which services should be provided within the units and which services would be beneficial to have in a centralized location. The subcommittee plans to have a construction budget proposal by the end of December. HHSC will have a call with SASH staff on Dec. 6 The subcommittee will reconvene Dec. 17 and Dec. 18. Amanda Flores said HHSC is developing an RFI to see which community organizations would be willing to provide services on the state hospital property. The RFI is anticipated to be released before the holidays. [Amanda will share the RFI with the SASH Executive Committee as soon as it is released]
Recommendations (Dr. Pliszka)	<p>Reviewed the draft recommendations document by Dr. Pliszka.</p> <ul style="list-style-type: none"> All of Doug Beach's recommendations will be incorporated into the document. Dr. Pliszka is working with Ross, Jeff and Amanda on Recommendation #3 - details will be flushed out by the end of the week. <ul style="list-style-type: none"> Dr. Taylor expressed her concern for the proposed hub model design and requested additional information. <ul style="list-style-type: none"> Ross Robinson explained that the proposal would be a solution for EOU and CSU issues related to length of stay by proposing that the hub be a SASH-like inpatient hospital unit. It would be a place that would provide immediate services for emergency detentions and would be able to serve in a similar capacity to an EOU, but for longer term care. <ul style="list-style-type: none"> In Camino Real, the property currently has crisis residential units and has built capacity for 8 additional EOUs; these EOUs would allow the police to bring in patients for a 48 hour stay. If Camino Real operated a regional hub then it would be able to keep patients longer than 48 hours while the patient continues to receive services in the region. Dr. Taylor: Would the hubs have the ability to do drug screenings and lab work? <ul style="list-style-type: none"> Ross Robinson said they would. The regional hubs would be placed adjacent to the hospital or in close proximity (e.g. Uvalde Hospital) so that medical services could be provided.

	<ul style="list-style-type: none"> • Currently, if CSU staff (e.g. at Lytle or Eagle Pass) determine that a patient needs to be medically cleared they are transported to the nearest hospital 15-20 minutes away; the hub model would operate with local agreements. • The Kerrville CSU is located 1/2 a mile from the hospital and already has a close working relationship. They have been in talks with the hospital to help train the hospital's ER and family practitioners on dealing with patients needing mental health services. • Jeff Tunnell reminded the committee that there are limits to the local resources in every region and the current system of care was piecemealed to address the gaps in services; this makes it difficult to standardize the regional hub model across the region. • Dr. Taylor recommended the white paper include best practice models for the list of services a hub should be able to provide. Chris Bryan (including executive committee) appeared to be in support of including 2 or 3 examples of best practice models in the white paper; Ross will work on incorporating these changes to the paper. • Dr. Taylor suggested whenever "private hospital beds" are mentioned in the white paper, she suggested it be replaced with "private or community hospital beds" • Ross Robinson mentioned that there is a need to see if/when an EOU becomes a proposed hub it would need to be certified as a private psychiatric facility (he will try to research it and add it to the paper). • Dr. Taylor was concerned that the paper placed an emphasis on residential units. In her experience, a PES is often only used to stabilize a patient, but the patient is not necessarily admitted. • Dr. Taylor recommended adding language that would support hospitals being able to provide court ordered medications. • Dr. Taylor made the case that individuals on emergency detentions should not be going to SASH. She recommends the paper include this as one of the guiding principles. Ross Robinson agreed and said that LMHAs should do emergency detentions. • Chris Bryan and Chris Yanas had a meeting with Senator Schwertner staff member Jonathan Connors and were told that the proposals need to talk very clearly about the pathway; the funding is for more than just the building. • Dr. Blader reminded the committee to also focus on services delivered to adolescents and asked the committee whether SASH should have an adolescent unit. <ul style="list-style-type: none"> • Doug Beach made the point that the committee needs to develop a plan for how to use the community beds for children. Chris Bryan added that the plan should also include the list of resources needed for the plan to executed. • Dr. Taylor requested that report include clearly defined regions, where the contract beds are located, etc. • Ross Robinson suggested HHSC should increase funding for Casa Amistad so that it operates more efficiently for the regional needs of Laredo and increase funding for bed days. The CSU is currently underfunded (last funded in 2009) • Amanda Flores explained that CSUs do not operate like Casa Amistad since Casa Amistad provides different services (Ross was under the impression that it was designed to provide CSU-like services). Casa Amistad is an inpatient unit with SASH-like level of service. • Ross Robinson proposed transferring Casa Amistad to Border Region Behavioral Health Center since Casa Amistad does not have the economies of scale to staff it appropriately to the right ratios needed for the acuity of the patients. <ul style="list-style-type: none"> • Ross Robinson will circulate edits to recommendation #3 by the end of the day. • Recommendation #4 was skipped • Recommendation #5
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	<ul style="list-style-type: none"> Chris Bryan suggested that the Texans Care for Children RTC policy recommendation may not be needed for recommendation #5. Chris Yanas echoed the concern that RTCs could be out of scope. <ul style="list-style-type: none"> Dr. Pliszka said he wanted to emphasize preventive services and suggested the description of the recommendation language be broadened. Ross Robinson voiced his concern with RTC beds in general. He has had a negative experience with RTCs that have not been overly therapeutic and instead were traumatizing for the patient. He suggested that the recommendation is currently written too broadly, and that the committee should include youth crisis residential centers (e.g. San Marcos as a recommendation of best practice). Dr. Blader responded that RTCs come up as a result of the foster care system and is part of the continuum of care. <ul style="list-style-type: none"> Ross Robinson said that DFPS will not license an LMHA since the licensing process is too cumbersome and criteria cannot be met (e.g. there are strict academic requirements for the child that the LMHA cannot meet). Dr. Blader supports having a long-term psychiatric unit for adolescents at SASH and said it should not serve an acute function (e.g. as a result of not having access to an RTC). Chris Bryan questioned whether it would be more effective for the SASH staff to contract adolescent services out to the community, and if it would be a better opportunity for public-private partnerships. Dr. Blader was in support of allowing another campus or entity to run the adolescent unit. Dr. Pliszka said the key issue is where the appropriate level of care is provided (long-term vs acute especially in rural areas). He insisted that the problem is that there are no beds in the community for adolescents therefore they are brought to SASH. <ul style="list-style-type: none"> Dr. Taylor suggested the recommendation should include keeping crisis and acute care services in the community. In the meantime, we need to continue to increase the regional support for adolescents. Ross Robinson explained that in the proposal we will need to describe a step-down process for adolescents. <ul style="list-style-type: none"> Blader mentioned that in some states "group homes" are used to provide therapeutic services and serve as a step down from an RTC. Dr. Pliszka summarized the discussion on this recommendation as: retain an SASH adolescent unit that will be focused on longer term care for adolescent that have failed in less restrictive environments, and that an array of regional services (such as respite) are needed to address acute care needs. <ul style="list-style-type: none"> Dr. Taylor said some crisis services in the regions will also be needed to provide suicide prevention services. Recommendations #7, #8, and # 9 will be made broader. <ul style="list-style-type: none"> Gilbert Gonzales recommended including Doug Beach's recommendation for #2 to #7. Gilbert will send Dr. Pliszka comments on the housing recommendations. Recommendation #10 <ul style="list-style-type: none"> Dr. Taylor suggested recommendation #10 (a) be wordsmithed so that it may include language related to the order to compel medication at a CSU and to drop #10 (c). Sheree Hess explained that only physicians in LMHAs under an ED or EAD can request prescribing an anti-psychotic. Currently, crisis workers must submit the request in person while physicians can do it online. She suggested changing this. Ross Robinson suggested adding the recommendation that the state appropriate funds to support 1115 Waiver programs (e.g. using funds to expand a LMHA's ability to provide 24/7 telepsychiatry services beyond that of a county jail). Additionally, he recommended
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	<p>that the state allow rural jails to use telepsychiatry to compel medication. Details about these two recommendations will be flushed out.</p> <ul style="list-style-type: none"> • Doug Beach suggested adding a recommendation focused on the geriatric population at SASH. He recommended the potential use of another facility for long-term care and looking into using an alternative facility for those individuals committed to multiple years so that space at SASH can be made for more acute patients. Doug also suggested researching step-down facilities that might be more in line with nursing homes with skilled professionals. <ul style="list-style-type: none"> • Dr. Taylor explained that there are no 'in-between' programs for the elderly (in between the level of care of SASH and a nursing home) • Chris Yanas stated that Commissioner Maples has mentioned (in previous presentations to other stakeholders) that there are state efforts to move populations with extended stays (365 Club) out of SASH/state hospitals. <ul style="list-style-type: none"> • Amanda Flores said HHSC is currently looking into the 365 Club population, but it seems that indeed currently nursing homes do not have the higher skilled nurses needed to care for this population. <p>Dr. Blader showed a mockup of the report.</p> <ul style="list-style-type: none"> • Amanda Flores will be sharing maps related to SASH with Dr. Pliszka who will forward them to the committee members. • Doug Beach suggested adding an appendix to the report that would list out the topics that were brought up by the executive committee members that still need to be discussed, need more information or lacked consensus.
Announcements	<p>Chris Yanas announced:</p> <ul style="list-style-type: none"> • MHM will be funding MMHPI to research the SASH workforce issues related to salaries and employee retention. • THA (Sarah Gonzalez) did a study of their hospital members in the ASH catchment region. <ul style="list-style-type: none"> ◦ The Executive Committee decided it too would like THA do a similar 14 question survey of the hospitals (includes privates) in the SASH catchment region to look at capacity and hospital utilization, and a way of finding out if any hospitals would like to provide contract beds or services to SASH. • Suggested that all organizations in the process of developing their 86th Legislative Agendas include funding for SASH as a legislative priority.
Next Meeting	<ul style="list-style-type: none"> • SASH Architecture Subcommittee is meeting on December 17 and 18. • SASH Executive Committee meeting will be scheduled by Chris Yanas using a survey for either December 19 or 20, 2018.

SASH Executive Committee Meeting

Thursday, December 20, 2018
11:30 a.m.
Methodist Healthcare
Ministries – Conference Rm. 3

Attendance:

Doug Beach (NAMI SA), Molly Biglari (Haven for Hope), Joseph Blader (UTHSA), Jelynn Burley (CHCS), Gilbert Gonzales (Bexar County), Allison Greer (CHCS), Fred Hines (Clarity), Sarah Hogan (STRAC), Tony LoBasso (MHM), Gilbert Loreda (UTHSA), Kristina Martinez-Fields (UTHSA), David Pan (CHCS), Steven Pliszka (UTHSA), Chris Yanas (MHM), Zahra Barsi (MHM), Jacqueline Cantu (MHM), Sebastien Laroche (MHM), Christina Phamvu (MHM)
By Phone: Chris Bryan (Clarity), Amanda Flores (HHSC), Amanda Mathias (MMHPI), John Pettila (MMHPI), Andrea Richardson (Bluebonnet Trails), Jeff Tunnell (Gulf Bend)

Review and Discussions on SASH Redesign Recommendations

- Chris Yanas (MHM): Will we be spelling out the full name, rather than using acronyms, such as for SASH. Also, some of these sentences are incomplete, just phrases.
 - Dr. Pliszka (UTHSA): These recommendations will be covered in the key sections of the report. They will not be written verbatim in the report but will serve as a guidance for Dr. Blader as he writes the white paper. We will be sure to use San Antonio State Hospital in the report.

Recommendations

1. This recommendation focuses on replacing SASH in current location in southeast San Antonio with several design aspects.
Ten voting members accepted the recommendation.
2. This recommendation focuses on enhancing the treatment programs for patients at SASH.
 - Dr. Pliszka (UTHSA): I received a comment on this recommendation that suggested including geriatric services into this section.
 - Jelynn Burley (CHCS): I agree with that recommendation. In addition, I propose that we include navigation and care coordination in 2c – improving discharge planning and transitional programming. We are looking to address the gaps in the care continuum that includes law enforcement navigation and care coordination. We can provide language on this recommendation for the report and forward to Dr. Blader.
 - Chris Bryan (Clarity): I recommend that we include the adolescent-equivalent to peer support services, which for children, is certified family partnerships. This recommendation would fall under 2g. We can provide language on this recommendation for the report.
 - Jelynn Burley (CHCS): For recommendation 2e on technology capabilities, will this address business agreements between parties to share information or is it a broad recommendation to modify the EHR?
 - Dr. Pliszka: The recommendation does include the recommendation to share information between parties.
 - Doug Beach (NAMI SA): We have talked about including geriatric populations in the last meeting. The issue with SASH is that they have a geriatric population that cannot be placed in nursing homes or other community settings. I recommend that we add a section (section h) to recommend to the state that it develop a long-term plan for the geriatric population.

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- Dr. Blader (UTHSA): Page 51 of the report under section three, subsection 11 talks about the landscape of the geriatric population. We can add more language in the report.

Ten voting members accepted the recommendation as amended with language to include navigation and care coordination (2c); certified family partnerships with children (2g); and long-term plan for the geriatric population (2h).

3. This recommendation focuses on regional hub plan (proposed by Ross Robinson and Jeff Tunnell)
 - Chris Bryan (Clarity): Does this regional plan recommendation include children or is it limited to adults? We would need to factor in structural space and separate units for children if it is included in the plan.
 - Jell Tunnell (Gulf Bend): The regional plan includes adults and adolescents because the regional LMHAs are overseeing both populations.

Ten voting members accepted the recommendation.

4. This recommendation focuses on expanding client-centered outpatient services and work to link outpatient services with SASH and private inpatient psychiatric facilities.
 - Jelynn Burley (CHCS): I recommend that we include the IDD population in this recommendation because they are an integral part of the mental health system. This recommendation should also include the proposal (Texas Care Connection) that involves the redesign of the 1115 waiver funds. CHCS and MHM can provide language on this recommendation to Dr. Blader.

Ten voting members accepted the recommendation as amended with an added section (e) for IDD and dual-diagnosis individuals and language on initiatives to expand community services.

5. This recommendation focuses on preventative child/adolescent mental health services.
 - Jelynn Burley (CHCS): I recommend that the language in the recommendation includes children with IDD. There is lack of preventive services for these children.
 - Allison Greer (CHCS): Is there a typo in the recommendation on 5a that talks about mental illness in adults?
 - Dr. Pliszka: This needs to be reworded. I am trying to say that treating children earlier will prevent chronic illnesses and serious mental illnesses as adults, but I understand that the language did not convey my thoughts as well. I can revise the language for the report.

Ten voting members accept the recommendation as amended with an added section (f) that emphasizes addressing services for children with IDD and revised language on 5a.

6. This recommendation focuses on a variety of programs for substance use treatment, which is very similar to the Texas House Select Committee on Opioids recommendations.
 - Jelynn Burley (CHCS): One of the Select Committee's recommendation is to expand substance use coverage through commercial insurance. I do not see that recommendation in our report, but I recommend adding it to our report.
 - Dr. Pliszka (UTHSA): Recommendation 6f would make changes to federal law to allow addiction and substance use disorder history to be displayed in a patient's EHR, instead of a separate form.
 - Jelynn Burley (CHCS): The LMHAs also agree with the recommendation to make changes to Title 42 of Code of Federal Regulations because we are moving towards integrated care.

Ten voting members accept the recommendation as amended with an added section (g) to recommend expanding substance use coverage in commercial insurance.

7. This recommendation focuses on the master plan on the SASH campus, including community services on site.
- Chris Yanas (MHM): Recommendation 7c (housing options) should be revised to make it a more comprehensive thought.
 - Dr. Pliszka (UTHSA): HHSC is working on releasing an RFI to see if community members would like to contract for services on campus. As far as I know, the RFI has not been released yet.
 - Chris Yanas (MHM): Chris Bryan and I were on a call with Jonathan from Senator Schwertner's office about upgrading the IT system for state hospitals. Upgrades were done to improve connectivity for the state supported living centers this past session and these efforts may expand to state hospitals in 2019 as they look to redesign the delivery system of care. Are there any other places in the report that recommend IT system connectivity for state hospitals?
 - Dr. Pliszka (UTHSA): Recommendation 2e talks about connected IT services, but we can expand on that recommendation in the report. If you provide language on the pilot programs on connectivity, we can make sure it is in the report.

Ten voting members accept the recommendation as amended to revise language on housing options (7c) and include pilot programs for e-health connectivity within the state hospitals.

8. This recommendation focuses on enhanced assisted outpatient treatment.
- Chris Yanas (MHM): recommend revising language in 8c to make it a more comprehensive thought with supporting background.
 - Dr. Pliszka (UTHSA): This recommendation will cross-reference recommendation 11d. In addition, we changed the word compliance with "adherence" in the report.
 - Dr. Blader (UTHSA): Would any of the members like to include positive treatment incentive models? *Several members agreed with this recommendation.*

10 voting members accept the recommendation as amended to include positive treatment incentive models and revising the language in recommendation 8c with supporting materials.

9. This recommendation focuses on expanding access to guardianship programs.
- Molly Biglari (Haven for Hope): I would like to recommend changing "guardian" throughout this recommendation to "guardianship" so the recommendation is not confused with the foster system.

10 voting members accept the recommendation as amended to change language to guardianship.

10. This recommendation focuses on the role of UT Health San Antonio at SASH.
- Allison Greer (CHCS): Has HHSC mentioned their intent on how to operate the hospital after it is built?
 - Amanda Flores (HHSC): The plan will be to have state/HHSC employees operate the hospital, which is how it is run today. Some of the operations/staff will change to reflect the changes in the new hospital.

	<ul style="list-style-type: none"> Chris Yanas (MHM): I would like to recommend striking recommendation 10a because we would like to keep all recommendations as positive improvements. This statement, as written, will hinder our advocacy efforts to garner support for the reconstruction of SASH. Recommendation 10b should include “continued collaborations” in the area so lawmakers and HHSC understand that UT Health San Antonio is involved and wishes to remain involved in the redesign process. <p>10 voting members accept the recommendation as amended to strike recommendation 10a related to SASH’s role on operating the state hospital and include continued collaborations in recommendation 10b.</p>
	<p>11. This recommendation focuses on various legal changes.</p> <ul style="list-style-type: none"> Jelynn Burley (CHCS): I would recommend including funding in recommendation 11c for competency restoration in an outpatient setting. If we don’t specifically ask for funding, the legislature may do an unfunded mandate. Dr. Pliszka (UTHSA): Recommendation 11e was recommended by the rural LMHAs (Ross and Jeff) because they have difficulty getting emergency detentions in their area due to regulations. <p>10 voting members accept the recommendation as amended to include language on funding for outpatient competency restoration.</p>
Additional Remarks	<ul style="list-style-type: none"> Dr. Pliszka (UTHSA): We will submit the white paper on January 2nd and the architects will send HHSC the master plan. Do we have any knowledge of the Executive Committee’s role after the report is submitted? <ul style="list-style-type: none"> Amanda Flores (HHSC): The role of the Executive Committee is up to the members. Members can continue to meet on a regular schedule or take a break and meet again after session. Austin State Hospital (ASH) is planning to meet during session. Allison Greer (CHCS): I recommend meeting during session, at least during the early parts of session. Chris (MHM) informed me that she is working on a one-pager for SASH Funding and I think it would be helpful to meet together as a committee to go over talking points and make sure we are all on the same page. Amanda Flores (HHSC): We are asking all entities involved with the state hospital to review talking points with HHSC before distribution to the Legislature. Chris Yanas (MHM): Our one-pager will be for MHM. Our team will be advocating for SASH funding on behalf of MHM, not on behalf of the Executive Committee. Jelynn Burley (CHCS): CHCS will be advocating for SASH funding on behalf of CHCS, not on behalf of the Executive Committee. Doug Beach (NAMI SA): Will the architects submit a report on the value of the new construction to the Executive Committee or just to HHSC? <ul style="list-style-type: none"> Dr. Pliszka (UTHSA): The architects will submit their report to the Executive Committee, as well as HHSC. The Executive Committee and architecture subcommittee will continue to stay intact and maintain the same flow of communication as it is now. After the Legislature approves funding for the construction, HHSC will contract with UTHSA on construction. Doug Beach (NAMI SA): I would like to stress the importance of maintaining community involvement in the design process of the hospital. There is a lot of decisions that are being made that will determine the operations of the hospital for the future. <ul style="list-style-type: none"> Molly Biglari (Haven for Hope): I would also like to stress the importance of having community members involved in the architecture subcommittee meetings. I was at the last architecture subcommittee meeting (on Monday) and

realized that it would be helpful to have some objective presence in the meetings to express the needs and opinions of our community.

- Announcements**
- Dr. Pliszka (UTHSA): Please provide revisions and language as soon as possible so we are ready to submit by January 2nd. Dr. Blader would suggest making recommendation in the actual report and using track changes so we are able to see all edits and comments.

- Next Steps**
- The following organizations, as soon as possible, should provide:
 - Center for Health Care Services (CHCS)
 - Language on navigation and care coordination for recommendation 2c.
 - Language on including IDD and dual-diagnosis individuals on recommendation 4e.
 - Coordinated language with MHM on language for initiatives to expand community services (Amend and Extend) for recommendation 4.
 - MHM
 - Coordinated language with CHCS on initiatives to expand community services through proposal to amend current 1115 Transformation Waiver (Texas Care Connection) for recommendation 4.
 - Language on pilot programs on e-health connectivity within state hospitals for recommendation 2e.
 - Clarity
 - Language on certified family partnerships with children for recommendation 2g.
 - NAMI SA
 - Language on long-term planning for geriatric population for recommendation 2h.
 - UTHSA
 - Language on emphasizing services for children with IDD on recommendation 5f.
 - Revision language for recommendation 5a on preventive community services for children.
 - Include substance use coverage in commercial insurance for recommendation 6g.
 - Revision language for housing options on recommendation 7c.
 - Language on positive treatment models for recommendation 8
 - Revision language in recommendation 8c with supporting material.
 - Revision language from guardian to guardianship for recommendation 9.
 - Removal language for recommendation 10a.
 - Revision language for recommendation 10b related to SASH's ongoing collaboration with HHSC.
 - Language to include funding for outpatient competency restoration on recommendation 11.

Appendix B: SASH Stakeholder Meeting Minutes

SASH Stakeholder Meeting – Bexar County

Monday, June 04, 2018

12:30 p.m. – 2:00 p.m.

Methodist Healthcare Ministries

4507 Medical Dr., 3rd Fl. Board Room

San Antonio, TX 78229

ATTENDANCE

Liza Jenson (Nix), Amanda Miller (CHCS), Brian Clark (CHCS), Jacob Cuellar (Laurel Ridge), Benigno Fernandez (Laurel Ridge), David Pan (CHCS), Dr. Rene Olvera (CHCS), Sherry Bailey (CHCS), Cecil King (CHCS), Jamie Molbert (MHS), Eric Epley (STRAC), Gilbert Gonzales (Bexar County), Dr. Sally Taylor (UHS), Dr. Christopher Wallace (UHS), Luis Santos (UHS), Velma Muniz (Bexar County), Katie Vela (SARAH), Kim Blast (CHCS), Bart Vasquez (SAPD), Allison Greer (CHCS), Lydia Mesquiti (UHS), Chris Yanas (MHM), Christina Phamvu (MHM), Sebastien Laroche (MHM), Amanda Mathias (MMHPI), Lauren Roth (MMHPI)

**Opening
Remarks**

- The HHSC website has great information and background documents on research of state mental health facilities and changes to the state hospital system
- We were blessed to receive \$1 million this legislative session in planning funds to gather information from SASH stakeholders and others in the 45-county catchment area to develop a plan and final report for HHSC. This will assist our efforts to secure funding for construction dollars for new facility, estimated to be \$270 - \$300m.
- Your stakeholder input on what is needed from the Bexar community is very important; we can use that information to help us to gather additional funds and support for programs that will benefit the SASH delivery system.
- Stakeholder input is valuable because it impacts the delivery system, not just the building

**Stakeholder
Input**

- **What is the view of the proper role of SASH? Who should we serve?**
 - Liza Jenson/Nix: SASH should serve the needs of those who are lacking resources and those who are in crisis
 - Some patients need more than what I can give them
 - Lacking resources – the type of patient that has multiple ineffective ambulatory visits and they need more than acute care for 30 days
 - David Pan/CHCS: It should also be a resource for community providers; so providers in the rural community can come to SASH and learn how to treat patients and take it back to their communities.
 - Gilbert Gonzales/CHCS: SASH should create an environment of recovery and resiliency as a person transitions into the community; we need coordination and continuity of care for these patients
 - Luis Santos/UHS: SASH should be able to provide patients to access to sunlight, physical activity and other resources when community hospitals don't have the access or cannot offer this type of care, due to infrastructure
 - Includes 1 on 1 staffing for patients who would like to go outside, but need to be monitored
 - There is a staffing issue for SASH – the reduction of staffing is counter-intuitive to the level of acuity in patients they serve
 - Bart Vasquez/SAPD: Public Safety
 - When we send a patient to SASH, they will stay for 90 or so days and we won't get a call about them afterwards
 - But when we send a patient to a community hospital, they are only there for 2-4 days and we are constantly having to pick them up again and bring them somewhere

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- CHCS clinicians go out with us on these calls to determine if a patient should go to SASH or not – it has helped tremendously with the reduction of mental health patients in our jails
 - Liza Jenson/Nix: SASH should have the ability for wraparound services, including medication, work-related programs and access to community services
 - Amanda Miller/CHCS – there is no coordination at SASH
 - In the community setting, a social worker sets up a patient’s discharge information and treatment plan
 - At SASH, people just get dropped off after they are discharged
 - **Why are people not attracted to work at SASH?**
 - Management, bureaucracy, state budget constraints, stress levels, salaries need to be streamlined and competitive with the market and other community hospitals
 - **We have heard other people mention that acute services should be somewhere in the community and not at SASH. What is your opinion on acute services at SASH?**
 - Christopher Wallace/UHS: I think SASH has come to that by default due to the lack of civil beds; we need to increase civil capacity
 - Sally Taylor/UHS: I believe in the right care, right time model. I would like SASH to be available if we identify someone at the front door of the ER that needs to be at SASH so we have availability in our inpatient for acute services. From what I heard, rural hospitals are able to access SASH directly, but we can’t do it from our front door. We can access it from our inpatient back door, but that means that we must take up a bed for someone that could just be directly transferred
 - **How many patients do you send to SASH currently?**
 - UHS – 0
 - Jamie Molbert (Methodist): The pathway to enter SASH is too long and there are all these rules and regulations on who may be admitted to SASH. It prevents us from sending people there. Have patients who are held at MHS for weeks waiting for SASH bed.
 - **Do the communities control the waitlist?**
 - Liza Jenson/Nix: There are unspoken rules on TAC that are not always communicated to the community hospitals on the priorities of the waitlist (rural vs communities)
 - There is a triage order for priority so the waitlist is constantly changing
 - The community partners are constantly having to call back to check the status of the waitlist – we need some sort of patient management system where we can see the waitlist (who is on it, priority, etc.)
 - Sherry Bailey/CHCS: For forensic patients, we can try to send a patient to Vernon if it is needed, but there is a long waitlist for forensic patients as well
 - **Do you see co-morbidities being turned away or denial of medical clearance at SASH due to medical capabilities?**
 - Liza Jenson/Nix: There is a difference in medical clearance in the ER setting and medical clearance in the admission setting
 - We need to define the two terms, the differences, and identify the gap
 - It would be nice for everyone to know the list of labs that are needed for admission
 - Christopher Wallace/UHS: there is a lack of availability for pregnant patients; if the patient is stable, they should be able to access services until discharge or delivery
 - Sally Taylor/UHS: for medical problems at SASH that need to be sent to another hospital, I heard that SW General will likely treat the patient, due to its proximity to SASH

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- Luis Santos/UHS: SASH needs services for co-morbidities with IDD individuals. Insurances won't cover nonverbal patients because they can't successfully complete mental health treatments (group therapy)
 - Christopher Wallace/UHS: rural community hospitals frequently send us patients when they don't have the capacity to treat the patient
 - **Do you have experience with continuity of care with any of your programs?**
 - David Pan/CHCS: we need a strong ACT team when a patient transitions to the community after discharge; there are no consistencies or protocols put in place for transition services at the State Hospital when they discharge a patient
 - Benigno Fernandez/Laurel Ridge: I find it easy to communicate with the rural LMHAs. Patients from the rural LMHAs always have good assessments, they maintain communication during the stay, and it is easy to follow up after discharge; I do not see the same accessibility of information with our LMHA
 - Liza Jenson/Nix: It is the opposite for us; the rural LMHA patients or the police will just show up unplanned to our hospital
 - Jacob Cuellar/Laurel Ridge: The patient is discharged from SASH and there is minimal visible f/u – no case management or plan for the patient
 - Christopher Wallace/UHS: I had a patient last week that was discharged from SASH 2 days prior and needed to be re-hospitalized. When I called SASH, they had already given the bed away; so it is hard to get patients who have been treated there to be readmitted due to lack of capacity
 - Bart Vasquez/SAPD: We have started looking for people after they have been discharged to help them get to their appointments and that is because of the help from CHCS
 - Amanda Miller/CHCS: housing and benefits are a huge barrier for patients after they are discharged
 - Sally Taylor UHS/: There used to be a transitional living facility at SASH; we should bring it back; they had case managers to helping the patient navigate the system
 - Christopher Wallace/UHS: We need some step-down outpatient services or an ACT Team at the state hospital to help with transitional services
 - We need to account for different levels of services
 - Sherry Bailey/CHCS: There is a lack of benefits upon discharge, which makes it hard to get any services
 - Katie Vela/SARAH: We started using SOAR to expediate benefits for long-term housing needs
 - Sherry Bailey/CHCS: We see undocumented individuals that can't be discharged because they are at risk when they will be discharged due to lack of services and resources
 - SASH does not look at immigration status upon admission
 - **What is your opinion on adolescents at SASH?**
 - Rene Olvera/CHCS: We need adolescent beds at SASH. I don't know any facilities that have capacity to treat more children
 - Sally Taylor/UHS: If you already have child facilities, can they be expanded? It may be hard for children in other communities to go to SASH because the parents will have to travel and there is no place for them to stay
 - Sherry Bailey/CHCS: Kids from CHCS will go to Waco or Austin, if there is room
 - Benigno Fernandez/Laurel Ridge: Austin is hard for transportation because they do family services and it is hard for families to travel; the waitlist for Waco is almost a year.

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- Rene Olvera/CHCS: We also have trouble with the juvenile justice patients and those from DFPS. DFPS and CPS placement children are destructive and have high needs, we need to find the resources to treat them. Many housing facilities can't manage these children.
 - Sally Taylor/UHS: Should SASH use beds for those kids or should we look at funding for other facilities that may have more staffing?
 - Rene Olvera/CHCS: Dallas has a community resource project for DFPS children – a shelter residential facility and it is very successful. I do not know the name, but can give it to you
 - **What other services do you think will be needed in order to provide better care in the community?**
 - Transitional team
 - Benefits coordinator
 - Housing coordinator
 - SAPD social worker
 - Patients need somewhere to go and need social support
 - ACT Team
 - Sally Taylor: Data sharing – it would be great to access records with discharge summaries
 - Liza Jenson: There are no wraparound services that are immediately accessible
 - Velma Muniz/Bexar County: we ideally want one person to follow the patient and coordinate their care
 - Christopher Wallace/UHS: there has been an increase in the number of mental health patients in jails – we shouldn't take away their benefits; it causes a disruption in their care
 - Katie Vela/SARAH: has been looking at the community navigator role to see if we can play a part in that for homeless individuals or if we should contract it out to someone else
 - **What is your opinion on substance use treatment in the community?**
 - Christopher Wallace/UHS: There is no adequate treatment available for long-term recovery – no funding or availability
 - It has been difficult for hospitals to integrate substance use disorders with other co-morbidities
 - Cecil King/CHCS: from a residential side, it is hard to find sober housing
 - Sally Taylor/UHS: Substance use treatment should be the standard of care when treating mental health because 99% of the patients probably already have the disorder or they are at risk of having the disorder
 - **What is lacking in technology to increase continuity of care in the community?**
 - Gilbert Gonzales/Bexar Co: we need to include social determinants of health in our EHRs, especially when the new generation
 - **Are you giving 30-day medication for patients upon discharge?**
 - Sally Taylor: We give them medication for 7 days and a script for 30 days
 - Liza Jenson: One of our doctors is not in the CHCS formulary, so the patient needs to see a CHCS doctor to convert the script and go from there
 - **What do you think needs to be communicated to the SASH Executive Committee?**
 - Jacob Cuellar/Laurel Ridge: do we know the number of civil beds that will be available at SASH? We talked to SASH leadership and they are unsure -said # would stay same.
 - Chris Yanas: not sure
 - Liza Jenson: We need to protect civil beds
 - Cecil King: Residential services

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- Bart Vasquez: Access to beds for law enforcement because the patients we pick up are a danger to themselves and others
 - Luis Santos: I just want to say that Tiffany Juarez (admissions coordinator) at SASH has done a great job with the admissions process
 - She has great customer services, she is always reachable and understands our role
 - She is also organized and will keep us updated on our patients or the admission processes
 - Sally Taylor: We need close coordination with jails at SASH and effort to increase civil capacity
 - Benigno Fernandez: we need multi-agency coordination at SASH, maybe a facility
 - Solution-focused treatment plans for patients
 - Jacob Cuellar: We need community wide triage and access to SASH; we are constantly getting pushed back due to the rural communities
 - Eric Epley: Would it be possible to get TAV Health to get ahold of the SASH waitlist for everyone to see? It would start the conversation on these triage conditions for the SASH waitlist. That is something we can do now.

SASH Stakeholder Meeting – Nueces County

Tuesday, June 26, 2018

11:30 am

Behavioral Health Center of
Nueces County

Attendance:

Chris Yanas (MHM), Christina Phamvu (MHM), Jaqueline Cantu (MHM), Amanda Mathias (MMHPI), Joseph Blader (UTHSA), Mike Davis (BHCNC), David Barrera (CIBH), David Schroll (Family Counseling Service), Sheila Smith (BHCNC), Victoria Rodriguez (BHCNC), Andrea Potter (BHCNC), Bonnie Boone (BHCNC), Cathy Garcia (Bayview Behavioral Hospital), Linda Fraser (BHCNC), Daniel Perez (Nueces County Sheriff's Office), Denise Pace (Corpus Christi Police Department), Dr. Daniela Badea-Mic (BHCNC), Andrea Vela (BHCNC), Mark Hendrix (BHCNC), America Contreras (BHCNC), Lina Lara (CIBH), Dr. Osbert Blow (CMO, Christus Spohn), Jenny Dorsey (Nueces County DA's Office), Mary-Esther Guerra (NC County Attorney)

Who do you think SASH should serve?

- Mark Hendrix: Adolescents; need inpatient beds – significant reduction in number of beds available
- Bonnie Boone: have higher need for adolescent beds, locally; the need for adult civil beds is still high; geriatric beds not as high
- Satellite SASH in different communities – this would be great for adults and adolescents
- We file on 2-3 patients/month, but only sent 2-3, based on availability (adolescents)
 - Some children are diverted to Laurel Ridge, Doctors Renaissance (RGV area)
- Workforce shortage concern – need for adolescent psychiatrists; see the same number of patients, but decrease in the number of psychiatrists
- Bayview Behavioral Hospital serves adolescents (10-17 years old)
 - Average of 16-17 adolescents at a time
 - Summer reduced to 12 to move to adult
 - Average LOS is 5-7 days, focus is on crisis stabilization – short term
 - Spohn only takes adults
- Daniela Badea-Mic (BHCNC): Concern is with the wait time to get into SASH
 - Pt eventually stabilized before they get admitted
 - Same situation in jail – people wait 1 year for competency restoration
 - Competency is voluntary not mandatory
 - Concern about LOS for civil and forensic
 - Patients stay there for years and won't attend competency classes d/t the classes being voluntary
- Mark Hendrix – what is happening to civil beds? forensic beds surpass civil; eventually state hospital will be all forensic; would like to see a protection of civil beds
- Mike Davis: is this model going to change? Are there consequences or misuse of beds?
- What changed in the last couple of years in the reduction of patients being sent to SASH; those factors need to be addressed
- Can communities have power over their waitlist?
 - We have a good relationship, if we need to prioritize a person – we work it actively vs passively
 - Historically, we haven't had a long waitlist like other centers d/t maintaining strong relationship with SASH personnel
- What are you doing in the community that reduces the waiting list?
 - We do not have any direct funding for inpatient beds; we don't have state dollars;
 - PESC dollars only go to crisis respite (requested from DSHS) – not a significant amount
- BHCNC Crisis Respite: someone in crisis, but not to the extent for acute need; we can monitor and deescalate (16 beds) with 1 nurse – not a hospital

	<ul style="list-style-type: none"> • Who needs to go to SASH? The process to get into SASH? <ul style="list-style-type: none"> ○ There is no process ○ There is no policy about medical clearance; SASH administration (Bob Arizpe and Tiffany Warren) decide who can get in <ul style="list-style-type: none"> ▪ Ex: someone with an ulcer may not be admitted ▪ People we send are psychotic who cannot have emergency medication ▪ Continued suicidal patients and don't respond to medication ▪ We don't send to SASH unless we exhaust all our resources ○ We send about 1 or 2 every few months – because process takes so long <ul style="list-style-type: none"> ▪ Have cases where people would wait for a month to get to a bed ▪ Need to coordinate bed and transportation ▪ Cannot send geriatric pts to SASH ▪ In past, had trouble sending patients with IDD • Substance Use sending to SASH? <ul style="list-style-type: none"> ○ Bonnie Boone: have not encountered problems sending patients with substance use ○ When pt has a court order to go to SASH, but SASH cannot accept pt, unsure what to do
What is working well with the pathways?	<ul style="list-style-type: none"> • Building good relationships help with discharge planning – both forensic and civil commitments <ul style="list-style-type: none"> ○ Able to coordinate pt back into the community; they work very well with us ○ Work with social workers and doctors on discharge plan from Day 1; ○ Discharges deliberately done on weekdays so we can greet them – don't let people fall through the cracks ○ Bonnie, who is SASH Liaison, goes to SASH every other week and sees patients
How should campus be set up to transition better?	<ul style="list-style-type: none"> • Recently, campus has shut down – would like to see it expand (pts should be able to use the grounds) • Looked at step-down program on campus? Transitional housing <ul style="list-style-type: none"> ○ Is transitional housing better in the communities or at SASH? <ul style="list-style-type: none"> ▪ It would be better in the community because we are trying to connect them to wraparound services in the community – need funding ▪ Recommendation – need psychiatric group homes • Nueces County has ACT and transitional programs to help patient back into the community • Can we use funding to address medical conditions at SASH? <ul style="list-style-type: none"> ○ patients with medical needs are turned down by SASH because they don't have the expertise • What are the chronic medical conditions that are a roadblock? <ul style="list-style-type: none"> ○ Uncontrolled diabetes ○ Sleep apnea ○ Wound care ○ If you have geriatric beds, you need a medical clinic ○ If you want long term care, you need integrated care – hard to treat psychiatric care without medical care
What needs to change for staff	<ul style="list-style-type: none"> • Salary • Caseloads (workers have increased caseloads in last couple of years) • SASH has shut down units because lack of support staff – need financial changes <ul style="list-style-type: none"> ○ Concerns with lack of security for staff

- It doesn't look like the nurses have a place of their own – separate staff areas
- If system with community doesn't change, then new building won't make a difference
- Will they take away beds during construction?
 - Construction can start with new buildings, have more options because they are not land locked

Within your community, what are the collaborations across systems that you can expand on?

- Need to develop partnerships with communities to improve outcomes
- Sandra Bland Act – BHCNC created community collaborative to create jail diversion programs and restoration of competency programs
 - Impact of utilization
 - Doing everything possible to not send patients to SASH
 - Partnerships: Nueces County, County hospital district, LMHA
 - Local partners include local substance use and recovery experts (Charlie's Place), CCPD for crisis intervention, sheriff's office, DA's office
 - Individuals who are frequently arrested for untreated mental illness and comorbid substance use problems – intervene at pre-charge and post-charge diversion
 - Catch and link them directly to care (outpatient and inpatient services)
 - CIT – pair law enforcement with mental health professionals on the streets
- ACT team is fantastic – well over 70-80% in the program and independently housed; have lower hospitalization rate; if we received additional dollars, we could do more of it
 - Our team can serve up to 40 people; currently serving 26
 - Majority of patients are uninsured
 - 3 case managers, 1 peer provider, 1 RN, 1 LVN, psychiatrist that provides 10 hours of week, RNs
- Victoria Rodriguez: 7 in 30 days post discharge follow up in youth and adolescent division
 - actively seeing patients with LPHA
 - can't give you data – tracked admission and readmission
 - no longer current DSRIP project, but may be returning
- if DSRIP is not funding, unable to continue with projects, even if successful
- we are fortunate to have Nueces county hospital district patients, able to use medication as long as it is on formulary
 - will utilize PAP for medications not on formulary
- Medical meds more of a challenge than psychiatric meds

Families being involved in care at SASH

- Distance is hardship
- Visitation facility for families on the weekends
 - Have not observed visitation;
 - Use of telemedicine to connect families in Nueces area to child at SASH?
 - We have telemedicine here, if SASH is able to connect with us
- Social workers good about getting families involved
- Most families are indigent, have trouble getting there

- Other feedback**
- What is SASH expected to do? The platform needs to change in terms of who SASH plans to treat
 - Rarely seeing 1 diagnosis now, most patients have 2 or 3 diagnoses for psychiatric conditions
 - If we have to address the building, leverage sustainable sources of energy and artificial intelligence that will fit the matrix and impact the aspect of mental health
 - Need to address forensic vs civil beds – need to protect civil beds
 - We can handle relatively quick turnaround for forensic patients – the doctors aren’t filing because they can’t send patients
 - Chagrin Valley Nursing Home in Ohio – set to look like a community, creating a sense of normalcy
 - Thrive Memory Care (Corpus Christi)

SASH Stakeholder Meeting – Gulf Bend Center/Criminal Justice Stakeholders

Tuesday, July 10, 2018
9:00 am
Gulf Bend Center – 6502
Nursery Dr., Victoria, TX
77904

Attendance:

Jeff Tunnell (GBC), Melissa Garcia (GBC), John Petrila (MMHPI), Nicole Way (GBC), Darlyn Sustaita (GBC), Lane Johnson (GBC), Ward Wyatt (Victoria Co. Sheriff's Dept.), Michael O'Connor (Victoria Co. Sheriff's Dept.), Rex Mayes (Victoria Co. Sheriff's Dept.), Micah Harmon (Lavaca Co. Sheriff's Dept.), AJ Louderback (Jackson Co. Sheriff's Dept.), JJ Craig (Victoria Police Dept.), Caleb Breshears (Victoria Police Dept.), Nora Kucera (Victoria Co. Pre-Trial Services), Jon Hein (Victoria Police Dept.), Rusty Henderson (Victoria Police Dept.), Rawley McCoy (Mental Health Advocate), Russell Copeland (Victoria Police Dept.), Roy Boyd (Victoria Co. Sheriff's Dept.) Chris Yanas (MHM), Christina Phamvu (MHM)

**Do you currently
access to SASH?**

- It takes about 1 and ½ hours to drive to SASH, which is not geographically convenient for our law enforcement. That is at least one person that we must take off the streets just to transport someone.
- Michael O'Connor (Victoria Co. Sheriff's Dept.): Victoria Hospital District has attempted to create an equivalent for SASH, but it has not been sustainable due to economic reasons
- Law enforcement personnel must go through Gulf Bend and local hospital districts to get patients admitted into SASH
 - Some counties would like to go directly through Gulf Bend and not involve the local hospital districts because of differences in goals
 - We are constantly waiting 4-5 hours at the hospital to hear back about bed placement; we have to bear the burden to watch the patient at the hospital
- Rawley McCoy: What percentage of SASH patients are from Bexar County?
 - John Petrila (MMHPI): estimating around 75-80%
 - Chris Yanas (MHM): I do not have that number with me, but I don't think it is as high as 70%. I can get you the number.
- John Hein (Victoria Police Dept.): We can't access SASH on the weekend. The patients end up waiting in the emergency room
 - Streamline clearance can take 2-3 hours (if we are lucky) for private hospitals, but we also had 3 or 4-day process
 - The long process takes an officer off the streets just to watch the patient
 - It also takes up medical personnel and resources
- Rawley McCoy (Mental Health Advocate): Has the state talked about a decentralized process for mental hospitals?
 - Patients should get the best care close to home; it is more efficient and less costly
 - We are concerned about the costs and resources to transport someone to SASH, especially in our rural communities
- Ward Wyatt (Victoria Co. Sheriff's Dept.): We need a satellite campus
 - We do not have the manpower in our communities to transport patients; some counties have 2 deputies in the street at a time and they can't afford to use a deputy to drive up to San Antonio.
 - we need a facility close to home where they have access to professionals
- Michael O'Connor (Victoria Co. Sheriff's Dept.): Victoria and surrounding 6 counties are part of a collaboration that started about 3 years ago
 - We advocated in Austin to allocate funding for more assistances for deputies that interact with mental health patients
 - We are eligible to apply for some funding for more police officers in our communities

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- We are waiting for funding
 - Recommend that the SASH Executive Committee review our white papers and policy reports about our issues and collaboration to reduce the waitlist for mental health services
 - JJ Craig (Victoria Police Dept.): There are many times where we can't have access to SASH
 - Don't look at just the people that successfully made it to SASH; you must look at the number of patients that do not get into SASH
 - There is a greater collection of numbers for people that we have attempted to get into SASH, but failed.
 - When a patient is re-evaluated 48 hours in the ER, they start to understand the process and can play the game to get discharged; even if they did not receive mental health care in the ER.
 - They go back in the street and the cycle starts over again
 - Rawley McCoy (Mental Health Advocate): There is a lack of inpatient facilities in this region
 - We need to look at ways to spread the money out; maybe build 150 beds in San Antonio and build other facilities in other core areas of the state that needs help
 - We need to recognize people have a mental illness and we need to focus on a patient-centered treatment system
 - Michael O'Connor (Victoria Co. Sheriff's Dept.) Need to incorporate MHMR patients; we see MHMR patients in the sheriff's department and we don't have access to care for these patients
 - We have been dealing with this for over 30 years, but this last session was the first session where there was traction
 - Nora Kucera (Victoria Co. Pre-Trial Services): We don't have any criminal cases going to SASH
 - Our criminal cases are going to Vernon (takes about 3-5 months to get someone in), which is about 7-8 hours away and we don't have the resources like the urban communities
 - Forensic beds are in demand; we have at least 10 patients in our jail system that are currently waiting on a bed in Victoria
 - Many of these cases are major felony, violent offenders that will need at least two officers to transport from cell to other areas of the jail
 - On the civil side, we are trying to figure out local solutions, but we are hurting on the forensic side. There are prolonged support times, legal fees and other resources to take into consideration for these patients.
 - Michael O'Connor (Victoria Co. Sheriff's Dept.): Our sheriffs are liable for those patients and they are disruptive and suicidal. It can be problematic for our community.
 - We need more beds because our hospitals are struggling to keep their doors open
 - UTMB is looking at collaboratives in the Houston area and at their cost for more availability
 - John Hein (Victoria Police Dept.): We have had patients taken to other areas of the state and they are turned away at the door
 - We need somewhere close because it takes up time and associated costs (ex: miles on our cars, wear and tear)
 - AJ Louderback (Jackson Co. Sheriff's Dept.): We have county hospitals that are vacant; why can't the state put money in those hospitals to create some mental health beds?
 - Our safety business plan is to get the patient medicated to go back into society
 - We need access to those beds that allow time for a patient to get medicated and treated to go back into society stable – we need a temporary place to relieve law enforcement

	<ul style="list-style-type: none"> • Michael O'Connor (Victoria Co. Sheriff's Dept.): Sheriffs are gearing up for the legislative session to advocate for local beds • AJ Louderback (Jackson Co. Sheriff's Dept.): We are identifying more mental health patients due to mandate. The state is mandating us to identify more issues, but they are not giving us any solutions. • Darlyn Sustaita (Gulf Bend Center): Since June 1, we have placed 5 individuals in SASH <ul style="list-style-type: none"> ○ Average LOS in ER is 3 days, but had one individual with LOS of 6 days ○ There were 29 individuals sent to private hospitals • Nora Kucera (Victoria Co. Pre-Trial Services): SASH needs to restructure who can get into their program. Urban communities that have access to private institutions should send patients there first. Rural communities should be able to access state beds before a county that has private resources. <ul style="list-style-type: none"> ○ The people who should be in state-run facilities should be patients from the rural areas ○ We shouldn't be spending the money on patients when we don't have the money. • Rawley McCoy (Mental Health Advocate): Don't spend all the money on a new building; send the money to regional areas and contract with local hospitals • AJ Louderback (Jackson Co. Sheriff's Dept.): We need temporary beds for a short period of time to get the person stabilized. When we have patients that are waiting over 48 hours, patients are getting violent and disruptive. • Rawley McCoy (Mental Health Advocate): The state is helping a small concentrated area with SASH, but they are neglecting the 44 surrounding counties – missing out on the big picture • Michael O'Connor (Victoria Co. Sheriff's Dept.): We have made legislative progress on the civil waitlist <ul style="list-style-type: none"> ○ Waiting on some funding on jail diversion (HB 13) and applying for SB 292 <ul style="list-style-type: none"> ▪ Mental health officers and case managers ▪ SB 292 will address continuity of care after they leave the jail system ○ Gulf Bend has been instrumental on innovative ways to combat unavailability • Ward Wyatt (Victoria Police Dept.): A big political issue is urban vs rural and when we do get funding, it is spread too thin • JJ Craig (Victoria Police Dept.) We see medical clearance as a roadblock to access to services
Additional Comments	<ul style="list-style-type: none"> • Ward Wyatt (Victoria Police Dept. – Governmental Affairs) <ul style="list-style-type: none"> ○ No money (not enough \$\$), combined with the lack of law enforcement officers on patrol (due to budgetary constraints) in spite of huge increase in call volume ○ Lack of inpatient facilities in our region ○ Need additional beds, specifically rural-allocated beds • Rex Mayes (Victoria County Sheriff's Office) <ul style="list-style-type: none"> ○ Available beds are necessary for patients needing in-care services. Beds at SASH can increase that availability ○ Our jail needs forensic beds available for inmates in need of inpatient care ○ Our rural counties need local temporary beds to stabilize patients in crisis to reduce responder time and assist families involved with the individual • Nora Kucera (Pre-Trial Services Victoria) <ul style="list-style-type: none"> ○ Restructure admission policies – we aren't getting more beds but you can restructure to aid rural communities ○ Forensic beds – Victoria and the rural south Texas communities should not have to wait on a Vernon state bed

SASH Stakeholder Meeting – Gulf Bend Center/Victoria Hospitals

Tuesday, July 10, 2018

12:00 pm

Gulf Bend Center, 6502 Nursery
Drive, Victoria, TX 7904

Attendance:

Jeff Tunnell (GBC), Melissa Garcia (GBC), John Petrila (MMHPI), Nicole Way (GBC), Darlyn Sustaita (GBC), Lane Johnson (GBC), Rawley McCoy (Mental Health Advocate), Lorena Kanak (Lavaca Medical Center), Angie Burgis (DeTar Hospital), Bill Jones (Jackson Co. Hospital), Lance Smiga (Jackson Co. Hospital), Erin Clevenger (Memorial Medical Center), Daniel Barrientos (Billy T. Cattin Recovery Outreach), Hoss Whitt (Refugio Hospital), Jeff Payne (Citizens Medical Center), Jay Montgomery (Citizens Medical Center), Chris Yanas (MHM), Christina Phamvu (MHM)

Do you have access to SASH

- Angie Burgis (DeTar Hospital): the wait time for bed placement is 36-72 hours
 - We have to go outside of the SASH region to get a bed
 - housing mental health patients for a long time
 - Decriminalization of mental health is great, but can't keep them in the ER. Without a dedicated space, we can't hold them; the judicial system issues an Emergency Detention Warrant (EDW) without facility acceptance
 - We have one psych safe room, but we are often housing more than 1 psych patient at a time
- Bill Jones (Jackson Co. Hospital): Boarding times in ERs vary from 2 days to 6 days; one patient spent about 3 weeks between jail and the ER for a civil admission
- Lorena Kanak (Lavaca Medical Center): for smaller hospitals, we don't have a designated psychiatric room like the larger facilities
 - Patients tend to come in for medical reasons and then admit that they are suicidal, so they hold up one of our 5 beds
 - We use telepsychiatry for consultations
- Angie Burgis (DeTar Hospital): From 9pm to 9am, there is no progress at SASH during nighttime hours
- Erin Clevenger (Memorial medical Center): – patients end up staying so long that their crisis ends and they go home
- Bill Jones (Jackson Co. Hospital): We have empty beds, as do many of the rural hospitals, but our physical layout is not set up to accommodate mental health patients
 - it is hard to integrate that type of patient with the cost consideration (reimbursement, specialized staff)
 - also, the community doesn't want to dilute the image of the hospital with patients that they consider "threatening," for lack of a better term
 - we lack the resources and staff available to watch them
- Jeff Payne (Citizens Medical Center) we have a heavy psych population because we are the county hospital
 - multiple delays on getting an EDW, or waiting on a bed from 1-6 days,
 - they aren't getting any psych care during this time. The ER is equipped for acute situations
 - We aren't providing mental health care in the ED, but giving them medication (ex: Ativan)
 - We can't transport during the night b/c of budgetary reasons
 - We don't have psych rooms in our ER and we have our security watch them 1:1

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- If patients want to leave after extended day and law enforcement isn't on EDW, then we call law enforcement and their families; but we can't hold them down
 - Average LOS is 12 hours for transfer for a patient with insurance
 - Higher LOS for unfunded patients
 - Gulf Bend helps us with placement for unfunded patients, but there is a lack of funding (PPV and PES grants)
 - Jeff Tunnell: We had \$794,000 for PPV started in September, and the money was depleted by February
 - PES has \$300,000 allocated and we are trying to hold that until the end of the fiscal year in August
 - Jeff Payne (Citizens Medical Center): If patients have insurance, hospitals will call partners for placement
 - Admissions seems to be driven by environmental factors (ex: what is going on in the world, holidays, etc.)
 - Lorena Kanak (Lavaca Medical Center): We tend to see more mental health patients during the holiday season, but that is also the same time we see a spike in medical patients, so they are having to fight for hospital beds
 - Some hospitals have up to 24 beds available in the ER, but other hospitals only have about 5 beds in the ER
 - Lorena Kanak (Lavaca Medical Center): we have a good relationship with our law enforcement, deputies will drive patients to get treatment
 - Jeff Payne (Citizens Medical Center): Does SASH use psych telemedicine? They can triage to see if a patient is critical and give recommendations
 - Rawley McCoy (Mental Health Advocate): What if we built regional centers close to home to reduce transportation and resources needed to transfer a patient to San Antonio?
 - Erin Clevenger (Memorial Medical Center): Patients go to SASH for 3 or 4 days and then they come back unchanged and come back to our ER
 - We are treating people and getting nowhere
 - Psychiatric care is not looked at on a medical perspective; if we treated the patients in stroke the same way we did for psychiatric care, we would be shut down
 - Bill Jones (Jackson Co. Hospital): There is a shortage of qualified people to care for psychiatric patients in our region and at SASH
 - Rawley McCoy (Mental Health Advocate): there is a fear that the state will think all mental health problems will be solved with the new building; will be harder to get funding to address the real need to solve the problem
 - We need to find a better solution and building these hospitals will not solve the problem
 - Daniel Barrientos (Billy T. Cattin): When people leave from SASH and go back into the community, if we don't reconnect them back into the community, they may relapse and get in some trouble
 - We see clients that are unfunded and they have the same struggles with the waitlist
 - If we don't reconnect people back into their communities when they come back from SASH, they will relapse
 - For someone who doesn't have treatment, it will be hard to get them into SASH
 - It is crucial to have something, a process, that will reconnect people back into their communities
 - We work with individuals who are coming into the community from prison
 - The longer someone stays in treatment, the less chance they will relapse – those in the criminal justice system

	<ul style="list-style-type: none"> • Jeff Payne (Citizens Medical Center): the typical patient is unfunded, has bad socioeconomic and family problems; SASH starts them on medications and when they come back, they don't fill their meds and cycle starts over again <ul style="list-style-type: none"> ◦ How do you break that cycle? ◦ Civil patients don't have the continuity of care or follow-up incentives like the criminal justice system; • Darlyn Sustaita (Gulf Bend Center): we have LPCs that try to do 7-day follow up, but patients refuse services • Lorena Kanak (Lavaca Medical Center): there is a mental health crisis and we need funding; it is only going to get worse • Bill Jones (Jackson County Hospital): Some sort of decentralization rather than the centralized system will be better for rural areas <ul style="list-style-type: none"> ◦ There are buildings all over rural Texas that have vacancies; the state will need to provide funding for staff • Jeff Tunnel (Gulf Bend Center): The state gave us opportunities this last session for mental health services, but we need local leverage • Jeff Payne (Citizens Medical Center): Look at the data from SASH catchment counties to guide them – see if there is a need for satellite campuses
Adolescents	<ul style="list-style-type: none"> • Lorena Kanak (Lavaca Medical Center): we are fortunate that Norma's House in Gonzalez County opened a satellite campus in the last few months, mainly for sexual assault • Jeff Payne (Citizens Medical Center): kids mostly have funding and we have several partners, so it is easier for them to get access <ul style="list-style-type: none"> ◦ Kids also have support from their parents • Angie Burgis (DeTar): we are seeing a higher incidence of pediatric psychiatric cases
Access to Medications	<ul style="list-style-type: none"> • Erin Clevenger (Memorial Medical Center): Most of us have community partners and faith ministries that can help temporarily, but it is still a problem with compliance from patients • Jeff Payne (Citizens Medical Center): The medications aren't expensive; it is just hard for some patients to comply; they would rather buy cigarettes or something else

SASH Stakeholder Meeting – Mental Health Consumers

Thursday, July 12, 2018

11:30 am

Methodist Healthcare Ministries
Boardroom

Attendance:

Doug Beach (NAMI SA), Terri Mabrito (NAMI SA), Verna Lister, Ed Dickey, Amanda Mathias (MMHPI), Lauren Roth (MMHPI), Joseph Blader (UTHSA), Steven Pliszka (UTHSA), Jill Jendrzey, Bill Glenn (NAMI SA), Paula Gardiner (NAMI), Sally Mosley (NAMI), Christina Phamvu (MHM), Chris Yanas (MHM), Sebastien Laroche (MHM), Jacqueline Cantu (MHM)

Who should SASH serve?

- Verna Lister: SASH should serve seriously mentally ill patients who are not compliant with medication. These are mostly people who have a history of being in treatment and then relapsing. Treatment at SASH has been amazing because they allow time for recovery, whereas private hospitals have a goal of stabilization and not long-term recovery. There is a weak transition into the community – an area that can be improved. There is a lack of coordination and collaboration between SASH and the community. SASH used to have a transitional program where people could gradually transition into the community and get accustomed to a routine; would recommend starting SASH starting up that program again.
 - Our recommendation is a transitional system at SASH where the community can come in and work with clients
 - My experience: the social worker had a family emergency around my son's discharge. I requested my son to be placed in outpatient treatment after discharge, but that didn't happen, and no one followed up. I'm not sure for the reason why my son wasn't placed into outpatient treatment, but there was a lack of communication. I expressed this concern to the doctor, social worker and administration, but I didn't see a change. Once my son was discharged, there was no communication between us and SASH
- Ed Dickey: our son (17 years old) has failed various protocols and medication formulas from four other facilities in SA and surrounding areas. The longest stay he had was at Southwest Mental Health (now Clarity) for 35 days. He ended up having to leave Clarity because his insurance ran out. Ten days after discharge, he went back into crisis. Three of the private psychiatric hospitals told us that our son needed longer term support and recommended SASH.
 - It was hard to get my son into SASH. SASH kept telling me, "there are no beds available." I was the president of NAMI SA and I had to go to the leadership in our community to explain our situation and the need for support from specific people that held the keys to SASH.
 - Once my son got into SASH, the treatment was exceptionally good. The staff was very compassionate, right on target with symptoms, and the professional medical care was better than the other hospitals. The private hospitals would relieve symptoms to some degree, but my son would relapse. SASH professionals looked into his history and responded appropriately. After a few weeks at SASH, I noticed the difference in our son; he was coming back into reality. I think the difference was due to a combination of the knowledge the staff had on his medication history (how some medications did not work) and close monitoring. SASH was able to hold my son long enough so that he would be stable and could function in the community.
 - There are patients where private hospital treatment and crisis management isn't enough to treat their illness and our son was an example of those types of patients. Other hospitals provided crisis management, but SASH provided a more stable medical formula that resulted in our son living independently and making his own

	<p>choices with support from us (his parents). There is no doubt that it was SASH that was able to help our son and allowed him to see the difference between living with good medical care versus trying to live with the illness.</p> <ul style="list-style-type: none"> o Recommendation: The doors to SASH need to be more available to the community. SASH makes a lifelong difference for people with mental illness. The sooner a patient get into adequate treatment (not always crisis management), the higher chance the patient has of staying on track. • Bill Glenn: Whatever we build, there needs to be an adequate number of beds for the territory you are responsible for. SASH is not insurance driven, so the treatment and discharge plan can be fulfilled. There are staffing issues due to wages, but discharge and treatment plans should be standardized. • Ed Dickey: the science has already proven that we need to treat early so the trauma to the children are reduced. The people at SASH who helped my son with discharge also assisted on getting him social security benefits. He is still utilizing the benefits today, but on a reduced level because he is able to work and be independent. SASH helped him become independent. The discharge coordinator also referred him to a psychiatrist upon discharge that he still uses today.
Acute care at the SASH?	<ul style="list-style-type: none"> • I think it would be a great benefit to have acute care at SASH. The private hospitals that provided acute care did not treat my son, they just monitored him. If there was acute care at SASH, that would be able to help my son early in his crisis, it would have made a big treatment. The quality of treatment and care at SASH is better than the other private hospitals, because they are able to experiment with more medications. • Verna Lister: there was no plan for after care or coordination back into the community at SASH. One of my daughters is living with us and is always in psychosis, but not getting the proper treatment. After our daughter was discharge from SASH, she did not have a follow up scheduled at CHCS. In addition, every time they were discharged, they wouldn't be referred to the same doctor. Discharge plans are diverse and depend on the situation. Our daughters have been at SASH three different times and the discharge plans were all different. • Sally Mosely (NAMI): I think it also has to do with history of treatment. Our son had been at CHCS and SASH wanted to send him back and we wanted to go somewhere else; I had to find other resources on my own. One of the places I found was Crystal Counseling, which is a one-stop shop for Medicaid patients.
SUD at SASH	<ul style="list-style-type: none"> • My daughter was diagnosed at 19 with a mental illness. Since then, we have been at SASH at least 6 or 7 times and the longest duration at SASH was 18 months. My daughter is unresponsive to medication and has a drug addiction that has not been addressed in her treatment plan at SASH. She is starting to decline as she is getting older. We have tried to get her into counseling, but she is getting denied because she is not willing to do counseling. She is currently at SASH after being sent to jail for a misdemeanor. When she is at SASH, she is stable, but the problems happen after discharge. She gets withdrawal symptoms 1-2 weeks after discharge and will go on the street to look for drugs. We are unable to apply for guardianship because the judge thinks that she is a young adult, but I don't think that she can make choices and live in society on her own. I think the most helpful treatment would be to place her in a long-term facility to address her mental health issues AND her drug addiction. When she was at SASH in the past, she wouldn't participate in substance use programs or engage in any other programs. SASH could not force her to participate. SASH ended up discharging her to one of her friends, who is a felon, but didn't

	<p>notify us (her parents) or other family members about her discharge. Their only explanation is that she is a legal adult and there isn't much they can do.</p> <ul style="list-style-type: none"> • Sally Mosley (NAMI): There is a supported decision-making document that is available for patients at SASH who aren't able to make decisions on their own and who have access to family support. I think it should be readily available and SASH should educate families about these documents.
How is family engagement at SASH	<ul style="list-style-type: none"> • Sally Mosley (NAMI): SASH does not tell you anything about change of medication or treatment. There is not enough involvement from the staff. I would have to call the nurses when I found out about changes in medication. If I didn't call, I wouldn't know anything about the treatment plan. I was included in two team meetings during my child's stay – a discharge meeting and a midterm progress meeting. • I had an excellent experience. I provided them with a complete history of my son (adult unit). They would call me because my son would not provide any history; they included me on the treatment meetings. This might have been because I developed a relationship with the social worker, so they could openly communicate to me about my son. • Ed Dickey: They kept us involved and informed, but it initially took multiple phone calls. I would make numerous visits, sometimes more than once a day, to let the staff members know that we were involved and supportive. There wasn't any family education from SASH. I have had other members of NAMI say that there isn't enough adequate information from SASH. We would receive information in medical terms and not know what they mean. I think there needs to be some sort of family education, especially during initial contact of the hospitalization. When families are thrown in this chaos, there are no resources for the family members. SASH has referred families to NAMI for resources and education. When patients are receiving treatment at SASH, they should work with NAMI to enroll family members into education programs to learn how to appropriately care for the patient. I have worked with Dr. Diane Robinson, a physician at SASH, to start providing education to family members. In addition, we (NAMI) are also starting a program to educate staff members on mental illnesses. I was surprised about the lack of information the mental health aides knew about mental illnesses in general. These mental health aides have the most interaction with our patients, but there is a lack of training on trauma-informed care.
Physical campus	<ul style="list-style-type: none"> • Sally Mosley (NAMI): The space now for adult's visitation is one just one big room with the TV on. The staff members are watching television, which makes it hard to talk without distractions. The environment is not conducive to having good communication with the patients – we need less noise. We aren't allowed in residential areas, so we are stuck with the room that has loud TVs, couches and some tables. • When my son was first hospitalized in 2000, visitation was on the unit and it was horrible. Then they started moving visitation to the community room. It would be nice to have communal area, but also some private rooms for more privacy (glassed cubicles for private speaking, but still able to watch patient). • Jill Jendrzey (NAMI): I think the hospital needs an outdoor area; there is a lot healing and wellness that goes beyond medication. When we start to look at treatment as the right cocktail for medication, we lose the person. SASH does not have enough staff to allow people to go outside. • <i>Safety Issues?</i> <ul style="list-style-type: none"> ○ My daughter has jumped the fence and left in a psychotic state into the community several times. There are missing parts of the physical fence and security guards are not around all the time. I recommend some video cameras for more protection for the patient

	<ul style="list-style-type: none"> Jill Jendrzey (NAMI): As we begin to look at safety as the only thing, we are missing the point of treatment. We started with privacy curtains, but that became dangerous. A patient is in a room with three other people who are also going through mental illnesses. Our doorknobs were taken off and we started to lose our sense of being a human. There are people restrained, which I think is a power control to keep people safe. We constantly heard “code green.” There are times where you feel stripped of humanity and your belongings could get stolen, which made you feel on edge. It is hard to feel safe with all these environmental factors. My understanding is that the fence was renovated to be built higher, but a lot of wellness happens when we take down barriers. It will take a lot of brainstorming on how to be safer but break down barriers. We should look into transitional care where we not only focus on follow up appointments, but opportunities for jobs or volunteer work. When I left SASH, I lost my house and I did not have a job. Verna Lister (NAMI): my daughter developed a relationship with someone there and it wasn’t helping her treatment; individual care needs to be addressed. However, I always felt safe visiting my daughter. Bill Glenn (NAMI): My wife worked there, and she had some concerns about safety, but I did presentations at SASH and felt safe. There are physical safety problems, but you need to build sufficient infrastructure, so the community can come in and help with discharge and follow up. Would technology be helpful to allow for family experience? <ul style="list-style-type: none"> It would be very helpful – it would allow daily contact, especially for those patients that need constant communication with their family members.
Any treatment?	<ul style="list-style-type: none"> Verna Lister: There are not a lot of therapies because the treatment seems to be medication driven. Sally Mosley (NAMI): There are group sessions, but not any technique therapies Jill Jendrzey (NAMI): You need to be at some sort of level for therapy. Peer support is a huge component that has helped patients. We should look into incorporating them into transitional care.
Other items	<ul style="list-style-type: none"> Sally Mosley (NAMI): I am concerned about daily hygiene. SASH need techs or CNAs to help with daily hygiene tasks. Some people aren’t capable to take care of themselves but would like to have some help. It would be great to have some job training, skills, or other vocational rehab that would help patients when they get out into the community. Ed Dickey: Long-term wellness and transition from patient to society involves family support. We need to incorporate family support. We should also consider cognitive behavioral therapy. UK has modified their concept transitions to include those techniques into the family unit, so the patients are receiving therapy from the clinician and the family.
Additional Issues handout	<ul style="list-style-type: none"> Fredyne Springer: family contact and interaction with doctors/nurses <ul style="list-style-type: none"> Receive emails or need a portal to see status of patient, meetings, discharge, aftercare, living integration, and/or placement Video conferencing and tools to educate and train for job assistance Sally Mosley <ul style="list-style-type: none"> Using the lowest dose of medications to keep patients functioning, yet not sedated most of the day, as sleeping the majority of the day post-discharge is non-productive An aide to assist with hygiene, such as bathing, wiping after toileting, brushing teeth, etc.

SASH Stakeholder Meeting – Coastal Plains Community Center

Tuesday, July 24th, 2018
11:30 am
Coastal Plains Community
Center, Portland, TX

Attendance:

Linda Ramos-Perez (CPCC), Joel Perez (CPCC), Courtney Sanchez (Corpus Christi Medical Center), Laura Lopez (Strategic Healthcare – Palms Hospital), Debra Saenz (CPCC), Melissa Campus (CPCC), Jorge De Los Santos (CPCC), Leo Trejo (CPCC), Lucho Veerdoren (Janssen Pharmaceuticals), Chris Yanas (MHM), Amanda Mathias (MMHPI), Christina Phamvu (MHM)

**Who should
SASH Service**

- Joel Perez (CPCC): historically, we have issues with getting patients with IDD into any hospital; when we look for any placement in our catchment area, the feedback we get is that they can't provide services because they can't provide monitoring. Historically, the IDD patients will stay in the ER for multiple days. If the patients are able to get an inpatient bed initially, whenever there is a psychiatric case, they are not allowed back into the inpatient facility.
 - We are able to send a patient down to the Valley (we have a contract with three hospitals south of us and at CCMC); they are able to accommodate us sometimes, but it is a challenge
 - *What organization is providing these services to these individuals between hospitalizations?* HHSC provided a crisis unit within the past 1 ½ years to deal with pre and post crisis, but we aren't always able to get a person into help before crisis; if the person is not our patient, we hear about the situation during crisis in the ER. We can get them treatment after crisis, but not during crisis.
- Debra Saenz (CPCC): I assist with helping individuals into the state facility. What I come across when a patient with IDD needs to go into the state – will have admission ask if the patient requires 1:1 monitoring, or if the patient's behavior is aggressive and will come intrusive, creating a risk for other clients.
 - We had a particular patient who was aggressive (youth); admissions had to take into consideration what they already had; there is a need for access for IDD patients; but they will typically be pushed further down on the waitlist to accommodate patients with just a primary mental illness.
 - We are hospitalizing our people in private beds; our utilization for state beds is low;
 - Criteria for admission: RGV waitlist is strictly number based; first come first serve
 - SASH does not admit based on the number on waitlist, admissions will ask:
 - *Where are they now?* – SASH will grab patients from other LMHAs that don't have contract for beds
 - Patient is in the community and no accessible beds in our area;
 - SASH has to take into consideration the time it takes for the doctor to review it; it will take longer if they need a medical clearance
 - CPCS trains its staff on what to put in the crisis assessments in order not delay the admission
 - It can take one aggressive patient scenario from another county to cause SASH to be more cautious on future admissions
 - There is no standardization on admission criteria

	<ul style="list-style-type: none"> • How business is done after hours is different than during the day. After hours communication is rare, but it happens <ul style="list-style-type: none"> ○ Transportation: Live Oak and Bee county have contracts that send patients by EMS, other areas are taken by sheriffs • Leo Trejo (CPCC): Having some sort of admission criteria would be great; there was some information that was sent to LMHAs about the need for medical clearance, even if it is not necessary • Linda Ramos-Perez (CPCC): adolescents are always the first option to close; we are seeing more kids that are diagnosed with autism and aren't getting admitted into SASH <ul style="list-style-type: none"> ○ It's hard enough to get adolescents without IDD into the state hospital; having to hospital shop for adolescents that may could be avoided if they were admitted into a long-term facility ○ We need more bed days for adolescents; we have a lot of foster care children coming through our doors who need access <ul style="list-style-type: none"> ▪ <i>Does DFPS have any beds for longer LOS contracted for these types of children?</i> <ul style="list-style-type: none"> • DFPS(?) will be building a facility in RGV that will serve adolescents ○ We try to accommodate our kids in local hospitals, but it is not a place for them ○ We need more opportunities for extended care; I'm a firm believer that children should stay within the community • Debra Saenz (CPCC): children shouldn't be taken behind a sheriff's vehicle in handcuffs; it is a distressing to me to send a child to the facilities – it will be traumatic for them • Leo Trejo (CPCC): We don't have any respite care in the communities for our families • Linda Ramos-Perez (CPCC): We have an emergency shelter in the Portland area that we can use sometimes, but there isn't much in the area <ul style="list-style-type: none"> ○ some of these admissions can be taken care of in a step-down unit ○ through the YES program, we provide respite for families • Joel Perez (CPCC): IDD does have access to respite, but the requirement is stringent; the respite that I contract with is in Seguin. If I am able to gain access, 90% of patients don't want to go to Seguin (Bluebonnet LIDDA)
Role of Acute Care at SASH	<ul style="list-style-type: none"> • Debra Saenz (CPCC): The role of acute care at SASH needs to be explained to all counties; we can do acute in the community, unless they have a higher need <ul style="list-style-type: none"> ○ Jails don't want them in their building, but it is the least restrictive setting for them ○ We would fix our community issues if we could have a 24-hour crisis stabilization unit ○ Everyone needs to be educated on the process • Linda Ramos-Perez (CPCC): We have patients who act differently in jail when getting services • Courtney Sanchez (CCMC): We had 2 teens in the past quarter who rotate in and out of the hospital because they put on a show • Debra Saenz (CPCC): If we have to hospitalize someone 3 times in the contract beds, the next admission will be in a state facility • Leo Trejo (CPCC): We work closely with families for other interventions; we work closely with jails on a modified competency restoration program and we get them their medications; we try other means before we readmit them back into a contract bed
Local hospitals refusing certain patients	<ul style="list-style-type: none"> • Courtney Sanchez (CCMC): we are in a nursing shortage; we may have to turn away patients who need 1:1 care to maintain staffing ratio (may have to close 4 beds for just 1 patient)

	<ul style="list-style-type: none"> o CCMC is part of the system that can do inter facility transfers • Leo Trejo (CPCC): Our contracted hospitals do not accept someone who is detained or has a charge • Debra Saenz (CPCC): Our contracts aren't for detox, but some hospitals are willing to provide services without payment <ul style="list-style-type: none"> o State facilities may not take patients if they have a primary diagnosis of SUD – we have never tried, but we would not take that route. But I have never been turned away from SASH if patient has a comorbidity
Services at SASH and discharge	<ul style="list-style-type: none"> • Debra Saenz (CPCC): Some state facilities will email me, which is the worst form of communication given our need for rapid response <ul style="list-style-type: none"> o SASH will call us initially when patient admitted or if they need additional resources o I have not come across any problems with SASH with regard to communication, but we also have a small utilization of services there • Leo Trejo (CPCC): We are fortunate we are able to contract with beds, but we do need more beds
Services in the community	<ul style="list-style-type: none"> • Leo Trejo (CPCC): We currently have two grants for psychiatric emergency grants (short-term) and PPE = \$1.4 million <ul style="list-style-type: none"> o We contract with local hospitals o For every 7 adults we hospitalize, we hospitalize 1 child o These psychiatric (NCA) grants have helped o We also work together with our stakeholders to look at other options o We are looking at possibly contracting with Camino for a step down for adults o We applied for SB 292 grant for jail diversion, but we asked for too much, so we did not receive funding this cycle <ul style="list-style-type: none"> ▪ We need to work with our judges; but I hope to work with these individuals who need inpatient care and get them into OCR for medications to reduce arrest. o We were awarded crisis dollars through MHM to hire 2 crisis employees in the community o We have an ACT-like program that meets weekly, but it is not the formal ACT team • Debra Saenz (CPCC): When are able to do follow up after hospitalization (these last few months) we are able to reduce hospitalization. We are seeing new admissions that aren't our clients. We are active in asking the patient for the trigger to the situation and communicating the indicators to staff to link patients to those resources. We have support groups and peer groups to reduce hospitalization. • <i>How are you all paying for unfunded patients in these programs?</i> Leo Trejo (CPCC): We have a patient assistance program to work with East Texas behavioral network to assist with LAI and psychiatric and primary care medications. We have primary doctors and addiction specialists that help our individuals who are in high need. We have pharmaceutical companies that come and share different creative ways to get new medications to patients, including sampling or vouchers. <ul style="list-style-type: none"> o Debra Saenz (CPCC): We started hiring more eligibility staff for our centers to increase the benefits for our patients. • Leo Trejo (CPCC): We do integrated care at our center. We did a study 2 years ago and the trends were fantastic (data was over a year). We had clients 4x less likely to be unemployed, 5x less likely to become in crisis. We started with the 1115 Medicaid Waiver, and after 4 years we made some changes to sustain it, but we can't go back to just

	behavioral health care after the program has included integrated care. Leo providing copy of the study.
Other Items	<ul style="list-style-type: none"> • Lucho Veerdoren (Janssen Pharmaceuticals): Have we looked at first break centers? Other states (such as NY, California) do this for patients who had their first psychotic break, whether it was true psychosis or drug-induced. • Leo Trejo (CPCC): Maybe use telemedicine to communicate with jails when there are no available beds • Linda Ramos-Perez (CPCC): in the past, we used to some telemed meetings with families in order for them to be involved with therapies; • Debra Saenz (CPCC): private hospitals will try to get information from the families, instead of involving us in the care; we only take part by providing medical information <ul style="list-style-type: none"> ○ They will call us on the phone to secure transportation for the patient to the contracted hospitals
Additional Issues	<ul style="list-style-type: none"> • Laura Lopez (Palms Behavioral Health): Palms Behavioral Health has no “set criteria” for admission, however, when staffing an IDD patient, it’s a case by case basis (everything is considered) and the number of acuity on a respective unit is always considered, including the patients’ ability to benefit from programming; while in-patient is also considered for admission. Mild IDD patients who can benefit from programming are also considered. Free standing psychiatric hospitals cannot admit patients with complicated health issues <ul style="list-style-type: none"> ○ Satellite offices for IDD and children would be ideal. The shortages of child units across the board are concerning. • Debra Saenz (Coastal Plains Community Center): the allocation of beds should be by LMHA and the admission criteria should be flexible per patient <ul style="list-style-type: none"> ○ Spoke very highly of Tiffany Juarez at SASH • Courtney Sanchez (Corpus Christi Medical Center – Bayview): There is a need for long term care, regardless of location (Ex: set locations or on campus at SASH) • Joel Perez (Coastal Plains Community Center): ensure inpatient services for individuals with a diagnosis of IDD. Historically, individuals are turned away due to an IDD; Autism is also becoming more of an issue. • Linda Ramos-Perez (Coastal Plains Community Center): There needs to be extended care treatment for children ages 10 to 18. There should also be telemedicine treatment participation for family sessions, family discharge, and staffing. There needs to be availability of services for youth with autism diagnoses. • Jorge De Los Santos (Coastal Plains Community Center): There needs to be consistent communication with treatment team at SASH. Telehealth would be beneficial for continuity of care for clients who have high needs. <ul style="list-style-type: none"> ○ There is continued trouble for lack of beds available at SASH. The wait times are 2 weeks or longer.

SASH Stakeholder Meeting – Border Region Behavioral Health Center

Wednesday, August 1, 2018
11:30 am
Border Region Behavioral
Health Center, Laredo, TX

Attendance:

Laura McCoy (BRBHC), Nikaury Rivera (BRBHC), Jacqueline Lopez (BRBHC), Laura Palomo (BRBHC), Geraldine Leven (Webb County Sheriff's Office), Magda Pedraza (BRBHC), Jose Rodriguez (BRBHC), Coriba Davila Gonzalez (Laredo MC), Mary Rubis (Juvenile Department – Webb County), Keith Ellison (Laredo MC), Amber Hernandez (Laredo MC), Bridget Vasquez (BRBHC), Magdalena Flores (BRBHC), Luis Diaz (BRBHC), Jesus Torres (Laredo PD), Jacqueline Villanova (BRBHC), Maria Sanchez (BRBHC), Amanda Mathias, Chris Yanas, Christina Phamvu

**Who should
SASH serve**

- Dr. Nikaury Rivera (BRBHC): I work with patients that need long term stabilization. When the patient is chronically ill, they require longer stays than a free standing psychiatric hospital can offer. SASH should serve this population.
 - We attempt to send patients every day to SASH. For the adult population, the funding is difficult. We have a lot of walk-in and rural patients. We have a lot of adult patients that are not enrolled. 87% of our children are funded.
- Laura Palomo (BRBHC): Half of the individuals going into crisis aren't insured. Majority of the new hospitalizations (patients we haven't seen before), we try to admit into the state hospital.
- Nikaury Rivera (BRBHC): Our patients are staying in the ER longer than they should because of the lack of access.
- Keith Ellison (Laredo MC): Things have changed at Border Region, but recently, our average LOS is around 3-4 days for patients. You need to have acceptance and transportation, which are barriers. We are starting to see 5-6 days in the ER in the last couple of months. We constantly have 3-5 patients that are currently occupying our ER.
 - We understand there is a national crisis, but we are concerned with this upcoming winter season because we have a higher acuity of illness.
- Nikaury Rivera (BRBHC): We also have several limiting factors. We need the sheriff's department for transportation and they don't have the workforce. Also, certain populations can't travel together, which is another barrier for us.
- Geraldine Leven (Webb County Sheriff's Office): We have two transport teams, one for the morning and one for the afternoon. We try to coordinate with Border Region, but we are working on getting additional staff. It does put everyone in a bind, and there is a domino effect when several people need transportation services.

What happens when you realize that a patient is delayed getting into SASH soon and they are in the ER?

- Keith Ellison (Laredo MC): Once a patient is in your inpatient side, then you need to be a psychiatric prepared facility because we acquire the patient. We are not a psych facility, so the patients will stay in the ER until they have a bed.

What other services are available for inpatient care?

- Maria Sanchez (BRBHC): If the patient doesn't go to SASH, we try to send patients to another facility, depending on funding. If the patient has funding, then it is easier to get them accepted into private hospitals. The current situation with SASH going on diversion is a concern. Rio Grande doesn't accept our patients because we aren't in their catchment area. ASH is also currently on diversion, so we don't have anywhere to send our patients.
 - If they are not funded, they stay in the ER. The patients that are disruptive, we try to place in private hospitals and Border Region has to pay for it. We have paid almost \$1 million last year to pay for these patients. We are on the same track this year, but we can't afford that. We do not receive any private PES dollars.

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- Magdalena Flores (BRBHC): We are supposed to be allocated a certain amount of dollars per year due to our population, but we haven't been able to access any beds. In years past, our utilization has been 100 – 106%, but right now we are utilizing about 30% because there isn't a bed available. We are hoping the state doesn't see a low utilization and then wants to cut funding because they think we don't need it. We need the funding, we just don't have the beds available to utilize the funding. On an average day, there are over 100 people competing for 1 bed across the state. We are having to compete with other areas of the state for this one bed and we don't have any resources in South Texas.
 - Nikaury Rivera (BRBHC): When they are in the ER, we are doing daily assessments. Sometimes things change, but there are certain criteria that we can't change. Suicide ideation patients have to be seen in an inpatient setting even if they are denying it the next day. Some people can be seen in outpatient, but that's not all the cases.
 - Maria Sanchez (BRBHC): The MCOT team tries to make sure that we have staff available to do the reassessments at the hospital and here at Border Region. SASH is down the road; if it is on diversion, we have a satellite unit here in Laredo, but it is not utilized
 - They have 16 beds, but there are only 4-5 people there because they don't have the staffing available. We have 2 individuals (from Border Region) at the satellite campus right now.
 - We have made a request to change the beds over to Border Region
 - If we are able to get the necessary funding, we would be able to run the beds. We need funding to acquire the staffing. When we put in the proposal, we put how much we think it would take to run the facility. Unlike SASH, we would not be tied to state salary levels for providers. We have a higher salary rate that we can offer.
 - Nikaury Rivera (BRBHC): As it is, we don't have the funding to run the unit. We need money to acquire staff. But once we get the staff, we would be able to run.

Acute Care

- Magdalena Flores (BRBHC): We mostly send acute care to SASH; our patients stay about 7-12 days. If we can get them on medication, we can work with our continuity of care staff to bring them back to the community for services here.
- Keith Ellison (Laredo MC): Our bed utilization is about 260 out of 326 beds. We would need to expand if acute care is in the community. We will need a ground up expansion and to look at telepsychiatry to deal with staffing. I can't tell you yes or no if we can expand our acute care.
 - We are trying to make sure we have adequate staffing on our current patients.
- Maria Sanchez (BRBHC): Doctors Hospital had a psych hospital about 15 years ago and it wasn't around for more than 1 year.

Are you hearing that private hospitals are turning people away, especially re-admission?

- Maria Sanchez (BRBHC): There are no psych hospitals in the area.
- Nikaury Rivera (BRBHC): We had to meet with DHR because we had a psychotic patient and they couldn't meet their needs. One of the managers said that they can't meet the need if they don't have the staff for 1:1 ratio or admitting doctor.
 - IDD or substance use (detox) patients are hard for psych hospitals to take care of if they are not equipped.
 - Pregnant patients and geriatric have trouble with admission
 - Autistic adolescents have trouble with admission d/t 1:1 ratio. We try to find a hospital that would be able to meet the need for our patients.

IDD population

- Magda Pedraza (BRBHC): one of the criteria for admission is that our patients cannot have an IQ below 70, but that is our whole population. There is nothing here to provide services and they need 1:1. When hospitals hear about IDD, they don't admit the patients.

	<ul style="list-style-type: none"> • Magdalena Flores (BRBHC): We are told to go to a respite center or a state school • Nikaury Rivera (BRBHC): a state school does not provide the care the patient needs. • Jose Rodriguez (BRBHC): it is almost impossible to get autistic adolescents into a hospital, especially when they are aggressive or a danger to their parents and themselves. • Magda Pedraza (BRBHC): There are some respite centers, but they do not admit patients who are aggressive.
Comorbidity	<ul style="list-style-type: none"> • Nikaury Rivera (BRBHC): access to substance use treatment across the state is limited and to us locally, even more so. Detox or chronic substance use patients tend to relapse and triggers psychiatric illness. <p><i>We are hearing that patients aren't being admitted even with a history of substance use</i></p> <ul style="list-style-type: none"> • Nikaury Rivera (BRBHC): Our hospitals have the capability to treat it, but they may not have the resources through staffing or funding. It depends if they have availability.
Standardization	<ul style="list-style-type: none"> • Nikaury Rivera (BRBHC): Private hospitals doctors will accept the patient because they want the business if the patient has funding, but often times, SASH has not wanted to review the case because they don't want to be the admitting doctors. • Magdalena Flores (BRBHC): We have heard that doctors don't have to admit because they are on diversion, so they won't even review the case. They won't tell us where to divert the patient.
Admission	<ul style="list-style-type: none"> • Jacqueline Villanova (BRBHC): Tiffany is our main contact, one of our MCOT staff members is constantly calling Tiffany about bed status. • Bridget Vasquez (BRBHC): We don't have any issues with discharge, but we struggle with discharge packets. We don't have the discharge packets when the patient comes in after staying at SASH or any private psychiatric hospitals. • Nikaury Rivera (BRBHC): That is a struggle across the board with the discharge packet when the patient comes in. • Bridget Vasquez (BRBHC): As soon as a patient gets in, we scan them in. We have to wait, sometimes up to 14 days to get the discharge packet from the hospitals. • Magdalena Flores (BRBHC): It is impossible to get discharge packets within 24 hours from SASH. We used to have to go to Casa Amistad every day to pick up packets, but now they aren't even open some days due to staffing. <p><i>Are you allowed to prioritize your waitlist? Do you have any control over your waitlist?</i></p> <ul style="list-style-type: none"> • The general waitlist is reviewed every day. We don't have access precisely, but we can advocate. It is based on relationships, rather than a standard process. • Nikaury Rivera (BRBHC): We need to talk about the type of clearance across the board for patient admission. We are the middle man, but it is really hard to get certain labs or tests done. If there was a standardized set of labs needed for clearance, it would be great for ERs. • Magdalena Flores (BRBHC): The extra labs are a deterrent for patients coming in for services. They see that they are required to get all of these labs done for admission, but they are going to have to cover the costs. They get the bill and come back to us, owing money, but not receiving service for their initial problem. • Maria Sanchez (BRBHC): We need to get medical clearance before transportation because the sheriffs aren't trained to handle the patient if something goes wrong medically. SASH needs to admit a patient through law enforcement.

Adolescents at SASH	<ul style="list-style-type: none"> • Jose Rodriguez (BRBHC): One of the hardest things for children is the separation of families. It would be ideal to keep the children closer to home. • Nikaury Rivera (BRBHC): the parent cooperation is very important during treatment. When families hear they have to travel far, families are not as interested. • Jackie Lopez (BRBHC): We have another barrier because we are at the border. The parents have to accompany the children and we have to be careful because they can't cross the border check point or they may not let them back. • Maria Sanchez (BRBHC): we have to have some of our employees transport the patient and often have to also pick them up because the parents can't go. • Nikaury Rivera (BRBHC): because of our financial situation, we have to worry about transportation and maintenance costs to transport our children.
Services in the community	<ul style="list-style-type: none"> • Jackie Lopez (BRBHC): for the children's program, we have the YES waiver that has reduced the need for hospitalization. We have specialized services, including music, art, and pet therapy to keep the kids in the community. • Nikaury Rivera (BRBHC): We have OCD 3 and 4 patients, and they are more hands on with the case manager. We have art adult therapy; we have a nutritionist with a community garden. • Laura McCoy (BRBHC): UT has improved on their primary clinic; unfunded or funded patients are able to be seen for primary care. The level of care is increasing; there are less admissions and they have the same doctors and continuity of care. Half of the people that are going to the hospital are uninsured. • Nikaury Rivera (BRBHC): With the telemedicine doctors, there are a lot of turnovers and problems getting providers to stay longer. The biggest complaint from the patients is the change in providers. We reduce hospital admissions by seeing the same doctor. • Maria Sanchez (BRBHC): The 1115 waiver is coming in with new requirements. Part of our new initiatives are included in the new requirements of the 1115 waiver. For the next year's grant, we are getting \$90,000 for an additional nutritionist through a grant. We are also building an in-house pharmacy and have a traveling health team. • Jackie Lopez (BRBHC): We have an MOU for a co-funded employee at Webb County Youth Village that helps with coordination and communication for services. Having someone there to talk to the patient when needed has helped tremendously. It has reduced the crisis. • Nikaury Rivera (BRBHC): we have a partnership with our local police department and sheriff's department with transportation and security. We swapped training with the fire department – they provided us first aid training and we provided them MH training. There is also upcoming collaboration with TAMU for counseling services. • Jesus Torres (Laredo PD): we have seen some reductions in the past year for mental health calls due to community efforts. <ul style="list-style-type: none"> ○ Someone calls in and you realize there isn't a need for a police officer. We respond by bringing someone who is trained in mental health along with the police officer. ○ We have some officers who refuse to transport a patient without handcuffs, but it is handled case by case basis ○ We don't have the staffing to handle the caseload • Jose Rodriguez (BRBHC): Our programs have also grown. We started out with 300-400 kids, now we have over 1600 in our programs. • Magdalena Flores (BRBHC): We have over 300 cases per month for crisis services. We are seeing a growth in crisis services and not all are hospitalizations, but the majority are. We have about 8000 unduplicated patients

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- It is hard to do prevention when we don't have access, or we don't have time to do preventive work
 - Keith Ellison (Laredo MC): You can see the growth of our population in Laredo in the census. I know everywhere is growing, but Laredo is growing even more.
 - Laura McCoy (BRBHC): we don't have enough doctors in the area to cover these people.

SASH Stakeholder Meeting – Camino Real Community Services

Tuesday, August 7th, 2018
11:30 am
Camino Real Community
Services

Attendance:

Ana Zamora (CRCS), Kody Zuniga (Atascosa Juvenile Justice Center), Veronica Sanchez (CRCS), Erika Moreno (CRCS), Tracie Enriquez (CRCS), Noemi Flores (City of Pearsall Judge), Melanie King (CRCS), Dr. Marcelo Villarreal (CRCS), Mike Benavides (Atascosa County Sheriff's Office), Martin Gonzalez (Atascosa County Sheriff's Office), Deanne Pape (CRCS), John Dominguez (Atascosa County Juvenile Probation Office), Emma Garcia (CRCS), Dwayne Villanueva (Karnes County Sheriff – by phone) Amanda Mathias (MMHPI), Chris Yanas (MHM), Christina Phamvu (MHM),

**Who should
SASH Serve**

- Emma Garcia (CRCS): We need to look at the civil population because the forensic population has made it almost impossible to have beds available for the civil population. We don't have any inpatient services in our area for our patients, so we rely on SASH or private hospitals in San Antonio when the patient cannot be served in our crisis stabilization unit. It makes it difficult when the capacity is not available for the unfunded patient. We are fortunate to receive funds from the state to buy private psychiatric beds and not use our dedicated dollars from our outpatient services.

Amanda: You are able to access private beds in the hospital. Who do you contract with?

- Emma Garcia (CRCS): We have multiple contracts with multiple hospitals in the SA area for an as-needed basis. The only hospital we use without a contract is Laurel Ridge, but we are able to use them for children and funded patients.

Amanda: How does your crisis center look?

- Ana Zamora (CRCS): We have two locations, one here in Lytle and one in Eagle Pass, that serve men and women 18 or older. Both units have 16 beds. The complications come when we are unable to detain them there because it is voluntary treatment and we can't detox or if there is a serious medical condition. We recommend 5-14 days for LOS but have extended stays when we need to link individuals to long-term resources or placement issues.

Amanda: Is there anyone else that you think SASH should serve?

- Erika Moreno (CRCS): There is a need to be able to maintain long term care even through there is a push from the state. There will also be those types of patients that will always need a confined setting. There is also a need for reinstatement for people with substance use issues and detox at a state facility because that's where our communities are stuck. We aren't able to find a substance abuse center that will take an unfunded patient. If SASH can somehow lower the age threshold to 10 years old, it would help us tremendously. Right now, we may have to drive to ASH for children services if we cannot get a private bed.
- Ana Zamora (CRCS): We have an issue with people not staying long enough (getting discharged early), especially for patients with chronic conditions.
- Melanie King (CRCS): A lot of the open units have gone to forensic and the long-term units have transferred to acute units. The changing population has changed the landscape of SASH. Right now, SASH has a lot of units that are sitting there, but there isn't any staff.
- Ana Zamora (CRCS): They will call us and tell us that they have beds, but they don't have staff.

Amanda: Do you have any feedback on staff?

- Emma Garcia (CRCS): My understanding is that some of their salaries are capped based on what HHSC approves. That will never work with a growing population. SASH can't compete with other San Antonio providers who can pay more.
- Kody Zuniga (Atascosa Juvenile Justice Center): When you have a salary that is at the lowest end, you will get what you paid for.

Amanda: Do you have any feedback on IDD services and your experiences with accessing services

- Ana Zamora (CRCS): There is a lack of resources for IDD patients. We even have trouble getting them into private hospitals. Wait time is often longer than 21 days.
- Emma Garcia (CRCS): SASH used to have a specialty unit in the late 80s for people with psychiatric illness but also had additional needs.

**Comorbidity
with Substance
Use**

- Erika Moreno (CRCS): We have people that we send to SASH and they let them out the same day because it is a substance use problem

Amanda: We heard that local hospitals are turning away IDD patients. Are you having trouble with other type of patients?

- Veronica Sanchez (CRCS): We have a hard time getting incarcerated people into the hospital because they are considered in a “safe location.” We keep getting called out to assess the same person, which is not efficient with our staff.
- Ana Zamora (CRCS): We will work with the police department to drop minor charges, but there are some that they can’t drop, and we can’t get them into the hospital. Those are the people that need hospitalization.
- Martin Gonzalez (Atascosa County Sheriff’s Office): I had three on a waitlist for the longest time and now we have one. There are patients that we are uncomfortable with releasing, because they are a danger to themselves and to others.
- Erika Moreno (CRCS): There needs to be some consistencies with the waitlist.
- Dwayne Villanueva (Karnes County Sheriff’s Office): We try getting patients into the state hospital through a court order. Once, SASH treated the patient, they would call and say that we need to pick them right away or they will release them, even if the patient has a court order. They ended up releasing the patient on the streets and we had to go and find them. Need to give rural counties time to travel there.
 - Melanie King (CRCS): When the patient goes to mental health court and they are released, they have to be released the same day.
 - Dwayne Villanueva (Karnes County Sheriff’s Office): I would like for them to give us a courtesy call, which would make things better for us and the patient.

Standardization

- Veronica Sanchez (CRCS): Part of redesigning the system is that if you have practices and processes in place that are personality dependent, it will not help the community. There needs to be protocol and wait or holding area for those type of patients. You can have the most beautiful facility, but if you don’t have processes or practices in place with respect for the community, it won’t fix the situation.

**Control of
Waitlist**

- Erika Moreno (CRCS): We don’t have any control of our waitlist
- Ana Zamora (CRCS): there had been times where we had a patient on the waitlist, but they were able to get them into the psychiatric hospital. We ask if another patient can take their places, but sometimes are denied. It depends on who we talk to.
- Emma Garcia (CRCS): Our crisis process leaves us uncomfortable because they are out in the community at all hours of the night. It seems impossible that there isn’t some type of centralized system where our employees can make one call instead of calling every hospital separately. We need a centralized bank system of all hospitals that lists the number of beds available.
 - We have to stay with the patient until there is placement, which drains our resources, our families’ resources and local resources.

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- Melanie King (CRCS): We don't get a denial right away, but it is a "we will get back to you" and then we wait 1 or 2 hours before we are denied.
 - Emma Garcia (CRCS): I think there is a place for the state hospital. We are a strong community, but we need that place of expertise and support to us. We try to manage those incidences that don't require that level of intensity and we are able to mitigate the longer term situations through our crisis center.
 - Private psychiatric hospitals cannot take the place of the state hospital. SASH has a certain level of expertise that can deal with very serious patients. We have had situations where people go to private psychiatric hospital and are waiting 7 days to get a bed at SASH because the level of need is greater than the capacity.
 - Ana Zamora (CRCS): SASH can have better progress with medications. The private hospitals don't want to use certain medication, but SASH provides better medications.

Acute care in community / private hospitals or at SASH?

- Ana Zamora (CRCS): It is a medication issue. If the private hospitals deny certain medication, they aren't able to treat the patient as effectively as SASH.
- Melanie King (CRCS): the private hospitals don't communicate with us and they don't want to know the patient's history. They will start a patient on a new medication without any communication or advice.

Continuity of Care

- Melanie King (CRCS): They might call me to get their history and I keep in touch throughout their stay. I just keep in contact with the staff, but they don't involve me with their treatment plan.
- Ana Zamora (CRCS): We are trying to use telemedicine equipment on the private side. If we cannot get communication on the day of discharge, we lose the patient. On the private side, we make the connection before they leave the hospital.
- Veronica Sanchez (CRCS): We need better engagement and more cooperation. If they complied with the rules, there shouldn't be a barrier to be involved with the treatment. We shouldn't have to invite ourselves, especially if we have the technology. I think the rules are there, but how do we get cooperation and engagement – not seeing the LMHA as a negative.
- Melanie King (CRCS): When we first started out, I used to show up at SASH and sit down (to take part in the meeting), which would upset them.
- Ana Zamora (CRCS): When we send patients that are chronically ill, they send them back without contacting our staff and release them without giving any knowledge of their treatment history.
- Tracie Enriquez (CRCS): When we dealt with Waco Center for Youth, we received a letter that had a specific person for coordination and setting up for discharge. They attached a letter for the parents on how to communicate and the services they will provide. I think we need that at SASH. Parents are completely in the dark and are unable to drive to SASH to see the patient. There is no communication of involving of the parents. I think it is very crucial for the children and families. If we are knowledgeable about the treatment, we can provide the support to the family.

Amanda: With kids, there are a lot of parents who don't know what to do and a couple of days later, the child is back. More of a respite system instead of care.

- Tracie Enriquez (CRCS): We see where it becomes respite because the parents are dealing with MH issues at the same time. There are parents who cannot provide the support. The child does have a mental health need and the parents are not equipped to handle the complex case.
- Ana Zamora (CRCS): Parents will tell us certain things, which then obligates us to send the patient to an inpatient center.

	<ul style="list-style-type: none"> • Tracie Enriquez (CRCS): I think it would be helpful to have therapies or services that would help the families. I know through our youth empowerment program there are some therapies that are beneficial to the children. Families are looking to use our specialized therapies that will connect or engage the patient. • Emma Garcia (CRCS): They need a warm handoff or a better job of communicating with us on a discharge plan. They need to make sure that the patient is linked to a resource in the community. I think that the communications need to be structured to ensure that the patient's care is valued.
Services that are deterring the admission to SASH	<ul style="list-style-type: none"> • Emma Garcia (CRCS): MH Crisis Task Force meetings have ongoing dialogue on improving and resolving issues at a local level to improve the systems. We look at the length of time to get someone out of the hospital and transportation. • Kody Zuniga (Atascosa Juvenile Justice Center): when juveniles are brought to the detention center, we can't accept them if they are in crisis because they will be housed outside of our facility. We have to send them to the hospital. Some counties won't even bring their children to us because of this process. We have started to house and accept the patient and make a crisis call if needed. That ends up tying our officers with admission burden and transportation. The judge has to be called out to make an emergency detention order and set up an officer for transport. Sometimes we have to send our staff two at a time and we get there and have to wait. Our officers have been on a 12-hour shift just to transport our patients to the hospital. If there is some communication with the admission process, it would help us be more efficient with transportation. • Tracie Enriquez (CRCS): We had a child who went into crisis and had to be detained. The child ended up hitting the officer and now has charges because it wasn't appropriate. We are setting our children up for failure when we can't send them to the hospital, which is where they need to go. • Mike Benavides (Atascosa County Sheriff's Office): We have had incidences where patients are waiting for transport and then they get aggressive. The jail cannot provide the care they need. We have officers getting assaulted from the patients. We don't want to press charges, but there are situations where we need to because of our insurance coverage. It happens a lot. We may not be able to send a patient because of charges and we are stuck with the patient longer. • Kody Zuniga (Atascosa Juvenile Justice Center): We do not have the training to provide the mental health care that is needed for the children. We can only restrict them from so many things and we need to restrain them. These kids need psychological help, but we don't have the resources in our centers. They are stuck waiting for a bed in our juvenile facilities and it is unfortunate. <p><i>Do you all have empty beds that would be able to house patients?</i></p> <ul style="list-style-type: none"> • Ana Zamora (CRCS): If there are empty beds, we don't know about them. When the patients are in the ER, the staff wants them out. We have a hard time asking the ER if they can keep the patient overnight while we are waiting for a bed. • Veronica Sanchez (CRCS): our hospitals are small, so I don't know if they have empty beds. • Ana Zamora (CRCS): I think it is more of a liability issue. We hear more of that rather than empty beds. • Dr. Marcelo Villarreal (CRCS): We need more communication with the outpatient doctor and the inpatient doctor on medication and treatment services. They will discharge a patient on a medication that we know will not work for the patient. I know it is hard to do doc-to-doc, but some sort of online portal where we can chat or comment so there can be a better transition back to the community. It is rare when I receive feedback on a patient's treatment, but it depends on the doctor that is treating the patient.

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- Noemi Flores (City of Pearsall Judge): We don't get any feedback on the patient. I don't know if they were released. I will get called to do an order, but I don't know when the patients are discharged, and they still have to serve time. We aren't working close with the local MHMR or crisis center for the information. Judges think it is a drug-induced psychosis and they don't understand the mental illness. Sometimes it is self-medication to deal with a deeper mental health issue.
 - Ana Zamora (CRCS): we are trying to do jail diversion through MCOT screening. We can't provide services, but we can give them resources for patients after they are released.
 - John Dominguez (Atascosa County Juvenile Probation Office): a lot of our patients don't trust law enforcement. When the LMHA staffer comes along with us, it helps the patient feel better.
 - Emma Garcia (CRCS): Our crisis residential unit and the expansion of the mobile crisis teams were funded by the 1115 Medicaid Waiver. We have done a lot of integrated care and partnered with the FQHC in Atascosa County and with UMC in Eagle Pass. We have been able to bring in much needed resources, such as private psychiatric beds. We are waiting for our funding for HB 13 to build our mobile capacity for IDD patients. We have expanded into our frontier counties to fund the integrated care that we couldn't do through 1115 Waiver. We could not find the match funding for SB 292 through our counties. It makes it difficult for the counties that do not have the taxing resources.