Health and Human Services

Form O
Consolidated Local Service Plan (CLSP)

Local Mental Health Authorities and Local Behavioral Health Authorities

Contents

Introduction

The Consolidated Local Service Plan (CLSP) encompasses all of the service planning requirements for Local Mental Health Authorities (LMHAs) and Local Behavioral Health Authorities (LBHAs). The CLSP has three sections: Local Services and Needs, the Psychiatric Emergency Plan, and Plans and Priorities for System Development.

CLSP asks for information related to community stakeholder involvement in local planning efforts. HHSC recognizes that community engagement is an ongoing activity, and input received throughout the biennium will be reflected in the local plan. LMHAs and LBHAs may use a variety of methods to solicit additional stakeholder input specific to the local plan as needed.

In completing the template, please provide concise answers, using bullet points. When necessary, add additional rows or replicate tables to provide space for a full response.

Section I: Local Services and Needs

I.A Mental Health Services and Sites

- *In the table below, list sites operated by the LMHA or LBHA (or a subcontractor organization) providing mental health services regardless of funding (Note: please include 1115 waiver projects detailed in Section 1.B. below). Include clinics and other publicly listed service sites; do not include addresses of individual practitioners, peers, or individuals that provide respite services in their homes.*
- *Add additional rows as needed.*
- *List the specific mental health services and programs provided at each site, including whether the services are for adults, children, or both (if applicable):*
    - *Screening, assessment, and intake*
    - *Texas Resilience and Recovery (TRR) outpatient services: adults, children, or both*
    - *Extended Observation or Crisis Stabilization Unit*
    - *Crisis Residential and/or Respite*
    - *Contracted inpatient beds*
    - *Services for co-occurring disorders*
    - *Substance abuse prevention, intervention, or treatment*
    - *Integrated healthcare: mental and physical health*
    - *Services for individuals with IDD*
    - *Services for at-risk youth*
    - *Services for veterans*
    - *Other (please specify)*

Operator (LMHA/LBHA or Contractor Name)	Street Address, City, and Zip	County	Services & Target Populations Served
Center for Health Care Services (CHCS)	Paul Elizondo Clinic 928 W. Commerce San Antonio, TX 78207	Bexar	• Population: Adults • Screening, assessment and Intake • TRR outpatient services • Services for co-occurring disorders • Integrated healthcare
Center for Health Care Services (CHCS)	Legacy Oaks 5372 Fredericksburg Rd, Building F San Antonio, TX 78229	Bexar	• Population: Adults • TRR outpatient services • Services for co-occurring disorders • Integrated healthcare • ACT and FACT

Operator (LMHA/LBHA or Contractor Name)	Street Address, City, and Zip	County	Services & Target Populations Served
Center for Health Care Services (CHCS)	Harvard Place Clinic 1920 Burnet San Antonio, TX 78202	Bexar	• Population: Adults • TRR outpatient services • Services for co-occurring disorders • Screening, assessment and Intake for PASSR services • Supported Employment • Early Onset Psychosis Program - POWER
Center for Health Care Services (CHCS)	Packard Clinic Mental Health and Specialty Programs 1123 N. Main, Ste 203 San Antonio, TX 78212	Bexar	• Population: Adults • TRR outpatient services • Services for co-occurring disorders • Community Alternatives to Incarceration Program (CAIP) – Non TRR – Includes: Felony Drug Court/MH/Co-occurring, MH Pre-trial/Jail Diversion services and MH services provided to clients referred that are on active community supervision. • Mental Health Court • AOT
Center for Health Care Services (CHCS)	Forensic Court/OCR 2711 Palo Alto Rd San Antonio, TX 78211	Bexar	• Population: Adults • Screening, assessment and intake • TRR outpatient services • Services for co-occurring disorders • Jail Diversion • Forensic Court • OCR • COT (Court Ordered Treatment) • TCOOMMI (Texas Correctional Office on Offenders/Medical and Mental Impairment)

Operator (LMHA/LBHA or Contractor Name)	Street Address, City, and Zip	County	Services & Target Populations Served
Center for Health Care Services (CHCS)	CenterCare Health and Wellness 8122 Datapoint Drive San Antonio, TX 78229	Bexar	• Population: Adults • Expanded outpatient clinic – Non TRR
Center for Health Care Services (CHCS)	Restoration Center 601 N. Frio San Antonio, TX 78207	Bexar	• Population: Adults • Screening, assessment, and intake • Services for co-occurring disorders • Substance abuse prevention, intervention or treatment • Extended observation and Crisis Stabilization Unit 24 hours a day, 365 days a year • Mobile Crisis Outreach Team • Crisis Transitional/Residential Services • Detox • OATS • MOMMIES • OSAR (Outreach, Screening, Assessment and Referral) • Substance Abuse Public Sobering • Primary Care • Opioid Drop In Center
Center for Health Care Services (CHCS)	Josephine Recovery Center 711 E. Josephine St. San Antonio, TX 78208	Bexar	• Population: Adults • Screening, assessment, and intake • Crisis Residential • Crisis Transitional Services (former LOC-5)

Center for Health Care Services (CHCS)	HIV Prevention, Intervention, & Outreach Programs 722-1 Isom Rd San Antonio, TX 78216	Bexar	• Population: Adults with or at-risk for HIV/AIDS • Screening, assessment, and intake • Targeted Outreach, free testing, education and counseling • Intensive Case Management
Center for Health Care Services (CHCS)	Prospects Courtyard 1 Haven for Hope Way San Antonio, TX 78207	Bexar	• Population: Adults • Screening, assessment, and intake • TRR outpatient services • Services for co-occurring disorders • Supported Housing • Integrated Treatment Program – Dormitory for homeless adult males • PATH • Homeless shelter
Center for Health Care Services (CHCS)	Long Term Care 8155 Lone Shadow Trail Converse, TX 78109	Bexar	• Population: Adults and Children • Home and Community Based Services • Respite • Nursing and Community Living Support Svcs.
Center for Health Care Services Center for Health Care Services (CHCS)	Drexel Clinic Bldg. A 227 W. Drexel San Antonio, TX 78210	Bexar	• Population: Children • TRR outpatient services • Crisis/Respite Residential • Crisis/Crisis Mobile Outreach Team
Center for Health Care Services Center for Health Care Services (CHCS)	Drexel Clinic Bldg. B 227 W. Drexel San Antonio, TX 78210	Bexar	• Population: Children • Intellectual and Developmental Disability Services • Day Activity and Habilitation Services
Center for Health Care Services Center for Health Care Services (CHCS)	Drexel Clinic Bldg. D 227 W. Drexel San Antonio, TX 78210	Bexar	• Population: Children • Intellectual and Developmental Disability Services • Calidad Day Habilitation

Center for Health Care Services (CHCS)	Bandera Clinic 6812 Bandera Rd. San Antonio, TX 78238	Bexar	• Population: Children • Screening, assessment, and intake • TRR outpatient services • Crisis/Crisis Mobile Outreach Team
Center for Health Care Services (CHCS)	Children's Clinic 5802 S. Presa San Antonio, TX 78223	Bexar	• Population: Children • Early Childhood Intervention Services • Dual Diagnosis
Center for Health Care Services (CHCS)	Children's Clinic 104 Story Lane San Antonio, TX 78223	Bexar	• Population: Children • System of Care Programs (United Way) • TRR Services
Center for Health Care Services (CHCS)	6800 Park Ten – South San Antonio, TX 78213	Bexar	• Population: Children • Youth Empowerment Services • Intensive Case management • Professional Services
NIX Behavioral Health (closed Nov. 2019)	1975 Babcock Rd. San Antonio, TX 78229	Bexar	• Population: Adults • 15 Beds PPB & CSU
San Antonio Behavioral Healthcare Hospital	8550 Huebner Rd. San Antonio, TX 78240	Bexar	• Population: Youth • Contracted inpatient beds
Southwest General Hospital	7400 Barlite Blvd. San Antonio, TX 78224	Bexar	• Population: Adults • 15 contracted inpatient bed capacity
Clarity Child Guidance Center	8535 Tom Slick San Antonio, TX 78229	Bexar	• Population: Children • Contracted inpatient beds for children 3-11 y.o.

I.B Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver Projects

- *Identify the Regional Health Partnership (RHP) Region(s) associated with each project.*
- *List the titles of all projects you proposed for implementation under the RHP plan. If the title does not provide a clear description of the project, include a descriptive sentence.*
- *Enter the number of years the program has been operating, including the current year (i.e., second year of operation = 2)*

- *Enter the static capacity—the number of clients that can be served at a single point in time.*
- *Enter the number of clients served in the most recent full year of operation. If the program has not had a full year of operation, enter the planned number to be served per year.*
- *If capacity/number served is not a metric applicable to the project, note project-specific metric with the project title.*

	1115 Waiver Projects				
RHP Region(s)	Project Title (include brief description if needed)	Years of Operation	Capacity	Population Served	Number Served/ Year
RHP 6	(1.1) Crisis Respite Residential Center (CRRC) for children and adolescents (5 to 17 years of age) with severe emotional disturbance.	7	14 Beds	children and adolescents (5 to 17 years of age)	DY7: 134 DY8: 180
RHP 6	(1.2) Expanded Outpatient Capacity: established to extend operating hours at a select number of Local Mental Health clinics or other community-based settings, in areas of the State where access to care is likely to be limited.	5	250	Adults	DY7: 8,813 DY8: 8,581
RHP 6	(1.3) Hospital Diversion Recovery Services: developed and implemented crisis stabilization services to address the identified gaps in the current community crisis system.	5	15 Beds	Adults	DY7: 469 DY8:392
RHP 6	(2.2) PCY Integrated Clinic: provides behavioral health and primary care services to homeless individuals residing at	4	(2) exam beds/providers	Adults	DY7: 125 DY8: 187
RHP 6	(2.3) Integrated Primary Care: services within existing Behavioral Health Care Services for substance abuse and HIV population within one location.	5	(4) exam beds/ providers	Adults	DY7: 1,572 DY8: 1,682

I.C Community Participation in Planning Activities

Identify community stakeholders who participated in your comprehensive local service planning activities over the past year.

	Stakeholder Type		Stakeholder Type
☒	Consumers	☒	Family members
☒	Advocates (children and adult)	☒	Concerned citizens/others
☒	Local psychiatric hospital staff	☒	State hospital staff
☒	Mental health service providers	☒	Substance abuse treatment providers
☒	Prevention services providers	☒	Outreach, Screening, Assessment, and Referral (OSAR)
☒	County officials	☒	City officials
☒	FQHCs/other primary care providers	☒	Local health departments
☒	Hospital emergency room personnel	☒	Emergency responders
☒	Faith-based organizations	☒	Community health & human service providers
☒	Probation department representatives	☒	Parole department representatives
☒	Court representatives (judges, DAs, public defenders)	☒	Law enforcement
☒	Education representatives	☒	Employers/business leaders
☒	Planning and Network Advisory Committee	☒	Local consumer-led organizations
☒	Peer Specialists	☒	IDD Providers
☒	Foster care/Child placing agencies	☒	Community Resource Coordination Groups
☒	Veterans' organization	☒	Other: _STRAC_____

Describe the key methods and activities you used to obtain stakeholder input over the past year, including efforts to ensure all relevant stakeholders participate in your planning process.

Organize monthly meetings, the Community Roundtable, that include stakeholders representing various community resources to include both private and public hospitals (adults & children), law enforcement, judges, first responders, PNAC, MH service providers, prevention services providers, local health department, Haven for Hope, SASH, and other community resource groups.
The Bexar County Community Collaborative was organized by the Center for Health Care Services (LMHA), in partnership with the City of San Antonio, Bexar County, and Bexar County Hospital District (d/b/a University Health System). In addition to these primary partners, other committed entities include: UT Health San Antonio, Southwest General Hospital, Haven for Hope, Southwest Texas Crisis Collaborative/Southwest Texas Regional Advisory Council, Methodist Healthcare System, Baptist Health System, Bexar County Health Collaborative, Clarity Child Guidance Center, South Alamo Regional Alliance for the Homeless, San Antonio Clubhouse, Lifetime Recovery, and Crosspoint. The National Alliance on Mental Illness-San Antonio (NAMI) is also an essential participating partner to ensure consumer and family input is integrated into all levels of planning.

List the key issues and concerns identified by stakeholders, including unmet service needs. Only include items raised by multiple stakeholders and/or had broad support.

- **Sustainability planning:** Continue to look at various funding opportunities for program sustainability after waiver funds are no longer available, the limitations to qualifying for the Affordable Care Act (ACA), and the denial of Medicaid Expansion in the State of Texas. CCBHC?
- **Personnel Workforce:** Adult and child psychiatrists, Advanced Practicing Nurses, Registered Nurses, Clinical Practitioners, and Therapists are needed in Bexar County as a whole.
- **Patient Information Exchange:** Constraints and requirements related to patient information presents challenges with data collection and information sharing.
- **Housing:** Insufficient and/or limited affordable permanent housing creates additional struggles for individuals transitioning back into the community.
- **Insurance:** Lack of insurance and increased medication costs are barriers to adequate treatment.
- **Dual Diagnosis Population**: Increased services for individuals with a Dual Diagnosis: Mental Health & Intellectual Developmental Disability

- **Psychiatric Bed Capacity:** Loss of psychiatric beds have strained local stakeholders and resources to develop alternatives to improper hospitalization and criminal justice encounters.
- **IDD:** To address the complex navigation of IDD services our community is in the planning phases of the development of the Multi Assistance Center (MAC). The MAC is an innovative one-stop facility that provides all medical and non-medical services needed for Individuals with special needs. The MAC care model is designed to be coordinated, comprehensive, complementary, and synergistic – thus ensuring improved communications among the different providers, where individuals and families, with assistance from navigators, will have the ability to meet all their needs through the fully inclusive and accessible campus.
- **Meth/Opioid:** The national opioid epidemic is beginning to reach Bexar County. In an effort to confront this public health emergency head-on, Bexar County, the City of San Antonio, and University Health System convened the Joint Opioid Task Force. The interagency public-private collaboration is seeking to decrease the number of opioid deaths in Bexar County and develop strategies to address the opioid crisis in a comprehensive manner.
- **Teen suicide:** New numbers from the Bexar County Medical Examiner's Office show the rates of teen suicides in Bexar County are rising over the past five years. A teen suicide taskforce has been convened to advance efforts to prevent teen suicide in the Alamo Area by engaging youth voices and build on best practices to provide clear and ongoing prevention messages; to improve access to care and strengthen the continuum of youth mental health care; and influence related policy.
- **Domestic violence:** In response to the domestic violence crisis in our community, a task force to investigate possible solutions to prevent any more deaths. The task force has been convened to focus on solutions and resources that include reaching out to people before domestic violence becomes a part of their daily lives.

Section II: Psychiatric Emergency Plan

The Psychiatric Emergency Plan is intended to ensure stakeholders with a direct role in psychiatric emergencies have a shared understanding of the roles, responsibilities, and procedures enabling them to coordinate their efforts and effectively use available resources. The Psychiatric Emergency Plan entails a collaborative review of existing crisis response activities and development of a coordinated plan for how the community will respond to psychiatric emergencies in a way that is responsive to the needs and priorities of consumers and their families. The planning effort also provides an opportunity to identify and prioritize critical gaps in the community's emergency response system.

The following stakeholder groups are essential participants in developing the Psychiatric Emergency Plan:

- Law enforcement (police/sheriff and jails)
- Hospitals/emergency departments
- Judiciary, including mental health and probate courts
- Prosecutors and public defenders
- Other crisis service providers
- Users of crisis services and their family members

Most LMHAs and LBHAs are actively engaged with these stakeholders on an ongoing basis, and the plan will reflect and build upon these continuing conversations.

Given the size and diversity of many local service areas, some aspects of the plan may not be uniform across the entire service area. If applicable, include separate answers for different geographic areas to ensure all parts of the local service area are covered.

II.A Development of the Plan

Describe the process used to collaborate with stakeholders to develop the Psychiatric Emergency Plan, including, but not limited to, the following:

- Ensuring all key stakeholders were involved or represented
- Ensuring the entire service area was represented
- Soliciting input

- The Bexar County Community Collaborative was organized by the Center for Health Care Services (LMHA), in partnership with the City of San Antonio, Bexar County, and Bexar County Hospital District (d/b/a University Health System). In addition to these primary partners, other committed entities include: UT Health San Antonio, Nix Behavioral Health Center, Southwest General Hospital, Haven for Hope, Southwest Texas Crisis Collaborative/Southwest Texas Regional Advisory Council, Methodist Healthcare System, Baptist Health System, Bexar County Health Collaborative, Clarity Child Guidance Center, South Alamo Regional Alliance for the Homeless, San Antonio Clubhouse, Lifetime Recovery, and Crosspoint. The National Alliance on Mental Illness-San Antonio

(NAMI) is also an essential participating partner to ensure consumer and family input is integrated into all levels of planning.

- CHCS has organized multiple stakeholders, task forces, advisory boards and subcommittees to examine and recommend improvements to existing crisis services. Included are the Community Roundtables, the Adult & Child CIT Committee, and the Jail Diversion Oversight Committee. Those attending have reflected significant diversity, representing individuals of all ages, family members, and advocates, mental health services providers, emergency health care providers, the public health system, law enforcement, probation and parole departments, the judiciary, substance abuse providers, and private foundations. As emerging and/or immediate issues arise, ad hoc work groups are formed and meet as full committees and/or subcommittees. Progress reports are provided for specific emphasis areas or priorities and new work assignments are made, as needed. The group continues to meet until their work plan has been accomplished. Policy councils, like the Community Roundtables and Treatment and Care Council, generally are permanent and meet at minimum every month.
- The Southwest Texas Crisis Collaborative (STCC), a division of STRAC, is an effort focused on ending ineffective utilization of services for the safety net population at the intersection of chronic illness, mental illness, and homelessness in San Antonio, Texas and Bexar County.
- Law Enforcement Navigation: Patients who are placed into emergency detention by law enforcement for their acute psychiatric needs and are medically stable are navigated to the appropriate psychiatric facility versus area emergency departments. This system change has decompressed local emergency departments, where psychiatric patients were often boarded for hours awaiting a more appropriate facility. All behavioral health facilities with inpatient beds are reporting their diversion status, and MEDCOM, a 24/7 dispatch center currently routing all trauma patients in the region, is now routing medically stable psychiatric patients to an appropriate facility.
- Signify is a collaboration software platform that provides for process consistency while helping identify and solve barriers to care. Signify will link social, financial, and community resources with physicians and care professionals across systems to ensure consumers make successful transitions to recovery and wellness. Service providers also will be able to access a custom network of local resources and support services to help remove barriers and improve care. Signify's cloud-based platform will first be connected via BAA agreements to the health providers, and eventually through an Organized Health Care Arrangement (OHCA). Data collected and distributed by Signify will enable impact comparisons at the provider and Collaborative levels, and quarterly reports will help the Collaborative members use the data to identify and fill gaps and expand "what works".

II.B Crisis Response Process and Role of MCOT

1. How is your MCOT service staffed?
    a. During business hours

- During business hours the MCOT team consists of 5 QMHP's. There is a medical provider on call for the MCOT team 24/7 at the Crisis Care Center. The QMHP's will provide active case management with the goal to reduce 911 calls and engage consumer back into services with stabilized treatment and treatment and screen for potential enrollment into PICC Programs of CTS.

- Combining the efforts of the PES System of Care and Law Enforcement Navigation, STRAC has also embedded licensed clinicians in MEDCOM 24/7 to assist in facilitating inter-facility transfer requests to the identified PES facilities. Placing a licensed professional in the middle of the transfer process allows multiple treatment options to be considered. Utilizing tele-screening, the clinician can assist in determining whether the patient would benefit from PES, inpatient treatment, or potentially avoid admission all together and be connected back to an assigned treatment team for follow up. Law Enforcement Navigation is addressing the mental health crisis at the scene and the PES System of Care is addressing the mental health crisis occurring in a hospital/emergency department who may not have the service line that would best treat the patient's conditions.

    b. After business hours

- After business hours MCOT has 1 QMHP. There is also a Medical Provider on call for the MCOT team 24/7 at the Crisis Care Center.

    c. Weekends/holidays

- On weekends MCOT has 2 QMHP's and during Holidays MCOT has 1 QMHP. There is also a Medical Provider on call for the MCOT team 24/7 at the Crisis Care Center.

2. What criteria are used to determine when the MCOT is deployed?

- MCOT is deployed for all incoming calls that are Urgent, Routine, Community, or State Bed Authorization. Law Enforcement is deployed for Emergent calls. Calls are screened and labeled by the Avail Crisis Hotline. Upon arrival, Law Enforcement will notify Avail of the Emergent situation and Avail in turn will notify MCOT.

3. What is the role of MCOT during and after a crisis when crisis care is initiated through the LMHA or LBHA (for example, when an individual calls the hotline)? Address whether MCOT provides follow-up with individuals who experience a crisis and are then referred to transitional or services through the LMHA or LBHA.

- Once a crisis call is initiated, MCOT does not take a lead role. The staff at the Crisis Care Center (CCC) will attempt to resolve the crisis and admit the individual to the extended observation unit where appropriate. CCC staff provides the 24 hour follow ups with each discharge from the CCC. MCOT is on a referral basis. If an individual calls the Hotline, MCOT is deployed to provide Crisis Intervention and Crisis Outreach Services to the individual. Upon resolution of the crisis, MCOT will provide a 24 hour follow up with the individual.
- The role of MCOT during a crisis when crisis care is initiated through the LMHA is to determine the least restrictive environment. If the crisis is resolved on scene, MCOT will do a follow-up within 24 hours. MCOT has a 90-day outpatient transitional program that is staffed with a provider, 4QMPH'-CS and 1 CSSP during business hours. After their 90-day period that individual that presented in crisis will be referred into the community or the LMHA for ongoing care.

4. Describe MCOT support of emergency rooms and law enforcement:

    a. Do emergency room staff and law enforcement routinely contact the LMHA or LBHA when an individual in crisis is identified? If so, is MCOT routinely deployed when emergency rooms or law enforcement contact the LMHA or LBHA?

○ Emergency rooms: MCOT is deployed to the hospital for screening for determination of eligibility for a private psychiatric bed (PPB) and SASH recommendation. ○ Law enforcement: Law enforcement will call MCOT workers to accompany them on a community call to assist in crisis intervention and to determine the appropriate level of care or least restrictive environment for the individual.

b. What activities does the MCOT perform to support emergency room staff and law enforcement during crises?

○ Emergency rooms: Eligibility screenings for private psychiatric bed (PPB) are performed for ER/Hospital staff ○ Law enforcement: Assist in crisis intervention and to determine the appropriate level of care or least restrictive environment for the individual in coordination with the Crisis Care Center.

5. What is the procedure if an individual cannot be stabilized at the site of the crisis and needs further assessment or crisis stabilization in a facility setting?
   a. Describe your community's process if a client needs further assessment and/or medical clearance:

○ MCOT is trained to consider and recommend the least restrictive alternative. MCOT teams consider all appropriate least restrictive alternatives while also establishing what additional/if any medical clearance is needed. If medical clearance is needed, MCOT staff utilize the Crisis Care Center or nearest Emergency ○ Department depending on direction from Center medical staff and the nature and urgency of the medical issue. MCOT teams also staff cases with the Center's UM about appropriateness for facility based care whether it's through one of Center's crisis beds or authorization for inpatient psychiatric hospitalization.

   b. Describe the process if a client needs admission to a hospital:

○ The Center participates in MedCom which is operated by STRAC. MedCom is a regional coordination center that facilitates trauma transfers to the appropriate level of care in the TSA-P area and adjacent Trauma Service Areas. Most recently it included psychiatric crisis. All psychiatric crises are coordinated with MedCom and partners to determine community capacity for hospitalization or appropriate setting for care.

- If an individual needs admission to a hospital they will be transported by either the LMHA or Law
- Enforcement. A provider to provider contact will be initiated between the LMHA and the hospital provider to coordinate the case.

c. Describe the process if a client needs facility-based crisis stabilization (i.e., other than hospitalization–may include crisis respite, crisis residential, extended observation, etc.):

- Seeking the least restrictive environment, individuals may be brought to the Crisis Care Center and admitted for up to 48-hour crisis observation. Additionally, we provide for additional residential services (7-10 days) after stabilization at the EOU or inpatient hospitalization at our Josephine Recovery Center location.
- With the recent funding of Senate Bill 292 the Center through a partnership with Nix Health a new 15 Bed Crisis Stabilization Unit will offer short-term residential treatment, including medical and nursing services, designed to reduce acute symptoms of mental illness and prevent admission to an inpatient mental health facility, including the state hospital. CHCS's Crisis Care Center will be the front door for services and will assess and admit consumers to the CSU. Established but currently on hold secondary to NIX closure.

d. Describe your process for crisis assessments requiring MCOT to go into a home or alternate location such as a parking lot, office building, school, or under a bridge:

- 1st point of triage is the crisis line.
- Crisis will assess level risk and/or danger
- Law enforcement will be notified and law enforcement & crisis line will notify MCOT personnel
- MCOT will go out with the officer or meet the officer at location
- If law enforcement not required, and there is a sense of unknowns and/or risk, 2 MCOT workers will field the location
- If know routine and no risks, one MCOT worker will tend the call, this is minimal.

6. What steps should emergency rooms and law enforcement take when an inpatient level of care is needed?
   a. During business hours

- If the individual is unfunded, they call Crisis to determine eligibility for a private psychiatric bed. If the individual is funded they may be taken to a hospital in the community.

b. After business hours

- If the individual is unfunded, they call Crisis to determine eligibility for a private psychiatric bed. If the individual is funded they may be taken to a hospital in the community.

c. Weekends/holidays

- If the individual is unfunded, they call the Crisis to determine eligibility for a private psychiatric bed. If the individual is funded they may be taken to a hospital in the community.

7. If an inpatient bed is not available:

a. Where is an individual taken while waiting for a bed?

- If an inpatient bed is not available and the individual does not meet criteria for the Center's crisis residential program, he or she is taken to the nearest Emergency Department. Beginning in June 2018, the Center through a partnership with Nix Health a new 15 Bed Crisis Stabilization Unit will offer short-term residential treatment, including medical and nursing services, designed to reduce acute symptoms of mental illness and prevent admission to an inpatient mental health facility, including the state hospital. CHCS's Crisis Care Center will be the front door for services and will assess and authorize consumers to the NIX CSU.

b. Who is responsible for providing continued crisis intervention services?

- CTS will provide a 90-day authorization for crisis intervention services and case management. The individual will then be referred to outpatient services where appropriate.

c. Who is responsible for continued determination of the need for an inpatient level of care?

- The Utilization Management Department is responsible for review of medical necessity and continued determination of need for inpatient admission.

d. Who is responsible for transportation in cases not involving emergency detention?

- The referring entity is typically responsible for the transportation of individuals who are voluntary and not on an emergency detention. For example, the emergency department may elect to place the person in a taxicab, contract with local law enforcement for off-duty officers to transport, or contract with local ambulance services to provide transport to the psychiatric hospital for admission.

Crisis Stabilization

8. What alternatives does your service area have for facility-based crisis stabilization services (excluding inpatient services)? Replicate the table below for each alternative.

Name of Facility	Josephine Recovery Center
Location (city and county)	San Antonio, Bexar County
Phone number	210-261-3800
Type of Facility (see Appendix A)	Crisis Residential/Respite Unit
Key admission criteria (type of patient accepted)	All patients that present to the Josephine Recovery Center are screened and assessed. Admission to the Observation Unit is determined upon medical clearance and no need for higher level of care.
Circumstances under which medical clearance is required before admission	Open wound, infectious diseases, uncontrolled hypertension, diabetes, intractable pain
Service area limitations, if any	Individuals who display violent behaviors cannot be served

Other relevant admission information for first responders	None
Accepts emergency detentions?	No

Name of Facility	Crisis Care Center
Location (city and county)	San Antonio, Bexar County
Phone number	210-225-5481
Type of Facility (see Appendix A)	Extended Observation Unit (EOU)
Key admission criteria (type of patient accepted)	All patients that present to the Crisis Care Center are screened and assessed. Admission to the Observation Unit is determined upon medical clearance and no need for higher level of care.
Circumstances under which medical clearance is required before admission	Open wound, infectious diseases, uncontrolled hypertension, diabetes, intractable pain
Service area limitations, if any	Individuals who display violent behaviors cannot be served
Other relevant admission information for first responders	None
Accepts emergency detentions?	Yes

Name of Facility	Child Crisis and Respite Center
Location (city and county)	San Antonio, Bexar County
Phone number	210-954-3989
Type of Facility (see Appendix A)	Crisis Respite
Key admission criteria (type of patient accepted)	All patients that present to the Crisis Respite Center are screened and assessed for short-term planned respite or post crisis episodes for children aged 5-17.
Circumstances under which medical clearance is required before admission	Open wound, infectious diseases, uncontrolled hypertension, diabetes, intractable pain
Service area limitations, if any	Individuals who display violent behaviors cannot be served

Other relevant admission information for first responders	None
Accepts emergency detentions?	No

Inpatient Care

9. What alternatives to the state hospital does your service area have for psychiatric inpatient care for medically indigent? Replicate the table below for each alternative.

Name of Facility	Southwest General Hospital
Location (city and county)	San Antonio, Bexar County
Phone number	210-921-2000
Key admission criteria	Suicidal, homicidal, exacerbated deterioration in functioning
Service area limitations, if any	15 bed capacity
Other relevant admission information for first responders	Contact the CHCS Mobile Crisis Outreach Team for potential admission recommendation

Name of Facility	Clarity Child Guidance Center
Location (city and county)	San Antonio, Bexar County
Phone number	210-616-0300
Key admission criteria	Suicidal, homicidal, exacerbated deterioration in functioning
Service area limitations, if any	Children 3-11 y.o. or when the State Hospital is at capacity
Other relevant admission information for first responders	Contact the Children's Mobile Crisis Outreach Team for potential admission recommendation

Name of Facility	San Antonio Behavioral Healthcare Hospital
Location (city and county)	San Antonio, Bexar County
Phone number	(210) 541-5300
Key admission criteria	Suicidal, homicidal, exacerbated deterioration in functioning
Service area limitations, if any	Children 3-11 y.o.

Other relevant admission information for first responders	Contact the Children's Mobile Crisis Outreach Team for potential admission recommendation

II.C Plan for local, short-term management of pre- and post-arrest patients who are incompetent to stand trial

10. What local inpatient or outpatient alternatives to the state hospital does your service area currently have for competency restoration?
    a. Identify and briefly describe available alternatives.

- Assertive Community Treatment (ACT): Psychiatric medication management, psychosocial rehabilitative services, and comprehensive support for individuals with frequent psychiatric hospitalizations.
- Assisted Outpatient Treatment (AOT): Civil court ordered program designed for individuals who are chronically non-compliant with psychiatric treatment and would otherwise require inpatient hospitalization.
- Senate Bill 292 Funding – helped to establish a Forensic Assertive Community Treatment (FACT) team to provide intensive, multi-disciplinary treatment and services to consumers with SMI and frequent jail bookings, history of incarceration or repeated criminal justice involvement. The FACT team provides core, fidelity-defined services of the Tool for Measurement of Assertive Community Treatment (TMACT). The FACT team has been trained on the Risk-Need-Responsivity (RNR) principles with plans to implement. By including an RNR component, the FACT team will have the capability to assess and reduce various aspects of criminogenic risk.
- Involuntary Outpatient Commitment Program (IOPC): civil court ordered program designed for individuals who are chronically non-compliant with psychiatric treatment and would otherwise require inpatient hospitalization.
- With the funding of Senate Bill 292, the Center established a Forensic Assertive Community Treatment (FACT) team to provide intensive, multi-disciplinary treatment and services to consumers with SMI and frequent jail bookings. The FACT team provides core, fidelity-defined services of the Tool for Measurement of Assertive Community Treatment (TMACT) and will implement Risk-Need-Responsivity (RNR) principles, thereby implementing the most state of the art clinical models of care for this population. By including an RNR

component, the FACT Team will have the capability to assess and, therefore, reduce, various aspects of criminogenic risk, e.g., criminal thinking, substance use, and associating with bad influences.
- Outpatient Competency Restoration Program (OCR): Provides supervision, treatment, training and residential and community-based placement following the legal finding of incompetent to stand trial.

b. What barriers or issues limit access or utilization to local inpatient or outpatient alternatives? If not applicable, enter N/A.

- In 2015, Methodist Healthcare Ministries of South Texas engaged the Meadows Mental Health Policy Institute (MMHPI) to review the performance of Bexar County behavioral health systems. A primary consideration was verifying the adequacy of the existing system of care for consumers with severe needs. According to the MMHPI study, the gap between need and resources widens in direct proportion to the intensity of consumer needs. Although CHCS serves a relatively higher proportion of consumers with complex needs than other LMHAs, systemic capacity across providers is insufficient. The absence of adequate and appropriate care was found to escalate disease progression and tax public health and justice systems.
- A second study funded by Methodist Healthcare Ministries in 2016, and conducted by Capital Healthcare Planning, sought to verify the service utilization patterns of highest need consumers, particularly the *3,354 adults* classified as both *high utilizers of tertiary care and frequently detained by law enforcement.* Key findings about this population subset follow: 54% have COPSD; most all have one or more chronic physical health conditions; 57% are covered by Medicaid; most all live in poverty or are very low income; and, 40% seek care across multiple systems and clinical settings each year. While these consumers represent 10% of the local safety net population, they account for 41% of total care encounters, averaging 38.8 encounters per consumer per year, at a cost of $201M to public and private health and legal systems

c. Does the LMHA or LBHA have a dedicated jail liaison position? If so, what is the role of the jail liaison? At what point is the jail liaison engaged?

- We do not have dedicated jail liaison position; however, we do have available Clinical Practitioners that will coordinate services as needed. The jail social workers distribute a weekly list of individuals currently receiving their services and we review that list to determine if any of the individuals have been served by CHCS in the

past year. In addition, we are able to determine if any of the individuals are being transferred from a state mental health facility (SMHF). If any individuals are identified on the weekly list, the Clinical Practitioners will visit the jail to provide information, complete assessments, and will attend court on their behalf if requested.
- In addition, if any court ordered defendant was arrested, we are available to assist with medications and educate the individual about competency disposition before a trial date is set.
- CHCS clinicians are assigned to the Central Magistrate's facility 24-7-365, to ensure that all consumers with screening results indicating possible SMI or COPSD who are eligible for a Personal Recognizance Bond or Commercial Bonds also are assessed are rapidly identified and he or she is quickly filtered into CHCS services.

If the LMHA or LBHA does not have a dedicated jail liaison, identify the title(s) of employees who operate as a liaison between the LMHA or LBHA and the jail.

- We have one Clinical practitioner I and two Clinical practitioner II's.

d. What plans do you have over the next two years to maximize access and utilization of local alternatives for competency restoration? If not applicable, enter N/A.

- To increase the mental illness and competency awareness and education, to avoid the revolving door phenomenon & minimizing mentally ill individuals from acquiring new criminal charges due to lack of treatment.
- With the funding of Senate Bill 292, CHCS will continue to explore options with community stakeholders to re-open the 15 bed CSU to offer short-term residential treatment, including medical and nursing services, designed to reduce acute symptoms of mental illness and prevent admission to an inpatient mental health facility, including the state hospital.
- Both ACT (treatment coordinated by a multidisciplinary team with high staff-to-client ratios that assumes 24/7 responsibility for clients' case management and treatment needs) and FACT (ACT-like program adapted for consumers involved in the criminal justice system and focused on preventing arrest and incarceration.

11. Does your community have a need for new alternatives for competency restoration? If so, what kind of program would be suitable (i.e., Outpatient Competency Restoration Program, inpatient competency restoration, jail-based competency restoration, etc.)?

- Existing Outpatient Competency Restoration programs are a great alternative for keeping Incompetent to Stand Trial defendants incarcerated if they are good candidate based on assessments. Also, an Inpatient Competency Restoration Program would be a more suitable venue for severe offenders. CHCS does not currently operate a jail-based competency restoration program.

12. What is needed for implementation? Include resources and barriers that must be resolved.

- Closer supervision to inmate in order to detect early sign of mental illness and quick referral for competency evaluation and treatment. One of the barriers is refusal of dismissing TBI/ABI, dementia, Alzheimer disorder/cases with 2nd or 3rd degree felonies. Defendants who suffer from these neurocognitive or chronic disorders are just being warehoused and will never be restored to competency.

II.D Seamless Integration of emergent psychiatric, substance use, and physical healthcare treatment

13. What steps have been taken to integrate emergency psychiatric, substance use, and physical healthcare services? Who have you collaborated with in these efforts?

- The Restoration Center provides emergency psychiatric, substance use, and physical healthcare services all in one location at 601 N. Frio, San Antonio, Texas.
- Collaboration with the South Texas Regional Advisory Committee and its members have resulted in the development of MEDCOM and Law Enforcement Navigation. Patients who are placed into emergency detention by law enforcement for their acute psychiatric needs and are medically stable are navigated to the appropriate psychiatric facility versus area emergency departments. This system change has decompressed local emergency departments, where psychiatric patients were often boarded for hours awaiting a more appropriate facility. All behavioral health

facilities with inpatient beds are reporting their diversion status, and MEDCOM, a 24/7 dispatch center currently routing all trauma patients in the region, is now routing medically stable to the appropriate facility.

- Signify is a collaboration software platform that provides for process consistency while helping identify and solve barriers to care. Signify will link social, financial, and community resources with physicians and care professionals across systems to ensure consumers make successful transitions to recovery and wellness. Service providers also will be able to access a custom network of local resources and support services to help remove barriers and improve care. Signify's cloud-based platform will first be connected via BAA agreements to the health providers, and eventually through an Organized Health Care Arrangement (OHCA). Data collected and distributed by Signify will enable impact comparisons at the provider and Collaborative levels, and quarterly reports will help the Collaborative members use the data to identify and fill gaps and expand "what works".

14. What are your plans for the next two years to further coordinate and integrate these services?

- With Senate Bill 292 and HB 13 and Local funding, CHCS and its partners will continue to support existing resources that include:
- 1. A 15-bed secure Crisis Stabilization Unit (CSU). The new CSU will offer short-term residential treatment, including medical and nursing services, designed to reduce acute symptoms of mental illness and prevent admission to an inpatient mental health facility, including the state hospital. CHCS's Crisis Care Center will be the front door for services and will assess and admit consumers to the CSU. 15 bed CSU was established with SB 292 funding that was closed in September 2019 when hospital closed that housed the unit.
- 2. FACT and ACT Teams. CHCS will establish a Forensic Assertive Community Treatment (FACT) team to provide intensive, multi-disciplinary treatment and services to consumers with SMI and frequent jail bookings. The FACT team will provide core, fidelity-defined services of the Tool for Measurement of Assertive Community Treatment (TMACT) and will implement Risk-Need-Responsivity (RNR) principles, thereby implementing the most state of the art clinical models of care for this population. By including an RNR component, the FACT Team will have the capability to assess and, therefore, reduce, various aspects of criminogenic risk, e.g., criminal thinking, substance use, and associating with bad influences. Model implementation also will reduce recidivism by matching interventions to each person's specific risk factors.
- Since the establishment of CHCS's current Assertive Community Treatment (ACT) team, fidelity standards have evolved. CHCS is eager to secure the training and preparation necessary for these teams to meet the HHS-endorsed

TMACT fidelity model while also incorporating the RNR framework. With RNR proficiency, ACT staff will be able to distinguish between consumers who have low to moderate criminogenic risk (and are therefore appropriate for ACT) and those with high criminogenic risk (and are therefore appropriate for FACT). Intensive training and technical assistance will be provided to new and existing staff to develop an evidence-based FACT team and to build the capacity of existing ACT Team members to meet current ACT fidelity standards.

- 3. Additional clinical staff at the Central Magistrate (weekends, holidays). By assigning CHCS clinicians to the Central Magistrate's jail diversion program 24-7-365, Bexar County will ensure that all consumers with screening results indicating possible SMI or COPSD who are eligible for a Personal Recognizance Bond also are assessed. With House Bill 13 funding, supplemented by local match, CHCS and its partners propose to expand existing resources. New investment will include:
- The Recovery Connection program and intensive case management resources to improve connections to and delivery of continuity care to a high need target population, especially those who have been recently discharged from the hospital. The Recovery Connection model applies a multi-disciplinary, team-based approach to ensure rapid access to ongoing treatment for funded and unfunded consumers with SMI who are unable to obtain timely appointments in the immediate post-discharge period.
- CHCS has expanded its Primary Care services to five locations including four outpatient clinics for adults and most recently one clinic for children locations serving over 600 consumers, which represents great progress in the journey to a full integration. Integrated care services involve monitoring Body Mass Index (BMI), control high blood pressure and tobacco screen and cessation in addition to traditional behavioral health care services.
- PICC (Program for Intensive Care Coordination) was developed in partnership with San Antonio Fire Department EMS Mobile Integrated Healthcare (SAFD-EMS-MIH), San Antonio Police Department Mental Health Unit (SAPD-MHU), and the Center for Health Care Services (CHCS). This multidisciplinary approach was created in an effort to reduce emergency detentions and the subsequent use of emergency and inpatient services by providing ongoing engagement and wraparound care tailored specifically to each patient's unique needs. The services may consist of ongoing engagement, case management, medication management, psychosocial rehabilitation, transportation, and connections to other community resources. By forming a team consisting of a Mobile Integrated Healthcare Medic, a specialized Mental Health Officer, and a Qualified Mental Health Professional, various skill sets and resources are available to the patient.
- Chronic Crisis Stabilization Initiative (CCSI) is a collaborative program with the San Antonio Police Department, San Antonio Fire Department and the Center aimed at reducing the utilization of Emergency Detention Orders (EDO's)

and therefore reducing the utilization of the Psychiatric Emergency Rooms (ERs) and PES beds. CHCS will provide additional personnel as listed in the staffing plan below to work with the existing CCSI program and its' resources to provide case management and mental health services to the targeted population. The target population will be based off of a High Utilizer list provided monthly by MEDCOM that will include individuals that have had (6) or more EDO's within the last 12 months.

- **II.E Communication Plans**

15. How will key information from the Psychiatric Emergency Plan be shared with emergency responders and other community stakeholders? Consider use of pamphlets/brochures, pocket guides, website page, mobile app, etc.

- CHCS will share this information via its website www.chcsbc.org and through its social media platform (Facebook and Twitter). Additionally, the Center publishes and distributes over 30 different brochures and flyers listing crisis facilities, locations, and hotline numbers for mental health and substance use disorders. The Center also utilizes a mobile app Mental Health and You to disseminate information regarding mental illness. The app provides a direct connection to our Crisis Hotline so that those in acute psychiatric distress are provided with prompt assessment and treatment. The Center is also a member of the Southwest Texas Advisory Council (STRAC). STRAC serves a 22 county area in south central Texas that includes Bexar County. All hospitals, first responders including law enforcement, fire departments, EMS and private behavioral health provider organizations meet monthly at a STRAC Behavioral Committee meeting. This would be another forum to share the Psychiatric Emergency Plan.
- Patients who are placed into emergency detention by law enforcement for their acute psychiatric needs and are medically stable are navigated to the appropriate psychiatric facility versus area emergency departments. This system change has decompressed local emergency departments, where psychiatric patients were often boarded for hours awaiting a more appropriate facility. All behavioral health facilities with inpatient beds are reporting their diversion status, and MEDCOM, a 24/7 dispatch center currently routing all trauma patients in the region, is now routing medically stable psychiatric patients to an appropriate medical facility.

16. How will you ensure LMHA or LBHA staff (including MCOT, hotline, and staff receiving incoming telephone calls) have the information and training to implement the plan?

- MCOT and LMHA staff participates in staffing's and informational meetings where they participate in education on the plan and the goals of CHCS in assisting individuals with mental illness in the community. CHCS uses Relias Training Software to insure all staff complete and maintain a record of all trainings. Crisis Intervention, MH First Aid and much other psychiatric emergency training are provided to all staff annually. Trainings are offered monthly for courses like SAMA and other training courses.

II.F Gaps in the Local Crisis Response System

17. What are the critical gaps in your local crisis emergency response system? Consider needs in all parts of your local service area, including those specific to certain counties.

Counties	Service System Gaps
Bexar	• Coordination and communication of services and responsiveness of all first responders to include police, fire and EMS first responders. Coordination has begun with a project for all first responders and the LMHA to meet monthly to identify barriers and develop solutions. The STRAC Behavioral Health Committee mentioned above meets monthly to address any gaps in service delivery. The Community Roundtable (CRT) has been meeting monthly for the past fifteen years. The CRT members includes local hospitals and other community healthcare organizations, political leadership, law enforcement leadership, the Bexar County MH Department, Universities and other educational organizations, NAMI, STRAC, and many other community stakeholders. The CRT monthly meeting continuously examines gaps in services and develops workgroups or uses existing workgroups to address needs and gaps in services.

Section III: Plans and Priorities for System Development

III.A Jail Diversion

The Texas Statewide Behavioral Health Services Plan highlights the need for effective jail diversion activities:

- *Gap 5: Continuity of care for individuals exiting county and local jails*
- *Goal 1.1.1, Address the service needs of high risk individuals and families by promoting community collaborative approaches, e.g., Jail Diversion Program*
- *Goal 1.1.2: Increase diversion of people with behavioral health needs from the criminal and juvenile justice systems*

In the table below, indicate which of the following strategies you use to divert individuals from the criminal justice system. List current activities and any plans for the next two years. Include specific activities describing the strategies checked in the first column. For those areas not required in the HHSC Performance Contract, enter NA if the LMHA or LBHA has no current or planned activities.

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
☒ Co-mobilization with Crisis Intervention Team (CIT) ☒ Co-mobilization with Mental Health Deputies ☒ Co-location with CIT and/or MH Deputies ☒ Training dispatch and first responders ☒ Training law enforcement staff ☒ Training of court personnel ☒ Training of probation personnel ☒ Documenting police contacts with persons with mental illness ☒ Police-friendly drop-off point ☒ Service linkage and follow-up for individuals who are not hospitalized	• Law enforcement, CIT, and MHD will meet at location but staff does not travel together. • If and when law enforcement transports an individual to our crisis facility or a local hospital, staff travels behind to ensure safe arrival and then provide service linkage to resources depending on disposition. • Provides Law Enforcement with an easily accessible drop off point for individuals being transferred to the Crisis Care Center.

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
☒ Other: Co-Location with Bexar County Law Enforcement and Bexar County Pre-Trial Services	All staff encounters with law enforcement, on behalf of the individuals, are documented. • MCOT staff provides CIT training for dispatch, first responders, Law Enforcement staff, court personnel, and probation personnel. • Co-location of Clinical practitioner at the Bexar County Central Magistrate Dept. to screen, assess, and divert to outpatient mental health Jail Diversion program, sobering or detox unit or Haven for Hope Dormitory Housing pilot program. • The Crisis Transitional Services team will provide wrap around services, case management and crisis intervention for those individuals that are not hospitalized.

Plans for the upcoming two years:

- Through the support of the DASH grant, CHCS built partitioned access to individual information in order to increase collaboration with Law Enforcement and expedite access to care with the entire team.
- With Senate Bill 292 funding the Center assigned clinicians to the Central Magistrate's jail diversion program 24-7-365, Bexar County will ensure that all consumers with screening results indicating possible SMI or COPSD who are eligible for a Personal Recognizance Bond and Commercial Bonds also are assessed and consumers' needs are rapidly identified and he or she is quickly filtered into CHCS services. At this time, only Crisis Care Center and MCOT provide "real-time" services in the community with local Law Enforcement on the Intercept 1 level.
- Continue with existing programs and services, continue working with criminal justice partners.

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
• Continue educating about competency & mental illness. Encourage lawyer to research the psychiatric background of their individual to direct to the right source and avoid long time incarceration and neglect with exacerbation of mental illness symptoms. • Incorporate the mental health crisis response needs of the Local Service Area (Bexar County) with existing coordination efforts such as the Southwest Texas Regional Advisory Committee which coordinates the County response to physical health care emergencies. • Continue to participate in Signify to track service utilization and verify impact on consumers' arrest or incarceration, or subsequent use of crisis services. Signify is a collaboration software platform that provides for process consistency while helping identify and solve barriers to care. Signify will link social, financial, and community resources with physicians and care professionals across systems to ensure consumers make successful transitions to recovery and wellness. Service providers also will be able to access a custom network of local resources and support services to help remove barriers and improve care. • Continue to educate existing programs and services, our criminal justice partners, the community, other medical providers, and those we serve about competency, mental illness, and access to treatment.	

Intercept 2: Post-Arrest: Initial Detention and Initial Hearings	
Components	**Current Activities**
☒ Staff at court to review cases for post-booking diversion ☒ Routine screening for mental illness and diversion eligibility ☒ Staff assigned to help defendants comply with conditions of diversion ☒ Staff at court who can authorize alternative services to incarceration ☒ Link to comprehensive services ☒ Other: Screening for substance abuse	• Potential individuals for outpatient, sobering/detox or Haven for Hope Dormitory Housing pilot program are screened and assessed at the Bexar County Magistrate Dept. by CHCS Clinical Practitioners for jail/magistrate diversion into mental health services or other diversions. • Provide screening and assessment for referred probation, parole and pre-trial referrals in all

Intercept 2: Post-Arrest: Initial Detention and Initial Hearings	
Components	**Current Activities**
	settings as needed, including the Municipal Court.

Plans for the upcoming two years:

- With Senate Bill 292 funding the Center has assigned clinicians to the JIAA jail diversion program 24-7365, Bexar County will ensure that all consumers with screening results indicating possible SMI or COPSD who are eligible for a Personal Recognizance and Commercial Bonds are assessed and consumers' needs are rapidly identified and he or she is quickly filtered into CHCS services.
- Continue to support the Magistrates Division to identify and divert individuals arrested for violations who have mental illnesses.

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
☒ Routine screening for mental illness and diversion eligibility ☒ Mental Health Court ☒ Veterans' Court ☒ Drug Court ☒ Outpatient Competency Restoration ☒ Services for persons Not Guilty by Reason of Insanity ☒ Services for persons with other Forensic Assisted Outpatient Commitments ☐ Providing services in jail for persons Incompetent to Stand Trial ☐ Compelled medication in jail for persons Incompetent to Stand Trial	• Attend hearings and advocate within criminal justice system for behavioral health interventions for existing and potential individuals. • Currently CRP (Community Reintegration Program) and CAIP (Community Alternatives to Incarceration Program) can accept individual referrals from the following: ○ Diversion at Central Magistration level when individuals are first brought in for arrest or tickets. ○ In outpatient based upon referrals from • Community Supervision programs such as Pre-Trial, Probation and Parole.

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
☐ Providing services in jail (for persons without outpatient commitment) ☒ Staff assigned to serve as liaison between specialty courts and services providers ☒ Link to comprehensive services ☐ Other:	• Individuals screened by specialty Pre-trial officer co-located in the Bexar County Adult Detention Center (local jail) that can request a conditional bond release to outpatient Jail Diversion program from presiding judge in either the district or county courts within the first 5-7 days or admission to local jail. • CRP and CAIP can usually provide an intake/screening appt. within 3-4 business days and access to prescriber services within 7-10 business days. • Ensures defendant is evaluated for competency if needed. Take a close look to the competency evaluation report; advocate for Outpatient Competency restoration services as first choice to avoid incarceration or inpatient referrals.

Plans for the upcoming two years:

- County personnel (judges, district attorneys, administrators, etc.) require further education to decrease stigma of mental illness being treated in the community and increase their knowledge on the array of outpatient mental health services available to individuals being served.
- With Senate Bill 292 funding the Center has established a Forensic Assertive Community Treatment (FACT) team to provide intensive, multi-disciplinary treatment and services to consumers with SMI and frequent jail bookings. The FACT team will provide core, fidelity-defined services of the Tool for Measurement of Assertive Community Treatment (TMACT) and will implement Risk-Need-Responsivity (RNR) principles, thereby implementing the most state of the art clinical models of care for this population. By including an RNR component, the FACT Team will have the capability

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
to assess and, therefore, reduce, various aspects of criminogenic risk, e.g., criminal thinking, substance use, and associating with bad influences. Model implementation also will reduce recidivism by matching interventions to each person's specific risk factors. • Since the establishment of the Center current Assertive Community Treatment (ACT) team, fidelity standards have evolved. The Center has secured the training and preparation necessary for these teams to meet the HHS-endorsed TMACT fidelity model while also incorporating the RNR framework. With RNR proficiency, ACT staff will be able to distinguish between consumers who have low to moderate criminogenic risk (and are therefore appropriate for ACT) and those with high criminogenic risk (and are therefore appropriate for FACT).	

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
☐ Providing transitional services in jails ☒ Staff designated to assess needs, develop plan for services, and coordinate transition to ensure continuity of care at release ☒ Structured process to coordinate discharge/transition plans and procedures ☒ Specialized case management teams to coordinate post-release services ☐ Other:	• Provide advocacy and services in the jail throughout incarceration to ensure individual has coordination during transition back into the community. • Provide intensive case management that coordinate wraparound services to ensure needs are met following release. • Currently CRP (Community Reintegration Program) and CAIP (Community Alternatives to Incarceration Program) can accept individual referrals from jails and prisons. • CHCS works with Bexar County MH Dept., Judicial Services (and associated programs), Adult Probation and State Parole Depts. to

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
	provide timely access for screening & intake into jail diversion and probation programs usually within 5 - 7 business days of referral received and access to prescriber services within 7-10 business days. CHCS can provide services to individuals that are re-entering the community from both jail and prison settings. • Provide continuity of care to offenders releasing from prison/jail to be linking in to needed treatment programs. • LMHA operates an Assertive Community Treatment Team to provide post release services to people with mental illnesses who have been released from jails.

Plans for the upcoming two years:

- With Senate Bill 292 funding the Center has established a Forensic Assertive Community Treatment (FACT) team to provide intensive, multi-disciplinary treatment and services to consumers with SMI and frequent jail bookings. The FACT team provides core, fidelity-defined services of the Tool for Measurement of Assertive Community Treatment (TMACT) and Risk-Need-Responsivity (RNR) principles, thereby implementing the most state of the art clinical models of care for this population. By including an RNR component, the FACT Team will have the capability to assess and, therefore, reduce, various aspects of criminogenic risk, e.g., criminal thinking, substance use, and associating with bad influences. Model implementation also will reduce recidivism by matching interventions to each person's specific risk factors.
- Since the establishment of the Center current Assertive Community Treatment (ACT) team, fidelity standards have evolved. The Center has secured the training and preparation necessary for these teams to meet the HHS-endorsed TMACT fidelity model while also incorporating the RNR framework. With RNR proficiency, ACT staff will be able to

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
distinguish between consumers who have low to moderate criminogenic risk (and are therefore appropriate for ACT) and those with high criminogenic risk (and are therefore appropriate for FACT). Intensive training and technical assistance will be provided to new and existing staff to develop an evidence-based FACT team and to build the capacity of existing ACT Team members to meet current ACT fidelity standards.	

Intercept 5: Community corrections and community support programs	
Components	**Current Activities**
☒ Routine screening for mental illness and substance use disorders ☒ Training for probation or parole staff ☒ TCOOMMI program ☒ Forensic ACT ☒ Staff assigned to facilitate access to comprehensive services; specialized caseloads ☒ Staff assigned to serve as liaison with community corrections ☒ Working with community corrections to ensure a range of options to reinforce positive behavior and effectively address noncompliance ☐ Other:	• Individuals are referred to CHCS by individual probation/parole officers or specialized county or district units in the community once it is determined that individual needs or could benefit from MH treatment. Individuals referred by their POs or specialized units for screening and assessment into CAIP or Specialty Court Programs (CRP or CC-12) will usually receive a screening and intake appt. within 5-7 business days of referral received. Different counties and district courts of Bexar County can also transfer individuals into Specialty Courts. • Provide screening and assessment for referred probation, parole and pre- trial referrals. • Work directly with Parole and Probation officers. • Work in co-located facilities with criminal justice staff.

	• Educate lawyers about mental illness, its effects, and available treatment. • LMHA operates a Mobile Crisis Outreach Team that is available 24/7/365 to routinely screen for mental illnesses and substance abuse disorders. The MCOT team assists various community organizations in training SAPD officers and Bexar County Sheriff's Deputies in Crisis Intervention Training (CIT). CIT is 40 hour week long training in crisis intervention and de-escalation techniques. CIT training is being provided at both Law Enforcement training academies and other first responder organizations.

Plans for the upcoming two years:

- The Recovery Connection program and intensive case management resources to improve connections to and delivery of continuity care to a high need target population, especially those who have been recently discharged from the hospital. The Recovery Connection model applies a multi-disciplinary, team-based approach to ensure rapid access to ongoing treatment for funded and unfunded consumers with SMI who are unable to obtain timely appointments in the
- PICC (Program for Intensive Care Coordination) was developed in partnership with San Antonio Fire Department EMS Mobile Integrated Healthcare (SAFD-EMS-MIH), San Antonio Police Department Mental Health Unit (SAPD-MHU), and the Center for Health Care Services (CHCS). This multidisciplinary approach was created in an effort to reduce emergency detentions and the subsequent use of emergency and inpatient services by providing ongoing engagement and wraparound care tailored specifically to each patient's unique needs. The services may consist of ongoing engagement, case management, medication management, psychosocial rehabilitation, transportation, and connections to other community resources. By forming a team consisting of a Mobile Integrated Healthcare Medic, a specialized Mental Health Officer, and a Qualified Mental Health Professional, various skill sets and resources are available to the patient.

- Chronic Crisis Stabilization Initiative (CCSI) is a collaborative program with the San Antonio Police Department, San Antonio Fire Department and the Center aimed at reducing the utilization of Emergency Detention Orders (EDO's) and therefore reducing the utilization of the Psychiatric Emergency Rooms (ERs) and PES beds. CHCS will provide additional personnel as listed in the staffing plan below to work with the existing CCSI program and its' resources to provide case management and mental health services to the targeted population. The target population will be based off of a High Utilizer list provided monthly by MEDCOM that will include individuals that have had (6) or more EDO's within the last 12 months.

III.B Other Behavioral Health Strategic Priorities

The Texas Statewide Behavioral Health Strategic Plan identifies other significant gaps in the state's behavioral health services system, including the following:

- *Gap 1: Access to appropriate behavioral health services for special populations (e.g., individuals with co-occurring psychiatric and substance use services, individuals who are frequent users of emergency room and inpatient services)*
- *Gap 2: Behavioral health needs of public school students*
- *Gap 4: Veteran and military service member supports*
- *Gap 6: Access to timely treatment services*
- *Gap 7: Implementation of evidence-based practices*
- *Gap 8: Use of peer services*
- *Gap 10: Consumer transportation and access*
- *Gap 11: Prevention and early intervention services*
- *Gap 12: Access to housing*
- *Gap 14: Services for special populations (e.g., youth transitioning into adult service systems)*

Related goals identified in the plan include:

- *Goal 1.1: Increase statewide service coordination for special populations*
- *Goal 2.1: Expand the use of best, promising, and evidence-based behavioral health practices*
- *Goal 2.3: Ensure prompt access to coordinated, quality behavioral healthcare*

- *Goal 2.5: Address current behavioral health service gaps*
- *Goal 3.2: Address behavioral health prevention and early intervention services gaps*
- *Goal 4.2: Reduce utilization of high cost alternatives*

Briefly describe the current status of each area of focus (key accomplishments, challenges and current activities), and then summarize objectives and activities planned for the next two years.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Improving access to timely outpatient services	• Gap 6 • Goal 2	• Limited provider capacity for prescribers and licensed clinical practitioners	• Continue to increase telemedicine utilization • Improve efficiency with enrollment to services • Offer competitive compensation packages in line with market compensation • Follow standard caseloads that account for acuity • Follow productivity standards • Employ prescriber scheduling within 3 – 5 days of needed visit • Address no show rate through changes to service agreement and utilization of walk-in status
Improving continuity of care between inpatient care and	• Gap 1 • Goals 1,2,4	• Providing follow-up services to individuals who have been admitted to	• Continue to offer current services in addition to linking individuals to a Care Manager within 2 days to

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
community services and reducing hospital readmissions		psychiatric hospital within 7 days of discharge • Seen by a Prescriber within 15 days of discharge from the hospital	complete the first face-to-face meeting 7 days after discharging from the hospital and engaging individual. • For existing consumers, CHCS will ensure assigned Care Manager sees individual face-to-face within 7 days of discharge or documents that an attempt was made. • With House Bill 13 funding the Center has invested to increase intensive case management resources to improve connections to and delivery of continuity care to a high need target population, especially those who have been recently discharged from the hospital. The Recovery Connection model applies a multidisciplinary, team-based approach to ensure rapid access to ongoing treatment for funded and unfunded consumers with SMI who are unable to obtain timely appointments in the immediate post-discharge period.
Transitioning long-term state hospital patients who no	• Gap 14	• Complete Utilization Reviews on a regular basis.	Continue current actions, with adjustments made as the State

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
longer need an inpatient level of care to the community and reducing other state hospital utilization	• Goals 1,4	• As the individual approach discharge readiness, they are linked to services that will assist them in transitioning/maintaining in the community. • Attends staffing and is available to the State Mental Health Facilities (SMHF) treatment teams on a routine basis. • Forensically committed individuals are linked to the Forensic Court Services Unit as needed. ABH/CBH serves individuals per the LOCA, with re-assessments completed as the individuals needs increase/change. • Crisis Services to include MCOT/CMOT screen potential admissions to SMHF's and makes recommendations to less restrictive alternatives as appropriate. • Individuals in Bexar County jail who are known/thought to be experiencing mental health issues are screened and diverted to civil commitments whenever possible to prevent potentially lengthy 46B commitments. • UM department reviews and authorizes any civil SMHF admissions.	Hospital Allocation Methodology (SHAM) is updated. • Continue current actions, with adjustments made as deemed necessary. With House Bill 13 funding the Center has invested to increase intensive case management resources to improve connections to and delivery of continuity care to a high need target population, especially those who have been recently discharged from the hospital. The Recovery Connection model applies a multidisciplinary, team-based approach to ensure rapid access to ongoing treatment for funded and unfunded consumers with SMI who are unable to obtain timely appointments in the immediate post-discharge period. • With Senate Bill 292 funding the Center in partnership with Nix Health developed a 15-bed secure

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
		Those admitted to SMHF are reviewed by Continuity of Care (CoC) for appropriateness for continued stay and linked to services as needed. • UM agreement is followed to include final authorization date and appeal process. Every effort is made to enroll individuals in CHCS on the date of discharge from a SMHF or Private Psychiatric Bed (PPB).	Crisis Stabilization Unit (CSU). The CSU offered short-term residential treatment, including medical and nursing services, designed to reduce acute symptoms of mental illness and prevent admission to an inpatient mental health facility, including the state hospital. CHCS's Crisis Care Center is the front door for services and will assess and admit consumers to the CSU. Developed, for 18 months—currently on hold as hospital closed. Currently seeking alternative location.
Implementing and ensuring fidelity with evidence-based practices	• Gap 7 • Goal 2	• Complete CBT, CPT, DBT certification training and supervision ensuring competency. • Care Managers are trained on fidelity based practices. • All programs are aligned with therapeutic intervention protocols to ensure fidelity and adhere to DSHS performance contract metrics, GFC contract requirements, and CAIP 1115 Waiver metrics.	• Working with SAMHSA and the PBHCI Grant in ensuring EBP's. • Continue to trend data and look for operational or other reasons/rationale if we are see fidelity become an issue. • Continue utilizing prescribed DSHS and TCOOMMI treatment models. • Continue to train our staff for fidelity based practices and review for

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
		• All clinicians receive ongoing coaching and feedback to ensure fidelity. • Utilize a Clinical Consultant to provide CBT individual and group supervision, as well as one-on-one coaching. • Provider individual supervision for QMHP's and LPHA's. • Conduct quality assurance reviews and clinical observations. • Developed Core Competencies for Clinical Staff.	quality assurance that such are being implemented. • Continue providing coaching and feedback. Establish process to provide additional training needed to enhance Clinical Core Competencies. • Implement Core Competencies evaluation, observation, and follow-up processes. • Since the establishment of the Center current Assertive Community Treatment (ACT) team, fidelity standards have evolved. The Center has secured the training and preparation necessary for these teams to meet the HHS-endorsed TMACT fidelity model while also incorporating the RNR framework. With RNR proficiency, ACT staff will be able to distinguish between consumers who have low to moderate criminogenic risk (and are therefore appropriate for ACT) and those with high criminogenic risk

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
			(and are therefore appropriate for FACT). Intensive training and technical assistance will be provided to new and existing staff to develop an evidence-based FACT team and to build the capacity of existing ACT Team members to meet current ACT fidelity standards.
Transition to a recovery-oriented system of care, including use of peer support services	• Gap 8 • Goals 2,3	• Peer integration. • Use of trauma informed therapeutic modalities. • Recovery model based treatment. • Implemented customer satisfaction surveys. • Positions for Peer Support specialists are posted and interviews are scheduled with qualified candidates. • Utilizing Family Partners to provide additional support, connect to services, and develop long-term recovery strategies. • The outpatient clinics are working towards fully implementing the ROSC model.	• Working to increase our Peer Support Services and employees. • Improve outreach to community partners to increase links for potential candidates for Peer Support specialists' positions. • Continue to train and incorporate ROSC strategies. • Provide Wraparound and Motivational Interviewing Staff training.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
		• IHWWP has implemented the ROSC model. • CHCS uses person centered TRR services where the individual plays a co-facilitative role in their treatment. The individual is involved in treatment planning, recovery planning, and personal needs. • Secured a SAMHSA System of Care grate in partnership with the City of San Antonio.	
Addressing the needs of consumers with co-occurring substance use disorders	• Gaps 1,14 • Goals 1,2	• Provide substance abuse based rehab services, seeking safety sessions, and staff with LCDC credentialing. • Care Managers are assessing needs for individuals with co-occurring substance use disorders and providing intervention as appropriate or referring to care. • The Integrated Clinician team works in conjunction with our internal Substance Abuse Programs and applies MI interventions to meet the needs of dual-diagnosed individuals.	• Working on getting a Substance abuse license at one of the mental health outpatient clinics. • Continue to address needs as related to co-occurring mental health and substance abuse disorders. • Continue to grow services for individuals with this need to include development of groups once facilities are approved. • Evaluate the efficacy and utilization of the Substance Abuse groups.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
		• Integrated Treatment Program utilized EBPs integrated treatment interventions to address dual disorders. • There are currently several programs for individuals with co-occurring disorders to participate in including: Opioid Addiction, Co-Occurring SA Disorders, Drug Court, and IOP, ITP • Providing substance abuse educational groups.	
Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers.	• Gap 1 • Goals 1,2	• Both ACT and ICT are located in an integrated, multidisciplinary clinic. • CHCS has expanded its Primary Care services to five locations including four outpatient clinics for adults and most recently one clinic for children, which represents great progress in the journey to a full integration. Integrated care services involve monitoring Body Mass Index (BMI), control high blood pressure and tobacco screen and cessation in addition to	• Continue to develop true integration model that will meet both the Behavioral Health needs as well as Primary Care. • CHCS needs to have larger/overarching access to primary care/integrated regardless of funding source or lack of funding. • Continue to assist individual in obtaining benefits to receive both mental health and primary care services. • Continuous quality improvement of services.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
		traditional behavioral health care services. Referring individuals to PCP for primary care services • Participating on the Primary Behavioral Health Care Integration (PBHCI) Planning and Coordination Committee • CHCS has achieved CCBHC certification	• Establish a process for utilization of this service. • Evolve our services and prescriber panel to include PCP's on site. • Explore possibility to partner with UTHSC at San Antonio Community Medicine Department to place Family Practice Residents. • Explore alternative payment models and incentives with Managed Care Organizations (MCO) for sustainability of integrated services/
Consumer transportation and access to treatment in remote areas	• Gap 10 • Goal 2	• We address this gap by providing bus tickets, scheduling home visits, and coordinating multiple provider appointments for same day to reduce client travel to clinics • Coordinate medical transportation but limitations include inability to transport other family members. • We provide choice of geographic location for client convenience.	• Secure Taxi vouchers to address gap in transportation. • Conduct focus groups with clients to identify needs including transportation challenges. • Increase telemedicine utilization.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
		• Assist with securing authorization for VIA trans.	
Addressing the behavioral health needs of consumers with Intellectual Disabilities	• Gap 14 • Goals 2,4	• Limited provider capacity for prescribers • Limitation on mid-level providers ability to prescribe • Limited prescriber's expertise in treating IDD population.	• Continue to recruit providers with experience working with this population. • Continue to participate in a community initiative for a planned Multi-Assistance Center to serve as a medical home and navigation center to individuals with IDD that include behavioral health needs.
Addressing the behavioral health needs of veterans	• Gap 4 • Goals 2,3	• Continue to serve eligible veterans and coordinate with other community organizations serving veterans.	• Continue to serve veteran population • Reinstate trauma informed leadership team

III.C Local Priorities and Plans

- *Based on identification of unmet needs, stakeholder input, and your internal assessment, identify your top local priorities for the next two years. These might include changes in the array of services, allocation of resources, implementation of new strategies or initiatives, service enhancements, quality improvements, etc.*
- *List at least one but no more than five priorities.*
- *For each priority, briefly describe current activities and achievements and summarize your plans for the next two years. If local priorities are addressed in the table above, list the local priority and enter "see above" in the remaining two cells.*

Local Priority	Current Status	Plans
Sustainability	☐ Early planning stages.	☐ Develop strategic sustainability plan.
Reduce preventable ER usage and 30-day readmissions related to behavioral health conditions	☐ Submitted and awarded funding for Senate Bill 292 and House Bill 13	• With Senate Bill 292 and HB 13 and Local funding, CHCS and its partners will continue to support existing resources that include: • FACT and ACT Teams. CHCS will establish a Forensic Assertive Community Treatment (FACT) team to provide intensive, multi-disciplinary treatment and services to consumers with SMI and frequent jail bookings. The FACT team will provide core, fidelity-defined services of the Tool for Measurement of Assertive Community Treatment (TMACT) and will implement Risk-Need-Responsivity (RNR) principles, thereby implementing the most state of the art clinical models of care for this population. By including an RNR component, the FACT Team will have the capability to assess and, therefore, reduce, various aspects of criminogenic risk, e.g., criminal thinking, substance use, and associating with bad influences. Model implementation also will reduce recidivism by matching interventions to each person's specific risk factors. • Since the establishment of CHCS's current Assertive Community Treatment (ACT) team, fidelity standards have evolved. CHCS is eager to secure the training and preparation necessary for these teams to meet the HHS-endorsed TMACT fidelity model while also incorporating the RNR framework. With RNR proficiency, ACT staff will be able to distinguish between consumers who have low to moderate criminogenic risk (and are therefore appropriate for

		ACT) and those with high criminogenic risk (and are therefore appropriate for FACT). Intensive training and technical assistance will be provided to new and existing staff to develop an evidence-based FACT team and to build the capacity of existing ACT Team members to meet current ACT fidelity standards. • Additional clinical staff at the Central Magistrate (weekends, holidays). By assigning CHCS clinicians to the Central Magistrate's jail diversion program 24-7-365, Bexar County will ensure that all consumers with screening results indicating possible SMI or COPSD who are eligible for a Personal Recognizance Bond also are assessed. With House Bill 13 funding, supplemented by local match, CHCS and its partners propose to expand existing resources. New investment will include: • The Recovery Connection program and intensive case management resources to improve connections to and delivery of continuity care to a high need target population, especially those who have been recently discharged from the hospital. The Recovery Connection model applies a multi-disciplinary, team-based approach to ensure rapid access to ongoing treatment for funded and unfunded consumers with SMI who are unable to obtain timely appointments in the immediate post-discharge period. • CHCS has expanded its Primary Care services to five locations including four outpatient clinics for adults and most recently one clinic for children

		locations serving over 600 consumers, which represents great progress in the journey to a full integration. Integrated care services involve monitoring Body Mass Index (BMI), control high blood pressure and tobacco screen and cessation in addition to traditional behavioral health care services. • PICC (Program for Intensive Care Coordination) was developed in partnership with San Antonio Fire Department EMS Mobile Integrated Healthcare (SAFD-EMS-MIH), San Antonio Police Department Mental Health Unit (SAPD-MHU), and the Center for Health Care Services (CHCS). This multidisciplinary approach was created in an effort to reduce emergency detentions and the subsequent use of emergency and inpatient services by providing ongoing engagement and wraparound care tailored specifically to each patient's unique needs. The services may consist of ongoing engagement, case management, medication management, psychosocial rehabilitation, transportation, and connections to other community resources. By forming a team consisting of a Mobile Integrated Healthcare Medic, a specialized Mental Health Officer, and a Qualified Mental Health Professional, various skill sets and resources are available to the patient. • Chronic Crisis Stabilization Initiative (CCSI) is a collaborative program with the San Antonio Police Department, San Antonio Fire Department and the

		Center aimed at reducing the utilization of Emergency Detention Orders (EDO's) and therefore reducing the utilization of the Psychiatric Emergency Rooms (ERs) and PES beds. CHCS will provide additional personnel as listed in the staffing plan below to work with the existing CCSI program and its' resources to provide case management and mental health services to the targeted population. The target population will be based off of a High Utilizer list provided monthly by MEDCOM that will include individuals that have had (6) or more EDO's within the last 12 months. •

Local Priority	Current Status	Plans

		establish a Forensic Assertive Community Treatment (FACT) team to provide intensive, multi-disciplinary treatment and services to consumers with SMI and frequent jail bookings. The FACT team will provide core, fidelity defined services of the Tool for Measurement of Assertive Community Treatment (TMACT) and will implement Risk-Need-Responsivity (RNR) principles, thereby implementing the most state of the art clinical models of care for this population. By including an RNR component, the FACT Team will have the capability to assess and, therefore, reduce, various aspects of criminogenic risk, e.g., criminal thinking, substance use, and associating with bad influences. Model implementation also will reduce recidivism by matching interventions to each person's specific risk factors. □ Since the establishment of CHCS's current Assertive Community Treatment (ACT) team, fidelity standards have evolved. CHCS is eager to secure the training and preparation necessary for these teams to meet the HHS-endorsed TMACT fidelity model

		while also incorporating the RNR framework. With RNR proficiency, ACT staff will be able to distinguish between consumers who have low to moderate criminogenic risk (and are therefore appropriate for ACT) and those with high criminogenic risk (and are therefore appropriate for FACT). Intensive training and technical assistance will be provided to new and existing staff to develop an evidence based FACT team and to build the capacity of existing ACT Team members to meet current ACT fidelity standards. • Additional clinical staff at the JIAA. By assigning CHCS clinicians to the Central Magistrate's jail diversion program 247-365, Bexar County will ensure that all consumers with screening results indicating possible SMI or COPSD who are eligible for a Personal Recognizance Bond also are assessed. With House Bill 13 funding, supplemented by local match, CHCS and its partners propose to expand existing resources. New investment will include: • The Recovery Connection program and intensive case management resources to improve connections to and delivery of continuity care to a high need target population, especially those who have been recently discharged from the hospital. The Recovery Connection model applies a multi-disciplinary, team-based approach to ensure rapid access to ongoing treatment for funded and unfunded consumers with

		SMI who are unable to obtain timely appointments in the immediate post discharge period. • A 15-bed secure Crisis Stabilization Unit (CSU). The new CSU will offer short-term residential treatment, including medical and nursing services, designed to reduce acute symptoms of mental illness and prevent admission to an inpatient mental health facility, including the state hospital. CHCS's Crisis Care Center will be the front door for services and will assess and admit consumers to the CSU. 15 bed CSU was established with SB 292 funding that was closed in September 2019 when hospital closed that unit.

Local Priority	Current Status	Plans
Increase Staff of Medical personnel	• Shortage across the state and within CHCS. • Offering practicum experiences opportunities. • Utilizing Telemedicine.	• Increase marketing to Medical Professionals and advocate increasing funding for hire. • Establish partnerships with UTSA, OLLU, and other Accredited Universities to provide opportunities for graduate students' involvement. • Increase utilization of Telemedicine.
Individuals need insurance/benefits	• Many individuals are unfunded and do not have insurance. Thus their MH, Sub. Abuse and Primary Care often goes untreated. • Individuals that do not have an extensive mental health history may	• Look at affordable fee for service model that targeted populations can afford. • Increase CBO or insurance employee base. • Continue to assist offenders at obtaining benefits at no cost to them and educating
Local Priority	**Current Status**	**Plans**
	not qualify for SSI/SSDI benefits. □ Due to being an offender, some might not qualify for insurance benefits and are unable to get the necessary treatment.	them on the need to get and maintain benefits if they qualify.

Access to quality/safe housing	• Not enough safe boarding homes. No real access to licensed boarding homes, as they charge quite a bit more than the unlicensed homes. • Difficulty placing sex-offenders at most facilities (to include JRC, H4H, and boarding homes).	• Need additional housing options/opportunities. • Need a "halfway house" or residential facility for these populations. Seek a grant for these resources. Without such resources, there cannot be full integration into the community.

III.D System Development and Identification of New Priorities

Development of the local plans should include a process to identify local priorities and needs, and the resources required for implementation. The priorities should reflect the input of key stakeholders involved in development of the Psychiatric Emergency Plan as well as the broader community. This will build on the ongoing communication and collaboration LMHAs and LBHAs have with local stakeholders. The primary purpose is to support local planning, collaboration, and resource development. The information will also provide a clear picture of needs across the state and support planning at the state level. Please provide as much detail as practical for long-term planning.

In the table below, identify your service area's priorities for use of any *new* funding should it become available in the future. Do not include planned services and projects that have an identified source of funding. Consider regional needs and potential use of robust transportation and alternatives to hospital care. Examples of alternatives to hospital care include residential facilities for non-restorable individuals, outpatient commitments, and other individuals needing long-term care, including geriatric patients with mental health needs. Also consider services needed to improve community tenure and avoid hospitalization.

a. Assign a priority level of 1, 2 or, 3 to each item, with 1 being the highest priority.
b. Identify the general need.
c. Describe how the resources would be used—what items/components would be funded, including estimated quantity when applicable.
d. Estimate the funding needed, listing the key components and costs. For recurring/ongoing costs (such as staffing), state the annual cost.

Priority	Need	Brief description of how resources would be used	Estimated Cost
	Crisis Warm Line	Establish a Warm Line where 100% State Bed Authorization calls and community informational calls are directed to minimize the volume of calls received to the Crisis hotline that are not related to crisis episodes and freeing up resources to address true crisis events. Progress toward—currently 80-90% of calls for state bed authorization are routed through Warm Line.	Est. $650,000
	Psychiatric Beds	Expand for psychiatric bed capacity to address shortage in Bexar County.	Est. over $10 million
	Methadone expansion Clinic	Increase the number of methadone slots and establish an evening clinic to meet the high demand and offer availability to meet consumer needs Additional MD added to Methadone clinic expanding capability from 700 to 800 patients..	$550,000
	Staffing (medical providers & medical/clinical staff)	Increase resources (human capital) to expand access and effectively staff for all crisis related	$1.2M
	Primary Care Sustainability	Uncertainty of payment models for integrated psychiatric, physical and substance abuse services puts at risk the treatment as most consumers are unfunded or underinsured.	Est. $5.2 million

	Mental Health Access and Services Sustainability	□ Loss of 1115 Waiver will impact access to needed upstream and downstream Mental Health Services.	□ $16.5 million

Appendix A: Levels of Crisis Care

Admission criteria – Admission into services is determined by the individual's rating on the Uniform Assessment and clinical determination made by the appropriate staff. The Uniform Assessment is an assessment tool comprised of several modules used in the behavioral health system to support care planning and level of care decision making. High scores on the Uniform Assessment module items of Risk Behavior (Suicide Risk and Danger to Others), Life Domain Functioning and Behavior Health Needs (Cognition) trigger a score that indicates the need for crisis services.

Crisis Hotline – The Crisis Hotline is a 24/7 telephone service that provides information, support, referrals, screening and intervention. The hotline serves as the first point of contact for mental health crisis in the community, providing confidential telephone triage to determine the immediate level of need and to mobilize emergency services if necessary. The hotline facilitates referrals to 911, the Mobile Crisis Outcome Team (MCOT), or other crisis services.

Crisis Residential – Up to 14 days of short-term, community-based residential, crisis treatment for individuals who may pose some risk of harm to self or others, who may have fairly severe functional impairment, and who are demonstrating psychiatric crisis that cannot be stabilized in a less intensive setting. Mental health professionals are on-site 24/7 and individuals must have at least a minimal level of engagement to be served in this environment. Crisis residential facilities do not accept individuals who are court ordered for treatment.

Crisis Respite – Short-term, community-based residential crisis treatment for individuals who have low risk of harm to self or others and may have some functional impairment. Services may occur over a brief period of time, such as 2 hours, and generally serve individuals with housing challenges or assist caretakers who need short-term housing or supervision for the persons for whom they care to avoid mental health crisis. Crisis respite services are both facility-based and in-home, and may occur in houses, apartments, or other community living situations. Facility-based crisis respite services have mental health professionals on-site 24/7.

Crisis Services – Crisis services are brief interventions provided in the community that ameliorate the crisis situation and prevent utilization of more intensive services such as hospitalization. The desired outcome is resolution of the crisis and avoidance of intensive and restrictive intervention or relapse. (TRR-UM Guidelines)

Crisis Stabilization Units (CSU) – Crisis Stabilization Units are licensed facilities that provide 24/7 short-term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected, clinically staffed, psychiatrically supervised, treatment environment that complies with a Crisis Stabilization Unit licensed under Chapter 577 of the Texas Health and

Safety Code and Title 25, Part 1, Chapter 411, Subchapter M of the Texas Administrative Code. CSUs may accept individuals that present with a high risk of harm to self or others.

Extended Observation Units (EOU) – Emergency services of up to 48 hours provided to individuals in psychiatric crisis, in a secure and protected, clinically staffed, psychiatrically supervised environment with immediate access to urgent or emergent medical and psychiatric evaluation and treatment. These individuals may pose a moderate to high risk of harm to self or others. EOUs may also accept individuals on voluntary status or involuntary status, such as those on Emergency Detention. EOUs may be co-located within a licensed hospital or CSU, or be within close proximity to a licensed hospital.

Mobile Crisis Outreach Team (MCOT) – Mobile Crisis Outreach Teams are clinically staffed mobile treatment teams that provide 24/7, prompt face-to-face crisis assessment, crisis intervention services, crisis follow-up, and relapse prevention services for individuals in the community.

Psychiatric Emergency Service Center (PESC) and Associated Projects – There are multiple psychiatric emergency services programs or projects that serve as step down options from inpatient hospitalization. Psychiatric Emergency Service Center (PESC) projects include rapid crisis stabilization beds within a licensed hospital, extended observation units, crisis stabilization units, psychiatric emergency service centers, crisis residential, and crisis respite. The array of projects available in a service area is based on the local needs and characteristics of the community and is dependent upon LMHA/LBHA funding.

Psychiatric Emergency Service Centers (PESC) – Psychiatric Emergency Service Centers provide immediate access to assessment, triage and a continuum of stabilizing treatment for individuals with behavioral health crisis. PESCs are staffed by medical personnel and mental health professionals that provide care 24/7. PESCs may be co-located within a licensed hospital or CSU, or be within close proximity to a licensed hospital. PESCs must be available to individuals who walk in, and must contain a combination of projects.

Rapid Crisis Stabilization Beds – Hospital services staffed with medical and nursing professionals who provide 24/7 professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute behavioral health crisis. Staff provides intensive interventions designed to relieve acute symptomatology and restore the individual's ability to function in a less restrictive setting.