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Purpose
The Valley Baptist Legacy Foundation (Legacy Foundation) engaged the Meadows Mental Health Policy Institute (MMHPI) to conduct a review of mental health systems in the Rio Grande Valley (RGV). The primary purpose of the assessment was to understand the current capacity of the RGV to meet its population’s mental health needs (ranging from mild to severe), develop practical recommendations that would allow local stakeholders to build on current strengths, and support advancement of the counties’ mental health services delivery systems.

Because of the high levels of comorbidity between mental health (MH) and substance use disorders (SUD), we also reviewed the capacity of substance use disorder treatment, particularly integrated treatment approaches for co-occurring conditions. We looked at the status of behavioral health and primary care integration to assess progress in this important area because this approach offers opportunities to promote health and well-being for people of all ages and also extends access to behavioral health care for populations that otherwise may not have access. We reviewed the needs of special populations, including veterans, youth, and families, as well as individuals with behavioral health conditions who are involved in the justice system.

A glossary of acronyms used throughout this report is included in Appendix B.

In total, the assessment covered multiple areas of behavioral health system needs, capacity, and functioning, with the goals of identifying opportunities for improvement and providing recommendations that would be practical to implement.

Approach
The MMHPI team included experts in behavioral health services, behavioral health integration with primary care, criminal justice, veterans’ services, and mental health and substance use disorder treatment delivery systems for adults and children, youth, and their families. The review process began in 2016 with meetings with key leaders from the Legacy Foundation and behavioral health service delivery systems in order to engage stakeholders in the review from the beginning. MMHPI then sent selected behavioral health providers an information request for program descriptions, benchmark data and reports, and financial information. We also began to collect data from other sources (e.g., Health and Human Services Commission, Texas Department of Criminal Justice, national benchmark states) to assist us with a comparison of the Rio Grande Valley service trends to other parts of Texas and other states, as well as a

---

1 Specifically, our review covered the Legacy Foundation’s funding area, which includes Cameron, Hidalgo, Willacy, and Starr Counties.
2 For the purposes of this report, we use the term behavioral health to describe mental health or substance use conditions.
comparison of Tropical Texas Behavioral Health and the Border Regional Behavioral Health Center – the two local mental health authorities (LMHAs) that cover the RGV areas involved in this assessment – to other comparable LMHAs in Texas.

Combining these data with county-specific prevalence estimates of mental health needs across the region, we were able to conduct a comprehensive analysis of the current capacity and utilization of behavioral health services compared to the prevalence of mental health conditions. This data-driven approach was supplemented by on-the-ground interviews and site visits to yield a population-level view of strengths and needs across the counties in the region.

We carried out supplemental analyses of the integrated behavioral health care (IBH) capacity and needs in the RGV, interviewing leaders from six provider agencies, including three federally qualified health centers (FQHCs), a primary care clinic, a state-operated health clinic, and Tropical Texas Behavioral Health, in addition to other stakeholders with perspectives on IBH. Agency interviews included a survey on core aspects of IBH programs.

A list of all people and programs that were engaged in this assessment is included in Appendix A.

This report focuses on needs and capacity at four levels:

- In the first section of the report, **Mental Health Needs and Capacity**, we highlight system-level findings on needs and overall service capacity. In this section, we calculate the prevalence of mental illness by county and for the RGV as a whole, including people with mild to moderate conditions as well as those with more severe conditions. We then compared data on the prevalence of behavioral health conditions with data on current service utilization to help us understand the overall capacity of services compared to the needs for those services. We organized these findings by populations and age groups.

- Then we focus on the **Major System-Level Findings** to provide an understanding of the strengths and gaps of the behavioral health delivery systems across the RGV. These findings focus on broader system capacity and needs related to the planning and organization of service delivery systems, and the strengths and gaps of services for specific populations: crisis systems; adult service systems; child, youth, and family delivery systems; integrated care delivery systems; and service systems for special populations, including individuals with co-occurring psychiatric and substance use conditions, individuals involved with the criminal justice system, and veterans. We also describe some of the challenges and opportunities related to housing, transportation, the workforce, and the use of telemedicine.

---

3 We are using integrated behavioral health to refer broadly to integrated primary care and behavioral health services, regardless of the setting in which they are provided.
• The **Major System Recommendations** section of this report focuses on strategies and considerations for the Legacy Foundation, counties, providers, and others to address the major system findings. This section offers practical strategies that stakeholders could implement as next steps. It also includes **State-Level Recommendations** to address system issues that will need to be addressed at the state level. This list of recommendations and achievable next steps provides the underpinning for a strategic implementation plan that is measurable, prioritizes tasks, supports accountability, and proposes a defined process to organize the work for the whole community.

• The final sections of the report address findings and recommendations for specific providers, including **Major Behavioral Health Providers** and **Other Organizations** that offer behavioral health or related supports. The recommendations focus on strategies that providers can use to improve the delivery systems for adults; children, youth, and families; integrated care; persons with co-occurring psychiatric and substance use conditions; veterans; and individuals involved with the criminal justice system. These recommendations were reviewed and vetted with the providers prior to publication. Only recommendations approved for public release by the provider agencies were included. In some cases, providers were made aware of additional findings and recommendations not included in this report. The findings and recommendations were designed to offer a range of provider-specific input that can be acted upon to help individual providers engage in and contribute to the proposed system-wide improvements. At the time the final report was submitted to the Legacy Foundation in August 2017, two providers had not provided feedback on their summaries, and therefore, that material was not included in the public release report.

The MMHPI team is honored to have had the opportunity to work with the Valley Baptist Legacy Foundation and the many agencies that participated in the assessment. We appreciate the participation of the numerous county officials, providers, and other stakeholders in the Rio Grande Valley noted in Appendix A.

**Mental Health Needs and Capacity in the Rio Grande Valley**

This section of the report describes behavioral health needs and capacity. The findings on needs is based on data collected by MMHPI on the prevalence of mental health conditions in the Rio Grande Valley (RGV) in comparison to information on service capacity and utilization. Key findings are highlighted prior to the detailed discussion of the findings.
**Highlights – Population Based Summary of Mental Health Needs**

Of the 1.2 million RGV residents, one in four have some level of mental health needs.

- There are 45,000 adults and 25,000 children who have the most severe needs.
- Of these, approximately 35,000 adults and 20,000 children live in poverty.\(^4\)
- Annually, approximately 700 adults with highly complex needs become trapped in cycles of “super-utilization,” with about 500 in need of intensive behavioral health treatment and about 400 in need of forensically-focused intensive behavioral health treatment (with a small amount of overlap between the two groups).
- About 2,000 children and youth need time-limited, intensive home and community-based supports to return from or avoid out-of-home placements.
- There are about 200 new cases each year of psychosis (including schizophrenia) among older adolescents and young adults who need early treatment to avoid the risk of developing highly complex needs.
- Over 45,000 individuals (adults and children over the age of 12 years) in the RGV have an alcohol or substance use dependence disorder. Of these, over 40,000 are adults and over 4,000 are youth. Based on national prevalence information, we estimate that 50% of the adults have a co-occurring mental health condition.

**Highlights – Capacity of Mental Health Services by Population**

- There is no comprehensive and complete repository of data collected for all behavioral health services, but the data that are collected indicate that the capacity of services is significantly below what is needed.
- About 76% of adults in the RGV who have a serious mental illness and live in poverty received some outpatient levels of services. It is not clear from the data whether these individuals received the appropriate level of care.
- About 50% (in the catchment area serving Starr County) and 26% (in the catchment area serving Cameron, Hidalgo, and Willacy counties) of children and youth with serious emotional disturbances and living in poverty receive ongoing treatment. However, very few receive intensive services: only 1% of children receiving ongoing care from TTBH and BRBHC are provided intensive services.
- For SUDs, specific data are not available to contrast needs with service capacity, but results from interviews suggest the need is well above current capacity.

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\(^4\) “in Poverty” defined as at or under 200% of the Federal Poverty Level
### Highlights – Largest Service Gaps

- According to our overall analysis of needs and utilization, as well as the findings from our site visits and interviews, the largest service gaps center on crisis services and ongoing intensive treatments that would provide alternatives to inpatient care for adults and out-of-home placements for children and youth.

- While there are many strengths in the services offered by many of the providers, there are significant resource limitations for behavioral health services for all populations, even more so for medically indigent individuals and families. These limitations include the following:
  - Across the board, services for all populations have not kept pace with population growth in the RGV.
  - While there are some excellent crisis services in specific communities, there is no system-wide crisis intervention program.
  - Crisis diversion services are dramatically underdeveloped for youth and adults.
  - As with the rest of Texas and most counties in the nation, a lack of resources for assertive case management for adults contributes to a cycle of “super-utilization.”
  - There is a very underdeveloped continuum of services between inpatient services and community-based outpatient services.
  - The co-occurring mental health and SUD delivery system is underdeveloped.
  - There are some effective intensive services for children and youth, but these are underdeveloped and access to crisis services and inpatient care is a challenge.
  - Additional significant service gaps include a lack of affordable housing in the RGV and a lack of residential treatment for alcohol and substance use disorders.
  - The criminal justice delivery system for individuals with behavioral health needs is developing, but has significant gaps in services that lead to incarceration rather than treatment.
  - Access to services for veterans is increasing but the stigma of mental illness continues to be a significant barrier to seeking treatment.

Specific findings on needs and capacity are more fully described in the following sections.
Finding NC-1: Mental Health Needs (N) and Capacity (C) in the Rio Grande Valley

The Rio Grande Valley comprises four rural counties – Cameron, Hidalgo, Star, and Willacy – located in the southernmost part of Texas along the Mexican border. These counties cover 4,316 square miles and have 47 incorporated cities and towns with populations ranging from 307 individuals in Granjeno to 138,082 in McAllen, along with numerous unincorporated communities. The total population of this region is about 1.2 million people ages six or older, with over 90% residing in Cameron and Hidalgo counties. Compared to other Texas counties, the poverty rate in this region is relatively high, with nearly two thirds of residents living in poverty.

Population Estimates for Rio Grande Valley (RGV) Area Counties

<table>
<thead>
<tr>
<th>County</th>
<th>Total 2015 Population Age 6+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>25,050,000</td>
</tr>
<tr>
<td>Cameron County</td>
<td>380,000</td>
</tr>
<tr>
<td>Hidalgo County</td>
<td>750,000</td>
</tr>
<tr>
<td>Starr County</td>
<td>55,000</td>
</tr>
<tr>
<td>Willacy County</td>
<td>20,000</td>
</tr>
<tr>
<td>RGV Area Total</td>
<td>1,200,000</td>
</tr>
</tbody>
</table>

This report is intended to address the needs of the entire population of the RGV because behavioral health needs affect the whole population, not just those who are indigent or served in the public sector. Because the prevalence of mental health needs of children ages 0–5 years are poorly understood, we have excluded children in that age range from all population and prevalence estimates. Overall in the region:

- In a 12-month period, one in three adolescents and one in five adults have mental health needs, and up to one in four adults and two in five adolescents have mental health and/or substance use disorders, based on the latest epidemiological research.

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5 Population is for 2015, and covers children and youth ages 6-17, and adults ages 18+. All population and prevalence estimates are rounded to reflect uncertainty in the underlying American Community Survey data and estimation process.


7 For the purposes of this report, “Rio Grande Valley (RGV) Area Counties” refers to the counties within the Valley Baptist Legacy Foundation’s funding area: Cameron, Hidalgo, Starr, and Willacy counties.

But, individual needs vary in intensity from very mild to extremely acute and chronic. An analogy to this is diagnosing cancer in primary care: many people have moles and benign masses, but a much smaller number actually develop life-threatening cancer.

- **About three out of every four (75%) friends and families of Texas voters are affected by mental health issues**, based on statewide surveys conducted by MMHPI. These same voter surveys find that the same proportion have family or loved ones affected by mental health as those who have family or loved ones affected by cancer.

- **We can also break down this population of people with severe needs in two further ways: severity and primary diagnosis.** We believe that one barrier to better treatment of mental illness is the tendency to group a range of diverse needs into a single, large group of “people with major mental illness” or “adults with serious mental illness.” This is not done for other severe medical conditions. For example, the most recent Texas Cancer Plan does not even note the total number of people in Texas with cancer (which is just over 500,000), nor does it break out the number of severe cases (e.g., “Stage Four” cases). Instead, the plan focuses on specific cancer conditions (e.g., breast cancer, prostate cancer) and the number of new cases that emerge each year (otherwise known as incidence).

**TECHNICAL NOTE:** The tables on the following pages list some of the most common mental illnesses and break out prevalence rates by severity for adults and children and youth. The population information is from 2015 and covers children and youth ages 6-17, and adults ages 18 and older.

- All population, prevalence, and need estimates are rounded to reflect uncertainty in the underlying American Community Survey data and estimation process.
- All percentages of people served are calculated with unrounded estimates of need (based on number of individuals served as reported by the state) in order to avoid misrepresentation.

For example, if our estimate of the number of people in need is 92, this number is rounded to 100 in the corresponding table to indicate that this is an estimate based on a sample. If six people were served, the percentage in need served would be calculated as 6/92 = 6.5%, which

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9 Meadows Mental Health Policy Institute (2014). *Texas Mental Health Survey.*
we would report in the same table. We would not calculate the percent served by using the rounded version of the number in need (e.g. 6/100 = 6%).

While the numbers associated with all behavioral health needs (approximately 340,000) may seem high, up to two thirds of pediatric needs and over 80% of adult needs (mild to moderate conditions) can be addressed by best practice integrated behavioral health services, allowing communities and health systems to focus their specialty resources on more severe subsets of need. For example, by identifying and addressing the needs of people with the highest utilization of expensive and/or restrictive care (less than 1% of the overall need includes the 700 adults with the highest complexity and service use, and just over an additional 1% includes the 2,000 children and youth with the most severe needs at risk of out-of-home and out-of-school placement), the use of resources can then shift in ways that have the potential to expand their reach.

**Twelve-Month Prevalence of Mental Health Disorders in RGV Area Counties in 2015**

<table>
<thead>
<tr>
<th>Mental Health Condition – Adults</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Adult Population</td>
<td>900,000</td>
</tr>
<tr>
<td>Population in Poverty</td>
<td>500,000</td>
</tr>
<tr>
<td><strong>All Behavioral Health Needs (Mild, Moderate, and Severe)</strong></td>
<td>220,000</td>
</tr>
<tr>
<td>Mild Conditions</td>
<td>90,000</td>
</tr>
<tr>
<td>Moderate Conditions</td>
<td>80,000</td>
</tr>
<tr>
<td>Serious Mental Illness (SMI)</td>
<td>45,000</td>
</tr>
<tr>
<td>Complex Needs**/ Super Utilization</td>
<td>700</td>
</tr>
<tr>
<td>Subset with High Forensic Needs</td>
<td>400</td>
</tr>
<tr>
<td>SMI in Poverty</td>
<td>35,000</td>
</tr>
</tbody>
</table>

---

12 “In poverty” refers to the number of individuals below 200% of the federal poverty level for the specified region.


## Mental Health Condition – Adults

<table>
<thead>
<tr>
<th>Specific Diagnoses 17</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia 18</td>
<td>5,000</td>
</tr>
<tr>
<td>First Episode Psychoses (FEP) Incidence – New Cases per Year Ages 18–34 19</td>
<td>200</td>
</tr>
<tr>
<td>Major Depression</td>
<td>65,000</td>
</tr>
<tr>
<td>Bipolar I Disorder</td>
<td>5,000</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>30,000</td>
</tr>
<tr>
<td>Alcohol Dependence Disorder</td>
<td>30,000</td>
</tr>
<tr>
<td>Drug Dependence Disorder</td>
<td>15,000</td>
</tr>
<tr>
<td>Number of Deaths by Suicide (including Children)</td>
<td>90</td>
</tr>
</tbody>
</table>

## Mental Health Condition – Children and Youth

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population – Children and Youth</td>
<td>6–17</td>
</tr>
<tr>
<td>Population in Poverty 20</td>
<td>6–17</td>
</tr>
<tr>
<td>All Behavioral Health Needs (Mild, Moderate, and Severe) 21</td>
<td>6–17</td>
</tr>
<tr>
<td>Mild Conditions</td>
<td>6–17</td>
</tr>
<tr>
<td>Moderate Conditions</td>
<td>6–17</td>
</tr>
<tr>
<td>Serious Emotional Disturbance (SED) 22</td>
<td>6–17</td>
</tr>
</tbody>
</table>

---


18 McGrath, J., et al. (2008). Schizophrenia: A concise overview of incidence, prevalence, and mortality. *Epidemiological Reviews*, 30, 67-76, p. 70. Literature on the prevalence of schizophrenia in adolescents is very sparse, perhaps non-existent. Based on the fact that estimates of the incidence (new cases) of schizophrenia include adolescents, we have roughly estimated 0.2% of the adolescent population has schizophrenia over a 12-month period.


20 “In poverty” refers to the number of individuals below 200% of the federal poverty level for the specified region.

21 National estimates of prevalence and severity breakouts unless otherwise cited are drawn from Kessler, R.C., et al. (2012). Severity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of Gen Psychiatry*, 62(6), 617-627. The data are from a study with youth. Kessler provides mild and moderate estimates for youth ages 13-17 years old and this rate has been applied to all children and youth ages 6-17. However, children aged 12 and under likely have lower prevalence of mental health disorders.

<table>
<thead>
<tr>
<th>Mental Health Condition – Children and Youth</th>
<th>Age Range</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>SED in Poverty</td>
<td>6–17</td>
<td>20,000</td>
</tr>
<tr>
<td>At-Risk of Out-of-Home / Out-of-School Placement</td>
<td>6–17</td>
<td>2,000</td>
</tr>
</tbody>
</table>

**Specific Disorders – Youth (unless otherwise noted)**

<table>
<thead>
<tr>
<th>Mental Health Condition</th>
<th>Age Range</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>12–17</td>
<td>10,000</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>12–17</td>
<td>3,000</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>12–17</td>
<td>6,000</td>
</tr>
<tr>
<td>Substance Use Disorders</td>
<td>12–17</td>
<td>10,000</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>12–17</td>
<td>300</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder – Children/Youth</td>
<td>6–17</td>
<td>2,000</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>12–17</td>
<td>1,000</td>
</tr>
<tr>
<td>Self-Injury/Harming Behaviors</td>
<td>12–17</td>
<td>15,000</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>12–17</td>
<td>8,000</td>
</tr>
<tr>
<td>First Episode Psychosis</td>
<td>12–17</td>
<td>70</td>
</tr>
</tbody>
</table>

**Specific Disorders – Children Only**

<table>
<thead>
<tr>
<th>Mental Health Condition</th>
<th>Age Range</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Anxiety Disorders – Children</td>
<td>6–11</td>
<td>15,000</td>
</tr>
<tr>
<td>Depression/All Mood Disorders – Children</td>
<td>6–11</td>
<td>2,000</td>
</tr>
<tr>
<td>Schizophrenia – Childhood Onset (before age 12)</td>
<td>6–11</td>
<td>4</td>
</tr>
</tbody>
</table>

The previous tables break out several specific subgroups:

- **Adults with highly complex needs caught in cycles of “super utilization”:** The concept

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24 Androutsos, C. (2012). Schizophrenia in children and adolescents: Relevance and differentiation from adult schizophrenia. *Psychiatriki, 23*(Supl), 82-93 (original article in Greek). The estimate is that among adolescents ages 13–18, 0.23% meet criteria for the diagnosis of schizophrenia. Another study from Sweden reported that 0.54% of adolescents were treated for psychotic disorders at least once during the ages of 13–19: Gillberg, C. et al. (2006). Teenage psychoses-epidemiology, classification, and reduced optimality in the pre-, per-, and neonatal periods. *Journal of Child Psychology and Psychiatry, 27*(1), 87-98.


of “super utilization” refers to the experience of about 700 adults with SMI who have the most complex needs (e.g., mental health plus substance use, other physical illnesses, housing instability) and whom systems repeatedly fail to engage and help, despite the provision of extremely high rates of services through hospitals (inpatient and emergency services) and jails. These people tend to have unmet needs related to multiple chronic conditions that are inadequately treated (or adequately treated for too short a time) and, as a result, experience repeat acute episodes of illness over multiple years.

Discussion of severe needs often focuses on inpatient bed utilization or overuse of jails, but the reality is that people with severe needs do not stay very long in these settings. Most adult inpatient stays last for less than a week, and the vast majority of those who stay longer at state hospitals are in care for weeks or months, rather than years. As a result, the vast majority of people in need are in the community. However, not all of the 45,000 adults in the Rio Grande Valley area with the most severe needs (referred to as serious mental illness or SMI) are at equal risk of emergency room or jail use. Two careful studies of the proportion of adults with SMI who are at high risk of homelessness, emergency room use, and inpatient use each year and those at risk of repeat forensic involvement suggest that the number of adults at highest risk—a group referred to as having high complexity—totals approximately 700 people per year, of whom about 400 need a forensically-focused version of such care, such as Forensic Assertive Community Treatment (FACT).

- **Children and youth at risk of out-of-home and out-of-district placements:** Similarly, of the nearly 25,000 children and youth with the most severe needs (referred to as serious emotional disturbance, or SED), a much smaller number (just under 2,000 per year) have needs severe enough to put them at risk of not being able to live at home or stay in school.

- **First episode psychosis:** Note that the number of people who develop schizophrenia is a subset of the people for whom an initial psychosis emerges. While approximately 70 adolescents and young adults each year will manifest a first episode of psychosis, not all develop schizophrenia. However, the total number of people with schizophrenia is

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29 Some individuals would qualify for both ACT and FACT, so the estimates include an overlap of about 100 people.
much larger (approximately 5,000) because many, if not most, people with psychosis fail to receive timely and effective treatment and thus experience the disorder for long periods of time.

Many of the recommendations in this report focus on a much smaller subset of need – the 55,000 people (about 35,000 adults and 20,000 children and youth) in poverty (under 200% FPL) with the most severe needs – as the benchmark of need to be met by the public behavioral health treatment systems. However, we also recommend the more widespread implementation of integrated health (IBH) care in primary care settings that, through earlier detection and intervention, can reduce the number of serious/severe conditions that involve significant reductions in functioning.

The following table provides estimates of SMI and SED among people living in poverty by county and in the RGV (Valley Baptist Legacy Foundation region).

**Twelve-Month Prevalence of Adults with SMI and Children/Youth with SED Living at or Below 200% FPL for Rio Grande Valley (RGV) Area Counties in 2015**

<table>
<thead>
<tr>
<th>Region</th>
<th>Adults with SMI</th>
<th>SMI Under 200% FPL</th>
<th>Children &amp; Youth with SED</th>
<th>SED Under 200% FPL</th>
<th>SMI + SED</th>
<th>SMI + SED Under 200% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>960,000</td>
<td>540,000</td>
<td>370,000</td>
<td>210,000</td>
<td>1,350,000</td>
<td>750,000</td>
</tr>
<tr>
<td>Cameron</td>
<td>15,000</td>
<td>10,000</td>
<td>8,000</td>
<td>6,000</td>
<td>20,000</td>
<td>15,000</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>30,000</td>
<td>20,000</td>
<td>15,000</td>
<td>15,000</td>
<td>45,000</td>
<td>35,000</td>
</tr>
<tr>
<td>Starr</td>
<td>2,000</td>
<td>2,000</td>
<td>1,000</td>
<td>700</td>
<td>3,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Willacy</td>
<td>800</td>
<td>600</td>
<td>300</td>
<td>200</td>
<td>1,000</td>
<td>800</td>
</tr>
<tr>
<td>Rio Grande Valley</td>
<td>45,000</td>
<td>35,000</td>
<td>25,000</td>
<td>20,000</td>
<td>70,000</td>
<td>55,000</td>
</tr>
</tbody>
</table>

The table on the following page shows the estimated prevalence of alcohol and drug dependence across each of the Rio Grande Valley counties in comparison to Texas as a whole. We are focusing on dependence (rather than both use and dependence) in order to emphasize the number of people who are most in need of substance use disorder treatment services. However, attending to substance use sometimes is crucial to overall treatment. For example, while specific data are not readily available, MMHPI epidemiological experts estimate that about 50% of adults with SMI have co-occurring substance use disorders. In the RGV, that

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Estimates of SMI and SED are taken from the following source: Holzer, C., Nguyen, H., & Holzer, J. (2015). *Texas county-level estimates of the prevalence of severe mental health need in 2015.* Dallas, TX: Meadows Mental Health Policy Institute. Because of rounding, the sum of rounded estimates may not equal the rounded sum of exact estimates.
would indicate that nearly 22,500 adults with SMI have a co-occurring substance use disorder that, if not treated in a way that is integrated with mental health treatment, would significantly interfere with their recovery.

### Twelve-Month Prevalence of Alcohol/Drug Dependence, Rio Grande Valley, 2015\(^\text{32}\)

<table>
<thead>
<tr>
<th>Region</th>
<th>Estimated Prevalence of Alcohol and Drug Dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adults Alcohol</td>
</tr>
<tr>
<td>Texas</td>
<td>630,000</td>
</tr>
<tr>
<td>Cameron</td>
<td>9,000</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>15,000</td>
</tr>
<tr>
<td>Starr</td>
<td>1,000</td>
</tr>
<tr>
<td>Willacy</td>
<td>500</td>
</tr>
<tr>
<td>Rio Grande Valley</td>
<td>30,000</td>
</tr>
</tbody>
</table>

### Finding NC-2: Core Public Outpatient System Capacity for Adults with Severe Needs

There is no comprehensive and complete repository of data for all the outpatient mental health services provided to adults who live in poverty. However, we do have data on LMHA services, which constitute the vast majority of outpatient, community-based care for people with SMI.

Much of the analysis in this section focuses on the service areas of the Border Region Behavioral Health Center (which serves Starr County, plus three additional counties), Tropical Texas Behavioral Health (which serves Cameron, Hidalgo, and Willacy counties), and two other local mental health authority (LMHA) service areas in geographically and demographically similar regions. Camino Real Community Services (CRCS) serves nine counties in a primarily rural and frontier area of the state, and Coastal Plains Community Center (CPCC) serves nine counties in the coastal bend region of South Texas.

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\(^{33}\) County-level alcohol and drug dependence estimates presented in the table are rounded to reflect the degree of error present within the prevalence estimation methodology. Rio Grande Valley prevalence estimate totals are based on the summation of unrounded county estimates, and in turn, do not reflect the summation of the rounded county estimates shown above.
Note that the 12-month prevalence data for each LMHA region within the Rio Grande Valley area have been included in some tables. Because the Border Region Behavioral Health Center serves a large area outside of the Valley Baptist Legacy Foundation (VBLF) region (three counties in addition to Starr), the sum of the numbers of people with SMI and SED in the Tropical Texas Behavioral Health (TTBH) and Border Region Behavioral Health Center (BRBHC) LMHA areas do not match the VBLF region total. Additionally, some of the tables show that, compared to TTBH, BRBHC serves a slightly higher percentage of need within its catchment area. However, it should be noted that, compared to BRBHC, TTBH has a significantly larger number of people in need of services and less funding per person, and it provides a higher level of service intensity.

The data in the following table reflect the services provided by BRBHC and TTBH, which document that 26% of those in need of care in the BRBHC catchment area and 24% of those in need of care in the TTBH catchment area received services across all outpatient levels of care (LOCs\textsuperscript{34}). These penetration rates are lower than the rates of comparison LMHAs (for Camino Real Community Services [CRCS], 45% of those in need received services; for Coastal Plains Community Center [CPCC], 59% of those in need received services).

<table>
<thead>
<tr>
<th>Adults</th>
<th>Border Region Behavioral Health Center (all counties)*</th>
<th>Tropical Texas Behavioral Health</th>
<th>Camino Real Community Services</th>
<th>Coastal Plains Community Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMI 200% FPL\textsuperscript{35}</td>
<td>9,000</td>
<td>35,000\textsuperscript{36}</td>
<td>4,000</td>
<td>5,000</td>
</tr>
<tr>
<td>All LOCs Served\textsuperscript{37}</td>
<td>2,360</td>
<td>8,067</td>
<td>1,922</td>
<td>2,900</td>
</tr>
</tbody>
</table>


\textsuperscript{35} Data is for 2015 and was obtained from Dr. Charles Holzer. Holzer, C., Nguyen, H., Holzer, J. (2016). Texas county-level estimates of the prevalence of severe mental health need in 2015. Dallas, TX: Meadows Mental Health Policy Institute.

\textsuperscript{36} The estimate for the number of individuals with SMI below 200% FPL within the Tropical Texas Behavioral Health region (35,000) is the same as the estimate for the Rio Grande Valley region. This is because Starr County, which is included in the RGV area but not in the Tropical Texas Behavioral Health Area, only has 1,700 estimated cases of SMI below 200% FPL. This number is not significant enough to change the rounded estimate.

The following table illustrates the per capita funding level for the benchmark LMHAs. Relative to CRCS and CPCC, BRBHC and TTBH are considerably under-funded, which helps explain their lower penetration rates. The column labeled “Per Capita Funding <200% FPL” provides the prospective per capita rate for adults and children/youth living in poverty. The column labeled “Per Capita SED/SMI Funding” provides the prospective per capita rate for the estimated SED/SMI population. In both cases, TTBH is the lowest-funded LMHA, or 39th of 39 LMHAs. BRBHC is second to last in each case. The 2018 waitlist, population growth, enhanced waitlist avoidance, and equity funding did not improve either LMHA’s relative standing.

**Per Capita Funding by TTBH, BRBHC and Comparison LMHAs for FY 2018-2019**

<table>
<thead>
<tr>
<th>LMHA</th>
<th>Per Capita Funding &lt;200% FPL</th>
<th>Per Capita SED/SMI Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Border Region Behavioral Health Center</td>
<td>$30.30</td>
<td>$419.27</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health</td>
<td>$30.09</td>
<td>$417.39</td>
</tr>
<tr>
<td>Camino Real Community Services</td>
<td>$47.65</td>
<td>$706.93</td>
</tr>
<tr>
<td>Coastal Plains Community Center</td>
<td>$68.97</td>
<td>$907.72</td>
</tr>
</tbody>
</table>

The following table illustrates the distribution of services across the Behavioral Health Services Section of HHSC-defined levels of care (LOCs), showing comparisons across the selected LMHAs. HHSC contracts with LMHAs to provide defined LOCs, referred to as Texas Resiliency and Recovery (TRR) levels of care. The LOCs are categorized by graduated levels of intensity to meet the various levels of service needs of children, youth, and adults entering the public mental health system.

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38 Border Region Behavioral Health Center serves Jim Hogg, Starr, Webb, and Zapata counties.
39 Tropical Texas Behavioral Health serves Cameron, Hidalgo, and Willacy counties.
40 Camino Real Community Services serves Atascosa, Dimmit, Frio, La Salle, Karnes, Maverick, McMullen, Wilson, and Zavala counties.
41 Coastal Plains Community Center serves Aransas, Bee, Brooks, Duval, Jim Wells, Kenedy, Kleberg, Live Oak, and San Patricio counties.
There are five adult LOCs for ongoing mental health services:

- **Medication Management (A1M):** This is the lowest level of service, typically involving less than an hour of care per month, generally for people who are stable and in a maintenance phase needing only medication. LMHAs rarely deliver this level of care.

- **Skills Training (A1S):** This also involves a low level of service, combining medication management with an hour or two of psychosocial rehabilitation and minimal case management. This is the more typical level of care delivered to people who are in a stable phase of treatment and only need minimal support.

- **Medication and Therapy (A2):** This adds two to three hours of evidence-based counseling to the service mix. This level of care is for people primarily in need of therapy for depression or anxiety (including severe anxiety, such as post-traumatic stress) in addition to medication and minimal support.

- **Team-Based Treatment (A3):** This is a more intense level of care for people with severe needs and significant gaps in functioning who are in need of active treatment and psychosocial skills training. Most people with serious mental illness who are not stable would need this level of care.

- **Assertive Community Treatment (ACT) (A4):** This is the highest level of service intensity, emphasizing prevention of repeated psychiatric hospitalizations and coordinating an array of services to meet other intensive and complex needs (e.g., housing stability, ongoing justice system involvement, co-occurring substance use). ACT is designed for people with serious mental illness who are not involved with the criminal justice system but still caught in cycles of “super utilization,” as noted above in the needs section of this report.\(^{42}\)

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

- **Crisis Response:** This is the initial response to a crisis through brief intervention, either by mobile crisis teams or through services at a facility, and can involve up to six days of follow-up.

- **Transitional:** This involves up to 90 days of additional crisis transition services until the situation is resolved.

The table below illustrates that, relative to the comparison counties, TTBH and BRBHC are providing more crisis care, but they are not serving more people in the higher levels of ongoing outpatient care. In fact, slightly lower percentages of people receiving ongoing outpatient levels of care through TTBH and BRBHC are served at team-based case management and Assertive Community Treatment (ACT) levels of care, relative to the other two comparison LMHAs.

The higher level of crisis service delivery in the RGV can be partially attributed to the innovative and robust crisis response system offered by TTBH, which includes services such as Mobile Crisis Outreach Teams (MCOTs) and partnerships with local law enforcement through the Mental Health Peace Officer (MHOT) program.

Adult Levels of Care Analysis, FY 2016

<table>
<thead>
<tr>
<th>LMHA / Region</th>
<th>Crisis Continuum</th>
<th>Ongoing Treatment Levels</th>
<th>Total Non-Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Crisis Response</td>
<td>Crisis Transition</td>
<td>Medication Management</td>
</tr>
<tr>
<td>BRBHC</td>
<td>499</td>
<td>174</td>
<td>*</td>
</tr>
<tr>
<td>% of LOCs</td>
<td>16%</td>
<td>6%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>TTBH</td>
<td>2,944</td>
<td>233</td>
<td>97</td>
</tr>
<tr>
<td>% of LOCs</td>
<td>26%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Camino Real</td>
<td>474</td>
<td>142</td>
<td>0</td>
</tr>
<tr>
<td>Real Comm.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of LOCs</td>
<td>19%</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>Coastal</td>
<td>370</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Plains</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comm. Ctr.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of LOCs</td>
<td>11%</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Most important is the fact that not enough people who receive crisis services subsequently have access to the more intensive team-based and ACT levels of ongoing outpatient care. For example, while we have estimated that about 500 people in the RGV need access to ACT annually, the ACT Comparative Analysis Table on page 19 shows that only about 39% of people in need in the RGV area actually receive ACT each year.

In 2015, Dr. Paul Rowan published a report that examined mental health service utilization patterns among adults with SMI and their respective federal payer sources between 2010 and

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43 A notation of “*” indicates five or fewer clients receiving the specified level of care.
44 See the estimate in the table “ACT Comparative Analysis – Adults with SMI in Poverty Known to Have Received ACT” on page 19. In a 12-month period, we estimate that 4.3% of RGV adults with SMI and living in poverty will need ACT level of care.
2012. Abstracted from Rowan’s report, the following table summarizes the number of adults on Medicaid with SMI who received inpatient and or outpatient services across each LMHA services area. This data does not reflect the total number of adults on Medicaid with SMI who received outpatient mental health services; some adults with SMI may have received treatment from non-LMHA providers.

**Unduplicated Number of Adults with Medicaid who Received Behavioral/Mental Health Services in Each LMHA Catchment Area, 2012**

<table>
<thead>
<tr>
<th>LMHA Catchment Area</th>
<th># of Adults with SMI Receiving BH Services through Medicaid</th>
<th># of Medicaid Adults Receiving Psychiatric Inpatient Services</th>
<th># of Medicaid Adults Receiving Mental Health Outpatient Services through LMHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Border Region Behavioral Health Center</td>
<td>3,392</td>
<td>125</td>
<td>928</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health</td>
<td>15,841</td>
<td>908</td>
<td>2,910</td>
</tr>
<tr>
<td>Camino Real Community Services</td>
<td>2,601</td>
<td>51</td>
<td>733</td>
</tr>
<tr>
<td>Coastal Plains Community Center</td>
<td>3,438</td>
<td>203</td>
<td>897</td>
</tr>
</tbody>
</table>

**Assertive Community Treatment (ACT).** ACT penetration can be examined using two different levels: (1) the need for ACT services can be based upon the estimated number of people with SMI at 200% FPL or (2) the need for ACT services based upon the actual number of people with SMI served within the public behavioral health system. The following table summarizes the degree of ACT penetration across LMHAs based on the proportion of consumers in need of ACT among low-income individuals with SMI. On average, LMHAs across Texas meet 25% of the estimated need for ACT when considering the need among people with SMI living below 200% FPL. This analytic approach suggests that BRBHC exceeds the Texas statewide benchmark for ACT services across LMHAs, while TTBH is serving only 28% of the estimated need.

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### ACT Comparative Analysis – Adults with SMI within the Public Mental Health System Known to Have Received ACT

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Adults with SMI Served in Public System</th>
<th>Need ACT</th>
<th>People Receiving ACT</th>
<th>Percent of the Number in Need of ACT Who Received ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>3,850,000</td>
<td>170,000</td>
<td>61,215</td>
<td>37%</td>
</tr>
<tr>
<td>Arizona</td>
<td>45,000</td>
<td>2,000</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Maricopa County</td>
<td>30,000</td>
<td>1,000</td>
<td>2,093</td>
<td>160%</td>
</tr>
<tr>
<td>California</td>
<td>380,000</td>
<td>15,000</td>
<td>6,282</td>
<td>38%</td>
</tr>
<tr>
<td>Colorado</td>
<td>70,000</td>
<td>3,000</td>
<td>5,488</td>
<td>182%</td>
</tr>
<tr>
<td>Denver City – County</td>
<td>15,000</td>
<td>700</td>
<td>1,300</td>
<td>188%</td>
</tr>
<tr>
<td>Nebraska</td>
<td>10,000</td>
<td>500</td>
<td>115</td>
<td>23%</td>
</tr>
<tr>
<td>New York</td>
<td>420,000</td>
<td>20,000</td>
<td>6,203</td>
<td>34%</td>
</tr>
<tr>
<td>New York City</td>
<td>10,000</td>
<td>500</td>
<td>726</td>
<td>155%</td>
</tr>
<tr>
<td>Texas</td>
<td>260,000</td>
<td>10,000</td>
<td>4,552</td>
<td>41%</td>
</tr>
<tr>
<td>Border Region Behavioral Health Center</td>
<td>2000</td>
<td>100</td>
<td>57</td>
<td>57%</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health</td>
<td>8,000</td>
<td>300</td>
<td>112</td>
<td>37%</td>
</tr>
<tr>
<td>Camino Real Community Services</td>
<td>2,000</td>
<td>80</td>
<td>59</td>
<td>74%</td>
</tr>
<tr>
<td>Coastal Plains Community Center</td>
<td>3,000</td>
<td>100</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

46 The state-level proportion of people served with a serious mental illness is reported from SAHMSA (2014) Mental Health NOMS: Central for Mental Health Services Uniform Reporting System. Retrieved from http://www.samhsa.gov/data/us_map?map=1

We calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI.

47 Based on an analysis by Cuddeback, G.S., Morrissey, J.P., & Meyer, P.S. (2006). How many assertive community treatment teams do we need? Psychiatric Services, 57, 1803-1806. For the purposes of comparison, these figures only include those adults with highly complex needs in need of ACT; they do not include those in need of Forensic Assertive Community Treatment (FACT).


49 In some instances, the number of people receiving ACT services exceeds the estimated number of people in need of ACT level services. In these cases, the percentage of people in need of ACT who received these services will be greater than one-hundred percent (100%). Although the ACT estimation formula applied within this analysis is standardized, ACT eligibility and service capacity vary across states and municipal regions and likely included different factors that influenced ACT service funding and performance in those respective regions.
When only people “known” within the publicly funded behavioral health system are examined, Texas exceeds the national per capita benchmark for ACT services compared to other select states and regions. Camino Real Community Services is approaching a best-practice benchmark, serving 74% of the estimated ACT need in its region. Based on this analysis, BRBHC’s two ACT teams should be capable of meeting the entire estimated need for ACT services within their region.

The quality of delivered ACT services is also important. Best-practice ACT services – including those in Texas – seek to systematically promote consistent outcomes across programs over time through a comprehensive process of interactive, qualitative fidelity monitoring using best-practice measures. Such an approach is particularly critical because high fidelity implementation of programs such as ACT is a predictor of good outcomes and of system-wide cost savings. Rigorous fidelity assessment also provides a basis for needed service delivery enhancements within a continuous quality improvement (CQI) process. In effect, qualitative clinical services monitoring will help ensure fidelity to the ACT model, evaluate whether settlement stipulations are being met, and contribute to a continuous quality improvement process.

TTBH employs the use of the current state-of-the-art Tool for Measurement of Assertive Community Treatment (TMACT) in monitoring and reporting on the fidelity of its operating ACT teams. The TMACT is the current standard in the field and represents the best currently known way to promote high quality ACT services. While TTBH uses the TMACT to guide its CQI process, most Texas providers instead continue to use the Dartmouth Assertive Community Treatment Scale (DACTS) developed in the late 1990s. Key advantages of the TMACT model include the following:

- More specialized requirements for staffing and role functioning for peer, housing, and substance use specialists on the team.
- Dynamic caseload modeling that allows caseloads to flex up or down depending on levels of staffing. This allows more flexible service delivery than the Texas standards, as caseloads for a standard team of 100 could maintain full fidelity and range as high as 125 (thus allowing for more capacity, alongside the enhanced staffing requirements).

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

TMACT also emphasizes movement on and off teams:
- It requires teams operating below full capacity (TMACT Standard OS7) to “actively [recruit] new consumers who could benefit from ACT, including assertive outreach to referral sites...[and] common referral sources and sites outside of usual community mental health settings (e.g., state and community hospitals, ERs, prisons/jails, shelters, street outreach).”
- It also requires teams to work to graduate consumers to lower levels of care through “regular assessment of need for ACT services [for current team members],” “explicit criteria or markers for need to transfer to less intensive service option[s],” and “gradual and individualized” transition “with assured continuity of care” and monitoring following transition, with “an option to return to team as needed” (TMACT Standard OS9).

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

HHSC defines supported housing as “[a]ctivities to assist individuals in choosing, obtaining, and maintaining regular, integrated housing. Services consist of individualized assistance in finding and moving into habitable, regular, integrated (i.e., no more than 50% of the units may be occupied by individuals with serious mental illness), and affordable housing.” The two main components of supported housing are the following:

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

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

The following table illustrates that access to supported housing is very low in most states and communities, including Texas and the RGV. Clients receiving supported housing services through TTBH reside in independent apartments throughout the TTBH catchment area (Cameron, Hidalgo, and Willacy counties).

**Adults with SMI in Poverty Known to Have Received Supported Housing (SH)**

<table>
<thead>
<tr>
<th>Region/LMHA</th>
<th>Adult SH Need</th>
<th>Adults Receiving SH</th>
<th>Percent of Need Receiving SH</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>3,550,000</td>
<td>75,875</td>
<td>2.40%</td>
</tr>
<tr>
<td>Arizona&lt;sup&gt;57&lt;/sup&gt;</td>
<td>40,000</td>
<td>2,396</td>
<td>5.70%</td>
</tr>
<tr>
<td>Denver City – County&lt;sup&gt;58&lt;/sup&gt;</td>
<td>15,000</td>
<td>1,650</td>
<td>11.20%</td>
</tr>
<tr>
<td>New York State&lt;sup&gt;59&lt;/sup&gt;</td>
<td>430,000</td>
<td>22,895</td>
<td>5.40%</td>
</tr>
<tr>
<td>Texas</td>
<td>540,000</td>
<td>14,130</td>
<td>3%</td>
</tr>
<tr>
<td>Border Region Behavioral Health Center&lt;sup&gt;55&lt;/sup&gt;</td>
<td>9,000</td>
<td>149</td>
<td>2%</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health</td>
<td>35,000</td>
<td>832</td>
<td>3%</td>
</tr>
<tr>
<td>Camino Real Community Services</td>
<td>4,000</td>
<td>221</td>
<td>5%</td>
</tr>
<tr>
<td>Coastal Plains Community Center</td>
<td>5,000</td>
<td>305</td>
<td>6%</td>
</tr>
</tbody>
</table>

<sup>55</sup> When we have benchmarks for evidence-based practices outside of Texas, we use the total estimated number of people with SMI in each region, applying a 58% factor based on Texas data to estimate the number who are living in poverty in order to better facilitate comparisons to the communities outside of Texas.


New York State “Received SH” data were estimated based on average lengths of stay and quarterly capacity and occupancy data. Texas data is for FY2015, and was provided from DSHS.


<sup>58</sup> Data received from Roy Starks and Kristi Mock of the Mental Health Center of Denver (personal communication, March 2014).

**Supported Employment (SE).** Supported Employment is an evidence-based practice that promotes rehabilitation and a return to mainstream employment for individuals with psychiatric disabilities in order to help them get and keep competitive employment. Supported Employment programs integrate employment specialists with other members of the treatment team to ensure that employment is an integral part of the treatment plan. HHSC defines Supported Employment as “competitive employment in an integrated work setting, consistent with the consumer’s strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.”\(^{60}\)

A considerable body of research indicates that specific Supported Employment models, such as Independent Placement and Support (IPS), are successful in increasing competitive employment among adults with SMI.\(^{61}\) In addition, the research consistently shows that SE is effective across a broad range of individual factors, such as diagnosis, age, gender, disability status, prior hospitalization, co-occurring substance use disorder, and education.\(^{62}\) As a result, the research literature recommends providing SE to all individuals with mental illnesses and/or co-occurring disorders who want to work, regardless of prior work history, housing status, or other population characteristics.\(^{63}\) A review of three randomized controlled trials found that, in general, 60-80% of people served by a SE model obtain at least one competitive job.\(^{64}\) Research suggests that about half of adults with SMI want to work.

In Texas, Supported Employment is not a billable service in and of itself, either for Medicaid (through fee for service or managed care organizations) or for state funds. Instead, many services that support a person getting and keeping employment can be billed under rehabilitation as skills training or psychosocial rehabilitation. Formal vocational rehabilitation (VR) services must be coordinated with the Department of Assistive and Rehabilitative Services (DARS). One coordination issue involves the DARS intake and eligibility process, which often entails substantial delays and works optimally only where there are strong relationships

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60 Retrieved from: https://hhs.texas.gov/node/44961  
between the mental health clinician and the DARS VR counselor. In a large system, this is particularly challenging. In addition, Targeted Case Management is billable under Medicaid. The Medicaid 1915(i) State Plan Amendment that Texas approved in late 2015 provides a more comprehensive and formal SE benefit for eligible individuals.\(^{65}\)

The following table illustrates that some systems have made SE available to a relatively high percentage of adults with SMI; in general, Texas provides more limited access. BRBHC and TTBH document a lower frequency in the provision of SE services than comparison centers, with zero to 4% of individuals in need of SE receiving the service.

### Adults with SMI in Poverty Known to Have Received Supported Employment (SE)\(^{66}\)

<table>
<thead>
<tr>
<th>Region/LMHA</th>
<th>Adult Population With SMI in Poverty(^{67})</th>
<th>Adults Needing SE(^{68})</th>
<th>Adults Receiving SE(^{69})</th>
<th>Percent of Need Receiving SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>3,550,000</td>
<td>1,800,000</td>
<td>54,190</td>
<td>3%</td>
</tr>
<tr>
<td>Arizona</td>
<td>120,000</td>
<td>60,000</td>
<td>12,137</td>
<td>21%</td>
</tr>
<tr>
<td>Maricopa County(^{70})</td>
<td>70,000</td>
<td>35,000</td>
<td>7,366</td>
<td>20%</td>
</tr>
<tr>
<td>California</td>
<td>550,000</td>
<td>280,000</td>
<td>893</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Colorado</td>
<td>120,000</td>
<td>60,000</td>
<td>1,380</td>
<td>2%</td>
</tr>
<tr>
<td>Denver City – County(^{71})</td>
<td>15,000</td>
<td>7,000</td>
<td>680</td>
<td>9%</td>
</tr>
<tr>
<td>New York (state)</td>
<td>460,000</td>
<td>230,000</td>
<td>1,634</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Texas</td>
<td>540,000</td>
<td>270,000</td>
<td>16,284</td>
<td>6%</td>
</tr>
</tbody>
</table>


\(^{66}\) FY 2015 data for LMHAs received from DSHS (personal communication, April 13, 2016). Texas data are from FY 2015. Data for communities outside of Texas are from 2013 for Arizona and Colorado; for New York and California, population data are from 2012 and data on the number of people receiving Supported Employment are from 2013.

\(^{67}\) All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. All percentages are calculated with unrounded figures.

\(^{68}\) The unemployment rate for people with SMI served in publicly funded mental health systems is approximately 90%, but research shows about 50% of people with SMI want vocational help. These rates were applied to SMI prevalence of each region to determine estimated need for Supported Employment.

\(^{69}\) State-level figures are based on state authorized mental health services, including Medicaid enrollees, reported in the SAMHSA’s NOMS system in 2012. Retrieved from [http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx](http://media.samhsa.gov/dataoutcomes/urs/urs2012.aspx)


\(^{71}\) Data received from Roy Starks and Kristi Mock of the Mental Health Center of Denver (personal communication, March 2014).
<table>
<thead>
<tr>
<th>Region/LMHA</th>
<th>Adult Population With SMI in Poverty</th>
<th>Adults Needing SE</th>
<th>Adults Receiving SE</th>
<th>Percent of Need Receiving SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Border Region Behavioral Health Center</td>
<td>9,000</td>
<td>5,000</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health</td>
<td>35,000</td>
<td>15,000</td>
<td>645</td>
<td>4%</td>
</tr>
<tr>
<td>Camino Real Community Services</td>
<td>4,000</td>
<td>2,000</td>
<td>232</td>
<td>11%</td>
</tr>
<tr>
<td>Coastal Plains Community Center</td>
<td>5,000</td>
<td>2,000</td>
<td>228</td>
<td>9%</td>
</tr>
</tbody>
</table>

**Peer Support.** A key best practice in service delivery is the use of peer support through certified peer specialists and family partners. Certified peer specialists are individuals who have experience living with a serious mental illness and receiving treatment. In the case of family partners, these individuals have parented a child with SED. In both cases, they have received training and certification to use their experience to help others feel a sense of hope and to assist with practical support as the people they serve go through a similar experience. Training peers offers an employment opportunity for individuals with lived experience of mental illness and expands the available workforce in scarcely resourced areas. Texas has engaged in a significant effort during the past decade to expand access to training and certification of peer specialists (for adults with SMI), family partners (for families of children with SED), and recovery coaches (for adults with SUD). The 85th Legislature approved Medicaid reimbursement for peer support, and rules to allow that will be developed in FY 2018.

Peer support has been designated as an evidence-based model since 2007 by the federal Centers for Medicare and Medicaid Services, and there is good evidence of its effectiveness and emerging evidence of its cost-effectiveness. However, Texas has relatively few peer providers compared to other states. According to the September 2014 Department of State Health Services report on the mental health workforce shortage, as of January 2014, Texas had 333 certified peer specialists, 99 certified family partners, and “over 300” recovery coaches, for

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73 Hogg Foundation for Mental Health (2014, October). *Peer support services outcomes.*
a total of just over 700 peer providers (2.75 per 100,000 Texans).\textsuperscript{75} By comparison, Pennsylvania has over 9.0 peers per 100,000 population.\textsuperscript{76}

The data in the following table illustrate that, although TTBH has hired many trained peer specialists, the number of individuals certified as peer specialists in the RGV area (per 100,000 individuals with SMI who are in need of services) is significantly lower than in the comparison LMHAs selected for this report and in Texas as a whole. At the time of our site visits, TTBH had hired 22 certified peers and family partners. BBHRC reported no peer specialists in 2015, but, at the time of the site visits, had hired two family partners.

<table>
<thead>
<tr>
<th>Region / LMHA</th>
<th>Need for Adults in Poverty</th>
<th>Trained Peer Specialists\textsuperscript{77}</th>
<th>Specialists per 100,000 SMI in Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>540,000</td>
<td>622</td>
<td>115</td>
</tr>
<tr>
<td>Border Region Behavioral Health Center</td>
<td>9,000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health</td>
<td>35,000</td>
<td>22</td>
<td>67</td>
</tr>
<tr>
<td>Camino Real Community Services</td>
<td>4,000</td>
<td>3</td>
<td>71</td>
</tr>
<tr>
<td>Coastal Plains Community Center</td>
<td>5,000</td>
<td>6</td>
<td>122</td>
</tr>
</tbody>
</table>

Finding NC-3: Other Adult Services Public Outpatient and Crisis System Capacity

The following table summarizes the overall adult service capacity across major outpatient public mental health service systems in the Rio Grande Valley. Our calculation of the number of unduplicated individuals served in outpatient settings indicates that there is capacity among the three major components of the system – BRBHC, TTBH, and the other Medicaid providers – to serve nearly two thirds (about 63%) of the estimated number of adults with SMI living in poverty, at least at some level of outpatient care. However, as indicated in the previous section,


\textsuperscript{76} MMHPI data collected internally.

\textsuperscript{77} For FY 2015, this is the number of trained peer support specialists by county in LMHA catchment areas (not LMHAs). The number of peer specialists with the LMHAs is different. “Trained Peer Specialist” represents the number of peer specialists who completed training and certification by October 2015. Not all trained certified peer specialists are currently employed as peer specialists. Data obtained from Dr. Stacey Manser, University of Texas (personal communication, September 9, 2016).
for many of those in need, the right types and intensities of care (Assertive Community Treatment, Supported Employment, and supported housing) are not always available.

**Adults Served by Core Public Providers vs. Adults in Need of Care, FY 2014**

<table>
<thead>
<tr>
<th>Adults Served</th>
<th>RGV Area Counties&lt;sup&gt;78&lt;/sup&gt;</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need: Adults in Poverty with Severe Needs (SMI 200% FPL Population)</td>
<td>35,000</td>
<td>Estimate of unduplicated cases served by core system.</td>
</tr>
<tr>
<td>Received Public Mental Health Outpatient Services at Any Level</td>
<td>21,762</td>
<td>Estimate of total served in ongoing levels of care.</td>
</tr>
<tr>
<td>Local Mental Health Authority (TTBH and BRBHC&lt;sup&gt;79&lt;/sup&gt;)</td>
<td>7,751</td>
<td></td>
</tr>
<tr>
<td>Health District</td>
<td>0</td>
<td>This is the unduplicated number of adults with SMI served in 2012; level of care received is not clear. More recent data than 2012 are not available from HHSC, and we believe this represents a conservative estimate of current service levels.</td>
</tr>
<tr>
<td>Medicaid FFS and HMO&lt;sup&gt;80&lt;/sup&gt;</td>
<td>14,011</td>
<td></td>
</tr>
<tr>
<td>Percent of Severe Need in Poverty Served by Core Public Providers</td>
<td>63%</td>
<td>Not necessarily served at the right level of care.</td>
</tr>
</tbody>
</table>

**Finding NC-4: Core Public Outpatient System Capacity for Children and Youth with Severe Needs**

The following table shows the number of children and youth with SED who received ongoing care through one of Texas’s specified levels of care in the two LMHAs in the VBLF service area. This number is relative to the estimated number of children/youth with SED living at/below 200% of the federal poverty level (FPL) in other regions. It is important to note that some, if not many, children and youth who have SED and who receive Medicaid could be receiving

<sup>78</sup> “RGV Area Counties” includes data from the four-county region included in this assessment: Cameron, Hidalgo, Starr, and Willacy.

<sup>79</sup> Data on number of adults from Starr County served by the Border Region Behavioral Health Center in FY 2015 received from Alda Rendon of the Border Region Behavioral Health Center (personal communication, August 17, 2016). To estimate the number of adults from Starr County served in ongoing levels of care by the LMHA, the proportion of the number of adults served in ongoing levels of care by BRBHC in FY 2015 and the total number of adults served by BRBHC in FY 2015 was applied to the total number of adults served by the LMHA in Starr County in FY 2015.

<sup>80</sup> Rowan, P. J., Begley, C., Morgan, R., Fu, S., & Zhao, B. (2014, September). Serious and persistent mental illness in Texas: County-level enrollee characteristics of Medicaid-supported SMI care, Texas, 2012. The University of Texas Health Sciences Center at Houston: School of Public Health. Retrieved from [https://sph.uth.edu/research/centers/chsr/assets/RowanEtAlCyLevelMedicaidSPMIMar2015.pdf](https://sph.uth.edu/research/centers/chsr/assets/RowanEtAlCyLevelMedicaidSPMIMar2015.pdf)
treatment from other non-LMHA providers. Nevertheless, it appears that TTBH is achieving a penetration rate that is somewhat lower than comparison LMHAs, while BRBHC is achieving a comparatively higher penetration rate.

**Unduplicated Number of Children and Youth with SED Living at or Below 200% FPL Who Were Served by the LMHA (September 2015 to August 2016)**

<table>
<thead>
<tr>
<th>LMHA/Region</th>
<th>Total Child / Youth Population in Poverty</th>
<th>Children / Youth with SED in Poverty</th>
<th>Children / Youth Served in Ongoing Treatment</th>
<th>Percent</th>
<th>Percent Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Border Region Behavioral Health Center</td>
<td>50,000</td>
<td>5,000</td>
<td>2,439</td>
<td>50%</td>
<td>83%</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health</td>
<td>200,000</td>
<td>20,000</td>
<td>4,827</td>
<td>26%</td>
<td>77%</td>
</tr>
<tr>
<td>Camino Real Community Services</td>
<td>20,000</td>
<td>2,000</td>
<td>855</td>
<td>44%</td>
<td>83%</td>
</tr>
<tr>
<td>Coastal Plains Community Center</td>
<td>20,000</td>
<td>2,000</td>
<td>931</td>
<td>48%</td>
<td>75%</td>
</tr>
</tbody>
</table>

The next table provides a comparison of the number of children on Medicaid, and how many children were served in inpatient and outpatient settings for each LMHA region.

**Children on Medicaid who Received Behavioral/Mental Health Services by Visit Type in Each LMHA Catchment Area, 2015**

<table>
<thead>
<tr>
<th>LMHA</th>
<th>Inpatient Children Served</th>
<th>Outpatient/Professional Children Served</th>
<th>Total Children Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Border Region Behavioral Health Center</td>
<td>255</td>
<td>8,517</td>
<td>8,520</td>
</tr>
</tbody>
</table>

81 “Children Served in Ongoing Treatment” data in this column are the unduplicated number served by the LMHA across LOCs C1, C2, C3, and C4, as well as CY (YES Waiver) and CYC (Young Child Services).
83 Data obtained from Texas Health and Human Services, April 2016. Data sources is AHQP Claims Universe, TMHP. ICD-10 Diagnoses codes were included because clients’ primary diagnoses is based on diagnosis at discharge. Diagnosis codes exclude substance abuse diagnoses. Client counts are not additive because clients may change counties and age groups during the fiscal year and thus may appear in more than one category.
<table>
<thead>
<tr>
<th>LMHA</th>
<th>Inpatient Children Served</th>
<th>Outpatient/Professional Children Served</th>
<th>Total Children Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tropical Texas Behavioral Health</td>
<td>1,503</td>
<td>38,689</td>
<td>38,698</td>
</tr>
<tr>
<td>Camino Real Community Services</td>
<td>103</td>
<td>3,223</td>
<td>3,224</td>
</tr>
<tr>
<td>Coastal Plains Community Center</td>
<td>187</td>
<td>4,298</td>
<td>4,300</td>
</tr>
</tbody>
</table>

Before 2013, only LMHAs could bill Medicaid for Mental Health Rehabilitative Services and Targeted Case Management (TCM). In 2013, Senate Bill (SB) 58, 83rd Legislature, Regular Session, integrated Mental Health Rehabilitative Services and TCM into the state’s Medicaid managed care program – reimbursed through capitated (or fixed, predetermined) rates – and enabled provider entities, other than LMHAs, to become credentialed and obtain reimbursement for the provision of these services. This was an important first step in expanding the capacity to provide these services statewide. Only LMHAs and provider entities that are organizations – not individual practitioners – can bill for TCM and Mental Health Rehabilitative Services. Since 2013, an increasing number of community-based organizations are becoming credentialed to provide these services. The 85th Legislature passed SB 74 to streamline and clarify credentialing requirements, and an associated HHSC rider (Rider 172) provides $2 million for grants to help providers (including both LMHAs and new providers) expand capacity to provide the most intensive level of care to high-need children and youth in the foster care system.

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

- **Medication Management** (C1): This is the lowest level of service, typically involving less than an hour of care per month, generally for children and youth who are stable and in a maintenance phase needing only medication or low levels of psychosocial or case management supports. A child or youth with SED would need to be relatively stable to receive this LOC.
- **Targeted Services** (C2): This LOC adds two to three hours of family/individual counseling or skills training to the service mix. This is for children and youth primarily in need of treatment with low levels of functional impairment. As with Medication Management, a
child or youth with SED would need to be functioning at a relatively stable level to receive this LOC.

- **Complex Services (C3):** This is a more intense level of care for children and youth with functional impairments who are in need of active treatment and psychosocial skills interventions aimed at preventing juvenile justice involvement, expulsion from school, displacement from home, or worsening of symptoms or behaviors. Most children and youth with SED who are not stable would need this level of care.

- **Intensive Family Services (C4):** This is the highest level of service intensity for children and youth, generally for those with significant involvement with multiple child/youth serving systems. It involves intensive family-focused treatment (target of two or more hours per week on average), generally delivered in the home or community. The level of functional impairment must be high, resulting in (or at least likely to result in) juvenile justice involvement, expulsion from school, out-of-home placement, hospitalization, residential treatment, serious injury to self or others, or death.

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

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

- **Young Child Services (YC):** These are services, targeting children ages three to five years, have a particular focus on the relationship between the parent and child.

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

- **Crisis Response:** This is the initial response to a crisis through brief intervention, either through mobile crisis or services at a facility, and can involve up to six days of follow-up.

- **Transitional:** This involves up to 90 days of additional crisis transition services until the situation is resolved.

The following table illustrates that a relatively smaller percentage of children and youth in both the BRBHC and TTBH service areas receive complex services or intensive family services (only 15% combined for BRBHC and 26% combined for TTBH), compared to Camino Real Community Services (55% together). Children and youth (and families) who need high intensity services but
do not receive them are more likely to experience adverse outcomes, including hospitalization, juvenile justice involvement, protective services involvement, and suicide.

**Child/Youth Levels of Care Analysis, FY 2016**

<table>
<thead>
<tr>
<th>LMHA / Region</th>
<th>Crisis Continuum</th>
<th>Ongoing TRR Treatment Levels</th>
<th>Specialized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Care</td>
<td>Crisis</td>
<td>Transition</td>
<td>Medication Management</td>
</tr>
<tr>
<td>Border Region Behavioral Health Center</td>
<td>185</td>
<td>24</td>
<td>158</td>
</tr>
<tr>
<td>% of LOCs</td>
<td>6%</td>
<td>68%</td>
<td>14%</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health</td>
<td>1,626</td>
<td>33</td>
<td>186</td>
</tr>
<tr>
<td>% of LOCs</td>
<td>4%</td>
<td>58%</td>
<td>25%</td>
</tr>
<tr>
<td>Camino Real Community Services</td>
<td>118</td>
<td>*</td>
<td>34</td>
</tr>
<tr>
<td>% of LOCs</td>
<td>4%</td>
<td>32%</td>
<td>51%</td>
</tr>
<tr>
<td>Coastal Plains Community Center</td>
<td>54</td>
<td>0</td>
<td>78</td>
</tr>
<tr>
<td>% of LOCs</td>
<td>8%</td>
<td>73%</td>
<td>10%</td>
</tr>
</tbody>
</table>

**Finding NC-5: Other Child and Youth Services Public Outpatient and Crisis System Capacity**

The following table summarizes the overall child/youth service capacity for children and youth with the most severe needs (serious emotional disturbances or SED) across major outpatient public mental health service systems in the Rio Grande Valley. Because the data on Medicaid do not differentiate between levels of need (mild to severe) for people served, our calculation of the number of unduplicated individuals served in outpatient settings is expressed as a range based on high (75% of total Medicaid served with SED) and low (25% of total Medicaid served with SED) estimates. Across the two major components of the public system (LMHA and

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84 A notation of “*” indicates five or fewer clients receiving the specified LOC.
85 The “% of LOCs” include all LOCs for children’s services.
Medicaid), there is currently capacity to serve between three in 10 (29.4%) and six in 10 (58.0%) children and youth in need, and in poverty, at some level of care.

**Children and Youth Served by Core Public Providers vs. Children and Youth in Need of Care, FY 2014**

<table>
<thead>
<tr>
<th>Children/Youth Served</th>
<th>RGV Area Counties</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need: Children and Youth in Poverty with Severe Needs (SED 200% FPL Population)</td>
<td>29,527</td>
<td></td>
</tr>
<tr>
<td>Received Public Mental Health Outpatient Services at Any Level</td>
<td>8,680 (low)</td>
<td>Estimated a range to account for lack of specificity regarding severity for Medicaid.</td>
</tr>
<tr>
<td></td>
<td>17,134 (high)</td>
<td></td>
</tr>
<tr>
<td>Local Mental Health Authority (TTBH and BRBHC)</td>
<td>4,456</td>
<td>Estimate of total served in ongoing levels of care.</td>
</tr>
<tr>
<td>Health District</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Medicaid FFS and HMO</td>
<td>16,904 Total</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4,226 (low)</td>
<td>It is not known what proportion of these services went to children and youth with SED or children and youth with less severe needs, so we made high and low estimates.</td>
</tr>
<tr>
<td></td>
<td>12,678 (high)</td>
<td></td>
</tr>
</tbody>
</table>

86 “RGV Area Counties” includes data from the four-county region included in this assessment: Cameron, Hidalgo, Starr, and Willacy.

87 Data on number of children and youth from Starr County served by the Border Region Behavioral Health Center in FY 2015 received from Alda Rendon of the Border Region Behavioral Health Center (personal communication, August 17, 2016). To estimate the number of children and youth from Starr County served in ongoing levels of care by the LMHA, the proportion of the number of children and youth served in ongoing levels of care by BRBHC in FY 2015 and the total number of children and youth served by BRBHC in FY 2015 was applied to the number of children and youth served by the LMHA in Starr County in FY 2015.

88 The number of children and youth with severe needs who were served through Medicaid FFS and HMO in the RGV area counties (Cameron, Hidalgo, Starr, and Willacy) was estimated based on the proportion of children and youth receiving psychotropic medications through Medicaid. The statewide estimate is based on the total unduplicated number of children and youth receiving Medicaid mental health services in FY 2015 (318,464) – Texas DSHS (personal communication, April 13, 2016). Here, psychotropic medication use is applied as a proxy to identify children and youth with severe needs. Among children and youth served with mental health services, 59.7% received psychotropic medications in FY 2012 – from Becker, E.A. (2013). UTHSCA update. Texas Health and Human Services Commission. (Slide 11 uses data from Office of Strategic Decision Support, Xiaoling Huang.) Applying this proportion to the FY 2015 unduplicated service total, we estimated that 190,123 children and youth received psychotropic medications in FY 2015. Finally, to determine the portion of children and youth in the RGV area counties from the statewide estimate, we divided the number of children and youth living in poverty (under 200% FPL, 190,123) within the RGV area counties by the total number of such children and youth in Texas (under 200% FPL, 3,566,287). The resulting proportion was applied to the statewide estimate of children and youth on Medicaid who were receiving psychotropic medication.
Finding NC-6: Inpatient and Crisis System Capacity

At the time MMHPI was conducting interviews for this assessment, public and private inpatient capacity in the community was reported to be about 400 inpatient beds in public and private hospitals as presented in the following table. As this report was going to press, it was announced that Valley Baptist Medical Center-Brownsville will be closing their behavioral health inpatient unit in August 2017. The information in the report reflects the state of inpatient bed capacity before this announcement was made. The Rio Grande State Center is the state hospital for the Rio Grande Valley. San Antonio State Hospital also provides inpatient beds for TTBH, which has had challenges with state facilities being on diversion, meaning they do not accept patients. TTBH has not been able to access public inpatient beds when needed and according to their assigned allotment of beds. As a result, TTBH spent about $2.2 Million during FY 2016 (funded by HHSC) to contract with local inpatient beds at South Texas Behavioral Health, Valley Baptist Medical Center – Brownsville, and Doctors Hospital Renaissance with resources. During this same time period, TTBH reported a significant decrease in out-of-region inpatient hospital utilization as a result of contracting with local hospitals. An average of four individuals per month were hospitalized outside the region, down significantly from the numbers in 2015.

Limitations in inpatient services capacity in the RGV for children and youth necessitated transport to Austin State Hospital for acute inpatient care. New beds opened in FY 2017 through Strategic Behavioral Health (Palms Behavioral Health), increasing access by 94 beds, including an adolescent unit, which is expected to further reduce the need for youth to be transported to Austin State Hospital for acute care. Yet, the concentration of all the psychiatric beds in two counties limits access because of transportation barriers.

One consistent report across stakeholders is that the RGV region lacks sufficient inpatient capacity to serve the demand of its population base. The following table provides a listing of available beds.

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89 As this report was going to press, Valley Baptist Medical Center-Brownsville announced they will be closing the hospital’s inpatient unit effective August 20, 2017, with no new patients accepted after July 31, 2017. VBMC-Brownsville noted the closing was due to “a challenging reimbursement environment, increasing operating costs and the addition of available treatment resources within our county...“. VBMC-Brownsville will continue operating its Outpatient Intensive Program. (Source: Letter to Valley Baptist Community regarding Valley Baptist Behavioral Health Facility Closure, July 18, 2017, Leslie Bingham, CEO).
Capacity Among Adult Inpatient Providers in Rio Grande Valley Four-County Region

<table>
<thead>
<tr>
<th>Adults Inpatient Providers and Facilities</th>
<th>Location of Facility (City, County)</th>
<th>Psychiatric Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors Hospital at Renaissance</td>
<td>Edinburg, Hidalgo County</td>
<td>87</td>
</tr>
<tr>
<td>Rio Grande State Center</td>
<td>Harlingen, Cameron County</td>
<td>55</td>
</tr>
<tr>
<td>South Texas Behavioral Health Center</td>
<td>Edinburg, Hidalgo County</td>
<td>134</td>
</tr>
<tr>
<td>Starr County Memorial Hospital</td>
<td>Rio Grande City, Starr County</td>
<td>0</td>
</tr>
<tr>
<td>Strategic Behavioral Health (Palms Behavioral Health) (also provides beds for youth age 13 and older)</td>
<td>Harlingen, Cameron County</td>
<td>94</td>
</tr>
<tr>
<td>Valley Baptist Medical Center-Harlingen</td>
<td>Harlingen, Cameron County</td>
<td>12</td>
</tr>
</tbody>
</table>

Our analysis suggests that the perception of poor bed capacity is a function of four factors: (1) the geographic distribution of psychiatric beds creates transportation barriers and limits access; (2) there is a lack of resources for inpatient care for people without insurance; (3) there is a lack of coordination among inpatient, crisis, and emergency room providers at a systems level; and (4) there are limited resources to provide community-based services that can support long-term community stability, and limited inpatient diversion and step-down services.

While the RGV region has made a concerted effort over the past decade to develop its behavioral health crisis services and create alternatives to incarceration and psychiatric hospitalization, crisis diversion programs tend to be facility specific, focusing on the diversion needs of a given provider or subset of providers rather than the community as a whole. As a result, the array of crisis services does not function as a system with defined pathways, which

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90 Source: Unless otherwise noted, capacity data comes from the DSHS 2014 Hospital Survey.
92 Source: South Texas Behavioral Health Center staff (personal communication, April 12, 2016).
93 Source: Starr County Memorial Hospital staff (personal communication, June 14, 2016).
94 Source: Strategic Behavioral Health (Palms Behavioral Health) staff (personal communication, July 28, 2016).
95 Subsequent to VBMC-Brownsville closing its inpatient unit, Valley Baptist Medical Center-Harlingen announced on August 30, 2017 the opening of a 12-bed inpatient geriatric behavioral health services unit to meet the needs of older adults in the RGV. Valley Morning Star. (2017, August 30). Geriatric behavioral health services now available at Valley Baptist-Harlingen. Retrieved from: http://www.valleymorningstar.com/life/health_wellness/article_ea1f315c-8df6-11e7-b5f4-c7c305fd70c5.html
contributes to redundant backups that prevent people from getting the right service at the right time—including, at times, psychiatric hospitalization. Development of a coordinated crisis response system across all payers, including Medicaid-managed care organizations (MCOs), is essential to make the best use of limited inpatient and other high cost resources. Note that the crisis array should ideally be jointly funded across all payers (e.g., state, Medicaid, local, private) in order to be efficient and effective rather than having each funding stream supporting a separate crisis care continuum. In the HHSC Sunset Commission report, Recommendation 6.1 for Issue 6 prioritized such cross-payer crisis coordination.96

Adult Inpatient Care

Lack of access to inpatient beds across the state is a problem that has been studied in depth. In January 2015, two important reports were released that attempted to define the need for inpatient beds in the state of Texas. These reports yielded estimates that the RGV region needs between 261 and 304 publicly and privately funded beds:

- **Rider 83 State Hospital Long Term Plan:** This HHSC report drew a great deal from the November 2014 consulting report by CannonDesign.97 CannonDesign recommended development of 570 beds in the near term (and an additional 607 beds to keep pace with population growth through 2024), for an overall statewide number of 5,424 publicly and privately funded beds in 2014. Based on the proportion of Texas adults with SMI living in the RGV region, this suggests a need for 261 psychiatric beds.

- **HB 3793 Report:** This DSHS report98 (Allocation of Outpatient Mental Health Services and Beds in State Hospitals) originated from the 83rd Legislature (HB 3793), which required a plan to identify needs for inpatient and outpatient services for both forensic and non-forensic populations. The legislation recommended that a Task Force comprising a diverse stakeholder group advise DSHS in determining the need and developing a plan to address it. The Task Force recommended a higher level of need for additional state funded beds (1,500, versus 607 by CannonDesign). Using this estimate yields an overall statewide need of 6,325 publicly and privately funded beds in 2014. Based on the proportion of Texas adults with SMI in the RGV region, this estimate suggests a need for 304 psychiatric beds.

While the state reports reviewed above indicate that the RGV region needs between 261 and 304 publicly and privately funded beds, current public and private inpatient capacity in the community (summarized in the previous “Capacity Among Adult Inpatient Providers in Rio Grande Valley Four-County Region” table) is reported to be 382 inpatient beds. At first glance this number appears to be sufficient, but because of multiple complicating factors, it is not.

The figure on the following page shows the locations of the hospitals with psychiatric bed capacity in the RGV counties as well as areas where adults (ages 18 and over) in poverty live, by census tract. Neither Starr County nor Willacy County has psychiatric inpatient beds available, and, as shown on the map, hospitals with inpatient capacity in Cameron and Hidalgo counties are concentrated in areas with generally lower rates of adult poverty.

**Psychiatric Bed Availability and Adult Poverty Counts, 2015**

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Average and maximum daily bed utilization data were available for Rio Grande State Center and Doctors Hospital at Renaissance.\textsuperscript{100} In 2013, Doctors Hospital at Renaissance (a 87-bed-capacity inpatient facility) had an average daily utilization rate of just eight beds, with a maximum utilization of 17 for the year.\textsuperscript{101} Data relevant to state hospital utilization (in the “State-Operated Psychiatric Hospital Average Lengths of Stay by Days and Age Group, FY 2015” table below) indicate that TTBH and BRBHC collectively have fewer admissions to state hospitals than the comparison LMHAs, relative to the number of adults with SMI in need and the number of children and youth with SED in need in their respective catchment areas. TTBH had the lowest rates of admission, relative to the number of people in need for both children/youth and adults/older adults.

**State-Operated Psychiatric Hospital Admissions by Age, FY 2015\textsuperscript{102}**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Tropical Texas BH</th>
<th>Border Region BH</th>
<th>Camino Real</th>
<th>Coastal Plains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/Youth</td>
<td>45</td>
<td>26</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>SED 200% FPL</td>
<td>20,000</td>
<td>5,000</td>
<td>2,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Admissions/SED 200% FPL</td>
<td>0.24%</td>
<td>0.54%</td>
<td>0.83%</td>
<td>0.97%</td>
</tr>
<tr>
<td>Adult</td>
<td>695</td>
<td>219</td>
<td>98</td>
<td>150</td>
</tr>
<tr>
<td>Geriatric</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>SMI 200% FPL</td>
<td>35,000</td>
<td>9,000</td>
<td>4,000</td>
<td>5,000</td>
</tr>
<tr>
<td>Admissions/SMI 200% FPL</td>
<td>2.10%</td>
<td>2.42%</td>
<td>2.30%</td>
<td>3.04%</td>
</tr>
</tbody>
</table>

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\textsuperscript{100} Utilization data were available for two additional inpatient hospitals; however, the calculated average daily use and maximum daily use were minimal.  
\textsuperscript{101} Data were drawn from the 2013 Texas Health Care Information Collection (THCIC) Hospital Discharge data set, as analyzed by MMHPI.  
\textsuperscript{102} Data received from Texas DSHS (personal communication, April 13, 2016). Data are for LMHAs.
State-Operated Psychiatric Hospital Average Lengths of Stay by Days and Age Group, FY 2015\textsuperscript{103}

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Tropical Texas BH</th>
<th>Border Region BHC</th>
<th>Camino Real</th>
<th>Coastal Plains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>45</td>
<td>33</td>
<td>32</td>
<td>31</td>
</tr>
<tr>
<td>Geriatric</td>
<td>87</td>
<td>n/a</td>
<td>139</td>
<td>6</td>
</tr>
<tr>
<td>Child/Youth</td>
<td>54</td>
<td>38</td>
<td>27</td>
<td>59</td>
</tr>
</tbody>
</table>

Another major indicator of system needs involves the average lengths of stay in public inpatient facilities across population age groups. With the exception of older adults, TTBH had the highest average lengths of stay among all LMHAs in the analysis (as shown in the previous table) and the highest number hospital days across each population group (as shown in the table on the following page). The length of stay for their older adult consumers was second highest among LMHAs for whom data were available. The lack of access to step-down services and housing is likely a contributing factor to the higher length of stay. BRBHC’s average lengths of stay were about average relative to the other LMHAs.

State-Operated Psychiatric Hospital Days by Age, FY 2015\textsuperscript{104}

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Tropical Texas BH</th>
<th>Border Region BHC</th>
<th>Camino Real</th>
<th>Coastal Plains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>31,275</td>
<td>7,227</td>
<td>3,136</td>
<td>4,650</td>
</tr>
<tr>
<td>Days per 1,000 in Need</td>
<td>946</td>
<td>797.7</td>
<td>736.7</td>
<td>942.2</td>
</tr>
<tr>
<td>SMI Population &lt; 200% FPL</td>
<td>35,000</td>
<td>9,000</td>
<td>4,000</td>
<td>5,000</td>
</tr>
<tr>
<td>Geriatric</td>
<td>522</td>
<td>n/a</td>
<td>278</td>
<td>6</td>
</tr>
<tr>
<td>Days per 1,000 in Need</td>
<td>15.8</td>
<td>n/a</td>
<td>65.3</td>
<td>1.2</td>
</tr>
<tr>
<td>Child/Adolescent</td>
<td>2,430</td>
<td>988</td>
<td>432</td>
<td>1,121</td>
</tr>
<tr>
<td>Days per 1,000 in Need</td>
<td>85.8</td>
<td>131.3</td>
<td>147.6</td>
<td>375.5</td>
</tr>
<tr>
<td>SED Population &lt; 200% FPL</td>
<td>20,000</td>
<td>5,000</td>
<td>2,000</td>
<td>2,000</td>
</tr>
</tbody>
</table>

Finding NC-7: Public Funds Available for Behavioral Health Services
Expenditures for behavioral health services include the total mental health funding provided to the counties within the VBLF catchment area that are served by BRBHC and TTBH as well as SUD

\textsuperscript{103} Data received from Texas DSHS (personal communication, April 13, 2016). Data are for LMHAs.

\textsuperscript{104} Data received from Texas DSHS (personal communication, April 13, 2016). Data are for LMHAs. Data were calculated by multiplying the number of admissions in FY 2015 by the average length of stay.
services funding and estimates of Medicaid funding for inpatient and outpatient care, jail and emergency room costs, other criminal/juvenile justice costs, and costs related to school-based services and child welfare services. While information is available for general revenue and other funding through the two LMHAs, spending information is not available for the broader system. As a result, we elected not to publish actual spending figures. However, based on our reviews of available data and key informant interviews, it was clear that coordinated planning across the major payers for public mental health – state general revenue, Medicaid, Delivery System Reform Incentive Payment (DSRIP), county expenditures, and local private funders (both foundations and contributors to uncompensated care) – is lacking, despite how essential such coordination can be to make the best use of these considerable, though limited, resources spent across the RGV currently.

MMHPI has developed cost estimates for two sets of costs associated with a lack of adequate funding and/or coordination across funding: costs of providing care in jail and costs of providing care in emergency room settings, which are summarized in the next table, by county, for 2015, the most recent year for which data were available. Note that a disproportionate share of these costs is driven by repeat use of these settings by the approximately 800 adults with highly complex needs who become trapped in cycles of “super-utilization,” with about 500 in need of intensive behavioral health treatment and about 400 in need of forensically-focused intensive behavioral health treatment (with a small amount of overlap between the two groups).

### Other Costs Related to Mental Health Needs for RGV Four-County Region, CY 2015

<table>
<thead>
<tr>
<th>County</th>
<th>Estimated County Jail Costs</th>
<th>Estimated MH Emergency Room Costs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameron</td>
<td>$7,850,000</td>
<td>$10,250,000</td>
<td>$18,100,000</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>$14,900,000</td>
<td>$18,750,000</td>
<td>$33,650,000</td>
</tr>
<tr>
<td>Starr</td>
<td>$1,400,000</td>
<td>$1,550,000</td>
<td>$2,950,000</td>
</tr>
<tr>
<td>Willacy</td>
<td>$480,000</td>
<td>N/A</td>
<td>$480,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$24,630,000</strong></td>
<td><strong>$30,550,000</strong></td>
<td><strong>$55,180,000</strong></td>
</tr>
</tbody>
</table>

105 Meadows Mental Health Policy Institute and Texas Conference of Urban Counties. (2015). *Survey of county behavioral health utilization*. Unpublished Document. Dallas, TX: Meadows Mental Health Policy Institute. Estimates were based on a 2012 Texas Health Care Information Collection hospital survey of 580 hospitals and costs from a 2013 Dallas Fort Worth Hospital Council Foundation report. All estimates have been updated to 2015 by adjusting for the increased population of people with serious mental illness as well as the rising costs of medical and other service costs.

106 Estimated costs are for mental health only and do not include costs associated with treatment for issues related to substance use disorders (SUD).
Note that this $55 million, which represents only a portion of the behavioral health-related costs in non-behavioral health settings and systems, can be considered an opportunity cost for the current system that can potentially support investment in a more efficient and effective crisis response system and continuum of crisis and jail diversion services. SB 292 and HB 13, passed during the 85th Legislative session and approved by Governor Abbott, offer grant funding that can support local collaboration to improve access to services.

**Finding NC-8: Funding for Veterans’ Services**

Funding for veterans served by the Texas Valley Coastal Bend Health Care System (VA-TVCBHCS) for the four VBLF counties totals $175,769,000 for all medical care, including behavioral health care. The percentage of the veteran population served by VA-TVCBHCS is about average compared to other states and Texas counties. Funding specific to behavioral health conditions was not available. Behavioral health services include a range of outpatient treatments that are targeted to the needs of veterans. Behavioral health inpatient care is also a benefit covered by the VA and provided at various hospitals in the RGV.

**Veterans Served by the Texas Valley Coastal Bend Health Care System (VA-TVCBHCS) in FY 2015, by County**

<table>
<thead>
<tr>
<th>County</th>
<th>Total Veteran Population</th>
<th>Estimated Number of VA-Enrolled Veterans</th>
<th>Number of Unique Patients Receiving Care</th>
<th>Percent of Veteran Population Served</th>
<th>Total VA Spending on Medical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameron</td>
<td>17,418</td>
<td>7,316</td>
<td>6,721</td>
<td>39%</td>
<td>$75,718,000</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>23,374</td>
<td>9,817</td>
<td>8,787</td>
<td>38%</td>
<td>$91,733,000</td>
</tr>
<tr>
<td>Starr</td>
<td>890</td>
<td>374</td>
<td>360</td>
<td>40%</td>
<td>$3,735,000</td>
</tr>
<tr>
<td>Willacy</td>
<td>867</td>
<td>364</td>
<td>332</td>
<td>38%</td>
<td>$4,583,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>42,549</strong></td>
<td><strong>17,871</strong></td>
<td><strong>16,200</strong></td>
<td><strong>38%</strong></td>
<td><strong>$175,769,000</strong></td>
</tr>
</tbody>
</table>

These figures represent the total veteran population in the RGV, those estimated to be enrolled in the VA system, the number of unique patients receiving any health care (not solely behavioral health care), the percent of the veteran population served, and the total VA spending.

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108 Veteran population estimates are for September 30, 2015.


This factsheet reported that as of FY 2014, VA-enrolled veterans represented 42% of the total proportion of the total veteran population nationally.
spending on any medical care by RGV county. Spending on behavioral health services was not available. The percentage of veterans served in the RGV is slightly below the average proportion (42%) of the veteran population served nationally.\textsuperscript{110} The stigma of having a mental illness or substance use disorder hinders veterans’ access to services because the personal or societal perception of weakness conflicts with the military expectation of accomplishing the mission regardless of personal discomfort. Mental health or substance use conditions may be misunderstood by veterans and their families as a weakness or self-pity rather than a treatable illness. Veterans also face added difficulty in accessing services because of the lack of readily available, trauma-informed outreach and treatment that is competent in working with the military culture.

**Major System Level Findings and Recommendations**

The Rio Grande Valley (RGV) is a dynamic, growing region with expanding economic opportunity. However, behavioral health services for the population as a whole – not just those receiving these services from the public sector – have always been limited and are not keeping pace with the community’s population and economic growth. The Meadows Mental Health Policy Institute (MMHPI) evaluation team identified numerous examples across the RGV of outstanding programs and leaders who are deeply committed to the populations they serve – many of which are among the best practices we have observed anywhere across Texas. We learned about excellent examples of collaboration and investment in new ways of working together to address the health needs of the entire population, as well as an emerging consensus on the need for county-level planning.

At the same time, there are significant service gaps that can be attributed to limits in available capacity for county planning. While there is broad recognition of the value of regional collaboration, in a region of over 1 million people, it is clear that each county and the communities within them have their own cultures, challenges, and needs so that building collaborations even within local communities will take effort and time. Furthermore, for the immediate future, efforts to bring people from across the counties together to promote multi-county collaborations will need greater focus on sharing lessons learned and promoting specific learning collaboratives rather than on actual collaborative efforts. With four county administrations, numerous cities and towns, 37 school districts, two LMHAs, five inpatient psychiatric programs, and three federally qualified health centers (FQHCs) managing public services – along with diverse substance use disorder treatment providers, large health systems with varying levels of capacity to address behavioral health needs, and a diverse array of private outpatient treatment providers – there is much that can be shared.\textsuperscript{111} But the challenges of the

\textsuperscript{110} ibid.

near future will require more focused system development and collaborative efforts at the county level.

To assist with service development and intra- and inter-county collaboration, we would like to emphasize the opportunities resulting from legislation passed during the 85th Legislative Session and signed by Governor Abbott.

- SB 292 creates a grant program with $37.5 million in funding to reduce recidivism, arrest, and incarceration among individuals with mental illness. This funding can be very helpful in addressing issues related to individuals with SMI who are involved in the justice system, especially related to some of the barriers (identified later in this report) to accessing services as well as new or further implementation (depending on the county) of the Sequential Intercept Model, which describes diversion strategies for justice-involved individuals through interventions along a series of interception points.\(^{112}\)

- HB 13 creates a grant program with $30 million in funding to provide incentives for state-local collaborations to support mental health initiatives. One of the challenges of collaboration is having funds to support planning. This legislation may be very useful to the RGV counties interested in pursuing further collaboration.

- SB 74 streamlines credentialing requirements for providers to improve access to behavioral health services for children and youth with high needs.

- SB 1, the state budget, includes $2 million to establish a grant program to increase access to high-quality treatment for children and youth with high needs who are involved in the child/youth welfare system, a population that is underserved throughout the counties in the RGV.

In performing system assessments, MMHPI recognizes that successful county systems have the ability to collaborate in managing resources to better meet the needs of the populations they serve. We know this is the case for behavioral health systems as well as systems that address other community needs such as health, housing, water, and transportation. We also know that no matter how suitable our recommendations are, they depend on the ability of the local communities to implement them as part of a long-term strategic process.

Therefore, one of the first things we look at in a system assessment is the extent to which the system has the ability to develop a collaborative approach to focus on behavioral health and whether that collaboration can be organized, empowered, and structured to carry out a

strategic improvement process for the population as a whole. One example of successful collaboration is the Unidos Contra la Diabetes (UCD) “collective impact” effort to prevent new cases of diabetes in low-income and underserved people in the Rio Grande Valley. This effort is being funded by Methodist Healthcare Ministries and the Valley Baptist Legacy Foundation. The UT School of Public Health-Brownsville and Proyecto Juan Diego are the Backbone Organizations for the effort. UCD brings together numerous service providers, social service agencies, insurance companies, and other stakeholders. Other examples can be found in county behavioral health initiatives involving collaboration among the LMHAs and other providers, which have resulted in exemplary services, the development of task forces and committees, and the procurement of grants that increased access to services.

MMHPI has found that the development of a county-level behavioral health leadership team (BHLT) that is structured, organized, and empowered to carry out initiatives has been a successful strategy in planning population-based behavioral health services in other parts of Texas and across the nation. While the goal is to maximize the use of resources across the RGV, its geography and complexity makes reaching this goal challenging. This situation is not unique to the RGV. There are very few multi-county collaboratives across Texas. Furthermore, Hidalgo and Cameron counties are two of the top 15 highest-populated counties in Texas, and we know of no large counties in the state engaged in any substantive behavioral health collaboration that goes beyond the borders of a single county. We recommend instead that the region begin with developing county-level efforts, cross-county learning, and initiatives for sharing lessons learned. As we outline the following findings related to each sub-population in need of behavioral health care, our recommendations emphasize a step-wise approach to forming county-level BHLTs that build on the successes of each county and their service providers.

System Level Findings (SF)
County-Level Planning Needs

System Level Finding SF-1: Within the overall behavioral health system, there are significant areas of strength, including the development of new programs and services. We also identified potential improvements related to overall needs in county-level collaboration and opportunities for these improvements within each major service delivery area: crisis, adult mental health system of care, children’s system of care (including juvenile justice and child welfare), and the substance use disorder continuum as well as behavioral health services within the health, criminal justice, and housing systems.

System Level Finding SF-2: There are examples of significant collaboration among individual providers and counties, yet organized planning at the regional level does not currently make sense given the size and complexity of the RGV. However, there is a lack of organized collaborative planning at the county level across all behavioral health populations (public and
private, mental health and SUD, inpatient and outpatient, and specialty populations) that supports the shared management of behavioral health resources and systems within each county, including those that address mild to moderate as well as more serious behavioral health conditions. This involves both a lack of broad collaborative planning across county and provider systems as well as a lack of resource support to carry out the work of the planning. The lack of formal, system-wide collaborative structures with shared values and a customer orientation for all behavioral health populations limits positive change.

Other counties in Texas have begun to develop behavioral health leadership teams (BHLTs). BHLTs are composed of cross-system representation of leadership and stakeholders from organizations throughout a county such as behavioral health services, LMHAs, psychiatric inpatient units, substance use disorder treatment providers, public health, social services, education, justice, city and county government, the faith community, nonprofit services, area businesses, and individuals with lived experience of mental illness and/or substance use disorders (SUDs). The BHLT members engage in a collaborative effort to adopt a mission and core values, identify priority areas, develop a set of deliverables, and form workgroups to meet goals they have developed that are aimed at best identifying and addressing behavioral health needs in their community.

Only five of the 10 biggest Texas counties – Dallas, Denton, El Paso, Tarrant, and Travis – have BHLTs in place. Bexar County is in the process of developing one, but Collin, Fort Bend, and Harris Counties only have smaller, more focused efforts in place. Initiatives in smaller regions, like Midland County, Smith County, and the counties of the Panhandle have begun to take shape, but they also face challenges with resource limitations and conflicts between members. BHLTs take effort and dedicated resources, but even the process of formation can help begin a dialogue that is focused on population health needs, shared values and purpose, and collaborative efforts to work together to improve system responsiveness and effectiveness.

System Level Finding SF-3: There are significant limitations in the current capacity for behavioral health services for all populations, and even more so for uninsured and undocumented individuals and families. There are limited services available in the region for the many individuals affected by mental illness and/or SUD in ways that may lead significantly to poor outcomes and high costs. There is limited access to private providers that have the capacity to serve individuals with complex needs. There are also more psychiatrists in inpatient settings than outpatient settings for the general population seeking mental health care beyond LMHAs. The frequent lack of psychiatry in outpatient services limits service capacity significantly.

System Level Finding SF-4: Because of the absence of a system-wide focus on county-level planning for behavioral health services, there is a significant population health challenge in
each county in RGV. The absence of formal, systematic, county-level planning efforts focused on behavioral health leads to inefficiencies in system design, requiring each funder to develop a parallel set of services for its own population, rather than providing a more aligned continuum of services that might be available for more people. The lead agencies for each major public funding source lack a high-level forum at the county level for coordinated behavioral health planning and system-level efforts (e.g., a “behavioral health leadership team”). Families and business leaders often do not know where to get help – or who is ultimately responsible for ensuring that help is available – for their loved ones or their employees.

System Level Finding SF-5: While there are some excellent county behavioral health planning initiatives, the lack of visibility of behavioral health at the highest county levels is a significant gap. As convener, the county can promote a vision for county services and has the authority to make important decisions that individual county organizations cannot address. As a strong leader in Cameron, Hidalgo, and Willacy counties, TTBH can take a leading role, but even it cannot take on the sole role as lead of a BHLT because of its primary focus on adults and children and youth with the most serious behavioral health conditions. BRBHC is in a similar position. In order for county-level planning efforts to become more comprehensive and focused across populations, they need the involvement of county leadership as well as top leaders from all key health and behavioral health providers.

System Level Finding SF-6: Cross-payer and cross-county collaboration is hampered by a focus on maximizing the use of separate funding streams. There is little coordination on maximizing state and federal funds and grants across funding streams, and there are no county-level planning efforts at all that address the use of private insurance funding, although some insurers have expressed a need for more collaboration. While local collaboration cannot control the rules of payers, collaborative planning can focus on how to take full advantage of these separate funding streams within the counties, the Regional Health Partnership, Medicaid managed care organizations, hospital systems, and other providers. It is also possible to influence the funding priorities of payers when collaborative systems have the data to demonstrate gaps and needs.

System Level Finding SF-7: Because of gaps in system-wide behavioral health planning efforts at the county level, individual providers must negotiate system development strategies and collaboration that require a broader set of partners. This often results in challenges and confusion about who is responsible for providing services and transportation for individuals who have high utilization of emergency department (ED) and inpatient services and/or come into contact with law enforcement. Aligning multiple types of limited resources to meet the overall service needs and expectations of the community as a whole is an important program planning issue that requires the investment and understanding of multiple parties and consequently requires broader system planning and commitment.
System Level Finding SF-8: Customer-oriented continuous quality improvement (CQI) is a system and organizational management process by which customer experiences and outcomes are central, and all system partners work together within a CQI change cycle framework to improve system responsiveness and performance. While individual providers have effective CQI processes, county behavioral health care systems do not have routine mechanisms at any level to engage in customer-oriented CQI.

Crisis Delivery System

System Level Finding SF-9: While there are some excellent crisis intervention services, there are no comprehensive county-wide crisis intervention programs. The crisis intervention programs for TTBH counties and for Starr County through BRBHC are strong, and TTBH has implemented an innovative model – the Mental Health (Peace) Officers Team (MHOT) – to supplement its Mobile Crisis Outreach Program. However, there are significant gaps in crisis services such as crisis respite and other diversion services. For private practitioners and hospitals, there is no defined crisis system that tracks individuals through the resolution of their crises.

System Level Finding SF-10: Crisis diversion services in the RGV are very underdeveloped compared to the number of inpatient beds and for the size of the region. Two 2015 reports yielded estimates that the RGV region needed between 261 and 304 publicly and privately funded inpatient beds. Current public and private inpatient capacity, as summarized previously in the table “Capacity Among Adult Inpatient Providers in Rio Grande Valley Four-County Region” on page 32, shows capacity of over 400 inpatient beds. While this number may appear to be sufficient given the estimated need for inpatient beds provided in the cited reports, the lack of diversion services and crisis beds puts added strain on existing inpatient capacity throughout the RGV region. The Wood Group operates a 16-bed crisis residential program under a contract with TTBH. The program has been operating for nearly ten years and is the only crisis diversion program in the Rio Grande Valley. This program, located alongside transitional housing, does not have enough crisis beds to address the need for diversion services across the RGV. It supports individuals through a crisis but does not have intensive treatment services available. While BRBHC is in discussions with Starr County Memorial Hospital to develop either a crisis diversion program or an inpatient program for adults and youth, crisis beds are presently limited to a single location (at The Wood Group) for the entire region. The need for crisis respite is especially acute in Starr County; Starr Memorial Hospital, which has the primary emergency department (ED) used in Starr County, has expressed interest in providing these crisis services if funding were available. The Starr County hospital district faces significant challenges with ED space and the county is confronted with limited transportation resources and excessive demands on law enforcement’s time, all of which contribute to individuals being taken to jail rather than travel long distances to inpatient
facilities. This results in over 800 individuals per year throughout RGV becoming trapped in a cycle of relying on crisis services, emergency departments, jails, and inpatient programs, or becoming homeless, ultimately contributing to “super utilization.” As noted above, SB 292, passed during the 85th Legislative Session and signed by Governor Abbott, creates a grant program with $37.5 million in funding to reduce recidivism, arrest, and incarceration among individuals with mental illness. This funding can be very helpful in addressing this issue, particularly for individuals with SMI who are involved in the justice system.

System Finding SF-11: There is an opportunity to provide more intensive services at the current crisis respite program and to provide more intensive case management services and programming as part of the overall crisis continuum. The Transitional Care Clinic in San Antonio, operated by the UT Health Science Center, helps individuals transition from hospital care to the community and is an example of what could possibly be developed in the RGV.113

System Level Finding SF-12: The current crisis diversion service array at The Wood Group includes limited Medicaid billable services (i.e., assisted living), even for clients who are on Medicaid. While TTBH provides and bills for a few services provided to clients who are staying at The Wood Group facility (e.g., Targeted Case Management, rehabilitation), there is no current mechanism for working collaboratively with Medicaid managed care organizations (MCOs) to establish expanded diversion services that would be clinically and financially advantageous to providers and clients.

Adult Delivery System

System Level Finding SF-13: The RGV’s adult mental health system of care for individuals with serious mental illness has an array of services developed through TTBH for three counties. BRBHC has developed an array of services for Starr County, its only county located in the RGV. It should be noted that there are two distinct systems of care – one for the TTBH service area and the other for the BRBHC service area. While some providers will serve counties region-wide, especially inpatient providers and some SUD providers, the historical development of two LMHAs serving the Rio Grande Valley has essentially resulted in two separate systems of care. There are also other key providers contributing to adult community services, including Behavioral Health Solutions of South Texas (BHSST), the VA-Texas Valley Coastal Bend Health Care System, and The Wood Group. As a result of constraints on both resources and collaboration, the capacity of all these services is well below what is needed. At the same time, there are opportunities for improvements in the delivery of behavioral health services to adults, which can be supported by the 85th Legislature’s increase in public mental health funding for the region by $3.5 million (90% of that going to TTBH), not including any additional funds that

can be accessed through the new state-local partnership grants (e.g., HB 13, SB 292, SB 74 rider) and continuation of existing state-local grant programs (Health Collaborative homelessness grants and Texas Veteran + Family Alliance grants).

System Level Finding SF-14: Capacity to provide case management and intensive case management following a crisis are lacking across the region, but a key gap is the lack of ongoing care for adults with highly complex health needs who are trapped in “super utilization of services,” repeatedly transitioning from inpatient and crisis services, particularly the 700 people with incomes under 200% of the federal poverty level (FPL) who have complex needs. While TTBH provides short-term case management post crises and BRBH provides follow up, when resources are available, for individuals who use their crisis systems, there are limited long-term resources for the LMHAs’ target populations and few or no resources for the general population with behavioral health needs who are treated in emergency departments, are hospitalized, reside at homeless shelters, or are held in jails (except where counties or police departments have agreements with the LMHAs to provide services to individuals in jails).

As noted earlier in this report, 500 people need non-forensic intensive treatment and 400 need forensically-focused intensive treatment.\(^{114}\) The data under Finding NC-1 above underscore the dramatic lack of intensive treatment capacity for adults, particularly for individuals with complex needs who are caught in “super-utilization” of crisis, emergency room, and inpatient services. It is likely that more capacity in this area (both intensive treatment and housing supports) that targets people with the highest needs who are using inpatient care, could reduce pressure on inpatient facilities as well as the flow of people with SMI into county jails. The new resources that will be available in FY 2018 under the new SB 292 grant program can be used to address this gap, if prioritized by the LMHAs and local counties (who must collaborate on the program).

System Level Finding SF-15: With one public and four private psychiatric hospitals, the region has increased its bed capacity by 94 beds in the last year to about 382 psychiatric beds in total. Based on the CannonDesign\(^{115}\) and HB 3793 reports\(^{116}\) the need for psychiatric beds in

\(^{114}\) Some individuals would qualify for both Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT). As a result, the estimates include an overlap of about 137 people.


the RGV region is between 261 and 304. Therefore, while 382 beds appear sufficient, because of multiple complicating factors it is not. Palms Behavioral Health added the 94 inpatient beds to the region, including adolescent beds. Yet, there remains concern about the breakdown of need and capacity across populations that would benefit from county planning and collaboration across counties. As shown on the map of hospitals services earlier in this report, neither Starr nor Willacy County has psychiatric inpatient beds available, and hospitals with inpatient capacity in Cameron and Hidalgo counties are concentrated in areas with generally lower rates of adult poverty. Furthermore, the RGV lacks the array of services necessary to avoid reliance on inpatient care. There are significant gaps in services for other levels of care in addition to the gaps in the crisis system noted above. For example, access to routine care — medication management, ongoing case management, and treatment services — is hindered by waiting lists. Related to screening for inpatient care, TTBH has initiated medical clearance through its integrated care clinics and the MHOT/MCOT. However, the resources to provide medical clearance during nights and weekends is limited, often resulting in individuals waiting in emergency departments overnight or longer. This is challenging for emergency departments, police, and sheriff departments that wait with individuals in emergency departments, as well as for the MHOT/MCOT and the BRBHC crisis program. There is also a need for step-down programs that offer support services for individuals leaving intensive inpatient care. The gap in step-down programs results in longer inpatient stays. There are also significant needs for supported housing services in all counties.

Both LMHAs have expanded research-based practices and integrated behavioral health and physical health initiatives. TTBH has decided to focus primarily on the expansion of research-based and best practices, using national protocols and standards. However, the region has a limited number of licensed clinicians, including psychiatrists that are available for service provision, training, and supervision of qualified mental health professionals (QMHPs), who provide most of the direct care services. This lack of licensed clinicians makes it challenging to provide ongoing supervision and training as well as implement research-based practices, integrated care initiatives, and best practice.

In addition, there is no routine mechanism that allows service providers to plan how to coordinate their services so that existing resources are used efficiently and people who ask for help can easily get to the right place. While these and other areas of improvement are tied to workforce challenges and a lack of resources, there are opportunities to improve collaboration, teamwork, and the quality of services provided. For example, the grant programs created with SB 292 (described in introductory part of System Level Recommendations) can be used to establish local collaboratives, which can bolster the availability of quality mental health services.

FyCMEQFggoMAA&url=https%3A%2F%2Fwww.dshs.texas.gov%2Fmhsa%2Freports%2FSPH-Report-2014.pdf&usg=AFQjCNGN68ButJ02hH0cTQDpeODSQA0bVg
to effectively divert individuals from jail as well as emergency rooms and hospitals since many individuals who become involved in the jail system have also been patients of the local ERs and hospitals.

**System Level Finding SF-16: Services for adults with mild to moderate behavioral health needs have also not kept pace with population growth.** Neither TTBH nor BRBHC can address the needs of this population because of their mandate to focus on individuals with the most serious mental health conditions. Care of individuals with mild to moderate needs is a challenge for social services organizations, such as Catholic Charities, that provide an array of non-mental health services. Given the limited behavioral health workforce throughout the RGV region (and the state as a whole), integrated behavioral health care (IBH) is a key strategy for addressing these gaps in service provision for individuals with mild to moderate behavioral health needs. IBH provides a holistic approach to an individual’s care, where both physical and behavioral health needs are addressed through evidence-based, person-centered practices in order to more significantly and sustainably improve the overall health of individuals being served. By implementing an IBH model within primary care provider settings, individuals with mild to moderate behavioral health care needs can have access to behavioral health assessment and treatment through their primary care physician without requiring referral to a specialty clinic.

**System Level Finding SF-17: There is no effective continuum of care between inpatient services and community-based outpatient services, either for step-down or diversion services.** This level of support is a key component in ensuring the successful transition of individuals from inpatient care to community-based services. Some facilities have the capacity and willingness, with appropriate support, to consider developing elements of such a continuum. Grant programs created from new legislation provide opportunities for the RGV community to explore ways to address this gap in the continuum of care through county-based collaborative efforts. SB 292 provides support for diversion efforts to reduce the recidivism of individuals with mental illness from cycling through jail and inpatient services, and HB 13 provides support more broadly for community health programs focused on service provision and treatment that will address gaps in local communities. Both programs provide opportunities to support facilities able and willing to contribute to the development of services and programs needed to fill these gaps in the continuum of care.

**System Level Finding SF-18: The RGV has no facilities that are currently offering a continuum of psychiatric emergency care in the area. Additionally, crisis respite programming in the RGV, provided by The Wood Group under contract with TTBH, is supportive to the individual, but does not provide the intensive level of care that some individuals require.** Consequently, individuals either end up in an emergency department or an inpatient bed. Crisis beds are located alongside transitional living beds, which, along with a lack of housing alternatives,
contributes to the tendency for individuals to stay longer than the typical crisis period of 72 hours and limits access to the crisis respite beds.

**Co-Occurring Mental Health and Substance Use Disorder Delivery System**

**System Level Finding SF-19:** As in every behavioral health system across Texas and the nation, the continuum of substance use disorder (SUD) services for adults, youth, and children in the RGV is underdeveloped, with significant gaps in the continuum of SUD services for individuals of all ages, with or without co-occurring disorders (COD). However, the RGV is fortunate to have a strong core of providers with the potential to expand and improve coordination of services and care among providers. TTBH has recently been assigned the responsibility for the Outreach, Screening, Assessment and Referral (OSAR) function and has expanded its substance use treatment program significantly. Behavioral Health Solutions of South Texas (BHSST), formerly the OSAR, serves 19 counties (including Starr County), primarily focusing on substance use and co-occurring disorders. BHSST also has facilitated Recovery Oriented Systems of Care (ROSC) meetings for SUD stakeholders and continues to be a resource to the RGV. BRBHC also provides substance use and COD-capable treatment.

The John Austin Peña Memorial Center (JAPC or Peña Center), a collaboration between the University of Texas Rio Grande Valley School of Medicine (UT-RGV SOM) and the Hidalgo County Health Department, offers primary health care to youth ages 12 to 18 years who are at risk for medical, mental health (behavioral issues, attention-deficit/hyperactivity disorder, and anger management), and appetite-driven conditions (alcohol, drugs, tobacco, etc.). This newly developed program, which receives most of its referrals from the juvenile justice system, has potential to expand further and round out the continuum of care.

Continuity of care following inpatient treatment is a challenge, mainly because of limits in available resources. The lack of step-down programs that offer support services for adults and youth leaving intensive inpatient care results in longer inpatient stays. And while some residential services are available for individuals with SUD, there is a significant gap in residential levels of care – as recommended by the American Society of Addiction Medicine (ASAM) – for individuals with substance use disorders. It is important to note that substance use is prevalent, especially use of opioids, cocaine, methamphetamine, synthetic marijuana, and other drugs. The need for medication-assisted therapies, which combines medicine with behavioral therapies to treat opioid abuse, is also a significant need. There are also significant needs for supported housing services in all counties.

Although there is an array of outpatient and inpatient services, providers do not routinely coordinate with each other to create a continuum of services at the county level. For example, Palms Behavioral Health is planning to implement intensive outpatient program (IOP) services for adolescents and adults with dual diagnoses, such as mental illness and chemical
dependency, yet the Valley Baptist Medical Center (VBMC) is already providing similar services. Given the region’s overall scarcity of providers, it will be important to assess the need for these types of programs in order to avoid duplication of services. There is emerging collaboration to bring together some mental health and SUD providers; however, this likely needs additional support for system-wide planning.

An additional opportunity for expanding treatment services, specifically for individuals with opioid use disorders, comes from the passing of the federal 21st Century Cures Act. The Cures Act allocates $485 million in grants to provide support to states for the prevention and treatment of opioid addictions. In May 2017, the Texas Health and Human Services Commission (HHSC) was awarded $27.4 million in grant funds through the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide focused prevention and treatment across the state. This funding will be used to accomplish such goals as expanding capacity and access to treatment, increasing training for providers, enhancing recovery and peer support services, and boosting outreach activities. These funds will provide HHSC with an opportunity to implement prevention and treatment services through contract amendments with existing provider organizations and LMHAs, as well as new contracts with universities invested in improving services in this area.

System Level Finding SF-20: Based on national prevalence data and interviews with providers in the RGV, individuals with co-occurring psychiatric and substance use disorders (COPSD) represent more than half of the people with severe needs across settings in the RGV and a large number of the overall population in need. TTBH is in the process of developing a strong system for integrating mental health and substance use disorder treatment, which would serve about 500 individuals across its programs and could become a model continuum of COPSD services for the RGV. A new Director of Substance Use Disorders Services began work at TTBH in January 2016 and is expanding training on ASAM levels of care, motivational interviewing, and research-informed COPSD approaches based on federal standards. This program, with appropriate resources, has the potential to work with other providers across the RGV to improve capacity and expertise in providing co-occurring services, build a recovery-oriented continuum of services that offer integrated (not parallel) COPSD interventions, and expand recovery coaching. Doctors Hospital at Renaissance has a dedicated co-occurring disorders (COD) unit and Valley Baptist Medical Center has the capability to work with individuals with COD, which is a strength.

Children, Youth and Families Delivery System

System Level Finding SF-21: Behavioral health care delivery systems for children, youth and family services in the TTBH counties and BRBHC/Starr County are also separate systems. They provide a relatively strong base of evidence-based services and best practices to build upon and expand, though overall capacity is underdeveloped throughout the RGV, just as it is throughout Texas and the nation. As noted in the capacity findings, the RGV has about 58,800 children and youth who have mild to moderate needs each year. As with most of Texas and the nation, most primary care practices across the RGV are not integrated and the vast majority of children and youth with mild to moderate needs have challenges accessing care. School-based care is available in some of the 37 school districts through the LMHAs, but, given the region’s large number of schools (and their caution in partnering with mental health programs), it is difficult to provide services for all schools within the school districts.

System Level Finding SF-22: There is a lack of community-based care for children and youth with the most intensive needs. These intensive family services are intended to meet the needs of children and youth who are involved with multiple child-serving agencies or who are at significant risk of being removed from their home or school. Approximately, only one in 50 children and youth with these needs now receive such care, but TTBH and BRBH have sound programs on which to build. SB 74 streamlines regulations that may enable other providers to address these complex needs as well (for example, the John Austin Peña Center). Even though Medicaid currently covers the costs of these services for most (but certainly not all) children, youth, and families with intensive needs, providers do not have the start-up funds needed to expand capacity to provide intensive community-based care. The primary barrier to increasing access to intensive community- and family-based services is one-time start-up costs, which MMHPI has estimated at approximately $5,000 per child service slot. Post start-up, most services for children and youth in poverty can be covered by Medicaid. The new state funding of $2.0 million provided with SB 74 can be matched to offset start-up costs.

TTBH has developed a strong wraparound program through the YES Medicaid Waiver program for youth with the highest needs. Wraparound is a service coordination function that, when combined with effective treatment, has good outcomes. The TTBH wraparound program collaborated with the Texas Institute for Excellence in Mental Health and with Washington State University on training and certification. The wraparound supervisor is certified. The wraparound team went through a six to nine-month process of fidelity monitoring, which will likely lead to their becoming the first program to be certified in nation. At the time of the review, the wraparound program served 178 children, youth, and families in three counties.119

119 These numbers vary from Table 13 on utilization of services by level of care (LOC) because that data is for FY 2015 and the date of the site visit was in 2016 when the program had grown significantly.
while another 235 children, youth, and families are on an inquiry list. TTBH is reluctant to call the inquiry list a waiting list because of the length of time families must wait to access these services. MMHPI estimates that approximately 1,000 children, youth, and their families would benefit from wraparound facilitation and associated intensive child and family treatment. This leaves a significant gap in services in the RGV.120

TTBH also provides the following key evidence-based practices and tracks fidelity through their quality management program: (1) Preparing Adolescents for Young Adulthood; (2) Aggression Replacement Training; (3) Seeking Safety; (4) cognitive-behavioral therapy (CBT); (5) Parent Child Interaction Therapy (PCIT); (6) Trauma-Focused CBT; (7) ASSIST – Applied Suicide Intervention Training (a two-day training); and (8) Mental Health First Aid. TTBH also co-locates staff in schools and has shared positions with juvenile probation, including one at juvenile detention facilities. In addition, TTBH has a specialized caseload for foster children and youth with the goal to expedite access to care. Yet, the proportion of children, youth and families served by TTBH was 15% of the population in need (2015 figures, as noted earlier on Table 13).

BRBHC provides wraparound services through the YES Medicaid Waiver in Starr County through its Child, Adolescent and Parents Services Program (CAP), which also includes family support services. In 2015, BRBHC was serving about 28% of children, youth, and families in need, as noted earlier on Table 13.

Overall, there are significant gaps in services for children and youth involved in multiple systems (mental health, juvenile justice, and child welfare), and the region’s resources do not address the needs for children/youth with SED (under 200% of the FPL) in the four-county region who need intensive care at any given time.

System Level Finding SF-23: Access to crisis respite and long-term inpatient care for children and youth is very limited – families must frequently travel to Austin or San Antonio to obtain long-term inpatient care for their children. TTBH contracts with three local inpatient hospitals to obtain crisis stabilization services for children and youth. With the opening of Palms Behavioral Health (Palms) and its development of an adolescent unit, additional services are available. At the same time, while travel to Palms is easier than traveling to Austin, access is limited by transportation barriers and distance to the counties within the RGV. However, there

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120 Meadows Mental Health Policy Institute (2015). Estimating the percentage of lower-income youth with severe emotional disturbances who need time-limited, intensive home/family/community-based services. Unpublished documents and data. Based on work in multiple states that have developed community-based service arrays in response to system assessments and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) legal settlements (WA, MA, CT, NE, and PA), and based on the input of leading national experts on the need for wraparound services.
are currently no designated state hospital beds in the RGV for children and youth. As a result, families seeking extended and longer-term care for their children are most often transferred and admitted to San Antonio State Hospital (SASH) or Austin State Hospital (ASH).

**System Level Finding SF-24:** Services for children and youth with mild to moderate behavioral health needs have not kept pace with population growth. This results in poorer outcomes when these children and youth have other challenges with SUDs, school, the juvenile justice system, and overall health. Families, school systems, and social service agencies experience the brunt of limited resources for this population.

**Prevention**

**System Level Finding SF-25:** Historically, Behavioral Health Solutions of South Texas has provided strong leadership and the Prevention Resource Center has provided regional data to identify prevention needs, both of which are strengths. Many small SUD prevention initiatives in the RGV, such as the Cameron and Willacy County Court Appointed Special Advocates (CASA), are addressing SUD prevention. While these efforts are useful, they do not have enough resources to provide the structure for more systematic prevention improvements that include holistic interventions that would have an impact on families across generations.

**System Level Finding SF-26:** In 2014, the number of deaths by suicide per 100,000 people in the RGV ranged from 6.6 for Cameron County to 6.8 for Hidalgo and 9.6 for Starr County. Yet, there are no organized suicide prevention activities within large health systems in the region. While Mental Health First Aid has been offered throughout many of the school systems, there is no holistic/universal prevention approach at a county or local level that targets both adults and school age youth, nor any indication of a strong school-based culture to address youth suicide prevention.

**Integrated Care**

Integrated behavioral health (IBH) represents a paradigm shift in both primary care and specialty behavioral health care settings. IBH entails more routine attention to behavioral health among primary care providers and other medically trained staff, as well as skillful attention to behavioral aspects of what are typically considered “physical” disorders, such as insomnia, diabetes, and obesity. Similarly, in specialty behavioral health settings that serve adults with serious mental illnesses, IBH has created a new understanding of the overall health of the people being served, offering the potential to extend health, wellness, and life expectancy.

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121 Data were not available for Willacy County. The statewide rate per 100,000 people was 12 in 2014. Source: Texas Department of State Health Services. (2016, September 23). *Texas health data: Deaths of Texas residents, 2014.* Retrieved from http://soupfin.tdh.state.tx.us/death10.htm
In collaboration with the St. David’s Foundation, MMHPI developed a report titled *Best Practices in Integrated Behavioral Health: Identifying and Implementing Core Components.* The report, published in August 2016, identified seven core components of IBH that can be used to determine the extent to which physical health and behavioral health care is integrated (versus simply co-located) for patients. The report offers a roadmap for providers, funders, advocates, and policymakers interested in promoting IBH and working systematically toward achieving its promise.

Early detection and intervention is an important factor in the successful treatment of behavioral health conditions. In many IBH settings (particularly primary care), the behavioral health needs of clients are typically in the mild to moderate range, often involving depression and/or anxiety. In the United States, one in five adults (20%) will experience a clinically significant form of depression in their lifetime, and about 7.5% of the US workforce has depression in any year. While more than 80% of people with depression can be treated successfully with medication, psychotherapy, or a combination of both, less than 22% receive adequate care. In the RGV region, about 182,300 adults and 58,800 children have mild to moderate behavioral health needs but are unable to have these needs addressed by the LMHAs because of the state mandate for LMHAs (such as TTBH and BRBHC) to focus on populations with the most serious behavioral health issues. IBH provides an opportunity for individuals with mild to moderate behavioral health needs to have those needs assessed and treated “in-place” in a primary care setting without the need to refer to a specialty behavioral health provider.

A 2016 MMHPI report titled *Increasing the Cost-Effectiveness of Depression Treatment with Collaborative Care* found that integrating psychiatric consultation into medical settings, with accountability for outcomes and costs, improves both mental health and medical treatment.

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123 Kessler, R.C., et. al. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62,* 593-603. For major depression alone, the chance of having the diagnosis at some point in one’s life is one in six.


outcomes while ultimately reducing the cost of care.\textsuperscript{128} One study from 2007 showed that individuals who received treatment for depression had 23\% less absenteeism and only one third as many missed days of work.\textsuperscript{129} In addition, the study went on to report that effective depression treatment led to an economic benefit of $1,982 associated with improved productivity at work and $619 per person associated with reduced absenteeism, amounts that are higher in today’s dollars.

In this way, IBH is helping providers and funders move past outdated understandings of health needs, intervention approaches, and limitations on the range of potential settings in which IBH can be successfully implemented to improve health outcomes and reduce costs associated with a lack of adequate treatment.

**Integrated Behavioral Health (IBH) Findings**

**System Level Finding 27:** There is a strong commitment to IBH among many providers in the region, with many implementing similar or at least complementary approaches to care. This commitment is shared by Methodist Healthcare Ministries, the Valley Baptist Legacy Foundation, and other important health system leaders in the region, and sets the stage for more intentional collaboration among providers at several different levels.

**System Level Finding 28:** An encouraging array of IBH programming and service delivery has emerged in the RGV, including evidence-based IBH models, such as the Collaborative Care and Primary Care Behavioral Health (PCBH) models. Exquisitely designed training programs and ambitious integrated programming are developing in some locations.

**System Level Finding 29:** While nearly all sites show evidence of rudimentary aspects of integrated care (including, for example, universal screening and testing for behavioral health or physical health conditions), much more development is needed for the more advanced aspects of integrated care, such as population health management and the development of more precise protocols and shared clinical pathways that can serve to make care truly integrated and well-organized.

**System Level Finding 30:** Not all providers can meet the IBH needs of all people in their settings and, especially given the universally-cited shortage of behavioral health providers, there is a need for cross-provider collaboration to ensure that the right people receive the right care in the right location. As mentioned above, providers now know enough about IBH to

\textsuperscript{128} See the Washington State Institute for Public Policy at http://www.wsipp.wa.gov/BenefitCost for a recent review of studies that concluded integrated mental health/physical health care in primary care settings is cost-effective.

systematically collaborate in this way, yet few memoranda of understanding exist between providers and most indicated to us that collaborative efforts have mostly died out or failed.

Criminal Justice Delivery System

System Level Finding SF-31: Individuals with behavioral health needs are over-represented and highly prevalent in all aspects of the criminal justice system, including law enforcement, jails, detention, courts, probation, and parole. Of particular concern are the 700 people trapped in cycles of “super-utilization” that use jails, particularly the 400 with primarily forensic needs. There are some notable strengths in the systems developed to serve these individuals, including the Mental Health Peace Officers Team (MHOT) at TTBH (funded through DSRIP and law enforcement contributions from some counties and police departments). MHOT is a model program for initial crises, but it needs to expand to provide coverage across the RGV 24 hours a day, seven (7) days a week, 365 days a year as well as initiate collaboration with medical first responders to provide onsite treatment options. Additional opportunities for local collaborations to implement programs for diverting individuals with mental health needs from the justice system are provided through the SB 292 grant program, with a focus on both reducing recidivism in jails and decreasing wait times for forensic beds at state hospitals.

For people returning to the community from prison, the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) provides intensive case management (50 individuals), transition case management for those on probation (75 individuals), and the supervision of parolees (75 individuals), but more case management options are needed.

System Level Finding SF-32: Some county sheriffs and police departments have developed effective strategies for collaboration, including those that fund a Mental Health Peace Officers Team (MHOT). For example, the Pharr Police Department provides an ideal model for collaboration between the justice system and service providers that has yielded promising results. However, these programs need to be brought to scale and implemented in other areas of the RGV. Given current gaps in capacity, lengthy wait times, and in some cases a lack of safe spaces at emergency departments (EDs) to help individuals de-escalate from behavioral health crises, across the RGV it is still easier for some officers to arrest and jail these individuals instead of taking them to an emergency department.

System Level Finding SF-33: Multiple issues hamper identification and coordination of care for people entering the criminal justice system:

- Access to supported housing and Supported Employment is very limited for justice-involved individuals because of the limited housing stock and the dual stigma (being mentally ill and also involved with the justice system) these individuals face.
- For people who are new to the justice system and for whom behavioral health data
have not been entered into the system, post-arrest jail diversion is often not possible since a Continuity of Care Query would not reveal their behavioral health condition.

- There are diverse practices in different counties and police departments, confusion over transportation responsibilities, and a lack of resources for licensed clinical consultation and case management.
- There are also significant gaps in other crisis services that need to be available at sequential intercept points (where the justice system and individuals with behavioral health conditions interact). None of the four counties have completed a comprehensive sequential intercept analysis of the behavioral health/criminal justice intercept points that could benefit from more effective collaboration and service coordination.

Veterans’ Services Delivery System

System Level Finding SF-34: While there is a wide array of services available to veterans through the Texas Valley Coastal Bend Health Care System (VA-TVCBHCS) and other providers, there are significant challenges for veterans in accessing services. The stigma of having a mental illness or substance use disorder is a barrier for veterans in accessing services because the personal or societal perception of weakness is anathema to the military maxim of accomplishing the mission regardless of personal discomfort. Mental health or substance use conditions can also be misunderstood by veterans and their families as weakness or self-pity rather than treatable illnesses. In addition, the lack of readily available outreach and treatment that is trauma-informed and competent in working with the military culture contributes to barriers veterans face in accessing services. Transportation is also a significant challenge for this population.

On the positive side, there is good collaboration between VA-TVCBHCS and TTBH, which operates a veteran’s drop-in program in Cameron County and is expanding services in Hidalgo County through the Texas Veterans + Family Alliance program. There is also effective collaboration between VA-TVCBHCS and the Department of Psychiatry at UT-RGV to support a residency program in 2017, provide tele-mental health, and develop specialized psychiatry services (e.g., electroconvulsive therapy).

Housing Needs

System Level Finding SF-35: The housing stock throughout the RGV is very limited and the need for supported housing is essential, especially for adults with serious mental illness and youth transitioning to independent living from foster care or their family home, as well as for veterans with behavioral health challenges. While access to supported housing services across Texas is low, state LMHA data from FY 2015 show that TTBH and BBHC served the lowest percentage of individuals in need when compared to other similar LMHAs. As shown previously in the Adults with SMI (200% FPL) Known to Have Received Supported Housing table, TTBH
provided this service to approximately 2% of the population in need within the catchment area (about 671 individuals), and BRBHC served approximately 1.3% of individuals in need within their catchment area (about 120 individuals). There is also a need for sober living housing coupled with access to recovery supports and services capable of fully addressing co-occurring needs. The approach to housing adopted by the VA and under consideration by TTBH is the Housing First Model, which focuses on assisting people with obtaining a home without the condition of treatment. This model provides a positive incentive to engage in treatment. While BRBHC, TTBH, and the VA have attempted to provide individuals with supportive housing models that include an apartment or home as well as other supports to help them remain in their homes, there is a need for the broader RGV region to address the housing shortage through local and county-level planning. As noted previously in findings related to SUD, there also is a significant need for ASAM residential levels of care, particularly half-way houses and supportive living environments.

Workforce Needs

System Level Finding SF-36: There are significant workforce gaps for all providers (especially those who speak Spanish), including psychiatrists and other licensed mental health and SUD professionals. This has an impact on both the capacity of these provider types and the supervision and training of qualified mental health professionals (QMHPs) working in the LMHAs and promotores/community health workers more broadly. The state’s current licensing standards make it challenging to license new staff, including psychiatrists. SB 674, which was signed into state law following the 85th Legislative Session, expedites the licensing process for psychiatrists who are already licensed and in good standing to practice medicine in another state. This will allow psychiatrists recruited from out of state to be fast-tracked through approval processes to be licensed for practice in Texas. While the QMHP staff at the LMHAs (for whom licensure is not required) are often bi-cultural, bi-lingual, and educated in the RGV, the opportunities for them to learn through on-the-job training are more limited because of the absence of licensed personnel.

System Level Finding SF-37: Reliance on certified peer specialists to provide supports for adults and youth, and certified family partners to assist families of youth with behavioral health conditions, is a best practice that is strongly embedded within TTBH and needed throughout the adult and child/youth systems of care. BRBHC has begun offering these supports through family partners. TTBH has modeled the effective use of peers throughout its system, including its peer-run drop-in centers, its Assertive Community Treatment (ACT) program, and other services. Peers and family partners participate in treatment team meetings and their valuable contributions were noted by psychiatrists and other licensed clinicians at TTBH. There is a need to share the lessons learned by peers and family members across the adult and child/youth systems of care, including the justice system. The use of peers embodies a recovery orientation that needs to be infused within all levels of care and for all behavioral
health populations. HB 1486, which was passed during the 85th Legislative Session and developed through the efforts of the Select Committee on Mental Health, establishes guidelines for the development of training and certification requirements for peer support specialists. Additionally, provider organizations will now be able to bill Medicaid directly for peer support services, rather than using the rehabilitation services billing code for these services.

Transportation Needs

System Level Finding SF-38: Limitations of transportation systems that cross cities and towns in the RGV contribute to poor access to services. While there are some outreach services and use of mobile vans to provide case management and other supports, access to buses and other public transportation is limited. Individuals generally must rely on personal vehicles for transportation to behavioral health care services. Some providers have vans that pick up known clients, such as the TTBH drop-in programs and the Veteran’s Administration Texas Valley Coastal Bend Health Care System, which is useful, but does not assist individuals who have yet to connect with services.

Use of Telemedicine

System Level Finding SF-39: The use of telemedicine, a key resource in a large geographic area with limited availability of licensed behavioral health professionals, has expanded throughout the RGV, but access to board certified psychiatrists, especially those fluent in Spanish, and other licensed professionals remains a challenge. Also, providers have challenges with orienting staff to best practice procedures for telemedicine and with using some of the equipment.

State Level Findings Related to LMHAs (STF)

State Level Finding STF-1: The mechanism HHSC uses to rebase its capacity targets for the LMHAs, especially when they exceed their capacity, presents some challenges. For example, if TTBH serves 135% of their targeted capacity and the next year DSHS increases the target capacity to 135% without a budget increase, TTBH must continue to stretch its resources to provide the greater capacity. Rather than receiving an adjustment to accommodate more individuals, TTBH receives the same funding with a requirement to maintain the higher capacity. This approach is unsustainable and in effect punishes TTBH for its innovation and outreach.

State Level Finding STF-2: The HHSC Clinical Management for Behavioral Health Services (CMBHS) system, a web-based clinical record keeping system for state-contracted community mental health and substance use disorder service providers, requires dual entry and creates errors and extra work for providers. While it is not uncommon for states to have dual
information systems for state-funded and Medicaid-funded services, this approach is outdated and inconsistent with insurance approaches and emerging value-based payment strategies.

**Major System Level Recommendations (SR)**

**County-Level Planning**

**System Recommendation SR-1:** To address gaps related to a lack of system-level coordination in each county, develop or strengthen existing county-level collaborative efforts and form comprehensive behavioral health leadership teams (BHLTs), using support from the Valley Baptist Legacy Foundation (Legacy Foundation) and/or the $30 million in grant funding from HB 13 to provide incentives for state-local collaborations on mental health. The teams should focus on the behavioral health needs of the whole population of each county, including a dedicated position (at least half-time) to support the collaborative efforts. These efforts should build on existing county collaborations to capitalize on current investments of people and time. Counties will need to determine the strongest starting places for county-wide collaborations. Membership could include a designated senior leader of the county and all key leaders of county services (e.g., sheriff and local law enforcement, juvenile justice, child and adult protective services, county medical/public health) that intercept with behavioral health issues, managed care organizations (MCOs) that serve the county, federally qualified health centers (FQHCs), primary care and behavioral health providers, hospitals, the Recovery Oriented Systems of Care (ROSC) participants, other current county-specific planning groups such as the Cameron County Mental Health Task Force and community prevention partnerships, representatives of the school districts, consumers and family members, and other stakeholders. Using the findings from this report, identify the priorities that each county needs to address. We offer this recommendation because of the complexity of the RGV and the need to develop a step-wise process to forming organized collaborative efforts within each county and share strategies across the region. Two existing BHLTs that exemplify successful collaborations are the Denton County Behavioral Health Leadership Team (DCBHLT)\(^{130}\) and the Panhandle Behavioral Health Alliance (PBHA):\(^{131}\)

- The DCBHLT was established in 2014 through a collaboration between United Way of Denton County and the Denton County Citizen’s Council on Mental Health, with assistance provided by MMHPI. The DCBHLT adopted a vision of “Comprehensive behavioral health for every person in Denton County,” and since its inception has accomplished a number of goals: It developed a mental health resource directory for Denton County; launched the Veteran Community Navigator Program, a pilot case management program providing centralized intake and assistance to veterans in crisis, through the state’s Texas Veterans + Family Alliance (TV+FA) program; partners with the

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130 For more information on the Denton County Behavioral Health Leadership Team, see: www.dentoncountybhlt.org
131 For more information on the Panhandle Behavioral health Alliance, see: panhandlebehavioralhealthalliance.org
Military Veteran Peer Network (MVPN) to conduct Veteran Cultural Competency Training; and partners with MMHPI in the Okay to Say™ campaign (okaytosay.org), a community-driven initiative to increase the awareness that most mental illnesses are treatable and offer messages of hope and recovery to Texans and their families.

- The PBHA formed in 2016 with a broad group of stakeholders representing the behavioral health service delivery system of 26 counties in the Texas Panhandle region. The PBHA partnered with MMHPI in 2016 to conduct a behavioral health systems assessment in the Panhandle region to identify specific areas of need and opportunities for growth. PBHA adopted the mission statement, “The PBHA collectively builds systems that improve the behavioral health life-cycle of care for all people of the Texas Panhandle,” and selected three areas of focus for their work in promoting behavioral health and wellness in the community: 1) Access to behavioral health care and alignment with physical health care; 2) Workforce and recruitment for behavioral health professionals; and 3) Prevention and early intervention for behavioral health problems. In addition to these areas of focus, PBHA has also partnered with MMHPI in bringing the Okay to Say™ campaign to the local community.

System Recommendation SR-2: Through each county BHLT, develop a “culture of collaboration” that emphasizes an inclusive community-wide behavioral health system collaboration based on shared values. This collaborative effort should be guided by the premise that the behavioral health needs of the entire population are the responsibility of all communities, and it should be a shared priority to welcome people in need – and each other – as priority customers of one another. To accomplish this, the county planning effort could work to engage all funders, including Medicaid managed care organizations, health plans, health systems, employers, etc., as well as others mentioned in SR-1 above.

System Recommendation SR-3: The county BHLTs should develop and articulate a vision of what the behavioral health system should look like – if it were fully responsive to the needs identified in this report – to support individuals with behavioral health issues in having safe and productive lives in the community and in their home, family, faith, work, or school. The results of this assessment should inform that vision; however, the vision cannot be established by an external review – it must be developed collaboratively by the county BHLTs, with extensive input from stakeholders representing adults, older adults, and children, youth, and young adults. The following figure provides an example of an ideal systemic approach to behavioral health.
Systemic Approaches to Behavioral Health Service Delivery

System Recommendation SR-4: Once the vision is established, each county BHLT should create a prioritized timeline for incremental development of strategies to address system gaps over a multi-year period. The priorities for sub-populations identified in this report could be a starting place for the county BHLTs.

System Recommendation SR-5: Develop work groups to address areas of highest priority, based on the priorities of the county BHLTs and the recommendations in this report. It may take some time for each county BHLT to form and prioritize its goals. However, the findings and recommendations in this report point to several areas, all of which cannot be addressed at once and will take time to implement. Examples of sub-populations and projects that would benefit from increased collaboration are listed below.

- Individuals of all ages using the crisis system would benefit from improved collaboration to address the gaps in crisis services for adults, children and youth, and older adults, such as diversion, crisis respite, and care coordination. Other examples of county-level collaborations, based on the findings in this report, but not in order of priority, are listed below.
  - Adults with complex needs trapped in “super-utilization,” cycling through repeat episodes of emergency department (ED), hospital and jail use;
  - Adults and transition age youth in need of housing, focusing on housing development;
  - Children and youth with serious emotional disorders (SEDs) and the highest level of needs to work on aligning the children’s systems of care and expanding access to
evidence-based intensive mental health services and wraparound initiatives;

- **Individuals in need of alcohol and substance use disorder (SUD) treatment and prevention**, to expand alcohol and SUD services, including residential treatment;

- **Individuals with complex medical needs**, including alignment with the Regional Health Partnership and The University of Texas School of Public Health – Brownsville Regional Campus to promote broader dissemination of primary health and behavioral health integration (this collaboration could include BRBHC, TTBH, the FQHCs, VA-TCBHCS, and other health care providers); and

- **Collaborations that could address workforce issues**.

The success of each BHLT will depend on the investment by each county and its stakeholders, and their commitment to work systematically to address challenges that are best addressed by a collaborative effort at the county level.

**System Recommendation SR-6**: Through the county BHLTs, and utilizing the data provided in this report, develop a financial blueprint that maps public (state and local) and private funding sources for services to identify the amount of available resources, types of services, target populations, and location of services. Then, identify how each service fits into regional and county systems of care for adults and older adults; children, youth and young adults; and special needs populations such as veterans and individuals who are homeless.

A key component of this strategy should be to make full use of new and existing local-state partnership opportunities. Three bills passed during the 85th Legislative Session have created new opportunities to address the unmet needs of individuals with mental illness in the RGV:

- **SB 292 was established with the intent of funding programs that will reduce recidivism, arrests, and incarceration of individuals with mental illness to keep them from cycling through county jails and the state psychiatric hospital system**. The program provides matching grants to county-based collaboratives and allows flexibility for communities to determine what services and supports are most needed to solve local needs. The first year of funding for this program is allocated specifically for community collaboratives that include highly populated urban counties of 250,000 or more, with the second year allocating 20 percent of funds for collaboratives that include less populated rural counties of less than 250,000. Grant recipients are required to meet a 1:1 local-state match for counties over 250,000 and a 1:2 local-state match for smaller counties under this population level.

- **HB 13 was established with the intent of funding programs that will help address gaps in mental health services and treatment in local communities**. This program provides matching grants to support community mental health programs that provide services and treatment to individuals experiencing mental illness. While SB 292 has a focus on urban collaboratives in its first year, HB 13 has a greater focus on funding rural
communities – 50 percent of the funds are reserved for programs located in counties with a population of less than 250,000.

- **SB 74 clarifies the requirements for entities that want to become Targeted Case Management and Mental Health Rehabilitative Services providers.** This bill is closely tied to the allocation of $2 million in the state budget (SB 1) to establish a statewide grant program to increase access to Targeted Case Management and Mental Health Rehabilitative Services for children and youth with high needs in foster care. The intent of this budget allocation is to fund start-up and training costs for providers to increase their capacity to serve these children and youth. The grant program is focused on providing funding to entities that are working toward either becoming Targeted Case Management and Mental Health Rehabilitative Services providers for children and youth with high needs in foster care, or to expand their existing capacity to provide these types of services.

Additionally, two existing state programs provide opportunities to secure funds for supporting local collaborations focused on mental health service provision:

- **The Texas Veterans + Family Alliance (TV+FA) program** was created by SB 55 in the 84th Legislative Session with the purpose of supporting community mental health programs that provide services and treatment to veterans and their families. A pilot program was launched in late 2015, with selected awardees beginning their programming in the summer of 2016, with operation supported by a total of $1 million in public funds (with a 1:1 match in local, private and in-kind funds). The second phase, which initiated the full program, provided two rounds of awards in 2016 and 2017, offering up to $10 million in state dollars (which, again, would be matched 1:1 in local, private, and in-kind funds). The 85th Legislature approved continued funding of the program at $20 million over the next biennium.

- **The Health Community Collaborative (HCC) Program** was created by SB 58 during the 83rd Legislative Session with the purpose of establishing or expanding community collaboratives that bring the public and private sectors together to provide services to people experiencing homelessness and mental illness. The Department of State Health Services was tasked with awarding a maximum of five grants to municipalities within counties with a population of more than one million. In its first two fiscal years (2014 through 2016), DSHS awarded more than $51 million in grants to Austin Travis County Integral Care (ATCIC), the City of Dallas, the Coalition for the Homeless of Houston, Haven for Hope – San Antonio, and My Health My Resources (MHMR) of Tarrant County. The 84th Legislature required the allocation of up to $25 million in general revenue over the biennium to fund collaborative grants within this program.

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System Recommendations: SR-7: As part of county BHLT planning, develop a strategy to address the stigma associated with mental illness and SUD, including stigma for veterans who have behavioral health conditions. Multiple approaches could be pursued with a quality improvement focus. For example, because transportation issues limit access to services for veterans, one useful strategy would be to collaborate with the VA-TVCBHCS to identify where veterans live in the RGV and then map access to providers. Following this step, the county BHLTs could focus on developing an expanded provider network to serve veterans. Transportation gaps could also be referred to each county’s transportation planning group. More broadly, MMHPI’s Okay to Say™ campaign can be utilized as a resource for addressing barriers to mental health treatment related to stigma. Okay to Say™ is a community-based campaign launched by MMHPI and its partners to increase public awareness that most mental illnesses are treatable and to offer a message of hope and recovery to Texans and their families. The goal of Okay to Say™ is to change the conversation and perceptions around mental illness, which ultimately can lead to increased understanding, advocacy, and support for those with mental illness; improved access to community services for diagnosis and treatment; and accelerated progress in the quality and delivery of mental health care.

Crisis Delivery System

System Recommendation SR-8: The highest priority for enhanced county-level (and possibly even some cross-county) collaboration is the crisis system, specifically the development of a comprehensive, regional integrated crisis system across all major public payers, hospital providers, behavioral health providers (mental health and substance use disorder), first responders, and the justice system. The system should provide access to a range of crisis services, including crisis diversion and alternatives to inpatient services and jails. Protocols and procedures for accessing services must be clearly written and shared among all parties. Similarly, protocols for diverting individuals from emergency departments and restrictive inpatient care should be widely shared and transparent. This high priority should be addressed immediately as part of planning to access state-local partnership funds under SB 292; the goal of this program (which is expected to begin providing grant funding in early 2018, requiring a 1:1 local-state match for counties over 250,000 and a 1:2 local-state match for smaller counties) is to reduce recidivism, arrests, and incarceration among individuals with mental illness and to reduce wait time for forensic commitments. SB 292 requires the formation of a community collaborative (or collaboratives; a minimum of a county, a LMHA, and a hospital district, if any, as well as other local entities designated by the collaboratives members) to plan and submit proposals for funding. This legislation presents opportunities for the development of needed services throughout the Rio Grande Valley, including:

- The establishment or expansion of crisis diversion services;
- Expansion of crisis respite services;
- Provision of Assertive Community Treatment (ACT) and Forensic Assertive Community
Treatment (FACT);
- Creation of multidisciplinary rapid response teams;
- Development of alternative solutions to competency restoration in state hospitals, such as outpatient competency restoration, inpatient competency restoration in a setting other than a state hospital, or jail-based competency restoration;
- Intensive mental health or substance use disorder treatment services;
- Continuity of care services for individuals being released from state hospital; and
- Provision of local community beds (community hospital, crisis, respite, or residential).

Several examples of successful jail diversion programs have been implemented in regions across the state. In Dallas County, a local collaboration\(^\text{133}\) has begun implementing the use of Multidisciplinary Response Teams (based on the successful model in Colorado Springs). This model creates a partnership between EMS, police, and local mental health providers by developing teams who respond as a single unit (of three) to the scene of mental health crises. It also expands options for addressing not only the crisis at hand, but also factors contributing to the cycle of chronic crisis and criminal justice system involvement. One example of an ideal jail diversion program is the Harker Heights Police Department Healthy Homes Program. This project embeds clinicians within the police department and allows for either an immediate response on scene in “pre-crisis” situations or referrals from patrolmen to homes or people for whom they have increasing concerns. The Health Homes Program’s overarching purpose is to link area social service organizations and community resources to families who would benefit most from them. The program offers a direct link to area resources, solution-focused interventions, crisis/grief counseling, domestic violence support, welfare checks, and in-home intervention planning. The program also expands the available behavioral health workforce by using intern-level clinicians from local universities to fill the need for licensed clinicians on the response team.\(^\text{134}\)

Funding to provide inpatient, outpatient, and jail-based restoration to competency services have the potential to alleviate the long wait times for services that contribute to extensive jail time or inpatient utilization.

The need for crisis respite is especially acute in Starr County; Starr Memorial Hospital, which has the primary emergency department (ED) used in Starr County, has expressed interest in providing these crisis services if funding were available. The Starr County hospital district faces significant challenges with ED space and the county is confronted with limited transportation

\(^{133}\) For more information on the development of this initiative, see: http://www.tmcec.com/files/6314/6245/8577/03__Wagner_BINDER_Stepping_UP.pdf

resources and excessive demands on law enforcement’s time, all of which contribute to individuals being taken to jail rather than inpatient care.

A full crisis array of services, as outlined in MMHPI’s report to St. David’s Foundation, ideally includes a continuum of services specifically created with the intention to stabilize and improve the individual’s symptoms and facilitate engagement in treatment in the least restrictive setting possible. The best practice in crisis services includes the following components: (1) psychiatric emergency centers, (2) hospital emergency departments, (3) 23-hour crisis stabilization/observation beds, (4) inpatient psychiatric care, (5) short-term crisis residential and crisis stabilization services, (6) emergency medical services, (7) mobile crisis services, (8) 24/7 crisis hotlines, (9) warm lines, (10) psychiatric advanced directives, (11) peer crisis services, and (12) transportation. Any development of additional inpatient capacity should occur within the context of developing the crisis service array. Inpatient facilities should consider working collaboratively with other providers in the RGV to refine their assessment of gaps in services for key sub-populations in the counties in order to best align inpatient capacity with geographical and population needs and potentially establish components of the crisis continuum.

- **System Recommendation SR-8a:** Establish county-based collaboratives to focus on the highest priority needs first and obtain as much funding as possible for the SB 292 grant program’s allowable services. Subsequently, county and cross-county crisis collaboration should consider investing in focused strategic planning to develop a business plan for a broad array of crisis diversion and step-down services, including expanding ongoing intensive services (ACT/FACT) for frequent crisis system users, short-term crisis residential capacity, and ambulatory intensive crisis intervention services that are available throughout the RGV. Consider locating these services at Starr Memorial Hospital in Rio Grande City. As noted in the findings section of this report, the Transitional Care Clinic in San Antonio, operated by the UT Health Science Center, is a model that (provided it is accompanied by a plan for sustainability) would be very useful in the RGV.

- **System Recommendation SR-8b:** In addition to planning for SB 292 funding and services, county-level crisis collaboration could also focus on acute care coordination, involving BRBHC, TTBH, acute care hospitals, VA-TVCBHCS, and MCO care coordination. Coordination efforts would focus on developing routine tracking and coordination to resolve continuity of care issues and engage individuals experiencing a crisis who are at risk of falling through the cracks.

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System Level Recommendation SR-8c: Incorporate crisis diversion beds within a proactive continuum of crisis intervention, so that intensive crisis case management (e.g., using models like Critical Time Intervention) and skill-based programming can be incorporated into the continuum and included in the provision of both diversion services and step-down crisis beds. The need for crisis diversion beds is among the highest needs in the RGV and should be a priority for SB 292 funding in the BRBHC and TTBH RGV service areas. Given the current low cost of The Wood Group service models, engaging Medicaid MCOs and other insurers in purchasing these levels of care and expanding them to other parts of the RGV would benefit all. However, the crisis respite programs should first be separated from transitional living programs (which tend to use up crisis respite bed capacity) before being expanded.

Adult Mental Health and Criminal Justice Delivery Systems

System Recommendation SR-9: Based on information for adults with incomes under 200% of the federal poverty level (FPL), the county BHLTs should also prioritize the development of sufficient capacity to provide ongoing care for the adults with highly complex needs who are caught in cycles of “super utilization” of crisis, jail, emergency room, inpatient, and homeless services. Tying this to SB 292, immediately begin planning a collaborative to bid on resources for Assertive Community Treatment and Forensic Assertive Community Treatment teams with outreach, and evidence-based models for those individuals with high utilization of services who currently are unsuccessful in negotiating transitions between levels of care or who are not able to maintain connections with usual services. Resources should also be targeted to the establishment of interdisciplinary rapid response teams to reduce law enforcement’s involvement with mental health emergencies, which would allow expansion of current crisis intervention capabilities. By addressing the needs of adults with “super-utilization,” individuals will benefit from improved quality of life and the “system” will benefit from decreased utilization and costs as well as decreased challenges associated with repeatedly seeing the same individuals use scarce resources.

System Recommendation SR-10: Given the expense of inpatient care, consider developing a strategic plan for utilization of inpatient bed capacity across the entire RGV region that focuses on the needs of the entire population and matches gaps in services. Any development of additional inpatient capacity should occur within the context of this planning. Inpatient facilities should consider working collaboratively with other providers in the RGV to refine their assessment of gaps in services for key sub-populations across the region in order to best align inpatient and outpatient capacity with geographical and population needs.

System Recommendation SR-11: At the county BHLT level, consider developing a strategic plan for implementing outpatient services for adults with mild to moderate behavioral health
needs who often rely on social services organizations that provide an array of services, but not specifically mental health services. The focus should consider individuals with Medicaid, Medicare, other insurance, or no insurance.

Co-Occurring Mental Health and Substance Use Disorder Delivery System

System Recommendation SR-12: At the county BHLT level, consider developing a strategic plan for an expanded array of substance use disorder (SUD) services – including co-occurring services and the American Society of Addiction Medicine (ASAM) level of care residential substance abuse programs – in the RGV for individuals with Medicaid, Medicare, other insurance, or no insurance. This should involve creating an organized collaboration among SUD providers so that efforts for collaboration and improvement are integrated rather than occurring separately. As mentioned previously, consider engaging the ROSC and the prevention coalitions in county BHLT activities.

Child, Youth and Families Delivery System

System Recommendation SR-13: Building on the work of TTBH Children’s System of Care (CSOC) and their existing collaboration with juvenile justice and child protective services, develop a planning process within each of the counties in the RGV that involves all child and family serving providers, and, working with all major payers and providers throughout the counties, expand this model to serve more children and youth. A key priority within this planning process should be to expand implementation of intensive home and community-based supports (including evidence-based models) for children and youth at highest risk of out-of-home placement, wraparound planning that takes full advantage of YES Waiver funding, early intervention services for severe mental illness manifesting in adolescence (including best practice first episode psychosis services), and school-based and school-linked services to maximize access to care and begin to address the “school-to-prison pipeline.” A trauma-informed care approach should also be included in the CSOC planning process.

Children and youth across Texas and the nation typically end up in inpatient care and residential treatment too often. It is important to understand that these levels of care are not places for ongoing treatment – they are specialized settings designed to address either acute needs (inpatient care) or an inability to reside at home (residential treatment). To ensure children and youth receive the right level of care for their behavioral health needs, MMHPI has developed a map of the “ideal system of care for pediatric mental health.” This ideal system can be organized into four components based on the level of intervention:

- Component 1 is **Integrated Behavioral Health Care** in a pediatric primary care setting. It is estimated that up to two-thirds of pediatric behavioral health care needs (particularly for children and youth with mild to moderate behavioral health needs) can be met in a
pediatric care setting with the right integration supports.\textsuperscript{137} School clinics provide a natural opportunity to embed integrated primary care for identifying and assisting children and youth with behavioral health concerns.\textsuperscript{138}

- Component 2 is **Specialty Behavioral Health Care**, which is provided by specialists in separate clinical settings. This level of care is most appropriate for about one fourth of children and youth with more complex behavioral health needs, such as bipolar disorder, post-traumatic stress disorder, and other conditions requiring specialized interventions.

- Component 3 is **Rehabilitation and Intensive Services**, which encompasses services provided to children and youth whose behavioral health conditions are so severe that they impair functioning across multiple life domains and require evidence-based rehabilitation in addition to specialized treatment of the underlying mental health disorder. The intent of these services is to provide the level of clinical intervention and support necessary to successfully return each child or youth to a healthy developmental path within his or her home or community.

- Component 4 is the **Crisis Continuum**, which includes mobile teams that can respond to a range of urgent needs outside of the normal delivery of care, and a continuum of placement options ranging from crisis respite to acute inpatient care. A crisis continuum for children and youth would include elements such as coordination with emergency medical services, crisis telehealth and phone supports, and an array of crisis placements tailored to the needs and resources of the local system of care.

While this array does not currently exist in any county in Texas, some components exist in the Rio Grande Valley region across the mental health, child welfare, and juvenile justice systems, but they require improved coordination.

**Prevention**

System Recommendation SR-14: Existing prevention networks can begin to engage in the county BHLTs’ prevention planning. Further, county and local prevention efforts can move from focusing on SUD to being more holistic by also addressing mental health, suicide prevention, and trauma. Trauma-informed efforts to build resiliency can help prevent multiple types of behavioral health conditions as well as break the cycle of multi-generational trauma. Through the county BHLTs, consider developing a broader set of prevention strategies to address the behavioral health (mental health and substance use disorders) needs of children,
youth, and families as early as possible. This includes children, youth, and families (with incomes less than 200% of FPL) that have mild to moderate behavioral health needs, those with first episode psychosis, and mothers with depression (40 to 60 percent of low income women have some type of depression), which presents a significant early risk to child development. Educate all providers on treating Medicaid eligible mothers with depression, and their children (Medicaid recently agreed to fund these services in its May 2016 bulletin). UT-RGV, BRBHC, TTBH directors of OSAR, ROSC, and the prevention coalitions should participate in this county-level BHLT planning.

Integrated Behavioral Health Care Delivery System

System Recommendation SR-15: Integrated Behavioral Health (IBH) offers the most promise for expanding capacity to treat mental health and substance use disorders more routinely and in the most cost-effective manner, particularly for the 182,300 adults and 58,000 children with mild to moderate needs. Key steps to consider in pursuing increased IBH capacity include the following:

- At the county BHLT level, develop an overarching strategy for integrated care to address priority populations in order to support cost-effective development of improved IBH within health care. Engage large systems, including university systems and hospital districts, to recognize the high prevalence of comorbid behavioral health needs in their existing medical populations as well as the contribution of behavioral health to high health costs and poor outcomes among individuals with serious physical illnesses and disabilities. This is an important starting place for understanding that IBH is a systemic approach that can make better use of existing resources and engage large health systems and health plans in developing a long-term strategy to pursue and develop IBH. MMHPI has developed a white paper, in partnership with the David’s Foundation, titled “Best Practices in Integrated Behavioral Health: Identifying and Implementing Core Components.” This white paper identifies and describes the various models and core components of IBH, offering a road map for providers, funders, advocates and policymakers interested in promoting IBH and working systematically toward achieving its promise.
- Develop new strategies to coordinate care between and among providers to reduce

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potential service duplication related to medical clearance and other care coordination needs (e.g., between TTBH primary care clinics and Su Clinica and other FQHCs).

- More broadly, efforts should be explored to link individual behavioral health practitioners in the community (both those who see people with insurance and the ability to self-pay and those who offer care on a sliding fee scale) with primary care practices in order to expand the reach of both. Further, IBH implies not just “parallel” referrals from primary care providers to behavioral health providers, but also embedding behavioral health consultation (using limited behavioral health resources) into the primary care practice team so that the whole primary health team has expanded ability to respond to behavioral health needs directly.

- Across the board, behavioral health service delivery needs to shift more from a private practice, stand-alone therapy model to more systemic approaches that include:
  - Early detection and routine care in primary care settings, including FQHCs, coordinated with behavioral health providers;
  - Outcome-driven and person-centered treatment in outpatient behavioral health and other specialty care settings;
  - Inpatient care that is embedded within a comprehensive continuum of crisis services in the RGV for life-threatening and other acute treatment needs;
  - Coordination of inpatient care within a network of linkages to leading providers across Texas, including academic medical centers that promote best practices and drive innovation.

System Recommendation SR-16: All IBH providers could examine the possibility of developing more team-based care for people with the most challenging co-occurring conditions encountered in their settings. Team-based IBH care programs have been implemented by several organizations, including the development of an IMPACT program for older adults at the Rio Grande State Center, the physical health/behavioral health (PH/BH) home for people with diabetes and behavioral health conditions at Su Clinica, and some strong elements of a team-based approach at TTBH. Additionally, Methodist Healthcare Ministries of South Texas, Inc. and the Valley Baptist Legacy Foundation fund the *Sí Texas: Social Innovation for a Healthy South Texas* (*Sí Texas*) project, which focuses on IBH models that effectively improve health outcomes for poverty, depression, diabetes, obesity, and other associated risk factors. *Sí Texas* subgrantees operate out of eight organizations, five of which are located in the RGV (TTBH, Nuestra Clinica del Valle, Hope Family Health Center, The University of Texas School of Public Health-Brownsville, and UTRGV). While isolated examples (such as those listed above) of team-based models are evident, the use of teams in general throughout RGV provider organizations is limited.

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System Recommendation SR-17: Each individual provider – and providers within each county collectively – need to develop a population health management approach to serving people with co-occurring PH/BH conditions. The Four Quadrant Model, described later in this report, can be used as an efficient problem-solving method to begin identifying the number of people falling into each of several clinical sub-populations, the current capacity to meet their needs through the implementation of appropriate IBH models, and the number of new programs (and staff) needed to meet their needs. In addition:

- **System Recommendation SR-17a:** Patient registries and other, simple-to-adopt population health management technologies could be used more widely in the RGV’s IBH programs.
- **System Recommendation SR-17b:** Some providers have special programs or even whole clinic sites dedicated to specific clinical populations (e.g., women’s health or pediatrics), and these sites represent excellent venues for the development of population health approaches that target specific co-occurring behavioral health and physical health needs. Specific models are developing in Texas for key clinical populations, such as the Dallas-area integrated care program for foster care children and youth with complex co-occurring physical health and behavioral health conditions.

System Recommendation SR-18: Screening, assessing, and referring people to the appropriate IBH program often will require providers to collaborate. In particular, it would be useful for primary care providers to develop memoranda of understanding (MOUs) with LMHAs (particularly TTBH) that outline target populations; co-location of staff arrangements; referral practices; shared resources, particularly related to telepsychiatry; clinical data sharing protocols; and management of psychiatric crises. The MOUs also should address primary care protocols for shared patients in order to maximize care coordination and minimize duplication of medical care.

System Recommendation SR-19: Efforts to implement Recommendation 17, above, could be facilitated by the development of an IBH learning collaborative in the RGV. Providers and training programs, such as the one provided by UT-RGV, could follow a collective impact model, such as Unidos Contra la Diabetes (UCD), as a vehicle for sharing best practices and engaging in region-wide population health management. UCD focuses on preventing diabetes in low-income and underserved populations and supports integrated care as a means to do so. This group provides a potential model for collaboration across RGV providers. The region’s leaders and experts in IBH can develop this IBH-focused collaborative and also have representation in the UCD program in order to ensure proper coordination across the region. In addition:

- **System Recommendation SR-19a:** An IBH subgroup of Unidos Contra Diabetes should rigorously examine the IBH workforce in the region and make plans for enhancing it. This is already happening through Unidos Contra Diabetes, and many training programs are addressing the need. The group could also track the number of primary care
providers – many of whom can be trained through embedded behavioral health specialists and directors of behavioral health – who attain a basic level of IBH competency. In addition, the group should set and formally track goals for training (and retaining in the region) family physicians, nurse practitioners, psychiatrists, psychiatric nurse practitioners, psychologists, social workers, licensed professional counselors, and licensed substance use disorder counselors.

- **System Recommendation SR-19b**: The IBH subgroup should also track the prevalence of need for IBH in primary care and specialty behavioral health settings by age group (child/youth, adult, and older adult), relative to the region’s capacity to meet that need. It should set multi-year goals for increasing the percentage of need met, clarify and periodically update the strategies that will be employed (including workforce related strategies – see above), and track the percentage of need met.

- **System Recommendation SR-19c**: The IBH subgroup should also track outcomes associated with enhanced IBH, including, for example, suicide rates per capita and by age group, potentially preventable emergency room and hospital visits and readmissions, and other indicators of well-being as measured by the Behavioral Risk Factor Surveillance System (BRFSS) and other ongoing measures in the region.

- **System Recommendation SR-19d**: Because many providers have, or soon will have, expertise in the implementation of specific evidence-based IBH models, as well as in targeted behavioral health and wellness interventions, the learning collaborative should compile a list of regional expertise, track the implementation of IBH evidence-based models across the region, host an annual IBH conference, and develop a training and consultation calendar or schedule for disseminating and adopting IBH best practices. The group should eventually move beyond a focus on IBH program models (e.g., Collaborative Care and Primary Care Behavioral Health models) and share best practices in implementing shared clinical pathways, such as diabetes-depression care, metabolic syndrome-serious mental illness care, and integrated behavioral medicine approaches to such common maladies as insomnia, headaches, and asthma.

**Veterans’ Services Delivery System**

**System Recommendation SR-20**: Immediately explore opportunities to work through collaborative(s) to obtain funding under the next round of the existing Texas Veteran + Families Alliance and the new HB 13 grant programs for expansion of needed veteran services and supports. One item to explore in particular would be supportive housing models to provide housing stability for veterans (and others) with complex needs who are caught in cycles of high utilization of emergency department services and inpatient care. The ASAM levels of residential care should also be considered for veterans (and others) who may be involved with the criminal justice system because of substance use/sobriety issues. The need for sober living housing is also critical. In addition, building on the efforts of TTBH and the Veterans Administration –
Texas Valley Coastal Bend Health Care system (VA-TVCBHCS), continue to train professionals and peers on best practices in trauma-based care and outreach services for veterans.

**System Recommendation SR-21:** As part of county BHLT planning, develop a strategy to address the stigma associated with mental illness and SUD, including stigma for veterans who have behavioral health conditions and are reluctant to seek services. Okay to Say™ can be a resource for assisting county-level BHLTs in accomplishing this goal. The campaign emphasizes that most mental illnesses are treatable and offers a message of hope and recovery to Texans and their families. Okay to Say™ provides an opportunity for local communities to partner with MMHPI in providing a mechanism for starting local conversations about mental illness to both increase public awareness and encourage individuals throughout the community to seek treatment and supports.

**Housing**

**System Recommendation SR-23:** Stakeholders in the RGV should immediately prepare to form collaborative(s) and obtain funding under the new HB 13 grant program for expansion of supportive housing models to provide housing stability for individuals who are experiencing “super utilization” of emergency departments, jails, and inpatient care. The ASAM levels of residential care should also be considered for individuals involved with the criminal justice system because of substance use/sobriety issues. The need for sober living housing is also critical.

**System Recommendation SR-24:** At the county BHLT level, begin planning with cities and towns on the development of independent housing options for adults and transition-age youth moving to independent living from foster care or their family home. At the same time, consider developing supportive housing models that assist individuals with behavioral health conditions to live independently. Refer to the Substance Abuse and Mental Health Services Administration (SAMHSA) materials on Permanent Supportive Housing, an evidence-based practice that promotes individuals’ tenancy rights in their own homes, and the Housing First Model, which was piloted nationally by the VA and, as a low barrier approach to providing individuals with a home, does not require the person to participate in treatment, but still provides supports to maintain tenancy.

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143 These materials are available through this web link: http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510.

Transportation
System Recommendation SR-25: As part of county BHLT planning, work with the Rio Grande Valley Development Council (LRGVDC) and other regional planning agencies to improve transportation options.

System Recommendation SR-26: As part of county BHLT planning and efforts to address transportation gaps, work with the Medicaid MCOs to develop a broader provider network in areas where there is limited available transportation.

System Recommendation SR-26: As part of county BHLT planning, study the cost effectiveness of using vans to pick up clients (similar to TTBH’s program for their drop-in services) versus paying a transportation company to transport clients to behavioral health services provider sites. Include all interested providers in the planning, including those that serve veterans.

Workforce
System Recommendation SR-27: As part of county-level collaborative planning efforts, develop a targeted workforce development plan at the college and university level to train and provide certificates for culturally diverse behavioral health specialists to provide services across an array of evidence-based practices and services. This workforce development plan would also include information technology training to support the use of electronic health records, behavioral health information systems, and telemedicine equipment. One goal is to encourage RGV Spanish-speaking and bi-cultural residents to obtain advanced degrees in behavioral health specialties.\(^\text{145}\) Starting with UT-RGV, which offers baccalaureate, master’s, and doctoral degrees in a variety of disciplines (and opened its School of Medicine in 2016), review opportunities for specialized training and quality evaluation activities (and expand this review to South Texas College in McAllen, Weslaco, and Rio Grande City; Texas Southmost College in Brownsville and other locations; and Texas State Technical College). Create a formalized strategic collaboration with all university training programs to expand residency and internship opportunities in local programs; also expand training and job opportunities for peers, recovery coaches, community health workers (CHWs), and family partners. Other workforce development recommendations include:

- **System Level Recommendation SR-27a:** Encourage strategies to increase access to licensed clinicians, who would provide direct services as well as training and supervision to fill gaps in the availability of clinical supervision and training.
- **System Level Recommendation SR-27b:** Encourage training and certification of

substance use disorder treatment providers in screening, assessment, and referral for mental health and primary care client needs.

- **System Level Recommendation SR-27c**: To address the gap in outpatient psychiatric services for people who are ineligible for TTBH services, all inpatient facilities should collaborate with other providers in the RGV to invest in recruiting psychiatrists as a strategy for facilitating the expansion of ambulatory and diversion services for the population. Efforts to increase physician capacity should attempt to incorporate fast-track options just established under SB 674.

**System Recommendation SR-28**: Expand the workforce by using certified peer support specialists and family partners throughout RVG services for adults, children, and youth, and in mental health, SUD, and integrated care programs. County BHLTs could review options to incorporate peer support specialists in various services as part of their overall efforts to improve their systems of care. Again, building on the lessons learned within the TTBH peer and family programs, develop a plan that fully integrates these staff as contributing members of treatment teams and in the provision of both direct rehabilitation services, and peer support services which, with the passage of HB 1486, can be billed to Medicaid.

**Use of Telemedicine**

**System Recommendation SR-29**: As part of collaborative planning efforts, coordinate the use and/or implementation of telemedicine to access licensed behavioral health professionals. To address the limited number of psychiatrists and other licensed behavioral health professionals, explore the potential use of telemedicine resources available through public and private resources outside of the RGV. The telemedicine plan should address provider participation standards, clinical documentation requirements, privacy requirements, training on the use of telemedicine, strategies to provide routine access throughout each county, and identification of “champions” to assist with implementation and guidance at provider sites, including the use of telemedicine equipment.

**Major State Level Recommendations (STLR)**

These recommendations focus on issues that must be resolved at the state level.

**State Level Recommendation STLR-1**: Work with HHSC to review the method it uses to rebase its capacity targets for the LMHAs, especially when they exceed their capacity. Rather than receiving an adjustment in funding to accommodate more individuals, being limited to the same funding with a requirement to maintain the higher capacity is unsustainable and in effect punishes LMHAs for their innovation and outreach.
State Level Recommendation STLR-2: Work with HHSC to review the requirement for LMHAs to provide dual entry into the Clinical Management for Behavioral Health Services (CMBHS) system, a web-based clinical record keeping system for state-contracted community mental health and substance use disorder service providers. This requirement results in extra work and could be addressed with more up-to-date approaches to health data information exchange.

Major Behavioral Health Provider Findings and Recommendations

Findings and recommendations for each major behavioral health provider engaged in the behavioral health systems performance review are included in this section.

- Tropical Texas Behavioral Health
- Border Region Behavioral Health Center
- Behavioral Health Solutions of South Texas
- Doctors Hospital at Renaissance
- Rio Grande State Center
- Strategic Behavioral Health (Palms Behavioral)
- The Veterans Administration – Texas Valley Coastal Bend Health Care System
- Valley Baptist Medical Center
- The Wood Group

Tropical Texas Behavioral Health (TTBH)

Overview

Tropical Texas Behavioral Health (TTBH) serves Cameron, Hidalgo, and Willacy counties through sites in Harlingen, Brownsville, Edinburg, and Weslaco. Additionally, TTBH serves Willacy County and Raymondville through the use of a mobile clinic. The mission of TTBH is to improve “the lives of people with behavioral health needs through the efficient and effective provision of quality services delivered with respect, dignity, cultural sensitivity, and a focus on recovery.”

As one of two state-designated local mental health authorities (LMHAs) in the region (Border Region Behavioral Health Center serves Starr County), TTBH provides services to individuals with severe mental illnesses (SMI) and serious emotional disturbances (SED), specifically the DSHS “priority populations” with disabling major depression, bipolar disorder, and schizophrenia, including 7,500 adults and 4,200 children/youth with SED. TTBH offers a wide range of crisis, outpatient, and specialty services for these priority populations. In

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147 The number of adults served is the unduplicated number served by the LMHA in FY 2015. A smaller number of adults is served in one of the ongoing levels of care (LOCs 1-4). Data obtained from Texas DSHS (personal communication, April 13, 2016).
148 The number of children and youth served is the unduplicated number served by the LMHA in FY 2015. A smaller number of children and youth is served in one of the ongoing levels of care (LOCs 1-4) and in the YES Waiver program. Data obtained from Texas DSHS (personal communication, April 13, 2016).
addition, pharmacies and primary care clinics are located at Edinburg, Harlingen, and Brownsville sites. TTBH employs over 950 staff and maintains an operating budget of $84 million, of which about one fifth supports 1115 Delivery System Reform Incentive Payment (DSRIP) projects.

<table>
<thead>
<tr>
<th>Service</th>
<th>Number Served (FY 2015 – 12 month period)</th>
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<tbody>
<tr>
<td>Adult Services</td>
<td>11,422</td>
</tr>
<tr>
<td></td>
<td>7,464 (ongoing LOC1-LOC4 care)</td>
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<tr>
<td>ACT – three teams agency wide</td>
<td>105</td>
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<tr>
<td>COPSD149</td>
<td>535</td>
</tr>
<tr>
<td>Children</td>
<td>5,907</td>
</tr>
<tr>
<td></td>
<td>4,234 (ongoing LOC1-LOC4, YES)</td>
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**Highlighted Agency Strengths**

TTBH is an excellent organization that has grown tremendously over the past five years, effectively assessing community needs and implementing innovations and evidence-based programs (EBPs) for adults and youth while successfully resolving the historical management challenges of previous administrations. Below, we highlight major agency strengths identified during our site visit and desk review. Several of these strengths are further discussed in the findings and recommendations section.

- The current administration is widely recognized throughout the Rio Grande Valley (RGV) as providing effective leadership since 2003, offering stable management and sizeable programmatic growth. Notably, TTBH has received awards for their “excellence in financial reporting.”
- The commitment to excellence and the mission and goals of the organization were uniformly discussed by a wide array of staff and managers, including peers, during the interview process.
- The Management Team and senior managers targeted the development of 1115 Waiver initiatives, aggressively seeking DSRIP funds, foundation resources, and grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) and other sources in order to expand services and develop evidence-based programs (EBPs). Seventy-five managers and senior staff throughout the organization and in various locations worked collaboratively to accomplish program expansion and capital improvements. Many of those interviewed during the site visits discussed their satisfaction with these initiatives and the extensive project management and planning

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149 Holly Borel (personal communication, April 15, 2016).
necessary to implement these projects successfully.

- TTBH’s approach to adopting national best practices and EBPs is systemic and involves a cadre of current and new staff developing skills in various practices. Multiple supervisors are designated as leads for different EBPs. As a result, this systemic approach to training creates a structure for developing and improving the delivery of EBPs and mitigates the potential impact of staff turnover and loss of expertise.

- TTBH has an ongoing emphasis and commitment to professional development, staff training, and access to opportunities for higher education. Several managers and staff discussed how they were able to obtain their bachelor level and advanced degrees while working at TTBH, or leaving for additional study and returning once completed.

- Many staff and managers are bi-cultural and bi-lingual in Spanish, reside in local communities, and were trained at the University of Texas Rio Grande Valley, which places interns in social work, counseling, psychology, nursing, and, most recently with the opening of the medical school, residents in psychiatry at TTBH.

- Since 2008, TTBH has achieved CARF accreditation for Assertive Community Treatment (ACT), adult outpatient mental health treatment, child and adolescent outpatient mental health treatment, integrated mental health treatment for adults, mental health case management, crisis services, and governance. By August 2017, TTBH hopes to have accreditation in place for their integrated care clinic, peer-run drop-in centers, and supported housing. Management Team members reported that CARF accreditation has provided useful tools to plan, implement, and improve the quality of services.

- TTBH was recently selected as a demonstration site for the Certified Community Behavioral Health Clinics (CCBHC) program and will participate in a planning and readiness assessment through a SAMHSA grant to the state of Texas to meet certification requirements. This initiative will expand the priority population beyond the current DSHS target populations and include children from birth to age three. It focuses on utilization of prospective payment systems similar to those in use for federally qualified health centers (FQHCs) and would provide enhanced Medicaid funding. TTBH was certified by the Health and Human Services Commission (HHSC) for CCBHC in September 2016.

- TTBH was recently awarded a SAMHSA Assisted Outpatient Treatment grant award that included a collaborative process with system partners, including NAMI and local law enforcement.

- TTBH is a recent grant recipient of the Texas Veteran’s Initiative, which demonstrates their collaboration with other partners and commitment to veterans.

- TTBH’s participation with local partners and stakeholders is generally very good. During site visits, the MMHPI team participated in several stakeholder sessions. TTBH works collaboratively with a range of partners and appears to be well respected. The Management Team has positive relationships with and receives funding from the Knapp
Community Care Foundation (for services in Weslaco), Valley Baptist Legacy Foundation (for services in Cameron County), and Methodist Health Ministries (for services in Brownsville).

- There are notable program examples that should be highlighted for their innovation and accomplishments:
  - The Mental Health Peace Officer/Mobile Crisis Outreach Team initiative;
  - The reduction in out-of-area inpatient utilization for adults through creative contracting with local hospitals;
  - Development of three primary care clinics within TTBH, including a diabetes education and management program;
  - Collaboration with the University of Texas School of Public Health (UTSPH) to provide behavioral consultation to health care outreach workers;
  - Integration of adult peers and family support peers into the organization as well as the operation of peer-run drop-in centers;
  - A co-occurring psychiatric and substance disorders (COPSD) program, expanded in 2013 through 1115 Waiver funding, that served about 1,100 individuals center-wide since 2015;
  - The veterans program that works with the Veterans Coalition and helps returning veterans readjust to life outside the military through peer groups and cognitive processing therapies;
  - The child/youth wraparound planning initiative, which is a model for the state;
  - School-based programs and the array of cognitive therapy, trauma interventions, and other evidence-based practices available to children and families; and
  - Placement of TTBH clinical staff within programs operated by local school districts, juvenile justice detention centers, and jails.

**TTBH Findings**

**Adult System of Care**

**TTBH Finding 1: Despite gaps in the crisis services array system wide, TTBH operates an innovative crisis response system for Cameron, Hidalgo, and Willacy counties.** TTBH provides a crisis line 24 hours a day, seven days a week, 365 days a year that handles an average of nearly 1,500 crisis calls per month, and dispatches the Mobile Crisis Outreach Teams (MCOTs) an average of 675 times per month. The MCOTs are located at all four TTBH sites. In addition to the MCOTs, TTBH’s crisis services include the successful Mental Health Peace Officers (MHOT) program, nine (9) crisis respite and transitional beds, and seven (7) assisted living beds available through The Wood Group Crisis Center (subcontracted by TTBH) located in Harlingen.

- The MCOT is the first responder for calls that come into the crisis line and work closely with the MHOT when peace officer presence is desirable. The MCOT/MHOT project is an innovative collaboration with 11 (at the time of the review) different local police and
county sheriff law enforcement agencies. A team of 22 peace officers work with the MCOT to improve the local response to individuals experiencing a mental health crisis, divert arrests, and reduce unnecessary waiting time in hospital emergency departments for law enforcement officers on routine patrol. Operating in four sites with separate entrances, this program provides pleasant, safe spaces for individuals in crises and safely offers some stabilization during the initial hours of the crisis as well as the opportunity to provide medical clearance if needed for individuals being referred to inpatient care through access to TTBH primary care clinics (during business hours).

- Members of the MHOT are well trained in verbal de-escalation techniques and collaborate with clinicians to stabilize crises, avoid arrests, and reduce inpatient utilization. Funded through DSRIP, local and county law enforcement agencies, and the Valley Baptist Legacy Foundation, the MHOT program has received positive acclaim. However, it has been a challenge to provide access to the MHOT after business hours when the team is on call. If there are multiple calls, the MHOT team member cannot handle every crisis or be in multiple locations at once. Another key issue is sustaining the funding for the existing program and expanding it throughout the RGV to meet demand.

- If a person engages with the MCOT but does not require hospitalization, the MCOT connects them to community resources, including psychopharmacology services, and follows the person for 90 days or coordinates care with existing services. This service is available and provided to anyone needing assistance in connecting with community resources after engaging with the MCOT, including indigent clients who are not state priority population members. Stakeholders report that this works well for current TTBH clients, but new clients and those served by TTBH who do not fit the state’s priority populations criteria have more challenges connecting with services. This is particularly an issue when new clients need timely medication follow up after hospitalization.

- The crisis respite beds operated by The Wood Group offer an alternative for people who do not require an intensive level of support during crises. The Wood Group’s transitional beds are available for individuals for up to 90 days until supported housing or other housing resources can be coordinated. Individuals in assisted living beds may remain permanently, if they desire.

- TTBH is able to provide clients with crisis stabilization through psychiatric emergency services (PES) contracts with local inpatient facilities.

**TTBH Finding 2:** The crisis service gaps for TTBH clients include access to 23-hour crisis respite/observational beds or other intensive short-term crisis residential and crisis stabilization services.

**TTBH Finding 3:** There has been significant reduction in out-of-region inpatient utilization for adults, including decreases in the utilization of state hospital beds. TTBH uses both
legislatively appropriated funding as well as funds provided by DSHS to purchase local beds. Lower costs have been achieved through effective purchasing strategies and lower inpatient utilization implemented by their progressive clinical program, as well as through assertive follow-up post discharge and effective crisis management. These outcomes demonstrate effective clinical and administrative management strategies.

**TTBH Finding 4:** TTBH places licensed clinicians in the region’s inpatient facilities to facilitate authorization and discharge planning, which is an excellent strategy to address continuity of care. The role of the licensed clinicians is to assist with discharge/transition planning and coordination of care. The discharge process includes linkage to MCOT staff dedicated to providing follow-up care, who connect individuals to services and provide follow up for 90 days post discharge. The community teams follow up with clients on a daily basis, scheduling appointments and assisting with discharge planning. They use crisis respite at The Wood Group as a step-down service. For individuals discharged on weekends, follow up is provided by the MCOT instead of the community teams. The TTBH Projects for Assistance in Transition from Homelessness (PATH) program for homeless individuals provides some services and access to shelters (e.g., Salvation Army, Loaves and Fishes, Ozanam Center) upon discharge. However, there are limited resources for temporary housing during crises and upon discharge from inpatient facilities.

**TTBH Finding 5:** The TTBH intake, authorization, and discharge planning process works smoothly for existing priority population clients, but not as well for priority population clients new to TTBH or for non-priority population clients. TTBH schedules follow-up appointments within seven days for all priority population clients (including new clients) who are discharging from inpatient care. Additionally, TTBH provides vouchers to hospitals they are contracted with to obtain up to 14 days of medications through the TTBH pharmacy to assist clients in the transition from discharge to their first follow-up appointment. The MCOT staff dedicated to providing follow-up care to clients and connections to community resources (mentioned previously in Finding 3) follow these new patients until they successfully attend their first follow-up appointment.

Securing follow-up services for non-priority population clients poses a challenge, as there is no funding to support the provision of ongoing care. Clients identified as part of a non-priority population are eligible to receive only up to 90 days of transitional services to link them with other community resources.

**TTBH Finding 6:** TTBH provides access to its non-emergent services through regular intakes scheduled by the TTBH centralized triage call center. Intakes are provided at TTBH clinics in Edinburg, Harlingen, Brownsville, and Weslaco, or through mobile clinic sites (two mobile van clinics are out-stationed in multiple community locations to conduct intake and provide
outpatient and rehabilitation services). The intake sites and mobile van teams include licensed professionals of the healing arts (LPHAs) and qualified mental health professionals (QMHPs). The mobile vans work with *promotores* to engage individuals and provide education on mental health services and treatment. TTBH publishes a monthly schedule of addresses the vans will visit, such as Women, Infants and Children (WIC) offices that provide food and nutrition services; the Walmart Supercenter; the First Methodist Church; La Sara Community Center; and other community locations. These vans target people in poverty who do not have access to resources. The use of mobile RV clinics is an innovative strategy to provide access to services.

TTBH Finding 7: Access to services through TTBH had improved significantly through the use of state funds provided to minimize waiting lists. However, waiting lists have had to be reinstated. The waiting list for adults was reduced by 800 slots since September 2015. However, that same month, TTBH had to start a waiting list for children/youth and by April 2016, a new waiting list had to be established for adults. The demand for services continues to exceed their capacity due, in part to inequities in funding LMHAs.

TTBH Finding 8: Staff responsible for obtaining insurance authorization/approval for certain services perform best practice activities related to eligibility determinations, work with insurers to obtain any needed prior authorization, and also collaborate with TTBH’s benefit coordinators who assist with benefits applications (SSDI). Pharmaceutical assistance program (PAP) staff obtain medications for individuals who are not insured through pharmaceutical indigent care programs.

TTBH Finding 9: Assertive Community Treatment (ACT) teams operate in three locations, report good fidelity with the highly regarded Tool for Measuring Assertive Community Treatment (TMACT) standards, and have CARF accreditation. As of November 2016, TTBH ACT was serving 174 individuals. Client ages range between 22 to 65 years old on average, with one individual age 80. Team members include a licensed professional counselor (LPC); qualified mental health professionals (QMHPs), who provide psychosocial rehabilitation; registered nurses (RNs); peer providers; and physicians. All ACT clients are provided with education on physical health by an RN, who coordinates care with the individuals’ primary care providers (PCPs). The RN also provides skills development and teaches self-management of medications. This initiative was started because many of the people receiving ACT services have serious co-morbid health conditions (e.g., cancer, diabetes) and substance use disorders (SUDs).

TTBH Finding 10: TTBH has a community-based psychosocial rehabilitation/case management program with a strong emphasis on deploying staff in the field to visit individuals in their home settings, a best practice approach. The case managers who were interviewed, primarily
bachelor level QMHPs, discussed the importance of visiting the “person’s world” to find out if their clients have shelter, are eating, and able to meet their basis needs, as well as checking on medications, overall mental health status, and skill development needs. Supervisors and case managers discussed the collaborative note-taking process they use with clients: the case manager and client are encouraged to spend their last ten minutes together discussing how to summarize their meeting, which helps both parties to determine next steps.

**TTBH Finding 11:** TTBH has by far the largest number of outpatient psychiatrists and psychopharmacology prescribers in the region. This is an excellent achievement in a resource-challenged region and reflects the positive working culture within TTBH.

**TTBH Finding 12:** TTBH has been able to implement best practice strategies for providing medications and tracking whether clients fill prescriptions. Evolve Pharmacy Solutions (previously known as US Scripts) is TTBH’s contracted pharmacy beneficiary manager and all prescriptions are processed through electronic transmission to a pharmacy on site at TTBH clinics or a chosen pharmacy in community. People who are indigent can choose a TTBH pharmacy or another pharmacy. TTBH has allotted over $12 million in patient assistance programs (PAP) for medications, which has freed up funding for other clients. Staff report that clients really like having access to the pharmacy in their clinics. Case managers and other staff rely on the pharmacies to help determine whether clients are refilling their medications.

**TTBH Finding 13:** TTBH has implemented evidence-based medication-assisted treatment (MAT), which uses a combination of traditional behavioral therapies and prescription medications in treating substance use disorders. While MAT is available, there is a need to further develop protocols and target expansion of its use. It is important to develop overarching guidelines for service access for individuals with COPSD who may be actively using substances, and expand the TTBH formulary to ensure access to anti-craving agents.

**TTBH Finding 14:** Peer leaders at TTBH report that peer leadership and peer support services are encouraged and supported. There were 23 peer support staff for adult services at the time

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150 Texas Administrative Code. Title 25, Part 1, Chapter 412.6, Division 1, Rule 412.305. A QMHP-CS or qualified mental health professional-community services is a staff member who is credentialed as a QMHP-CS who has demonstrated and documented competency in the work to be performed and: (A) has a bachelor’s degree from an accredited college or university with a minimum number of hours that is equivalent to a major (as determined by the LMHA or MCO in accordance with §412.316(d) of this title (relating to Competency and Credentialing)) in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; (B) is a registered nurse; or (C) completes an alternative credentialing process identified by the department.

of MMHPI’s visit. Lessons learned about integrating peers in the workforce, on treatment teams, and in running programs were discussed by peers and managers. The leadership has reduced productivity targets for peers to accommodate part-time positions and the nature of their work. Peers participate in case staffings for Level of Care (LOC) 3 services, with Assertive Community Treatment Teams, and with psychiatrists. Physicians, including one of the PCPs, reported they have come to rely on peers because they see their clients improve with peer support. One of the peer leaders ran a recovery group in the Cameron County jail that resulted in changes to jail policies for individuals with behavioral health conditions. This same peer leader, with support from the TTBH Management Team, obtained a grant to provide additional peer support groups for women in jails.

**TTBH Finding 15: It is notable that TTBH has three peer-run drop-in recovery centers located at their Edinburg, Harlingen, and Brownsville sites.** These centers have separate entrances, which encourages individuals to drop in and participate in supportive skill development activities without having to go through the formal check-in at the clinic. At the drop-in sites, individuals can cook a meal, participate in recovery-oriented training, use computers to conduct job searches, and have access to showers and laundry. Clothing (and clothes washing) is also available, which is especially helpful for individuals who are homeless. Peer specialists participate in training through Via Hope (a state-funded training and technical assistance center that certifies peer specialists and family partners). Additionally, Valley Baptist Legacy Foundation provided funding to the San Antonio Clubhouse to train the drop-in center staff in how to implement the clubhouse model.

**TTBH Finding 16: When individuals served by TTBH become involved with the criminal justice system, TTBH follows them throughout their involvement.** For example, if a client is arrested, TTBH will focus on jail diversion. Jail diversion and peer re-entry services are provided and offered by TTBH to all jails in the region. Additionally, contracts with Hidalgo and Cameron counties support the provision of psychiatric services to individuals in the jail. They provide medications and clinical services, and may consult with the judge and/or probation department to develop diversion options. Referrals may come directly from the jail for known TTBH clients or when the jail identifies individuals who appear to have behavioral health issues. TTBH has the capacity to use the DSHS Clinical Management for Behavioral Health Services (CMBHS) system to identify and match individuals booked into the jail system, and will work with these individuals to assist with diversion and/or re-entry from the jail into community life.

**TTBH Finding 17: The implementation of three primary care clinics within the Edinburg, Harlingen, and Brownsville sites (staffed by primary care physicians [PCPs], advanced practitioner nurses [APRNs] or physician assistants [PAs], and licensed vocational nurses [LVNs], certified nurse assistant, chronic care nurses, dieticians, and recently-added care coordinators, plus administrative and support staff) is an impressive accomplishment.** At the
time of the site visit, a fourth primary care clinic was planned for Weslaco, but funding has not yet been identified. These clinics provide primary care mostly for adult clients with serious mental illnesses who do not already have a PCP, use the same electronic health record as behavioral health services providers, and have joint integrated staffings among primary care and behavioral health clinicians. The primary care clinics provide medical clearance during business hours for individuals requiring inpatient psychiatric care, which reduces emergency department utilization. TTBH used DSRIP funds for two of these clinics and Methodist Health Ministries and Valley Baptist Legacy Foundation supports the Brownsville clinic. For individuals on psychotropic medications, prescribers authorize baseline lab work and annual or as-needed updates. This includes laboratory screening for the management of diabetes, cholesterol, thyroid, kidney, and other functions. TTBH tracks body mass index (BMI) to help clients manage their overall health and obesity. Routine screening is also a best practice in primary and behavior health integration (PBHI) for individuals with serious mental illnesses. TTBH is exploring Medicaid financing for primary care services through the health plans covering the RGV. One significant challenge is finding PCPs to staff the operations, especially Spanish-speaking physicians. At the time of the site visit, there was one full-time physician and reliance on “locum tenens” physicians hired as needed to fill vacancies. As of November 2016, all available physician positions were filled.

**TTBH Finding 18:** The collaboration between the University of Texas (UT) School of Public Health in Brownsville and TTBH, which teams about 150 community health workers with behavioral health consultants to conduct health and behavioral health screening, should be considered for replication and expansion. The model, based on a collaborative approach, facilitates health screening, person-centered conversations, and subsequent administration of the PHQ-9 if there is any indication of possible depression, followed by referral to churches, local supports, and, potentially, professional counseling. Through this project, they have served over 4,000 individuals and are beginning to document the impact of this work through a series of published articles.

**TTBH Finding 19:** TTBH reports there is limited coordination of care for TTBH clients, except on an individual patient basis, between their primary care clinics and FQHCs. Past efforts to collaborate did not result in any active formal policies or agreements to coordinate care. Both TTBH and one of the FQHCs reported that workload issues were part of the challenge in establishing working agreements. With implementation of the CCBHC requirements, TTBH expects to develop MOUs with all referral partners, including FQHCs.

**TTBH Finding 20:** DSHS recently transitioned the responsibility for Outreach, Screening, Assessment and Referral Centers (OSARs) substance use disorder service contracts for Cameron, Hidalgo, Willacy and Starr Counties to TTBH. OSARs, funded by DSHS, are the first point of contact for those seeking substance use disorder (SUD) treatment services in Texas. In
light of this new arrangement, the TTBH Management Team is organizing SUD services under a new position and expanding training on co-occurring psychiatric and substance use disorders (COPSD) by using stage-matched assessments and interventions, and American Society of Addiction Medicine (ASAM) guidelines, for level of care determinations; involving more peers; and expanding co-occurring disorder services for adolescents and within child/family treatment.

With the transfer of OSAR responsibilities to TTBH on September 1, 2016, TTBH now provides the OSAR services for the region. Four (4) staff transitioned from the South Texas Behavioral Health Solutions OSAR program to become employees of TTBH; the additional five (5) positions are being filled by new employees. TTBH is placing OSAR staff at the other LMHAs in the region in order to improve access to SUD services for individuals with mental health conditions. The OSAR responsibilities assigned to TTBH cover a broader geographic area than the mental health and developmental disabilities service area assigned to TTBH, which further complicates regional planning efforts within the RGV and requires TTBH to coordinate with other LMHAs in the region to deliver services to several other counties outside of Cameron, Hidalgo, and Willacy counties for SUD and COPSD services. There are residential services available, but there is limited capacity to step adults and youth down from residential services, which is a significant service gap. Presently, the only available residential services are state-funded programs located in Corpus Christi and Laredo.

**TTBH Finding 21:** TTBH has done an exceptional job of integrating COPSD into its service array and stands out as a positive model for LMHA integration of these services. In January 2016, TTHB hired a Director of Substance Use Disorders Services to oversee the SUD and COPSD systems of care. The position was filled by an experienced licensed professional counselor (LPC), who has experience working at the Veterans Administration and most recently worked with a private substance use disorder provider in the RGV. During the site visit, the director described the willingness of the Management Team and staff to develop more expertise in providing SUD services throughout TTBH, which currently has 19 COPSD staff disseminated throughout the agency, including on ACT and Level of Care 3 teams. The COPSD program began in 2005 and was expanded through the 1115 Waiver in 2013; it has served about 1,100 clients since its expansion.

The director will manage subcontracts with SUD providers as well as contracts with the U.S. Probation Officers and the Bureau of Prisons to provide services for individuals who are on parole or probation, and will oversee new SUD outpatient and intensive outpatient programs.

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152 TTBH actually covers counties outside the Rio Grande Valley for OSAR. In addition to Cameron, Hidalgo, Willacy and Starr counties, the OSAR catchment area includes Aransas, Bee, Brooks, Duval, Jim Hogg, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio, Webb, and Zapata counties.
for both adults and adolescents. As of November 2016, the licensing of the new SUD outpatient and intensive outpatient service programs was nearing completion.

**TTBH Finding 22:** TTBH provides supportive housing and is interested in a Housing First model, which provides housing without the requirement to participate in treatment. Currently, TTBH provides supportive housing to 264 individuals in scattered site and group settings funded through the Texas HHSC and HUD Tenant Based Rental Assistance (TBRA). These services include case management and skills training in community living. Similar services are available to help some individuals living in assisted housing. There are no licensed board and care facilities available nor are there structured residential settings for their clients with intensive support needs.

TTBH identified the lack of residential housing options as a significant services gap in the Rio Grande Valley. Presently, there is no existing funding source to provide housing that is unrelated to treatment, as housing currently funded by DSHS and PATH funds are supporting transitional housing only. While TTBH is interested in a Housing First model, the challenge of securing funds was identified as a barrier preventing them from moving forward with the adoption of such a model.

**TTBH Finding 23:** TTBH also provides homeless services through the PATH grant, including outreach, engagement, and treatment, as well as welcoming homeless individuals to the peer-run drop-in centers located at their three largest sites. Peer staff will pick up homeless individuals at shelters and other sites to encourage their use of the drop-in centers. TTBH tries to address challenges due to limited shelter options; only three shelter options exist, and one requires some type of personal identification, which is a disincentive for some TTBH clients.

**TTBH Finding 24:** TTBH has a Supervisor of Veteran Services who is a veteran and provides services to enhance veterans’ coping skills as they adjust to civilian life. She also offers supervision to other peer providers and is in high demand. There is a veteran’s drop-in center in Harlingen where TTBH provides peer-to-peer support, cognitive processing therapy (an EBP), Seeking Safety (a trauma-focused EBP), case management, and community resource coordination. The supervisor provides support to several peer-led groups, which offer a best practice known as Bring Everyone in the Zone (BEITZ), and has been involved in the Veteran’s County Sequential Intercept Mapping initiative. She participates in Operation Resilient Families (ORF), an experimental learning program that empowers veterans and their families to address post-deployment challenges. Two staff work with the judge/court to support veterans who become involved with the criminal justice system through the Veterans Specialty Court. The supervisor also works with other stakeholders such as NAMI and a veteran’s coalition.
TTBH was recently awarded two new grants for the Texas Veteran + Family Alliance (TV+FA) program. One grant will go toward the expansion of services at the Harlingen Veteran Drop-In Center (DIC), and the second toward the development of a new veteran DIC in Hidalgo County.

**Children’s System of Care**

**TTBH Finding 25:** The MCOT crisis line offers outreach and intervention for children, youth, and their families, and the Youth and Family Services teams in all locations incorporate crisis response into their unique programs. For example, the wraparound program tracks and responds to crisis.

**TTBH Finding 26:** TTBH reports that access to crisis respite and long-term inpatient care for children and youth is very limited, and families must frequently travel to Austin or San Antonio to obtain long-term inpatient care for their children. TTBH contracts with three local inpatient hospitals to obtain crisis stabilization services for youth. However, there are currently no designated state hospital beds in the Valley for children and youth. As a result, families seeking extended and longer-term care for their children are most often transferred and admitted to San Antonio State Hospital (SASH) or Austin State Hospital (ASH).

**TTBH Finding 27:** TTBH management and clinical staff with Youth and Family Services demonstrate a strong commitment to building agency and community capacity for the delivery of EBPs and best practices for youth and families. They currently serve youth ages three to 17 years and offer numerous best practices and EBPs: ASSIST (applied suicide intervention training), Aggression Replacement Training (ART), cognitive-behavioral therapy (CBT), Trauma-Focused CBT, Nurturing Parenting, Preparing Adolescents for Young Adulthood (PAYA), Seeking Safety, wraparound planning, and natural community supports. Mirroring the adult training approach, the supervisors for youth services use the Train the Trainer model, which allows for continuous training and the capacity to maintain expertise when there is staff turnover. For example, TTBH engaged the founder of Nurturing Parenting to offer a Train the Trainer initiative to build internal capacity for coaching staff.

**TTBH Finding 28:** Services for children and youth include a strong wraparound planning program and YES Waiver services incorporating the wraparound model that serve a combined 176 families across three counties and is recognized as a model for the state. The wraparound planning program served 31 children (at the time of the site visit) in wraparound planning services, which emphasize family-led, youth-guided service planning and supports and utilizes the Child Adolescent Needs and Strengths (CANS) assessment tool, a best practice tool for wraparound planning and children’s systems of care. Additionally, TTBH served 145 children in YES Waiver services that incorporate the wraparound model. Sixteen (16) staff provide wraparound services, which last between 12 and 18 months. Caseloads average 10 to 12 youth and families, which is consistent with national standards. Family partners (family members of
youth with behavioral health challenges trained as peer support staff) also support families with the wraparound planning process. There are seven (7) children on an inquiry list pending enrollment into the YES Waiver services that incorporate wraparound planning. As noted in the behavioral health needs section of this report, TTBH is the lowest funded LMHA per capita in the state.

The need for wraparound planning services far outstrip the availability throughout Texas, but TTBH has a strong base of programming upon which to build. Before the YES Waiver was developed, the Management Team used grant funding to bring the Washington State University wraparound planning model to TTBH, during which time the TTBH wraparound team went through a six to nine month learning process and collected data on fidelity. As a result, TTBH understands the wraparound planning process and how this drives the Medicaid YES Waiver program funding. If the family has Medicaid, TTBH is able to cover the wraparound costs. TTBH has one of four certified wraparound coaches in the state (certification is a two-year process). The Texas Institute for Excellence in Mental Health reported that TTBH’s wraparound program is a model for the state and likely to be one of the first wraparound planning programs to be certified in nation.

**TTBH Finding 29:** Fourteen (14) certified family partners work across all TTBH sites, which is an impressive number. Via Hope certifies the family partners, all of whom have lived experience with managing behavioral health challenges with their own children or other family members. Two family partners participated in site visit interviews and discussed their roles in facilitating access to a broader array of community resources for youth and their families. They participate in the child and family team service planning processes and are able to help identify resources such as exercise programs, music therapy, and similar activities that would be useful to support the needs of youth and their families. The family partners expressed strong support for TTBH’s approach to incorporating peers into the agency.

**TTBH Finding 30:** TTBH has built effective relationships with other child serving agencies, which have been strengthened by TTBH’s willingness to share costs, co-locate services, and change their procedures based on the needs of youth served across agencies. For example, TTBH has a partnership with the Cameron County Juvenile Justice Department to share two positions located at the juvenile detention facility to provide skills training and other services. In addition, the TTBH MCOT provides crisis services to the facility. They have also used telemedicine to improve access to psychiatric services. In Harlingen, a full-time position is co-located with juvenile justice. Services include crisis screening and management, completion of the Massachusetts Youth Screening Instrument (MAYSI), and providing guidance to probation

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153 Via Hope provides training and certification of family partners throughout the state.
officers working with youth. This work has resulted in developing specialized caseloads with dedicated probation officers supervising youth on probation who have behavioral health conditions.

In 2016, the Department of Family Protective Services (DFPS) and TTBH developed the Fostering Access to Community Engagement (FACES) program to allow staff from both organizations to collaborate on common issues and cases. Through this collaboration, access to behavioral health services has improved, including access to psychiatric evaluations. Five full-time staff are dedicated to this program and currently serve 131 youth in the foster care system. Staff participate in court hearings and support foster parents who experience challenges with addressing the mental health needs of their foster children (the “Nurturing Parenting” program would be included with supports provided by these staff).

Since 2014, TTBH has organized a partnership with juvenile justice and the school systems to develop an evidence-based children’s system of care (SOC) for the RGV, using wraparound principles. This effort was initiated with seed funding from the Texas System of Care Consortium under the auspice of HHSC, and addresses children and youth served by multiple systems. It emphasizes family-led, youth-guided service plans that support youth in their homes and communities, minimizing out-of-home placements and psychiatric hospitalization. As yet, these two initiatives (FACES and SOC) have not yet coalesced into a unified children’s system of care development effort incorporating wraparound planning offered by TTBH.

TTBH Finding 31: TTBH has co-located twenty (20) staff in schools¹⁵⁴ to provide school-based services and has provided the Mental Health First Aid training to more than 2,100 educators and other community members, which is an impressive number. With 37 independent school districts across the four counties in the RGV,¹⁵⁵ it is a challenge to develop school-based programs. TTBH began fingerprinting staff in order for them to work at school sites, an example of how TTBH reduces barriers to collaborating with system partners. In addition, TTBH obtained a Safe Schools grant to start the co-location process. However, there have been significant challenges associated with the number of schools as well as the time and planning necessary to address school districts’ concerns about having “outsiders” co-located in the schools. As of November 2016, TTBH was providing services to 204 children in the co-located school-based services program at the following levels of care:

¹⁵⁴ TTBH staff are co-located in several school districts, including: Brownsville ISD, Edinburg CISD, Harlingen CISD, Horizon Montessori Public Schools, Idea Public Schools, McAllen ISD, Midvalley Academy Charter District, Pharr-San Juan-Alamo ISD, and Raymondville ISD. TTBH staff (personal communication, October 2017).
TTBH Co-Located School-Based Services by Level of Care

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<thead>
<tr>
<th>Level of Care (LOC)</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOC-2 – Targeted Services</td>
<td>155</td>
</tr>
<tr>
<td>LOC-3 – Complex Services</td>
<td>25</td>
</tr>
<tr>
<td>LOC-4 – After Care</td>
<td>2</td>
</tr>
<tr>
<td>LOC-YC – Young Child Services</td>
<td>16</td>
</tr>
<tr>
<td>LOC-YES – YES Waiver</td>
<td>16</td>
</tr>
</tbody>
</table>

**TTBH Finding 32:** TTBH provides limited primary care clinic services for youth because most families obtain primary care services for their children through health plans. About 80% of the children and youth served by TTBH are covered by Medicaid or the Children’s Health Insurance Program (CHIP), which provide access to pediatricians. Also, families with several children that are not all served by TTBH find it more convenient to take their children to one health provider. Most children and youth do not have the same chronic illnesses as many adults with mental health issues. Consequently, outside of vaccinations, emergency care (for broken bones, stitches), and sick child care/school physicals, there is little need for pediatric care outside of annual well-child check-ups. TTBH still offers primary care services to children and youth who do not have access to these services elsewhere, but the organization has encountered significant challenges in working with health plans to contract for and authorize these services to pay for them.

**TTBH Finding 33:** TTBH is implementing a first episode psychosis (FEP) program, an innovative evidence-based practice that is targeted to adolescents and young adults with the goal of starting treatment as early after the initial episode of psychosis as possible and helping people to remain on their developmental trajectories. FEP care is provided through a team of specialists that includes a psychiatric APRN, an employment/education specialist, a skills trainer, a peer specialist, and a licensed professional counselor. The TTBH program will be based in Edinburg and provide a team-based intervention. The caseload ratio will be 1 professional to 10 clients. At the time of the TTBH site visit, positions were posted and being recruited, with the goal of starting the program in the fall of 2016.

**TTBH Finding 34:** TTBH has substantially increased its capacity to serve children and families, but there is a crisis in the foster care system statewide and a significant gap in providing intensive mental health services for foster children, which would benefit from TTBH’s expertise. It was noted by the Stephen Group’s 2015 report (*Meeting the Needs of High Needs Children in the Texas Child Welfare System*) that there is a significant gap in the supply of “step-down settings” across Texas. This is also the situation in the RGV. MMHPI has also found in its local system assessments that most Texas communities have little to offer children and families.
who need mental health services that are more intensive than a routine outpatient visit, but less intensive than residential care. TTBH has excelled in tailoring services to children and for this reason is in a good position to work with the state to expand capacity to serve these children. Currently, TTBH serves 131 youth in foster care, which is a significant number when compared to other LMHAs. As foster children are in the custody of the state, it is the state’s responsibility to fund their mental health services.

**TTBH Finding 35:** TTBH has partnered with many community organizations to provide community education and reduce stigma, co-hosting and supporting various activities on school campuses, with the fire department, and others. Families are spearheading these activities and focusing on sharing their stories. They have organized anti-suicide campaigns, provided animal-assisted therapy, and worked with a biker group to “ride” against child abuse. These activities demonstrate positive community involvement and assist TTBH in assessing service needs. These initiatives would be enhanced by a targeted early intervention and prevention plan to identify children and youth with behavioral health conditions.

**General Findings**

**TTBH Finding 36:** The CARF accreditation process and emphasis on delivering EBPs in fidelity to program standards are good examples of TTBH’s continuous quality improvement (CQI) approach. TTBH demonstrates a good understanding of the technology of CQI and utilizes best practice “plan, do, study, act” (PDSA) change processes to address areas where improvement is needed to meet internal standards.

**TTBH Finding 37:** TTBH reports significant challenges in hiring psychiatrists and primary care physicians (especially those who speak Spanish), nurses, and licensed mental health professionals. As a result, TTBH is increasingly relying on telemedicine because of the shortage of psychiatrists. For example, some initial evaluations following hospital discharge are done via telemedicine. Weekly case staffing with the psychiatrist and the psychiatric physician assistant are conducted through telemedicine with the goal of identifying the need for a client to have a telemedicine appointment rather than waiting for an in-person session.

**TTBH Recommendations**

**TTBH Recommendation 1:** TTBH is an ideal organization for investment of philanthropic funding and for expanding its role as a county leader for the counties it serves. The excellence of the management team, the emphasis on delivering EBPs and best practices (including collaborating with system partners in delivering these services), and the strong stewardship of community resources suggest that TTBH is an effective organization that should continue in a position of county BHLTs focusing on service development. Our system analysis shows that TTBH does a good job within its defined role as the state’s LMHA serving the three counties in
the RGV, and in many ways has gone beyond this role, demonstrating an understanding of population health management, implementation of best practices, and effective partnerships. The biggest challenge is that there are many individuals who need behavioral health services but do not fall under TTBH’s priority populations as defined by the state. However, there is no entity in the RGV that can plan services for the broader population in need of behavioral health services. TTBH is the most likely significant county leader, but given its mandates, other partners must be involved as decision makers and funders to determine how to fill the gaps for the total population and geography, as there are many people that no organization currently has the capacity to serve.

**Adult System of Care**

**TTBH Recommendation 2:** TTBH should take the lead to address the opportunities under the SB 292 grant program to reduce recidivism, arrest, and incarceration among individuals with mental illness, and to reduce wait time for forensic commitment in order to expand available services allowed under the grant. This effort should be coordinated with the major behavioral health providers serving the TTBH counties in the RGV to determine if any of the hospital systems can provide alternatives to state hospital restoration to competency services (either on an inpatient or outpatient basis), crisis respite services, and other diversion services. TTBH could collaborate directly or in parallel with the BRBHC, but the priorities of each geographic area should be addressed, including crisis respite.

**TTBH Recommendation 3:** To capitalize on TTBH’s strong approach in managing crises for Cameron, Hidalgo, and Willacy counties, it is important for TTBH to track the proportion of crisis responses that are managed by the MCOT, the MHOT, or other TTBH programs as well as crises managed directly by law enforcement or by none of the above. This information will assist TTBH in providing a rationale for expanding the MCOT and MHOT and setting the stage for the development of a comprehensive RGV-wide crisis response program in collaboration with the BRBHC for Starr County and other facilities.

**TTBH Recommendation 4:** TTBH should continue with its efforts to adopt the Housing First model and work with local housing authorities to develop Permanent Supportive Housing for adults and older youth who can live independently with some support. Adoption of the Housing First model, where having a home is not a condition of treatment, should be a priority consideration for funders of both transitional and permanent housing and can be implemented in a step-wise approach. This is also a RGV system issue and requires the input of local housing authorities and other community resources in any planning effort.

**TTBH Recommendation 5:** TTBH should develop protocols for information sharing between its primary care clinics and other primary care practitioners with whom they are likely to share patients. With the implementation of the CBHCH, this is a high priority need due to the scarcity
of resources and the need to coordinate care as TTBH’s primary care clinics further develop. At a minimum, memoranda of agreement for sharing information and coordinating care between TTBH and other primary care providers are essential to ensuring that shared clients are obtaining the health care services they need and avoiding duplication of laboratory tests and other medical services.

**TTBH Recommendation 6:** TTBH should continue its collaboration with the UT School of Public Health by providing continuing consultation to community health workers. This model has the potential to be replicated and would be an ideal project for grant funding.

**Children’s System of Care**

**TTBH Recommendation 7:** TTBH should build on its strong base to expand access to Level of Care 3 and Level of Care 4 services, including intensive mental health services for high needs children in foster care and supportive housing for foster youth transitioning out of care. These children often have complex needs and would benefit from intensive mental health services within the foster care setting as well as services and supports as they transition into young adulthood. This is an area for the state to expand its funding.

**Border Region Behavioral Health Center**

**Overview**

Border Region Behavioral Health Center (BRBHC) is a non-profit community mental health center and state-designated local mental health authority (LMHA) headquartered in Laredo, Texas, with service locations in Jim Hogg, Starr, Webb, and Zapata counties. Their mission is “to provide cost-effective services that improve the quality of life of those we serve by promoting independence in the community.” Starr County is BRBHC’s sole service area in the Rio Grande Valley. BRBHC has a clinic in Rio Grande City located near the Starr County Memorial Hospital and its outpatient clinics.

BRBHC operates with a $13.9 million budget and has 319 staff, including 24 staff in Starr County consisting of 10.5 full time equivalent (FTE) staff for the Adult Behavioral Health Services Unit; 6.5 FTE for the Child, Adolescent and Parenting (CAP) Program; six (6) FTEs for the Intellectual and Developmental Disabilities (IDD) Program; and a program manager. In total, BRBHC serves 3,597 individuals annually. BRBHC provides mental health services to nearly 700 individuals in Starr County (426 adults and 260 youth).

**Adult Mental Health Services**

The Adult Behavioral Health Services Unit serves adults ages 18 and above using the Texas Resilience and Recovery (TRR) model. Services include: screening, intake and assessment, psychiatric evaluation, medication training and support, pharmacological management, peer
support, crisis intervention services (hotline, respite, short-term residential placement), case management, Assertive Community Treatment (ACT), psychosocial rehabilitation, counseling, jail diversion, supported housing and employment, Mobile Crisis Outreach Team (MCOT), veterans services, Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) Intensive Case Management, the Path for Assistance in Transition from Homelessness (PATH), and skills training.

**Children’s Mental Health Services**

The Child, Adolescent and Parent Services (CAPS) Program serves children and adolescents ages three (3) to 17 years with a diagnosed mental illness, emotional disturbance, behavioral problems, prior in-patient psychiatric hospitalization, or who are at-risk of expulsion from school. Services include: crisis hotline, screening, assessment, case management, intensive case management, medication training and support, Mobile Crisis Outreach Team (MCOT), jail diversion, rehabilitation skills training, flexible community supports, family case management, family training, family partners, parent support groups, and wraparound services through the YES Waiver.

**Highlighted Agency Strengths (contributions to RGV systems of care)**

- BRBHC has a strong commitment to Starr County and recently purchased a new building for its operations in Rio Grande City, which is the second largest city in BRBHC’s coverage area.
- Five new initiatives stemming from the 1115 Waiver include expansion of telemedicine, workforce enhancement, crisis stabilization resources, integration of primary care, and crisis prevention.
- While the BRBHC CEO recently departed, the interim administrative leadership (chief financial officer and human resources director) and clinical leadership are respected within the Valley.
- The BRBHC Board includes members appointed by the Starr County Judge.

**BRBHC Findings**

**BRBHC Finding 1**: BRBHC has initiated the provision of integrated primary and behavioral health care by contracting with a local physician for primary care services, and noted that access to services provided by the Family Health Center to BRBHC clients has been an asset.

**BRBHC Finding 2**: Starr County residents served by BRBHC face challenges in accessing inpatient care, including distances required to travel to inpatient facilities and particularly when the state-operated Rio Grande State Center (RGSC) or San Antonio State Hospital (SASH) are on diversion and have no available beds. These challenges also apply to transportation to private hospitals in the surrounding areas.
**BRBHC Finding 3:** Access to state-operated inpatient beds is often limited because these facilities are at or over capacity (largely as a result of the number of forensic commitments from other areas), resulting in BRBHC having to pay for the use of private psychiatric hospitals out of existing funds. In 2016, BRBHC paid $132,500 for private psychiatric hospitalizations for clients in Starr County. In 2015, total private psychiatric hospital costs were $547,000 across all of BRBHC’s catchment area. BRBHC reports that access to two to three psychiatric beds within Starr County would alleviate this situation somewhat.

**BRBHC Finding 4:** BRBHC reportedly works well with the sheriff’s department and noted an overall increase in collaboration with local law enforcement. In January 2017, a CIT training session was held in Laredo, which was made available to all surrounding counties. BRBHC noted lower participation from law enforcement in more rural counties because of the time commitment and a general shortage of manpower in their communities.

**BRBHC Finding 5:** While BRBHC coordinates well with the sheriff’s department, the statutory requirement for law enforcement to transport individuals to psychiatric hospitals results in coordination challenges because lengthy transport times pull law enforcement away from their other duties. In addition, transporting individuals with behavioral health conditions to psychiatric hospitals requires coordination among local police departments and the sheriff’s department. Since resources are limited, there are no other entities that can provide this service.

**BRBHC Finding 6:** Similar to all counties in the RGV (and most across Texas), there is a significant behavioral health care workforce shortage in Starr County, particularly for psychiatrists. BRBHC has three psychiatrists in total, with one offering bilingual services who is available on site and part time to Starr County. Additionally, BRBHC contracts with locum tenens companies for psychiatric services for both children and adults in the community, as well as in East Texas for 24 hours a day, seven days a week (24/7) psychiatric crisis services coverage. Despite these contracted resources, there are few options for face-to-face care. Telemedicine, provided through a contract with locum tenens companies as well as South Texas Behavioral Health, is the main avenue to access psychiatry services, but its use focuses on existing BRBHC clients and is available after hours or during crises. Additionally, BRBHC reported having difficulty with the equipment from South Texas that is required for telemedicine services, and noted an average current wait time of two hours. BRBHC must rely on temporary physician staffing agencies for psychiatrists. Access to bi-cultural and/or bi-lingual psychiatrists is also a significant gap in Starr County and in the RGV.

**BRBHC Finding 7:** The number of crisis calls is increasing and a significant portion of the calls are from new clients (those not already enrolled in treatment). For example, BRBHC had 12 crisis calls the week prior to our meeting and most were from new clients. This is a strain on the
Valley Baptist Legacy Foundation Rio Grande Valley Behavioral Health Systems Assessment

Crisis intervention program, which is not adequately funded. BRBHC identified a need for additional MCOT positions to serve Starr County, and, as a result, posted to hire two new positions to meet this need.

**BRBHC Finding 8:** Access to the crisis intervention program in Starr County is available primarily during business hours. After hours crisis intervention services have limited capacity to respond directly through BRBHC. During crises, access to psychiatrists is typically provided through telemedicine by East Texas. BRBHC contracts with Avail Solutions for 24/7 crisis services for all psychiatric crisis services in the surrounding Border Region area and East Texas.

**BRBHC Finding 9:** Access to integrated primary care and behavioral health services has been a challenge. While the accessibility of the Family Health Center has been an asset to clients, once appointments are made further away from the center, clients tend not to keep appointments. BRBHC is continuing to work with other primary care physician offices in Starr County and is conducting outreach with Nuestra Clinical Del Valle for clients of the Border Region.

**BRBHC Recommendations**

**BRBHC Recommendation 1:** Continue enhancing and integrating primary care and behavioral health care by working with local physicians and federally qualified health centers (FQHCs). Assess the feasibility of implementing core elements of integrated care, such as collaborative care models that emphasize universal screening of behavioral health conditions in primary care settings and provision of behavioral health consultation to primary care providers. Expansion of this approach with FQHCs or other primary care physician offices would increase access to behavioral health care.

**BRBHC Recommendation 2:** With Starr County and Starr Memorial Hospital, take advantage of the pending SB 292 grant program to reduce recidivism, arrest, and incarceration among individuals with mental illness, and to reduce wait time for forensic commitment to enhance the crisis response system in Starr County and surrounding counties. Form a collaborative with Starr County’s Hospital District/Starr Memorial to bid on the grant and develop crisis respite beds at a broader array of psychiatric crisis response/diversion settings, including the development of crisis and psychiatric inpatient capacity at Starr County Memorial. The collaborative could be part of a broader Rio Grande Valley collaborative (with TTBH) or focused on Starr Count and surrounding areas. In addition to BRBHC and the hospital, the collaboration should include all municipal police departments in the county, the sheriff department’s patrol and jail divisions, the probation department, pre-trial providers, public defenders, the district

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attorney, the county judge’s office, the felony court judge, the misdemeanor court judge, urgent care clinics, and EMS providers (ambulance providers). Development of additional capacity at Starr Memorial is a high priority for start-up funds from grants or the state because of the high use of services by uninsured individuals and the low per capita state funding allotted to the Border Region. Consider a solution with DSHS similar to TTBH, which has received state funding from state facilities to pay for inpatient services at local hospitals. Planning for a broader array of crisis and inpatient services should be a high priority for Starr County, especially focusing on a broader array of crisis and step-down services, and for uninsured individuals needing ongoing treatment following crisis intervention or inpatient treatment.

**BRBHC Recommendation 3:** Recognizing Starr County’s challenges with limited resources and great distances to travel to access services (resources are an estimated 150 miles away in any direction outside of Starr County), a high priority for funding would be to support implementation of a modified Mental Health Officer Team (MHOT) model developed by TTBH in partnership with various sheriff and police departments. Modification could include the incorporation of paramedics and para-medicine first responders to provide appropriate care to individuals in crisis. The reliance on law enforcement to provide mental health first response could be limited to situation that involve public safety. The current model includes financial contributions from law enforcement agencies and other sources, provides assistance during psychiatric crisis for insured and uninsured individuals, and relieves most other officers on routine duty from transporting clients who are experiencing emergencies. Local para-medicine or ambulance providers could be engaged to participate as the primary mental health crisis response for crises without a clear public safety concern. Because resources within Starr County and its law enforcement agencies are particularly limited, grant funding could be prioritized for the establishment of a MHOT. This would include start-up costs and ongoing operations of the MHOT.

**BRBHC Recommendation 4:** Continue to explore expansion of telepsychiatry and other professional services to Starr County sites, East Texas psychiatric services, and South Texas Behavioral Health Center, for provision of crisis assessments.

**BRBHC Recommendation 5:** While BRBHC is working to implement a jail diversion program in Starr County and is researching the possibility of a Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) program, we encourage the county and local law enforcement, as well as municipal and county medical first responders (EMS), to assess systemic responses across the Sequential Intercept Model\(^{157}\) (SIM) as part of a Valley-wide initiative to complement existing plans. There are five sequential intercept points within the

model where law enforcement, first responders, and mental health providers can collaborate to identify opportunities to divert individuals with mental illness away from the criminal justice system and into treatment, and provide a more comprehensive response to those who are arrested. Recommendations for each Intercept include:

- **For Intercept 1: Crisis Response, Pre-Arrest Diversion** – Improve the coordination of crisis response services with other community crisis services. Engage all first responders, including medical first responders, to implement a multidisciplinary team approach which provides services on the crisis scene, manages non-emergency distress calls, links persons to services, and engages in data-driven outreach and preventative services while reducing the need for law enforcement to be the first responders for mental health care.

- **For Intercept 2: Post-booking Diversion** – While post-booking diversion does occur in Starr County, it focuses on screening, assessment, and identification. Solidify procedures for mental health screening, identification, Magistration, and bonding to be in compliance with Texas Code of Criminal Procedure 16.22 and 17.032.

- **For Intercept 3: Therapeutic Justice Services within the Courts** – Bring to scale the utilization of therapeutic justice concepts into all court services, including the utilization of a risk assessment tool to determine program eligibility and treatment tract.

- **For Intercept 4: Services within the Jail and Reentry** – Provide mental health training to county jailers to increase the recognition of and response to persons in need of mental health care in the jail. Engage local providers, faith-based institutions, and area non-profits to increase jail in-reach services and plan for reentry that links to community care.

- **For Intercept 5: Community Corrections** – Ensure community mental health services are informed criminal justice principles and practices. Incorporate the use of risk/need/responsivity models in community mental health for persons who have had frequent arrests or are on probation or parole and are not assigned to a specialty case load. Collaborate with local law enforcement and EMS/medical first responders to compare information on individuals with complex need who are high utilizers of services. Additionally, continue to enhance collaborations with community corrections (e.g., juvenile and adult probation) to compare people who use crisis services with probation and parole caseloads. For individuals identified through these comparisons, provide engagement services, including engaging those who are not yet enrolled in mental health care.
Behavioral Health Solutions of South Texas

Behavioral Health Solutions of South Texas (BHSST), headquartered in the city of Pharr in Hidalgo County, serves 19 counties (including Starr County) in a variety of capacities, offering prevention, intervention, and treatment services that primarily focus on substance use and co-occurring disorders. BHSST began as the Council on Alcohol and Drug Abuse of the Rio Grande Valley in 1991 and then changed names following the Texas Commission on Alcohol and Drug Abuse (TCADA) merger. The mission statement for BHSST is as follows:

Behavioral Health Solutions of South Texas (BHSST) provides a multilevel approach inclusive of prevention, intervention, treatment and research to reduce substance abuse and related co-existing conditions in our communities, encourage healthier life-style related to at risk public health behaviors, and promote stronger families. Our multi-level approach centers on age appropriateness, cultural and language relevancy in an environment that is research and outcome based. BHSST aims to be a leader in the development of resources appropriate to its communities by strengthening collaborations and engaging community members to guide our efforts.

BHSST offers prevention services for general populations of youth (ages six to 19 years) and their families. These services address health and wellness as well as substance use prevention, and also target children/youth at high risk for substance use. BHSST prevention services utilize evidence-based practices such as the Positive Action curriculum and the Project Towards No Drug Abuse, for example. In addition, BHSST provides Parenting Awareness and Drug Risk Education (PADRE), a community-based intervention program serving Cameron and Hidalgo counties, targeting parenting males or expecting fathers who have substance use disorders (SUDs), or those at risk for SUDs; the Pregnant Post-Partum Intervention program for women at risk for SUD in Hidalgo and Cameron counties; and the Rural Border Intervention, which targets “Colonias” in Starr, Willacy, Zapata, Brooks, Duval, and Jim Hogg counties to provide rural border communities with access to a continuum of behavioral health services.

BHSST also offers recovery support services (RSS), a program available in Hidalgo County that mobilizes community-based recovery supports and services to help individuals initiate and sustain recovery from substance use disorders. BHSST also provides a Youth Recovery Community Services program for Hidalgo County youth between the ages of 13 and 21 who have substance use and/or co-occurring disorders.

As a DSHS-licensed outpatient mental health treatment services provider for adults, BHSST also offers services in Hidalgo County to individuals who are uninsured or insured through Medicaid. These services are provided through a twelve (12) week treatment program that

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158 For more information on this organization, please see http://www.bhsst.org/.
utilizes motivational interviewing and a cognitive behavioral therapy-based curriculum through six (6) individual and 24 group sessions.

Until August 31, 2015, BHSST was the Outreach, Screening, Assessment and Referral (OSAR) provider for DSHS Region 11. This arrangement was changed in the 2015 legislative session, requiring that OSAR services be managed through the local mental health authorities (LMHAs) statewide. Since then, Tropical Texas Behavioral Health has managed OSAR services for all 19 counties in south Texas (including Cameron, Hidalgo, Starr and Willacy counties), though TTBH contracted with BHSST to continue providing OSAR services for FY 2016. As of September 1, 2016, Tropical Texas Behavioral Health no longer contracted with BHSST for these services and began to provide them directly.

BHSST provided data on the volume of services delivered through OSAR in the four counties in the RGV during the period from September 1, 2014 through August 31, 2015. The data included the number of adults and youth served, per county, and can be summarized as follows:

<table>
<thead>
<tr>
<th>Population Served</th>
<th>Hidalgo County</th>
<th>Cameron County</th>
<th>Willacy County</th>
<th>Starr County</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>786</td>
<td>274</td>
<td>12</td>
<td>12</td>
<td>1,084</td>
</tr>
<tr>
<td>Youth</td>
<td>140</td>
<td>9</td>
<td>0</td>
<td>3</td>
<td>152</td>
</tr>
</tbody>
</table>

Finally, BHSST has played an important role as a convener of community collaboration regarding substance abuse services in the Rio Grande Valley. BHSST reported that it has taken a leadership role in helping to form the Recovery Oriented System of Care Collaboration for the Rio Grande Valley (ROSC-RGV), with guidance (but no funding) from HHSC. This entity met quarterly during 2014, but has met more intermittently since then.

**Highlighted Agency Strengths (contributions to RGV systems of care)**

- BHSST has a long standing role in providing local leadership and advocacy for substance abuse prevention and treatment services in the Rio Grande Valley.
- BHHST is one of the major providers of prevention services as well as a willing participant in prevention coalitions in local communities
- BHSST conducts research projects affiliated with universities. As the Prevention Resource Center for South Texas, BHSST is developing an annual regional needs assessment
- BHSST is one of the conveners of the regional ROSC collaboration.
BHSST Findings

**BHSST Finding 1:** BHSST provides a continuum of services, including prevention, research, and treatment throughout the RGV. However, the volume of these services is small compared to the need. There are long-standing and continuing resource limitations for substance abuse treatment as well as a lack of awareness of and advocacy for the availability of services in the community.

**BHSST Finding 2:** BHSST reports that there are very limited resources for indigent, Medicaid, or Medicare funded substance abuse services in the RGV. There are no available residential or detox programs for the public sector adult population, and only a few outpatient providers in the region; there are even fewer services for youth. People in need are frequently referred to programs in Corpus Christi and San Antonio.

**BHSST Finding 3:** There have been some efforts to develop regional collaboration for substance abuse services through the ROSC as well as many local prevention collaborations funded by DSHS. BHSST references Willacy County’s CASA (Communities Against Substance Abuse) as a particularly effective collaboration. However, substance abuse service planning has not been a high priority in the RGV and has not attracted resources or political traction. Substance abuse-related project proposals submitted by BHSST were not funded in the 1115 Waiver.

**BHSST Finding 4:** BHSST reports that there is a lack of ability to routinely identify and address substance use disorders in primary care settings, and little movement to address the importance of this issue with additional resources. Further, there is limited ability to provide integrated interventions in some mental health settings and most substance abuse settings. The exceptions include the existing capacity in RGV inpatient units to address co-occurring disorders during brief inpatient stays and increasing capacity to address co-occurring disorders within TTBH’s clinics. In addition, there needs to be more provision of routine mental health consultation to existing substance abuse providers and fewer barriers to accessing psychotropic medications for individuals with mental illness who may also be using substances.

Recommendations

**BHSST System Recommendation 1:** There is a significant need for resources to train and certify substance abuse providers in screening, assessment, and referral for other mental health and primary care client/patient needs. This should be a high priority for funding.

**BHSST System Recommendation 2:** The need for promoting integrated behavioral health care within primary care settings through education of primary health care practices and MCOs about the improvements in outcomes and ultimate efficiencies that can be gained through collaborative and consulting integrated care models.
**Doctor’s Hospital at Renaissance Health System (DHRHS)**

Doctors Hospital at Renaissance Health System (DHRHS) is a large hospital-based health and behavioral health delivery system located in Edinburg, Texas. The behavioral health component includes the Behavioral Hospital at Renaissance, an 87-bed psychiatric facility that serves children, adolescents, adults, and senior adults in separate pods, and a range of ambulatory services that are being developed along with ambulatory health services in the region. The mission of DHRHS is “to improve the well-being of those we serve with a commitment to excellence: every patient, every encounter, every time,” while the philosophy of the Behavioral Hospital at Renaissance is the belief “in providing care that is specific to a person’s needs and facilitates continuity of care before admission and following discharge.”

**Psychiatric inpatient services** include the 87-bed Behavioral Hospital, which provides specialized units for all age ranges, as well as a unit identified as providing co-occurring mental health and substance use disorder services, including detoxification. Specialized units include:

- The Child & Adolescent Psychiatric Program (featuring separate programs for children ages three to 12 years and adolescents ages 13 to 17 years),
- The Adult Psychiatric Program (featuring rapid stabilization, a comprehensive evaluation and assessment by an interdisciplinary team, short-term and symptom-focused interventions, long-term placement referrals, and a co-occurring mental health/substance use disorder program), and
- The Geriatric Psychiatric Program (featuring crisis intervention, evaluation, stabilization of deteriorating psychosocial function, medication, and caregiver support services).

All services have relatively short lengths of stay and emphasize discharge planning, referrals, and continuity of care. Discharge planning is facilitated by the presence of an on-site utilization management clinician from Tropical Texas Behavioral Health (TTBH). The psychiatric unit does not accept patients who have had forensic involvement. DHRHS and some local providers identified this as a key issue; it may also have an adverse impact on the unit’s census. Like other facilities in the region, DHRHS reports challenges negotiating with Medicaid managed care organizations (MCOs). They have made recent efforts to have on-site meetings with MCO care managers to discuss their concerns.

**Psychiatric emergency and crisis services** at DHRHS include a mobile assessment unit (a team of licensed professional counselors that covers emergency rooms and medical units for psychiatric evaluations). DHRHS does not have a psychiatric emergency service, nor does it operate any type of crisis diversion program. In response to community need, they are considering opening a crisis stabilization unit in Edinburg and also have been discussing the possibility of such a unit in Starr County.
Ambulatory and community-based services at the Behavioral Hospital at Renaissance include an intensive outpatient program (group, family, and individual therapy in a structured therapeutic environment for individuals with mental illness and their families), outpatient group therapy (e.g., psychoeducation, family support, newly diagnosed chronic conditions, substance abuse), school-based health clinics (with the Edinburg Consolidated Independent School District, McAllen Independent School District, and the Pharr-San Juan-Alamo Independent School District), ambulatory mental health services associated with community-based health centers, and integrated behavioral health services with their diabetes specialty clinics in Weslaco, Mission, and Edinburg. DHRHS would like to develop telepsychiatry services to promote access to outlying areas.

DHRHS also has Community Health Councils, which work with community members, including the sheriff’s department, to assess the needs for various support services.

Highlighted Agency Strengths (contributions to RGV systems of care)

- DHRHS is one of the largest health care systems in the region and a significant provider of behavioral health services.
- DHRHS provides specialty inpatient units or programming for children, adolescents, older adults, and people with co-occurring mental illness and substance use disorders.
- DHRHS has a strategic commitment to population health and has identified a senior vice president position to oversee clinical integration for the system. They are conceptualizing the importance of improving integrated behavioral health care (IBH) throughout their delivery system as well as attempting to integrate behavioral health into developing and expanding services.
- DHRHS is working to develop telemedicine services to help fill the void of provider shortages.
- DHRHS is developing community counseling centers that provide traditional outpatient counseling.
- DHRHS is developing outpatient substance use treatment services.
- DHRHS is implementing the integration of ambulatory behavioral health services with health centers throughout Hidalgo and Starr counties in partnership with Starr County Memorial Hospital.
- DHRHS has initiated integration of behavioral health services into school-based health clinics.
- DHRHS has made a strong organizational commitment to being a training and research site for the UT-RGV School of Medicine and would like to include psychiatry residency and psychology internship training opportunities as areas of focus. It has specific capability to provide behavioral health practitioners with training in IBH in the context of a community-oriented health delivery system.
• DHRHS leadership is interested in using data for performance improvement and collaboration with both payers and providers across the region to address gaps in service.

**DHRHS Findings**

**DHRHS Finding 1:** DHRHS operates a large inpatient unit with specialty services for multiple age groups and operates the only co-occurring disorder service in the RGV. However, the inpatient program utilization is below capacity. This may be related to the fact that the unit does not admit individuals with previous forensic involvement.

**DHRHS Finding 2:** DHRHS does not operate a psychiatric emergency service, nor any crisis diversion beds. It is considering opening a crisis stabilization unit, based on input from community stakeholders.

**DHRHS Finding 3:** DHRHS reported a significant lack of outpatient services capacity for individuals with behavioral health needs, particularly for children, both for insured and uninsured individuals. DHRHS further notes that there is a dramatic absence of residential and ambulatory substance abuse services in the Rio Grande Valley, and that their own services only meet a very small component of the need.

**DHRHS Finding 4:** DHRHS has launched a collaboration with Starr County Memorial Hospital, through which they are considering the development of an array of behavioral health crisis and ambulatory services along with multispecialty medical services.

**DHRHS Finding 5:** DHRHS recognizes the importance of integrating behavioral health and primary health services and has taken the initiative to achieve integration in school-based health clinics, diabetes clinics, and some community health clinics.

**DHRHS Finding 6:** DHRHS is unique among regional health systems by positioning itself to become a leader in system-wide IBH development that improves engagement of patients with complex medical, behavioral, and social needs, and reduces preventable readmissions. However, it does not have a specific framework for how to do this, nor has it initiated specific integrated physical health/behavioral health services for people with high use of medical services who might have unmet behavioral health and social needs.

**DHRHS Finding 7:** DHRHS is unique among regional health centers by appointing a Chief Academic Officer and having a deliberate strategy to develop the capacity and expertise to become a regional center of excellence in medical training and research. However, it is not clear if this will result in the UT-RGV Department of Psychiatry placing residents at DHRHS.
DHRHS Recommendations

**DHRHS Recommendation 1:** DHRHS should work to improve access to and utilization of its existing inpatient capacity. One approach might be to develop a formal data-driven performance improvement plan to enhance safe management of individuals with a higher acuity of needs.

**DHRHS Recommendation 2:** DHRHS should participate in collaborative(s) formed in response to the SB 292 grant program to reduce recidivism, arrest, and incarceration of individuals with mental illness; reduce wait time for forensic commitment; and assess opportunities to provide crisis diversion, crisis respite, and inpatient and outpatient restoration to competency services. Enhancements of crisis services should especially focus on implementation of crisis stabilization, crisis intervention, and other intensive ambulatory behavioral health services in Starr County, including collaboration with the Border Region Behavioral Health Center and, potentially, inpatient and outpatient competency restoration service programs.

**DHRHS Recommendation 3:** DHRHS should continue to take every opportunity to integrate behavioral health services into newly developed community-based ambulatory health programs and to collect data on the impact of such integration on costs and outcomes.

**DHRHS Recommendation 4:** DHRHS is in a position to model the utilization of national best practice strategies and tools (e.g., OATI) to develop a system-wide improvement approach to IBH across all its services.

**DHRHS Recommendation 5:** The UT-RGV School of Medicine and DHRHS should continue collaboration to take advantage of DHRHS’s capability to provide behavioral health training experiences that are integrated into primary care and family medicine in a community-based health system.

### Rio Grande State Center (RGSC)

Rio Grande State Center (RGSC), located in Harlingen, provides residents of the Rio Grande Valley with outpatient medical services, inpatient mental health services, and long-term services for individuals with intellectual and developmental disabilities.\(^{159}\) The mission of the Rio Grande State Center is “to improve health and well-being in South Texas through safe, innovative, integrated healthcare and support services.”\(^{160}\) As a three-component adult facility,


RGSC has a total capacity of 128 beds, which, as shown in the table below, are allocated to meet the behavioral health needs of individuals receiving services.

<table>
<thead>
<tr>
<th>Service</th>
<th>Capacity (# of Beds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Psychiatric Treatment – Acute Services</td>
<td>40</td>
</tr>
<tr>
<td>Inpatient Psychiatric Treatment – Forensic Services</td>
<td>15</td>
</tr>
<tr>
<td>Intellectual and Developmental Disabilities</td>
<td>73</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>128</strong></td>
</tr>
</tbody>
</table>

RGSC serves mostly indigent, uninsured residents of eight counties: Brooks, Cameron, Duval, Hidalgo, Jim Wells, Kenedy, Kleberg, and Willacy. More than half of the inpatient capacity is utilized for individuals with intellectual and developmental disabilities. Individuals receiving forensic treatment come from areas throughout Texas for competency restoration. Because of this influx of forensic patients from outside the immediate area, RGSC is frequently at maximum capacity. Staff reported that the need to serve this forensic population is limiting their ability to serve local patients who need more intensive inpatient services. The facility serves the most acutely ill individuals and has an average length of stay of about two weeks, which is longer than the length of stay for typical inpatient acute care. Individuals in the forensic unit stay an average of 84 days. Approximately 25% of individuals who are admitted have been previously served at TTBH. All patients admitted to inpatient psychiatric treatment and residential intellectual or developmental disability (IDD) services are provided general medical services by a staff physician.

The RGSC Outpatient Medical Clinic (OPC), also located in Harlingen, is a primary care medical clinic which offers medical and outpatient behavioral health care services through partnerships with several local organizations, including: UT-RGV School of Medicine, Methodist Healthcare Ministries, the HHSC Region 11, Border Health, Chronic Disease Heart & Stroke, UT Health Science Center – San Antonio, UT Health Science Center – Houston, UT School of Public Health, MHP Salud, Behavioral Health Solutions of South Texas, and Gracias Texas. The clinic serves individuals who reside in Cameron, Hidalgo, Willacy, and Starr counties, and reported serving 2,836 individuals throughout fiscal year 2015. At the time of the site visit, the clinic was beginning to implement integrated care (this is discussed in the report section on Integrated Health Care).

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Similar to other provider organizations throughout the RGV, RGSC faces challenges with workforce shortages, both at its main campus and the OPC. As mentioned above, the OPC currently refers individuals to local provider organizations for counseling services. Through collaborations with the UT-RGV School of Medicine Internal Medicine Residency Program and its new psychiatry residency program, the OPC is working toward integrating in-house behavioral health care into the primary care services it provides by creating a residency training opportunity for clinical rotations. The RGSC OPC currently has residents from the internal medicine program and expects to receive psychiatry residents in July 2017. Psychiatry residents will have the opportunity to learn integrated physical health/behavioral health practices and follow patients throughout their residency. In an effort to integrate behavioral health in the primary care setting, the OPC uses the PHQ-9 to screen all patients for depression at each clinic visit. RGSC hopes to place future psychiatry residents in the IDD and inpatient units as part of the development of UT-RGV’s Center of Excellence, which will focus on the overlap between neurology and psychiatry.

Highlighted Agency Strengths

Rio Grande State Center provides much needed behavioral health services to primarily indigent and uninsured residents of the Rio Grande Valley. Below, we review major strengths of RGSC and the services it provides. Several of these strengths are further discussed in the findings and recommendations sections that follow.

- RGSC has both a vision and philosophy which promote quality, individualized services for Texans living in the Rio Grande Valley through partnerships with consumers, family members, and local service providers.
- With a three-component facility, the RGSC main campus has the ability to integrate multiple types of services into one location (IDD, mental health, and medical), including integrated physical health/behavioral health services at its Outpatient Medical Clinic.
- RGSC maintains what it characterizes as a “very good” working relationship with Tropical Texas Behavioral Health (TTBH). With regular overlap in the individuals both organizations serve, it is estimated that 25% of RGSC patients have already been seen for services at TTBH. TTBH also regularly accepts discharged patients from RGSC into its services.
- RGSC maintains an annual recidivism rate of 17%, reporting that most patients who are discharged from the facility do not enter back into services, although staff do recognize that they are likely brought into services with other local providers.
- RGSC continues to foster strong partnerships with local entities, including provider organizations, funders, and institutions of higher education.
RGSC Findings

RGSC Finding 1: Longer placement options are an issue for individuals served at RGSC. Housing supports, such as Permanent Supportive Housing, and available family support are often limited for individuals with mental health needs, particularly after being released from services. As a result, local mental health authorities must assist some people in obtaining housing in local homeless shelters following discharge. Staff reported longer-term placement options tend to be more readily available for individuals with intellectual or developmental disabilities (IDD).

RGSC Finding 2: RGSC is faced with workforce shortage challenges, both on its main campus and with its Outpatient Medical Clinic.

- The IDD program at RGSC has been without a psychiatrist for the past six years, which presents continuing issues in treating individuals who are dually diagnosed with both a mental health condition and IDD.
- Peer support has been explored in the past, and RGSC currently has one peer specialist on staff through a contract with TTBH.
- The Outpatient Medical Clinic has a significant need for staff physicians, psychiatrists, and behavioral health specialists. While the partnerships with the UT-RGV Medical School are expected to bring much needed capacity to serve individuals with behavioral health needs, additional full-time RGSC staff members in these positions are needed to meet the growing needs of individuals in the community.

RGSC Finding 3: RGSC is not a detox facility, although providers and patients in the community often assume this is part of its regular operations. RGSC staff reported that co-occurring psychiatric and substance use disorder diagnoses are very common for the individuals they serve (estimated at 90% of individuals served). Physicians will prescribe a detox schedule, which nurses manage with the patients; however, there is no standard protocol currently in place for detox procedures with dually-diagnosed individuals. Medication-assisted detox is included in the RGSC formulary, but staff report they are not providing this type of detox very often.

RGSC Finding 4: RGSC currently has no capacity for inpatient adolescent beds; most adolescents in need of inpatient treatment are sent to San Antonio State Hospital or local private hospitals for services. In 1998, RGSC converted 20 adult beds in Edinburg to a 15-bed unit dedicated to inpatient services for adolescents. However, because of inadequate funding, the unit was ultimately closed in 2001, leaving RGSC with no capacity for adolescent beds.

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RGSC Finding 5: Various challenges exist for individuals making the transition from inpatient services at RGSC to outpatient services at Tropical Texas Behavioral Health. While TTBH works quickly to secure services for patients after discharge from RGSC, there is currently no mechanism by which they can work collaboratively to proactively connect with – and prevent readmission for – people who may “fall through the cracks.”

RGSC Recommendations

RGSC Recommendation 1: Prepare for and participate in collaborative(s) formed in response to SB 292 grant opportunities to reduce recidivism, arrest, and incarceration of individuals with mental illness, and to reduce wait time for forensic commitment. In response to limited resources, collaborate with system partners to develop expansion priorities for target populations and implement a range of diversion and treatment services that address the following major system gaps: 1) mental health jail diversion; 2) alternatives to competency restoration in a state hospital, including outpatient competency restoration (OCR) programs to allow justice-involved individuals with mental illness and co-occurring psychiatric and substance use disorder diagnoses to receive competency restoration services within their community rather than in a state mental health facility;\(^{164}\) 3) additional Assertive Community Treatment and Forensic Assertive Community treatment with an outreach component; 4) intensive mental health services and substance use disorder treatment, including intensive outpatient programs; 5) expansion of an interdisciplinary rapid response teams to reduce law enforcement’s involvement with mental health emergencies; and 6) provision of local hospital, crisis respite, or residential beds.

RGSC Recommendation 2: Identify opportunities to create a continuum of care on the RGSC campus, in partnership with other agencies in the RGV, basing the continuum on the services identified in Recommendation 1.

RGSC Recommendation 3: Consider utilizing more peer support and recovery-oriented services as components of the services identified in Recommendation 1.

RGSC Recommendation 4: Improve consistency in the treatment of co-occurring disorders and expand the use of medication-assisted treatment.

RGSC Recommendation 5: Partner with TTBH to implement a continuous quality improvement (CQI) collaboration in order to track individuals who may get “lost” during transfer between the

two agencies. Develop strategies to proactively connect with – and prevent readmission for – people who may “fall through the cracks.”

**Strategic Behavioral Health – Palms Behavioral Health (PBH)**

Palms Behavioral Health (PBH) is a 94-bed inpatient psychiatric hospital campus in Harlingen operated by Strategic Behavioral Health, a privately-owned psychiatric hospital company based in Memphis, TN. Strategic Behavioral Health planned the opening of PBH (its second facility in Texas; the first is located in College Station) in response to perceived community need for inpatient psychiatric services in Harlingen (other major inpatient facilities are located some distance away in Hidalgo County). PBH reports that it has a strong organizational focus on quality improvement and data, including a protocol for six-month follow-up tracking of admissions to monitor readmissions to the same facility.

The facility, located close to Harlingen Medical Center, opened on August 2, 2016, initially with 94 beds allocated as described in the table below.

<table>
<thead>
<tr>
<th>Population</th>
<th>Capacity (# Beds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>42</td>
</tr>
<tr>
<td>Geriatric</td>
<td>24</td>
</tr>
<tr>
<td>Adolescent</td>
<td>18</td>
</tr>
<tr>
<td>Children</td>
<td>10</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>94</strong></td>
</tr>
</tbody>
</table>

Two units were added in the fall of 2016: a 10-bed Children’s Unit and an 18-bed Adolescent Unit. Outpatient services – partial hospital and intensive outpatient programming – opened in January 2017. PBH has recruited two local outpatient psychiatrists to work on its inpatient unit. Like other inpatient facilities in the Tropical Texas Behavioral Health (TTBH) service area (Cameron, Harlingen and Willacy counties), PBH contracts with TTBH to receive PBH’s referrals of indigent patients. Additionally, TTBH plans to provide PBH with an on-site utilization management coordinator to facilitate discharge planning.

Palms Behavioral Health also accepts referrals for treatment from emergency rooms (ERs) throughout the RGV as well as direct admissions from patient calls, family calls, or other direct referrals. They have a well-designed telemedicine program to facilitate basic medical clearance for these types of direct admissions (rather than relying on the emergency room), and accept individuals covered under Medicare, Medicaid, private insurance, and through the Veterans Administration (VA). PBH directs individuals with higher medical risks (e.g., individuals who arrive while under the influence alcohol or other drugs) to local ERs.
Leadership at PBH reported a strong interest in collaborating with the local community and shared that they had made considerable efforts to establish positive community public relations in advance of their opening in August 2016.

**Highlighted Agency Strengths (contributions to RGV systems of care)**

- Palms Behavioral Health has an attractive campus with a large number of beds available to treat populations of all ages.
- Palms Behavioral Health has recruited an experienced director of clinical services who is familiar with the system of care in the RGV and has sought to establish community collaboration during the facility’s planning and implementation process.
- The geriatric unit is strong in concept and may serve a priority need in the South Valley, where there is a significant geriatric population.
- Palms Behavioral Health is interested in meeting any potential need for more child and adolescent beds.
- Palms Behavioral Health has a contract with TTBH, similar to other area facilities, which allows PBH to refer indigent individuals to TTBH for services.
- Palms Behavioral Health leadership expressed a strong commitment, backed up by current data-driven protocols, to implement high-quality programming, including services that address trauma, co-occurring substance use disorders, and medical issues.

**PBH Findings**

**PBH Finding 1:** PBH does not operate a psychiatric emergency service, nor do they plan to operate any crisis diversion beds; this remains a significant gap in services in the RGV.

**PBH Finding 2:** PBH has created capacity for telemedicine medical clearance to facilitate admissions. However, it also has a policy to require all individuals under the influence of substances to go to emergency rooms for clearance, which may create barriers to timely and appropriate access to care.

**PBH Finding 3:** PBH is establishing a state-of-the-art geriatric unit that could become a valuable addition to the service array in Cameron County.

**PBH Finding 4:** PBH is developing trauma-informed and co-occurring programming by employing Seeking Safety and other standardized models.

**PBH Finding 5:** PBH has developed a promising collaboration with TTBH for working with uninsured people and facilitating their transition planning post discharge.
PBH Finding 6: PBH is very interested in being an engaged partner in the RGV system of care as well as in exploring how best to support an expansion of ambulatory services in order to reduce hospitalizations. Currently, however, there is no organized mechanism by which that participation can formally occur.

PBH Finding 7: PBH’s parent company, Strategic Behavioral Health – new to Texas – is committed to quality improvement programming. While Strategic Behavioral Health has a strong focus on quality improvement (QI) and data collection, it is not yet clear what QI capability PBH will implement for improving continuity of care and reducing readmissions.

PBH Recommendations

PBH Recommendation 1: PBH should collaborate with other inpatient facilities to assess whether there is continued need for 94 inpatient beds. If available beds are underutilized and not needed, PBH may consider repurposing its resources for crisis diversion, transitional residential, and ambulatory services.

PBH Recommendation 2: PBH should plan to participate in collaboratives formed to bid on funding that will be available under the SB 292 grant program for the diversion of individuals from inpatient care and jails, including funding for the provision of crisis diversion, crisis respite, residential care, and intensive outpatient services. The option to provide inpatient or outpatient restoration to competency may also be available through SB 292.

PBH Recommendation 3: PBH should develop a QI process to track and improve continuity of care and recidivism, ideally in collaboration with TTBH and other providers.

PBH Recommendation 4: PBH should consider expanding its model geriatric service continuum throughout the region and, through collaboration with geriatric service providers in the RGV, consider investing in enhancements to the continuity of care for the individuals they serve.

PBH Recommendation 5: PBH should consider strategies to (1) reduce barriers to direct admission based solely on use of substances (such as alcohol), (2) provide guidance for its telemedicine clearance team on safe protocols for these admissions, and (3) develop processes in its admission unit to facilitate both rapid admissions for those in need as well as appropriate diversion interventions for those who may be best served in other levels of care.

PBH Recommendation 6: To prevent duplication of services, PBH should consider coordinating its planning for mental health intensive outpatient programming with the existing program operated by VBMC in Harlingen.
PBH Recommendation 7: PBH should consider expanding its array of trauma-informed, recovery-oriented, and integrated programming to comprehensively cover all of its units. As part of this effort, PBH should also consider renaming its adult units to avoid the stigma of labeling one unit for “low functioning” adults.

Texas Valley Coastal Bend Health Care System (VA-TVCBHCS)

In October 2010, the U.S. Department of Veterans Affairs (VA) created the Texas Valley Coastal Bend Health Care System (VA-TVCBHCS) as an independent health care system to better address the health care needs of veterans in the twenty counties that make up the Laredo, McAllen, Harlingen, and Corpus Christi VA service areas. These counties were previously part of the VA health care system in San Antonio. VA-TVCBHCS’ vision is as follows:

VA Texas Valley Coastal Bend Health Care System will continue to be the benchmark of excellence and value in health care and benefits by providing exemplary services that are both patient centered and evidence based.

This care will be delivered by engaged, collaborative teams in an integrated environment that supports learning, discovery and continuous improvement.

It will emphasize prevention and population health and contribute to the nation’s well-being through education, research and service in National emergencies.165

As a health care system comprising a combination of VA staff and an extensive network of contracted providers, the VA-TVCBHCS provides secondary and tertiary health care in medicine, surgery, psychiatry, and rehabilitation medicine. It operates a 100-patient Home Based Primary Care program and a 200-patient Care Coordination Home Tele-Health Program.

Summary of RGV Veteran Populations Served, September 1, 2014 – August 31, 2015166

<table>
<thead>
<tr>
<th>County</th>
<th>Total Veteran Population</th>
<th>Number of Unique Patients Receiving Care</th>
<th>Percent of Veteran Population Served</th>
<th>Total VA Spending on Medical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameron</td>
<td>17,418</td>
<td>6,721</td>
<td>39%</td>
<td>$75,718,000</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>23,374</td>
<td>8,787</td>
<td>38%</td>
<td>$91,733,000</td>
</tr>
</tbody>
</table>

The VA-TVCHCS provides health care services, including behavioral health services, at the VA Health Care Center in Harlingen as well as through clinics located in Laredo, McAllen, and Harlingen. Mental health and substance use disorder services include:

- Outpatient mental health therapies and medication management;
- A suicide prevention program, which is active at all clinics and provides a more intensive level of care for those who are high risk;
- Outreach teams, including issue-specific specialty teams (e.g., substance use disorders) that provide intensive, aftercare, and family care, as appropriate;
- Trauma services offered at all sites;
- Intensive case management for mental health recovery;
- Services, including home- and community-based services, for those with serious mental illness;
- Intensive outpatient programing (IOP) for individuals with co-occurring mental health and substance use disorders;
- Veterans Justice Outreach Program;
- Integrated behavioral health care services in primary care clinics;
- A larger tele-mental health program (including tele-psychiatry and tele-psychology) that utilizes a network of VA-TVCHCS staff;
- Vocational rehabilitation;
- Peer support embedded into programs;
- Expanded transportation services to assist veterans with traveling to clinics;
- Homeless services.

Highlighted Agency Strengths (contributions to RGV systems of care)

- The average mental health wait time for the VA-TVCHCS is 2.81 days according to the

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166 Summary of RGV Veteran Populations Served, September 1, 2014 – August 31, 2015

<table>
<thead>
<tr>
<th>County</th>
<th>Total Veteran Population</th>
<th>Number of Unique Patients Receiving Care</th>
<th>Percent of Veteran Population Served</th>
<th>Total VA Spending on Medical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starr</td>
<td>890</td>
<td>360</td>
<td>40%</td>
<td>$3,735,000</td>
</tr>
<tr>
<td>Willacy</td>
<td>867</td>
<td>332</td>
<td>38%</td>
<td>$4,583,000</td>
</tr>
<tr>
<td>RGV Area Total</td>
<td>42,549</td>
<td>16,200</td>
<td>38%</td>
<td>$175,769,000</td>
</tr>
</tbody>
</table>

most recent VA numbers.\textsuperscript{168}

- VA-TVCBHCS’ emphasis on primary care and mental health integration gives veterans immediate access to providers of mental health services, particularly for individuals with mild to moderate mental health needs.
- VA-TVCBHCS is also using tele-mental health to deliver mental health services, including a unique relationship with The University of Texas Rio Grande Valley (UT-RGV) in Edinburg to serve college students with busy schedules.
- VA-TVCBHCS also works with justice-involved veterans through its Veterans Justice Outreach Program.
- VA-TVCBHCS offers extensive vocational rehabilitation services.
- As VA-TVCBHCS has expanded services, staffing has increased from 25 in 2006 to over 200 at this time. VA-TVCBHCS hires people who want to serve veterans and create a health care environment their own families would want to visit.
- There is good collaboration between VA-TVCBHCS and TTBH; TTBH operates a veteran’s drop-in program in Cameron County and is expanding services in Hidalgo County through the Texas Veterans + Family Alliance.
- The VA is also working with the Department of Psychiatry at UT-RGV to support a residency program, which will have its first class in 2017, hopefully resulting in more providers staying in the area.
- VA-TVCBHCS is also starting joint clinics with the UT-RGV Department of Psychiatry faculty to develop services that are not provided in the area (e.g., electroconvulsive therapy).
- VA-TVCBHCS started a van route using volunteer drivers to provide transportation for veterans to and from appointments.

**VA-TVCBHCS Findings**

**VA-TVCBHCS Finding 1:** The stigma of having a mental illness or substance use disorder is a barrier for veterans in accessing services because the personal or societal perception of weakness is anathema to the military maxim of accomplishing the mission regardless of personal discomfort. Mental health or substance use conditions can also be misunderstood by veterans and their families as weakness or self-pity rather than treatable illnesses. In addition, the lack of readily available outreach and treatment that is trauma-informed and competent in working with the military culture contributes to barriers veterans face in accessing services.

\textsuperscript{168} U.S. Department of Veterans Affairs, Veterans Health Administration. (n.d.). *Patient access data: October 2016 data releases – pending appointments (as of 15 October 2016).* Retrieved from https://www.va.gov/HEALTH/docs/DR56_102016_Pending_and_EWL_Biweekly_Desired_Date_Division.pdf
VA-TVCBHCS Finding 2: Access to mental health treatment with a wait time of 2.81 days is excellent. Collaboration with psychiatry units at local hospitals to quickly admit veterans and support discharge planning has been successful.

VA-TVCBHCS Finding 3: Limited access to public transportation makes it very challenging for veterans and their families to access services. However, volunteer drivers use a VA van and have established a route to assist veterans.

VA-TVCBHCS Finding 4: While inpatient psychiatric beds are largely available in the Valley, the process of completing an involuntary commitment across county lines is hindered by the lack of a standard approval form. Each county utilizes a different version of the form provided by the State Statute, with some completed electronically and others completed using carbon copy paper. This creates challenges in completing required forms for transferring individuals to services, and often requires extensive time from administrators and providers to complete the process.

VA-TVCBHCS Recommendations

VA-TVCBHCS Recommendation 1: Continue strong collaborative efforts with local hospital systems and emergency departments to address psychiatric emergencies and the provision of inpatient care, including effective discharge planning. Consider participation in the newly-formed crisis services collaborative meeting.

VA-TVCBHCS Recommendation 2: Continue strong collaborative efforts with TTBH, which has operated the Cameron County Veterans Drop-In Center for two years. TTBH recently expanded services at the Cameron County Veterans Drop-In Center and is opening the Hidalgo County Veterans Drop-In Center through the Texas Veterans + Family Alliance, the innovative grant program created by the Texas Legislature pursuant to Senate Bill 55 (84th Legislature) that supports community mental health programs in providing and coordinating services and treatment for Texas veterans and their families.

VA-TVCBHCS Recommendation 3: Continue pursuing the delivery of integrated behavioral health care within primary care settings through education of primary health care practices about the improvements in outcomes and ultimate efficiencies that can be gained through collaborative and consulting integrated care models.

VA-TVCBHCS Recommendation 4: As a strategy to address gaps in transportation services that could augment the existing VA-TVCBHCS van program, consider expanding the provider network to offer access to providers in communities closer to veterans.
Valley Baptist Medical Center

Valley Baptist Medical Center (VBMC) is a large for-profit hospital, now owned and operated by Tenet, which has inpatient, emergency, and outpatient services in two locations, one in Brownsville and one in Harlingen. Behavioral health is supported strategically following the transition to ownership by Tenet and for-profit status. VBMC “helps people achieve health for life through compassionate service inspired by faith, and are dedicated to continuing our strong tradition of providing quality, compassionate health care that puts people first.”

VBMC-Brownsville operates an adult intensive outpatient program (IOP) and until August 20, 2017, operated a 37-bed adult psychiatric inpatient unit. Upon the closing of VBMC-Brownsville’s inpatient unit, VBMC-Harlingen opened a 12-bed inpatient Geriatric Behavioral Health Unit. In addition, the Harlingen campus provides an IOP service, along with some provision for coverage of the emergency room, located in a medical office building next to the hospital.

A breakdown of admissions, average length of stay, and payer mix for the VBMC-Brownsville inpatient unit (prior to its closing) is outlined in the table below.

<table>
<thead>
<tr>
<th>Adult Inpatient Psychiatric Unit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions per month</td>
<td>130-180</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>5-7 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payer Mix</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>35%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>30%</td>
</tr>
<tr>
<td>Private insurance</td>
<td>5%</td>
</tr>
<tr>
<td>TTBH contracted beds ($550/day)</td>
<td>5-10%</td>
</tr>
<tr>
<td>VA contracted beds</td>
<td>5-10%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
</tr>
</tbody>
</table>

170 As this report was going to press, Valley Baptist Medical Center-Brownsville announced they will be closing the hospital’s inpatient unit effective August 20, 2017, with no new patients accepted after July 31, 2017. VBMC-Brownsville noted the closing was due to “a challenging reimbursement environment, increasing operating costs and the addition of available treatment resources within our county...”. The letter noted VBMC-Brownsville will continue operating its Outpatient Intensive Program.
171 Retrieved from: http://www.valleymorningstar.com/life/health_wellness/article_ea1f315c-8df6-11e7-b5f4-c7c305fd70c5.html
While the VBMC-Brownsville inpatient unit was operational, it prided itself on being more accessible to patients with acute and complex needs than other inpatient programs in the RGV. The Behavioral Health Director was routinely on call 24 hours a day, seven (7) days a week for admissions. VBMC had a stable team of psychiatrists who had expertise in addiction psychiatry and worked with a team of on-site primary care physicians to provide medical capacity on the unit. Additionally, there was a physician’s assistant with psychiatric specialization who provided services on the inpatient unit, as well as three social workers (plus interns) who provided services to families, discharge planning, and some group therapy.

At the time of this assessment, VBMC had just hired a licensed counselor (and was recruiting a second clinician) to create a “mobile assessment team” to provide limited crisis coverage of their emergency rooms (ERs) and physician practices. In 2016, Valley Baptist Medical Center at Brownsville reported receiving 2,687 individuals in the ER who presented with some type of psychiatric concern.

VBMC operates two intensive outpatient programs, one at each campus. Each program provides three hours of group programming three times per week, covered by the same team of four social workers, along with the two inpatient psychiatrists. Although the capacity of the program is over 20, and the highest census in one location has been 23, the current program operates at a census of around 10 at each site. The program bills Medicare and Medicaid, and charges (but does not collect) $800 per day.

VBMC makes a strong effort to attract referrals and engage patients in the IOP program. They provide free initial assessments and access to transportation. The program accepts referrals from the ER and inpatient units and provides outreach to individual physician practices in the VBMC community as well as to other human service providers. The program has a cognitive-behavioral focus and uses measurement tools to track symptoms and outcomes (e.g., PHQ-9; General Anxiety Disorder [GAD] screening).

Of note, there is a significant 20% “bump” in service utilization during the winter, due to the use of services by “Winter Texans.”

Highlighted Agency Strengths (contributions to RGV systems of care)

- Until its closing, VBMC maintained a well-run adult psychiatric inpatient facility in Brownsville that made an effort to facilitate admission for patients with complex challenges from across the region, and usually had capacity and availability.
- VBMC offers two small IOP programs that provide limited capacity to provide short-term, community-based services for individuals with higher levels of need.

\[172\] Data received from Becky Tresnicky of Valley Baptist Medical Center (personal communication, February 2017).
• VBMC has on-site capacity in addiction psychiatry as well as on-site physicians to manage co-occurring medical needs.
• There is a hospital-wide suicide protocol initiated by Tenet.
• VBMC also reported it has a process for collecting ER data for both campuses on individuals with behavioral health needs.
• VBMC is making a concerted effort to expand its array of outpatient services, including mobile assessment in the ER.
• VBMC has a plan to open an adolescent inpatient unit in 2017.
• VBMC also reported it has a process for collecting ER data for both campuses on individuals with behavioral health needs.
• VBMC is making a concerted effort to expand its array of outpatient services, including mobile assessment in the ER.
• VBMC has a plan to open an adolescent inpatient unit in 2017.
• VBMC has considerable space available at its Brownsville campus where it could develop an array of crisis diversion services.
• The IOP Director participates on the Harlingen campus committee for planning a Level 3 Trauma Center in order to integrate the provision of community crisis debriefing services.
• VBMC leadership has positive connections within the region, including TTBH, the Cameron County Mental Health Task Force, and participates on the state Medicaid Behavioral Health Medical Director’s Committee.

VBMC Findings

**VBMC Finding 1:** The VBMC psychiatric inpatient unit at Brownsville provided quality acute care for individuals with psychiatric disorders, including those with co-occurring substance use and health conditions. The unit had capacity for all payers and was not at full occupancy, raising the question about further investing the region’s relatively scarce resources in developing inpatient beds instead of developing crisis diversion and outpatient capacity.

**VBMC Finding 2:** The VBMC psychiatric inpatient unit had challenges in discharge and continuity of care planning for all populations. Some of these challenges related directly to a lack of outpatient capacity in the region, reported policy and procedure barriers in accessing community services, a dramatic lack of substance abuse treatment capacity in the RGV, and internal barriers to developing a full array outpatient services at VBMC.

**VBMC Finding 3:** There is potential to develop a full array of crisis services at the VBMC-Brownsville campus, provided that a successful financial model for those services can be developed in collaboration with a wide range of payers.

**VBMC Finding 4:** VBMC reports the need for high level collaboration with Medicaid MCOs in the region to address both payment challenges and continuity of care issues.
VBMC Finding 5: The VBMC IOP services are well designed and high quality, but because the program requires participation in group treatment three days a week, they do not have the resources to meet the range of other outpatient needs in the community.

VBMC Finding 6: There is no capacity to offer individualized outpatient services (whether crisis intervention or routine) beyond the initial assessment. Also, the limited availability of bilingual and translation services is another barrier to accessing services.

VBMC Finding 7: VBMC reports that there is no organized regional collaboration that shares responsibility for individuals moving through the acute care system, nor tracks those individuals for the purpose of continuous improvement.

VBMC Finding 8: VBMC has participated in developing the Cameron County Mental Health Task Force and reports that this task force has potential for increasing its effectiveness in addressing community needs, but will require significant technical assistance in order to achieve that potential.

VBMC and System Recommendations

VBMC Recommendation 1: Establish a mechanism at VBMC, on both campuses, for providing and billing outpatient behavioral health services, with an emphasis on crisis intervention and continuity of care. Participate in collaborative(s) formed in response to the SB 292 grant program to reduce recidivism, arrest, and incarceration of individuals with mental illness; reduce wait time for forensic commitment; and assess opportunities to provide crisis diversion, crisis respite, and inpatient and outpatient restoration to competency services.

VBMC Recommendation 2: Work other Cameron County Mental Health Task Force leaders to develop a plan to revitalize the task force as an effective forum for collaboration to improve the behavioral health system in Cameron County.

The Wood Group Crisis Respite Program

The Wood Group Crisis Center is a 16-bed residential crisis respite program in Harlingen, Texas, operated by The Wood Group, under contract with Tropical Texas Behavioral Health (TTBH). The mission of The Wood Group is to provide quality behavioral health services that assist individuals with mental illness or other special needs to live healthy and productive lifestyles within their communities. A private company based in Wichita Falls, The Wood Group has
provided services within the Texas public behavioral health system for 29 years and operates crisis services in thirty sites across Texas.\textsuperscript{173}

The program in Harlingen, one of The Wood Group’s “older” programs, has been operating for about 10 years and is the only crisis diversion program in the Rio Grande Valley. As of September 1, 2016, the program transitioned to a mix of nine beds specifically for crisis respite services (previously seven) and seven (previously nine) beds for long-term transitional residential services for individuals with serious psychiatric disabilities. Staffing includes a site administrator (an experienced case manager and rehabilitation services provider) and case managers.

<table>
<thead>
<tr>
<th>Program</th>
<th>Capacity</th>
<th>Average LOS</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Respite</td>
<td>9 Beds</td>
<td>3 Days</td>
<td>$70.56 / Day</td>
</tr>
<tr>
<td>Transitional Residential</td>
<td>7 Beds</td>
<td>2 – 6 Years</td>
<td>$730 / Month</td>
</tr>
</tbody>
</table>

The crisis respite program accepts admissions 24 hours a day, seven days a week, primarily from the Tropical Texas Behavioral Health Mobile Crisis Outreach Team, but has limited ability to manage higher levels of acuity because of limited staffing and a lack of medical supervision or security. The admission criteria support a welcoming approach and facilitate engagement with individuals with challenging issues (e.g., under the influence of substances, needing re-stabilization of medications, homeless and referred from emergency rooms, experiencing domestic issues or other short-term crises). The typical stay in a crisis respite bed is around three days. The intervention focuses on creating a safe space; providing shelter, food, and clothing; and connecting with case management from TTBH. The program also coordinates with TTBH for medication services. The Wood Group does not bill third party payers, including Medicaid, for its crisis bed services, viewing Medicaid billing as a challenging administrative burden.

The Wood Group acknowledges that the program is underutilized (during the site visit, only two of the crisis beds were occupied) and leadership reports that feedback from crisis workers indicates that the program’s ability to manage individuals in crisis falls short of what The Wood Group believes it can manage, so they refer for inpatient admission instead. The Wood Group is aware that a nine bed capacity falls short of the regional need for crisis beds and would welcome developing a higher level of diversion care. However, there has not been a strong interest in the RGV in allocating resources for that purpose.

\textsuperscript{173} In addition to RGV, the Wood Group operates crisis services in Abilene, Amarillo, Austin, Beaumont, Big Spring, Denton, Eagle Pass, Gatesville, Georgetown, Harlingen, Kenedy, Lytle, San Antonio, Texas City, Tyler, Waco, and Wichita Falls.
Highlighted Agency Strengths (contributions to RGV systems of care)

- The Wood Group has a great deal of experience throughout Texas in operating a range of crisis diversion levels of care. They are committed to the public sector and welcome the opportunity to participate with LMHAs and other partners to identify and respond to community needs.
- The Crisis Respite Program is the only crisis diversion program in RGV.
- The program is currently well managed, operates with a high level of efficiency, and is shifting toward more of a rehabilitative focus.
- The Wood Group is very open to participation in crisis system planning for the region and development of a more comprehensive service array.

Other Organizations Findings and Recommendations

Catholic Charities of the Rio Grande Valley

Catholic Charities of the Rio Grande Valley (CCRGV) is a regional social service agency covering Cameron, Hidalgo, Starr, and Willacy counties, with offices in San Juan and Brownsville. The mission of CCRGV is “to provide for the needs of our community through selfless service and under the sign of love.” This mission is carried out by 15 staff under the direction of the executive director.

The primary activity of the organization is basic economic support for impoverished populations, including immigrants (of all kinds) and disaster victims. In addition to its counseling program, specific services provided by CCRGV include the following:

- Emergency Assistance Program provides short-term utility, housing, and medical assistance for those in need.
- Homeless Prevention services include temporary financial assistance and housing relocation and stabilization services focused on housing for homeless and at-risk households, supported by an Emergency Solutions Grant (ESG).
- Disaster Relief Program provides home assessment and case management for people recovering from a federally declared disaster.
- Food Programs, supported by USDA funding, provides over 60,700 meals to children at 59 sites.
- Humanitarian Respite Center, located in McAllen and part of the Humanitarian Crisis Relief effort, provides immigrants who had crossed the border with no-cost services and basic humanitarian care such as: food, water, shower facilities, shelter, and education on U.S. and immigration process as well as awareness and education on human trafficking.
- Pregnancy Center, supported by state funding, provides counseling, education, support, and material assistance for the benefit of children (unborn and up to the first year of life) and their parents.
Counseling Program
The CCRGV Counseling Program provides short-term counseling services to individuals, couples, and families who are experiencing life crises. People with more severe mental health issues are referred to TTBH. CCRGV also provides counseling, education, and resources to women looking for alternatives to abortion, as well as assistance and counseling through its Military Family Relief Project to military servicemen and women who had been deployed to Iraq. CCRGV does not provide substance abuse services.

- CCRGV has two counselors on staff, one in each office. The executive director, a licensed counselor, also provides counseling services and supervises counseling interns. CCRGV offers a sliding fee scale ($2 per visit per $1,000 of annual income) and does not bill insurance. They refer to local primary care physicians for medication services.

Referrals for CCRGV counselling services come directly from other agencies and regional churches/dioceses.

Highlighted Agency Strengths (contributions to RGV systems of care)

- CCRGV plays an important role in the Rio Grande Valley through collaborations among non-profit human services providers, leadership with the Faith Communities for Disaster Recovery regional disaster response effort, and relationships with many of the behavioral health service provider organizations in the RGV.
- CCRGV helps to address the gap in availability of counseling services to low income populations.
- More important, CCRGV, by virtue of its role in providing economic support services to impoverished populations, including immigrants, is deeply engaged with the needs of some of the most marginalized communities in the Rio Grande Valley.

CCRGV Findings and Recommendations

CCRGV Finding 1: CCRGV is able to provide some mental health counseling services to impoverished and immigrant populations. However, as reported by their staff, this capacity is much less than these populations need and it only addresses a small fraction of the gap in access to mental health counseling for low income, uninsured individuals in the RGV.

CCRGV Finding 2: While CCRGV provides only a small volume of counseling service, it is in touch with major populations in need across the region through its economic assistance activities.

CCRGV Recommendation 1: CCRGV should be included in regional collaborations on behavioral health because of their extensive knowledge about impoverished and immigrant populations.
John Austin Peña Memorial Center

John Austin Peña Memorial Center (JAPC or Peña Center), a collaboration between the University of Texas Rio Grande Valley School of Medicine (UTRGV-SOM) and the Hidalgo County Health Department, offers primary health care to adolescents ages 12 to 18 years who are at risk for medical, mental health (behavioral issues, attention-deficit/hyperactivity disorder, and anger management), and appetite-driven conditions (alcohol, drugs, tobacco, etc.). JAPC offers a one-stop shop described as “inter-professional care in an integrated fashion” covering primary health care that is supported and supplemented by additional disciplines that address holistic needs such as behavioral health, exercise, nutrition, and oral health care.

JAPC identifies the following specific goals for the center:

- Advance access to treatment for adolescents with substance use/appetitive-driven disorders, psychiatric illness, and health concerns;
- Promote inclusion and integration of behavioral medicine to the scope of primary care;
- Improve access to oral health services;
- Improve collaboration and integration of scarce specialty resources;
- Improve outreach to build community capacity for complex, high-risk, triply-diagnosed adolescents; and
- Integrate services in the community (McAllen ISD, Pharr Boys and Girls Club, Family services).

Launched in April 2015, JAPC was established on land donated by Hidalgo County. Since its launch, the center has served over 500 adolescents. Referrals to the program come primarily from the Hidalgo County Juvenile Justice Department (40%) and the area’s alternative schools and other referral sources (60%).

Services

The Integrated Care Collaborative Unit (ICCU) at the Peña Center is a community-based clinic offered through the UTRVG Medical School with collaboration from the College of Education, P-16 Student Educational Outreach and the College of Health Affairs. This unit brings together 12 professionals from a range of disciplines (psychiatry, pharmacy, vocational rehabilitation, nutrition, nursing, a physician assistant, social work, and others) to provide and enhance integrated care in order to improve the mental health outcomes of children and adolescents in the Rio Grande Valley (RGV) who are at high risk and have high-acuity needs. This core group of interdisciplinary staff provides primary health care and supportive services and/or arranges other services that youth need, either at the Peña Center or through referrals to other organizations. The ICCU refers to Tropical Texas Behavioral Health (TTBH) for outpatient behavioral health services, including substance use treatment, and with Doctors Hospital at Renaissance for detox services. Counselors at the Peña Center use various psychotherapy techniques involving both medication management and psychotherapy for the treatment of serious mental illness.
methods, including cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), and mindfulness. In 2016, the Peña Center documented over 4,000 visits for the year. In the local ISD Options campus, the Center offers classes in self-esteem, self-efficacy, resilience, school psychology services, and home outreach. The Center also offers screening with the Substance Abuse Subtle Screening Inventory (SASSI) for substance use, PHQ-9 for depression, and the Rapid Assessment for Adolescent Preventive Services (RAAPS) for adolescent behavior screening. The clinic offers full-service primary care and integrated care with the other professions. Clinic outreach work in 2017 will include a larger school (Nikki Rowe High School), where the Clinic will collaborate with the school counseling services, the first offenders program, and school health.

In addition to the services described above, the Center offers programming to support physical fitness, nutrition, education (including tutoring and GED services), career counseling, art and music therapy, mediation, gardening, and pet therapy. During school holidays, the Center offers specific camps that provide clients with art therapy, physical therapy, diet and nutrition, group therapy and family therapy.

Two telehealth systems are available, but have not been fully deployed due to challenges in implementing a memorandum of understanding (MOU) with the county. The Peña Center currently uses telehealth to connect students with preceptors, and plans on placing the telemedicine units in the alternative school to support outreach.

JAPC staff participate in wraparound planning with probation officers in Hidalgo, as well as boot camp services twice a week. Also, as part of their second phase of development, JAPC would like to provide mobile staff to coordinate care by visiting youth and families in their homes, alternative schools, other schools, and juvenile justice sites with greater frequency than is currently available. They also intend to provide Al-Anon and Alateen meetings, and have the goal of training parents in Mental Health First Aid.

Highlighted Agency Strengths

- The ICCU provides a venue for medical residents (graduate medical education) from different disciplines to work together. The medical school is the first in its field to provide training in the inter-professional delivery of care, and students have the opportunity to volunteer for clinical experience. This approach not only trains professionals who may stay in the RGV, but also builds community service capacity. Students from programs such as nutrition, pharmacy, rehabilitation, education, counseling, social work and nursing/physician assistant have the opportunity to join other students for their clinical experience.
- The staff focuses on harm reduction rather than total abstinence of substances, which is
a positive engagement strategy for youth.

- Staff are passionate and excited about wanting to help youth and families in the community. When they identify a need, they try to find a solution. For example, the use of synthetic marijuana was a significant problem among high school students. Staff provided an education program for all 12,000 seniors in the Edinburg Independent School District (ISD), which was followed by a drop in drug use. The team has facilitated multiple workshops for bi-national conferences, international conferences, and communities.

- The program has support from Hidalgo County, including the county’s donation of JAPC’s building and ICCU’s partnership with the Hidalgo County Juvenile Justice Department.

- The ICCU is providing some services to youth who might otherwise not have access to such services (e.g., GED classes, nutrition classes, cooking classes, and linkage to community resources).

- The ICCU is broadening its reach by going into the community and to Colonias to provide services such as dentistry and telemedicine.

- The ICCU has the ability to run all clinical laboratory tests in-house. This eliminates any cost to the family and additional costs to the clinic.

- The ICCU accepts walk-in appointments; parents and youth can show up to the clinic and no one is turned away regardless of income or immigration status.

- The ICCU is planning the development of a Patient-Centered Medical Home co-located to provide services to family members and community.

JAPC Findings

JAPC Finding 1: JAPC has an innovative approach to evaluating and serving adolescents with complex health conditions through direct and coordinated care with system partners. The center has grown very quickly, as has its funding, including a recent $1 million dollar grant from the Methodist Healthcare Ministries of South Texas, Inc. This rapid growth has resulted in positive strategies for providing services to youth and families.

JAPC Finding 2: The next phase of development calls for significant expansion and refinement of its administrative practices. JAPC has the space and is considering the provision of inpatient care, a transition clinic, and/or a drop-in center.

JAPC Finding 3: Treatment for substance use is provided through TTBH and detox services are offered through Doctors Hospital at Renaissance. Typically, the best practice is provision of integrated outpatient SUD treatment by one behavioral health professional rather than splitting care between multiple professionals/providers. However, because the JAPC is still in the early
stages of development, and staffing is limited, the approach of coordinating with partners may be necessary.

**JAPC Finding 4:** The ICCU reports success with youth that initially score high on depression (PHQ-9). With the support and services provided, depression scores dropped significantly in a two-week period.

**JAPC Finding 5:** The ICCU has not yet billed Medicaid or other insurance for services. Presently, all services are provided through grant funds. Their plan is to begin billing individuals/families using a sliding scale with a flat fee for service.

**JAPC Finding 6:** At present, JAPC may not always be the sole primary care provider, which requires coordination with other providers. JAPC would like to develop into a patient-centered medical home and also provide full family primary care, because many families like to obtain their health care in one place. At present, full family care is not available.

**JAPC Finding 7:** JAPC has deployed the use of the SASSI, which they report has greatly enhanced diagnosis and treatment abilities.

**JAPC Recommendations**

**JAPC Recommendation 1:** Building on innovations at JAPC, it would be very helpful if the leadership participated in future system-wide efforts to plan for behavioral health services and integrated care approaches. For example, across the RGV, there are huge gaps in crisis and housing services, and some behavioral health inpatient beds are not utilized. With JAPC ready to expand, it would be useful to design services that not only fit the needs of youth in their program, but also address some of the systemic gaps in the RGV.

**JAPC Recommendation 2:** As JAPC expands, it will be important to assess the specific behavioral health services that will be provided within its operations, including whether it will offer evidence-based treatment for addressing substance use and/or co-occurring psychiatric and substance use conditions (COPSD), or continue to refer youth to other providers.

**JAPC Recommendation 3:** It will be important to formalize coordination of care agreements with referral organizations and other health systems. As noted by JAPC, the limited resources available in the RGV make it imperative to coordinate care and avoid duplication of primary medical care and behavioral health services.

**JAPC Recommendation 4:** Billing Medicaid and other insurers for services to youth who have coverage is essential to the long-term financial health of the JAPC. It is important to explore payments from the Medicaid managed care organizations and other insurers. Recognizing that
many of JAPC’s clients may not have insurance, or that the services may not be covered by
insurance (e.g., educational services), it is even more important to obtain reimbursement for
primary care and behavioral health services that are covered. The Meadows Mental Health
Policy Institute can provide assistance with exploring reimbursement options for these services.

**JAPC Recommendation 5:** Integrating at the community-level, especially in the school and at
home, is critical for long term change. Maximizing resources by engaging students from the
entire region as well as the community and organizations is the answer to community capacity
building and workforce development.

**The University of Texas Rio Grande Valley School of Medicine Department of
Psychiatry and Neurology**

The University of Texas Rio Grande Valley School of Medicine (UTRGV-SOM) opened in the
summer of 2016 with an inaugural class of 55 medical students. The UTRGV-SOM Department
of Psychiatry and Neurology has faculty employed by UTRGV as well as community-based
faculty. The department and school has a community-based focus, emphasizing collaborative
leadership, cultural awareness, and patient advocacy. According to the School of Medicine’s
website

> “The University of Texas Rio Grande Valley School of Medicine offers an exceptionally innovative
learning experience designed to instill students with scientific, clinical and research expertise of
the highest professional standards.”

**Highlighted Agency Strengths**

- In contrast to the traditional methods for creating residencies, the UTRGV-SOM
developed its residency programs to be available to students from other medical
schools, both before and along with the development of the school of medicine, rather
than waiting until their own students began graduating.
- The psychiatry residency program, which began in July 2017, involves multiple
institutions based in the community. Its three core community partner organizations are
Rio Grande State Center, the Department of Veterans Affairs, and Tropical Texas
Behavioral Health (TTBH). Additional residency placements are available at Valley
Baptist Medical Center – Harlingen and Origins Recovery Center.
- The program is designed to provide residents with six months of experience in
psychiatric inpatient care, with the majority of their time spent in outpatient care.
Residents are required to complete a rotation in primary care during their first year and
gain experience in psychiatric assessment and treatment, both medication and therapy,
throughout their residency training.

- The Department of Psychiatry is spearheading the development of a pre-doctoral psychology internship program accredited through the American Psychological Association. As the anchor institution for the internship, UTRGV-SOM Department of Psychiatry, together with MMHPI, has engaged local stakeholders to begin planning a training experience, with the goal of enticing early career psychologists to stay on in the RGV.

**UTRGV-SOM Findings**

**UTRGV-SOM Finding 1:** In the short time since UTRGV-SOM has opened, the psychiatry residency program has already created strong partnerships with state agencies such as TTBH and Rio Grande State Center, demonstrating the commitment of UTRGV-SOM to retain graduating residents in community practice within the RGV.

**UTRGV-SOM Finding 2:** UTRGV-SOM has initiated discussions with other hospitals in the area to explore the possibility of creating more residency programs as well as involving more community institutions in the existing programs. Palms Behavioral Health has shown an interest in hiring a director for residency programs, and has a sufficient model of care to be involved as a training site for psychiatry and other residency programs. Barriers to creating psychiatry residency clinical training sites at other hospitals such as South Texas Behavioral Health Center and Doctors Hospital at Renaissance include limitations in psychiatrists and child/adolescent psychiatrists to provide supervision, funding, and interest in developing their own residency programs.

**UTRGV-SOM Finding 3:** UTRGV-SOM Department of Psychiatry received seed funding from the Hogg Foundation for Mental Health to support technical assistance to develop a pre-doctoral psychology internship program accredited through the American Psychological Association. They also received significant funding from the Legacy Foundation to support the overall development and implementation of the internship program, as well as additional funding to help establish the UTRGV Brain Health Center.

**UTRGV-SOM Finding 4:** As the sole university department of psychiatry in the region, UTRGV-SOM Department of Psychiatry has the opportunity to take a leadership role in training and developing best practices across the system. This would include engaging psychiatry practitioners and mental health community programs as partners in this endeavor.

**UTRGV-SOM Finding 5:** UTRGV-SOM is initiating development of a regional strategic plan to address population health needs. The plan will be integrated into a statewide plan to be used for the entire UT System.
UTRGV-SOM Recommendations

UTRGV-SOM Recommendation 1: Continue to partner with other behavioral health entities in surrounding communities to develop training experiences (e.g., internships and residencies) and employment opportunities that support recruitment and retention of graduating residents/providers in the RGV.

UTRGV-SOM Recommendation 2: Continue to seek out opportunities to connect and build relationships with other behavioral health providers in the area in addition to those providing residency placements. This may include seeking opportunities to assist in any regional collaboration developments by offering the expertise and support of the Department of Psychiatry for improving services regionally.

UTRGV-SOM Recommendation 3: Continue to develop a close partnership with the activities of the UTRGV School of Public Health – Brownsville, which has a very strong model of community services, physical health/behavioral health integration, and collective impact in the area of population health. This partnership is providing rich learning opportunities for UTRGV-SOM residents and trainees.

UTRGV-SOM Recommendation 4: Continue to promote integrated behavioral health (IBH) in the region and provide emerging professionals with opportunities to learn how to provide integrated care in a team-based setting.

UTRGV-SOM Recommendation 5: Through psychiatry residency and psychology internship experiences, UTRGV-SOM students would benefit from being exposed to working in community mental health settings where they have the opportunity to work with low-income and underserved communities, as well as individuals with serious mental health issues. In this way, students may see working in these environments as a viable career option rather than gravitating solely toward private practice settings.

UTRGV-SOM Recommendation 6: The department of psychiatry can be a leader in the school of medicine by exposing all medical school students to behavioral health care early in their medical education and supporting its incorporation throughout the curriculum to the greatest extent possible.

175 UTRGV-SOM Recommendations 7-10 are based upon recommendations provided in the following report: UT Southwestern Medical Center (2017, February). White paper: A summary of findings and recommendations developed by leaders in psychiatry, education, policy and training from across the state of Texas. Dallas, TX.
UTRGV-SOM Recommendation 7: Continue to seek out and participate in opportunities to connect with other psychiatry residency programs across the state to share information and best practices in training students and residents.

UTRGV-SOM Recommendation 8: Continue to provide opportunities for residents and students to engage in diverse training opportunities in the community to learn how to best meet the health needs of the community. This might include rotations and training opportunities in a variety of treatment environments.

UTRGV-SOM Recommendation 9: Emphasize the importance of the continued relationship between students, residents, and their patients across the treatment process; continue to provide and enhance opportunities for experiences that promote these relationships.

UTRGV-SOM Recommendation 10: Continue to guide students and residents in providing treatment based on measured outcomes, using data to best understand how to meet the needs of the individual and the community.

The University of Texas Rio Grande Valley - Doctors Hospital at Renaissance Family Medicine Clinic
The University of Texas Rio Grande Valley - Doctors Hospital at Renaissance Family Medicine Clinic (UTRGV-DHR FMC), located in Edinburg, is the product of a collaboration between UTRGV School of Medicine and Doctors Hospital at Renaissance. The UTRGV-DHR FMC serves as a physician training center for residents in family medicine, providing team-based, collaborative, integrated education and healthcare training to help new physicians best meet the needs of the local community.176

Highlighted Agency Strengths

- The UTRGV Family Medicine Clinic, located at Doctors Hospital at Renaissance, offers integrated health care services using the Primary Care Behavioral Health (PCBH) model. At the time of our site visit, the clinic was in the process of attesting for certification as a Patient Centered Medical Home (PCMH).
- UTRGV Family Medicine Clinic staff provide services primarily to individuals who are uninsured, have little or no access to medical care, and often experience the added stress of seeking services without immigration documentation. This provides a much needed service to individuals with some of the greatest barriers to accessing care.
- The Family Medicine Clinic offers a three-year residency program in family medicine. Family medicine residents are coached in working with behavioral health providers and

consultants in their day-to-day work as well as providing instructions to patients on seeking behavioral health care at the clinic. Since providers who have not been exposed to this type of team-based approach early in their careers often find it difficult to work in IBH settings, providing this training to residents supports the implementation of IBH.

• The Family Medicine Clinic is developing a residency program in Preventive Medicine. With the high rate of diabetes in the RGV, this is a critical service to offer the region and to incorporate into residents’ training. Training primary care providers, psychiatrists, and preventative medicine doctors together in an IBH model is a powerful and innovative combination that will benefit the community currently served by the clinic and individuals served by these physicians in the future.

UTRGV-DHR FMC Findings

UTRGV-DHR FMC Finding 1: The UTRGV Family Medicine Clinic, located at Doctors Hospital at Renaissance, offers integrated health care services using the Primary Care Behavioral Health (PCBH) model. At the time of the key informant interviews, the clinic was in the process of attesting for certification as a Patient Centered Medical Home (PCMH).

UTRGV-DHR FMC Finding 2: UTRGV Family Medicine Clinic staff provide services primarily to individuals who are uninsured (about 70 – 80%), have no access to medical care, and often experience the added stress of seeking services without immigration documentation.

UTRGV-DHR FMC Finding 3: The clinic employs two behavioral health consultants who aim to see about 10 – 15% of the patient population. With a patient panel of around 3,000, the clinic sees an average of 15-20 patients in a normal clinic day (about three during half-days), and currently has no waitlist for services. Of the primary care patients that are served in the clinic, the Behavioral Health Consultants are available to see them on a same-day basis based on various behavioral and mental health needs that are screened for (e.g., depression) and may emerge as part of the visit (e.g., insomnia, medication adherence, motivation for behaviors like exercise and healthy eating).

UTRGV-DHR FMC Finding 4: The Family Medicine Clinic offers a three-year residency program in family medicine. Family medicine residents are coached in working with behavioral health providers and consultants in their day-to-day work as well as providing instructions to patients on seeking behavioral health care at the clinic. Psychiatry residents and preventative medicine residents are likely to participate in this training experience when their residency programs begin. Currently, the clinic does not have any behavioral health trainees, with the exception of a few social work interns.
UTRGV-DHR FMC Finding 5: With a Sí Texas grant from Methodist Healthcare Ministries and the Valley Baptist Legacy Foundation, the UTRGV Family Medicine Clinic is able to provide a “one-stop shop” for patients to receive behavioral health care services at the same time they come to the clinic for primary care services. Each patient is screened for behavioral health needs using the PHQ-9 and GAD-7; some have co-occuring substance use disorders. While the clinic does not have exclusionary criteria for their services, patients cannot receive ongoing traditional psychotherapy at the clinic. Leadership of the clinic aim to define behavioral health more broadly in the future to encompass such issues as smoking cessation and sleep hygiene. Such system-wide buy-in to broaden behavioral health beyond mental health and substance use to include patient activation, motivation, and commitment to behavioral changes in their life allows for a population health informed approach to primary care delivery.

UTRGV-DHR FMC Finding 6: A significant challenge for the UTRGV Family Medicine Clinic to address is the high facility fees that are charged to patients. The ultimate cost for services often discourages patients from returning to the clinic after an initial appointment.

UTRGV-DHR FMC Recommendations

UTRGV-DHR FMC Recommendation 1: Continue to provide innovative training experiences for Family Medicine residents. The training program for family medicine residents is an outstanding example of redefining the way that physicians-in-training are encouraged to take a holistic approach to patient care.

UTRGV-DHR FMC Recommendation 2: Explore additional funding streams and grant opportunities to sustain the clinic’s IBH work. Because the clinic serves such a large number of uninsured individuals, it will be challenging to sustain its work. The clinic may consider getting consultation or technical assistance for developing strategies to maximize partnerships and access new funding streams.

UTRGV-DHR FMC Recommendation 3: Continue to participate with the Unidos Contra Diabetes collective impact group. Continuing active support of the Medical Integration Workgroup’s efforts will provide an opportunity to ensure that integrated care and behavioral health are included in a strategy to best address high rates of diabetes in the region.

UTRGV-DHR FMC Recommendation 4: Position the Family Medicine Clinic as a leader in IBH in the RGV region. The clinic might consider offering trainings in their successful implementation of the PCBH model and the IBH training offered to family medicine residents.
The University of Texas School of Public Health – Brownsville Regional Campus

The University of Texas, School of Public Health – Brownsville Regional Campus (UTSPH-BRC) was started in 2001. The school has four faculty and has used considerable resources from the National Institute of Health, earmark funds, foundations (Methodist Healthcare Ministries, Valley Baptist Legacy Foundation), 1115 Waiver funds, and other state and federal funds to hire 150 staff to provide direct services in Cameron (primarily) and Hidalgo counties in an effort to have a direct impact on community health, while at the same time gathering data for research and health improvement activities.

The initial focus for UTSPH-BRC was to determine the true population health needs in the Rio Grande Valley, identifying obesity (51% of Hispanic men and women are obese), diabetes (27.6% of adults aged 18 years and older have diabetes), and their related conditions as priority targets. As UTSPH-BRC conducted more research on this population, they discovered a high association of depression with diabetes and determined that those who were diagnosed with behavioral health conditions had poorer outcomes with their diabetes than those who did not have these diagnoses. They also found that those who know they have diabetes were significantly more likely to be depressed than those who had undiagnosed diabetes, suggesting an important role for addressing depression at the time diabetes is diagnosed. Additionally, they have gathered data on cognitive functioning associated with diabetes and obesity out of concern that diabetes has an early effect on cognition. Their research and outreach programming has now extended to Hidalgo County and to Laredo in Webb County.

In order to address issues related to the interplay between physical and behavioral health, UTSPH-BRC has taken on an activist approach to collaborative impact throughout the region. The department created a “community advisory board” which functions as a collaborative steering committee for community health improvement planning, with a current focus on nutrition and physical activity, including weight reduction and increasing exercise, as well as an emphasis on screening for diabetes (43% of those with diabetes are undiagnosed) and pre-diabetes in the Brownsville community. The department participates in both the Unidos Contra Diabetes and Sí Texas efforts as an anchor organization, both of which are focused on preventing Diabetes and committed to incorporating behavioral health.

The services provided under the auspices of various UTSPH-BRC projects are extensive. Recognizing that their target population is not going to access traditional health and behavioral health services, they have brought on 150 staff, many of whom are community health workers (CHWs), to provide in-home outreach and engagement at community locations and health centers (Salud de Vida primarily) throughout the region. They have also worked with the two

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large federally qualified health clinics to create patient-centered medical homes to provide more effective and efficient services – including behavioral health services – to larger numbers of patients. The CHWs, who can receive continuing education credit for Mental Health First Aid training, facilitate health screening and person-centered conversations, and then administer screening tools (e.g., the PHQ-9) if there is any indication of possible depression, followed by referral to churches, local supports, and, potentially, professional counseling. UTSPH-BRC has contracted with TTBH to provide behavioral health consultants to these outreach workers and health centers in order to increase their likelihood of engaging individuals in counselling and medication management, and therefore promoting better health outcomes. Through this project, they have served over 4,000 individuals and have a series of published articles that quantify health burdens and risk factors, and document the social, health, and financial impact of this work.

**Highlighted Agency Strengths**

- UTSPH-BRC demonstrates a strong capacity to use collaborative impact and collective impact strategies to improve public health in Cameron County, with increasing outreach to other communities in the region as a whole.
- Further, UTSPH-BRC recognizes the high prevalence and impact of overlapping behavioral health and primary health needs in the RGV population, particularly in the area of chronic diseases such as diabetes.
- UTSPH-BRC has demonstrated the capacity to implement public health strategies that influence community health, and to collect (and publish) data that evaluate the success of those strategies, including the importance of attending to behavioral health needs.
- UTSPH-BRC has attracted considerable resources to provide public health services, reaching over 4,000 individuals with diabetes (many of whom are uninsured and have co-occurring behavioral health issues) and many more through patient-centered medical home programs and community-wide campaign programs in 10 communities.
- UTSPH-BRC is aware of the strong stigma against behavioral health in the RGV community and is very interested in being a potential partner in anti-stigma efforts such as Okay to Say and Mental Health First Aid training.
- Finally, UTSPH-BRC is willing and able to step forward to provide additional leadership in integrating behavioral health into a broad, collaborative public health effort that addresses health disparities, costs, and outcomes in the region, and to partner with MMHPI and other participants in the region in order to have a broader impact on policy and practice. UTSPH-BRC is particularly keen to engage in innovative public health, population-based approaches to behavioral health, particularly depression, anxiety, and, to some extent, cognitive function.
UTSPH-BRC Findings

**UTSPH-BRC Finding 1:** UTSPH-BRC demonstrates how integrated community outreach services can have an impact on co-occurring diabetes and behavioral health issues (e.g., depression and anxiety) in the Rio Grande Valley. These efforts have been studied and shown to produce positive results. Thousands of individuals have been served, but the needs across the Rio Grande Valley are much greater and go beyond a focus on diabetes to include other chronic diseases, as well as social, environmental, and economic conditions.

**UTSPH-BRC Finding 2:** UTSPH-BRC has demonstrated capability as a convener of collaborative impact and collective impact projects to address health improvement in Cameron County and beyond. At least one of these projects has begun to integrate a focus on depression. These projects further demonstrate existing successful partnerships with state and local (foundation) funders.

**UTSPH-BRC Finding 3:** UTSPH-BRC understands the science of using community and public health strategies to enhance large scale system improvements and is willing to partner with other entities to understand how to integrate attention to health and behavioral health needs on a broader scale in the region. UTSPH-BRC is also prepared to evaluate the impact of such efforts on costs and outcomes.

**UTSPH-BRC Finding 4:** UTSPH-BRC has begun a relationship with the new UT-RGV Department of Psychiatry and is well positioned to take on a broad role as a community convener on public health.

**UTSPH-BRC Finding 5:** UTSPH-BRC does not have much experience in mental health system policy and funding in Texas and may need guidance on how best to secure public or private health delivery system investment in their activities.

UTSPH-BRC Recommendations

**UTSPH-BRC Recommendation 1:** Continue to develop and expand current efforts to provide integrated health and behavioral health services through behavioral health consultation to community health workers, and continue to gather data demonstrating the impact of these services on costs and outcomes. Expand behavioral health training (e.g., Mental Health First Aid) for all community health workers in the region. This is an opportunity for continued strategic investment by local foundations.

**UTSPH-BRC Recommendation 2:** Build on the current efforts in primary health/behavioral health integration to engage large regional health systems in gathering data that illustrate the potential impact of such efforts on costs and outcomes for the populations they serve, and to
illustrate the value of implementing those broad efforts as the payment system moves to a more quality-focused, at-risk, and outcome-based methodology. UTSPH-BRC can be a valuable partner and consultant in such efforts.

**UTSPH-BRC Recommendation 4:** Engage in innovative, population-based approaches to behavioral health care that raise culturally awareness, create community activities that are known to affect behavioral health (such as physical activity, nutrition, social and environmental changes), and that are related to policy changes within communities.

**UTSPH-BRC Recommendation 5:** Become involved as a key partner or convener – in either Cameron County or across the region – in developing collaborative impact activities that focus on integrated health and behavioral health. Engage in efforts that are specifically focused on behavioral health system improvement.

**UTSPH-BRC Recommendation 6:** Consider continuing collaboration with MMHPI and local system funders/providers to increase familiarity with mental health system policy and funding in Texas, as well as developing efforts to create strategies for securing public or private health delivery system investment in these activities.

**Other Organization Findings**

**Other Organization Finding-1:** The RGV has additional agencies with a mission to support community members with minimal resources or poverty with their social and mental health needs. While there are some efforts to bring these agencies together, further work can be done to bring them into strategic planning around common issues in areas such as workforce development, coordination of care and CQI initiatives.

**Other Organization Recommendations**

**Other Organization Recommendation-1:** Using the County level BHLT structure, include these other agencies as initiatives are development and when it is most relevant to each agency’s mission. Invite their participation to the region wide BHLT, once established.
Physical and Behavioral Health Integration in the RGV

In order to assess the integrated behavioral health care (IBH)\textsuperscript{178} capacity and needs in the Rio Grande Valley, MMHPI interviewed administrative and clinical leaders from the six provider agencies listed in the table below. Prior to conducting the interviews, MMHPI requested that each agency complete a survey on core aspects of its IBH program. Additional key informants were interviewed about integrated behavioral health and related issues, including the Cameron County Mental Health Task Force, officials at the Border Region Health Center, and the Doctors Hospital at Renaissance Behavioral Hospital. The table below summarizes the provider agencies included in the assessment, identifies their location and what type of organization they are, and provides a basic description of each agency’s IBH program model.

IBH Program Models Utilized by Rio Grande Valley Provider Organizations

<table>
<thead>
<tr>
<th>Location(s)</th>
<th>Type of Organization</th>
<th>Description of Integrated Care Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brownsville Community Health Center</td>
<td>FQHC</td>
<td>One (1) embedded behavioral health specialist in primary care clinic.</td>
</tr>
<tr>
<td>Hope Family Health Center</td>
<td>Primary Care Clinic</td>
<td>Sí Texas-funded HOPE program implements the Integrated Behavioral Health Care model to address both primary care and behavioral health care needs at the same facility.</td>
</tr>
<tr>
<td>Nuestra Clínica del Valle</td>
<td>FQHC</td>
<td>Two (2) embedded behavioral health specialists in primary care clinics working collaboratively with providers; the director of behavioral health trains all staff in behavioral health screening and interventions.</td>
</tr>
<tr>
<td>Rio Grande State Center Outpatient Clinic</td>
<td>State-Operated Outpatient Clinic</td>
<td>Sí Texas-funded IMPACT Model\textsuperscript{180} for older adults with depression and co-occurring disorders.</td>
</tr>
</tbody>
</table>

\textsuperscript{178} We are using integrated behavioral health to refer broadly to integrated primary care and behavioral health services, regardless of the setting in which they are provided.

\textsuperscript{179} For more information on the Sí Texas HOPE program, see: http://www.hopefamilyhealthcenter.org/what-we-do/integrated-behavioral-health-care.html

\textsuperscript{180} For information on the IMPACT model (now more frequently referred to as the “Collaborative Care Model”) and its effectiveness see: http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment/
<table>
<thead>
<tr>
<th>Location(s)</th>
<th>Type of Organization</th>
<th>Description of Integrated Care Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Su Clínica Familiar</td>
<td></td>
<td>Brownsville, Harlingen, Raymondville, Santa Rosa</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health</td>
<td></td>
<td>Brownsville, Edinburg, Harlingen</td>
</tr>
<tr>
<td>The University of Texas-Rio Grande Valley Medical School</td>
<td></td>
<td>McAllen</td>
</tr>
<tr>
<td>The University of Texas School of Public Health-Brownsville(^{182})</td>
<td></td>
<td>Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg Starr, Willacy, Zapata, and Webb counties</td>
</tr>
</tbody>
</table>

**Core Integrated Behavioral Health Capacity**

While precise figures were not always available, we obtained estimates of the number of people receiving IBH services over a 12-month period, relative to an estimated number of people in need. The Brownsville Community Health Center estimated need by examining mental health screening data, but in other cases, when need estimates were not available, we used a conservative estimate of 29 percent among primary care populations.\(^{183}\)

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\(^{182}\) For more information on the Sí Texas Salud y Vida 2.0 program, see: http://www.mhm.org/library?task=document.viewdoc&id=60

### Need for IBH and Estimated Need Met Over 12 Months, Among RGV Adults with Mental Health Conditions Living at/below 200% of the Federal Poverty Level

<table>
<thead>
<tr>
<th>Provider Agency</th>
<th>Population / Patient Panel</th>
<th>Estimated Need for IBH</th>
<th>12-Month IBH Capacity</th>
<th>Percentage of Need Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brownsville Community Health Center</td>
<td>22,000</td>
<td>11,000</td>
<td>120</td>
<td>1%</td>
</tr>
<tr>
<td>Hope Family Health Center</td>
<td>No data available</td>
<td>No data available</td>
<td>No data available</td>
<td>No data available</td>
</tr>
<tr>
<td>Nuestra Clinica del Valle</td>
<td>28,000</td>
<td>8,120</td>
<td>1,400</td>
<td>20%</td>
</tr>
<tr>
<td>Rio Grande State Center Outpatient Clinic</td>
<td>N/A</td>
<td>N/A</td>
<td>None yet served</td>
<td>N/A</td>
</tr>
<tr>
<td>Su Clínica Familiar</td>
<td>No data available</td>
<td>No data available</td>
<td>4,200</td>
<td>No data available</td>
</tr>
<tr>
<td>Tropical Texas Behavioral Health</td>
<td>7,464</td>
<td>5,076</td>
<td>1,500</td>
<td>No data available</td>
</tr>
<tr>
<td>The University of Texas-Rio Grande Valley Medical School</td>
<td>N/A</td>
<td>N/A</td>
<td>At time of assessment, had just begun IBH</td>
<td>N/A</td>
</tr>
<tr>
<td>The University of Texas School of Public Health-Brownsville</td>
<td>No data available</td>
<td>No data available</td>
<td>No data available</td>
<td>No data available</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td>471,287</td>
<td>79,270</td>
<td>5,720</td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Care (SMI)</strong></td>
<td>34,760</td>
<td>23,636</td>
<td>1,500</td>
<td></td>
</tr>
<tr>
<td><strong>All Adults</strong></td>
<td>506,047</td>
<td>102,906</td>
<td>7,220</td>
<td></td>
</tr>
</tbody>
</table>

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184 We did not include those receiving only medication management without integrated services.

185 Estimate is based on Brownsville’s own data, using mental health screening tools.

186 This is a rough estimate. We did not have data on Su Clínica’s capacity. We multiplied the Nuestra Clínica capacity by three, given that they had three times as many behavioral health specialists in their IBH program as did Su Clínica.

187 Based on Druss & Walker (cited above), 68% of the 7,464 adults with SMI served in ongoing levels of care (LOCs) by TTBH were estimated to need integrated care. However, we estimate that there are 33,061 adults with SMI living at or below 200% of the federal poverty level in the RGV and more than 20,000 of them need IBH.

188 We did not have data from TTBH on the actual number receiving IBH. However, in our experience in similar programs, one site can serve up to 500 at any given time. TTBH has three sites.

189 We estimated there are 34,760 adults with SMI living at/below 200% of the FPL in the RGV.

189 Citing the National Comorbidity Survey Replication, Druss & Walker (cited above) showed that 68% of adults with mental disorders have medical conditions and 29% of the 58% of adults with medical conditions have mental disorders. We used the former percentage in estimating the need for IBH among adults with SMI living at/below 200% of the federal poverty level and the latter figure to estimate need for IBH among all other adults living at/below 200% FPL. We provided a much smaller estimate for children/youth, only focusing on the sub-population of children/youth with SED, 37% of whom have been estimated to have a co-occurring chronic medical condition.
While we do not have precise figures from providers, or even estimates in the case of some providers, we can estimate that the need for integrated behavioral health services far exceeds the current capacity to meet that need in the Rio Grande Valley. Most providers are keenly interested in developing or greatly expanding their IBH capacities, and many are implementing various components of best practices.

**Prevailing IBH Program Models**

The selection of a specific model is helpful in providing a framework that is evidence-based and offers a common set of concepts and a vocabulary to which all staff can refer. It can also better position an organization for obtaining grant funding from foundations and other entities. The Four Quadrant Model, outlined in the following table, can be used to in planning what IBH model is most appropriate for an organization based upon the clinic’s sub-populations, capacity, and new programs and staff required to meet their IBH needs.

**Modified Four Quadrant Model for IBH Program Planning**

<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Levels/Severity of Behavioral Health and Primary Health Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Setting</td>
<td>Quadrant I (BH: Low, PH: Low to High)</td>
</tr>
<tr>
<td></td>
<td><strong>Essential Integrated Care</strong> – Primary Care Behavioral Health Model</td>
</tr>
<tr>
<td>Specialty Behavioral Health Setting</td>
<td>Quadrant III (BH: Medium, PH: Low to High)</td>
</tr>
<tr>
<td></td>
<td><strong>Intensive Integrated Care</strong> – Collaborative Care Models</td>
</tr>
<tr>
<td>Primary Care Setting</td>
<td>Quadrant II (BH: High, PH: Low/Medium)</td>
</tr>
<tr>
<td>Specialty Behavioral Health Setting</td>
<td><strong>Essential Integrated Care</strong> – Behavioral Health Primary Care Model</td>
</tr>
<tr>
<td></td>
<td><strong>Intensive Integrated Care</strong> – Person Centered Healthcare Home</td>
</tr>
</tbody>
</table>

About half of providers interviewed for this report do not appear to be intentionally implementing a particular IBH model; they are embedding or co-locating providers in their settings (behavioral health providers in primary care settings and primary care providers in Tropical Texas Behavioral Health), referring people to them for care, and utilizing varying levels of coordination in those settings.

However, some providers have specifically adopted an evidence-based model and in some cases, they have received training from experts in those models. For example, the UT-RGV Medical School clinic in McAllen specifically adopted and received training in the Primary Care Behavioral Health (PCBH) model. The Rio Grande State Center has chosen to implement the

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evidence-based IMPACT model, a variant of the Collaborative Care Model, for older adults with depression and co-occurring chronic health conditions.

Analysis of IBH Core Components Across Organizations

In collaboration with the St. David’s Foundation, MMHPI developed a report titled *Best Practices in Integrated Behavioral Health: Identifying and Implementing Core Components.* The report, published in August 2016, identified seven core components of IBH that can be used to determine the extent to which physical health (PH) and behavioral health (BH) care is integrated (versus simply co-located) for patients. The report offers a roadmap for providers, funders, advocates, and policymakers interested in promoting IBH and working systematically toward achieving its promise.

The following table provides a brief definition of each IBH core component included in the St. David’s Foundation report.

<table>
<thead>
<tr>
<th>IBH Core Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Organizational Culture</td>
</tr>
<tr>
<td>The importance of <em>both</em> physical and mental health is highlighted in your organization’s vision, mission, and strategic planning documents. Leadership actively supports integrated care by promoting it in all organizational functions (e.g., staff development, performance assessment, and information systems).</td>
</tr>
<tr>
<td>Population Health Management</td>
</tr>
<tr>
<td>Patients are assessed and differentiated by their primary co-occurring conditions and utilization patterns. Vital physical health and behavioral health outcomes are tracked. Patient registries and other health information technologies are used to manage outcomes and costs across populations to apply the right interventions at the right time.</td>
</tr>
<tr>
<td>Structured Team Approach</td>
</tr>
<tr>
<td>Providers capable of meeting both physical and behavioral health needs are, to the fullest practical extent, physically located in the same space and have a team-based, shared workflow, with team huddles, warm hand-offs, and continuous communication.</td>
</tr>
<tr>
<td>Integrated Behavioral Health Staff Competencies</td>
</tr>
<tr>
<td>Providers have skills such as effective collaboration with colleagues, patient engagement, and motivational interventions that may differ somewhat from those developed in the specialty settings where most providers are trained.</td>
</tr>
</tbody>
</table>

### IBH Core Components

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universal Screening for the Most Prevalent Physical Health and Behavioral Health Conditions</strong></td>
<td>In primary care, regular and universal screening is conducted for common mental health and substance use conditions, and ones associated with the costliest co-occurring illnesses. Likewise, behavioral health settings incorporate screens for common and costly physical health conditions.</td>
</tr>
<tr>
<td><strong>Integrated Treatment Planning</strong></td>
<td>Each patient has one integrated treatment plan that includes physical health and behavioral health conditions.</td>
</tr>
<tr>
<td><strong>Person-Centered Treatment Planning</strong></td>
<td>Treatment plans are person-centered, incorporating the values, lifestyles, and social contexts of the people who are obtaining health care. An example of this is stating treatment goals in the patient’s own words.</td>
</tr>
<tr>
<td><strong>Systematic Use of Relevant Evidence</strong></td>
<td>Providers use a systematic clinical approach that targets specific physical and behavioral conditions prioritized for care, with shared protocols and guidelines. Evidence-based health and wellness programming, which helps people learn to manage their illnesses and make lifestyle/behavior changes, is readily accessible to patients. This approach may include the use of specific integrated care models, such as the Collaborative Care or Primary Care Behavioral Health models.</td>
</tr>
</tbody>
</table>

Below, we review the overall status of the implementation of integrated care across the RGV providers we interviewed, utilizing the core component as a lens for commenting on strengths and areas for growth.

**Overall Regional Rating on Leadership Culture: Mostly Implemented**

Many RGV providers have embraced IBH and have attempted to implement it as widely as current funding and resources will allow. Some have directors of IBH or embedded specialists who are attempting to imbue the entire organization with IBH competencies. The UT-RGV training program for family medicine residents is an especially outstanding example of an organizational commitment to IBH at the most rudimentary of levels (health professional training) by adopting an evidence-based model and framework and hiring expert staff to implement it. The Social Innovation Fund/Collective Impact project spearheaded by Methodist Healthcare Ministries, now embodied in Unidos Contra Diabetes and several grant-funded IBH efforts in the region, is helping the region as a whole to adopt an IBH perspective, and it is having a positive effect on providers.

However, many primary care providers would benefit from a more formal incorporation of behavioral health in their mission and visions statements, their strategic planning, their efforts
to diversify payer mixes, and their horizontal organizational functions such as hiring practices and staff development, training, and evaluation (and vice versa for behavioral health providers).

**Overall Regional Rating on Population Health Management: Beginning to Implement**
Some providers have developed care coordination mechanisms and there are isolated examples of providers using rudimentary population health management techniques, such as electronic health record-based alerts and flags to aid in illness management. However, the systematic examination of the population’s integrated care needs, and matching specific IBH programs or services to meet those needs and track the health and cost-related outcomes, is not yet evident in the RGV.

**Overall Regional Rating on Structured Use of a Team Approach: Inconsistently Implemented**
Providers who have adopted specific evidence-based IBH models are using stronger team-based approaches to IBH. Other providers are using care coordinators and care coordination, more generally, to help coordinate and integrate care for people with more complex co-occurring conditions. And some, like TTBH, regularly employ behavioral health and physical health staffings for clinical case reviews.

Nevertheless, a stronger population health management approach could help identify clinical sub-populations who are in need of the type of team-based care evident in the Collaborative Care Model (including the IMPACT version of it) and to ensure that team-based approaches are used to meet their needs. In addition, the development of more routine team-generated assessments and treatment plans at the individual level, and the dissemination and adoption of shared clinical pathways for common physical health/behavioral health (PH/BH) co-occurring conditions (such as diabetes and depression), are also needed.

**Overall Regional Rating on IBH Staff Competencies: Inconsistently Implemented**
Some programs have utilized expert trainers to help IBH staff develop expertise in a particular model. (Again, the UT-RGV family medicine residents training program and clinic is a prime example.) However, to achieve the full promise of IBH, providers need to ensure that embedded physical health or behavioral health workers’ roles are more routinely broadened to allow them time to train other staff in IBH competencies. The Nuestra Clínica Del Valle FQHC is a good example, in that its director of behavioral health trains physical health staff on the basics of behavioral health screening and other techniques. In general, however, much more needs to be done to train PH staff on basic interventions such as motivational interviewing, and to train behavioral health staff how to routinely screen for common physical health conditions or health-related behaviors such as smoking.
Many programs also need to specifically identify IBH competencies that workers should have and update staff development and training plans to address them.

**Overall Regional Rating on Universal Screening: Nearly Fully Implemented**

Nearly all programs we interviewed were either using universal screening or were moving toward the use of universal screening. TTBH had begun using routine laboratory tests for people who are prescribed antipsychotic medication and other psychotropic medications, for example, and the UT-RGV training program cited above not only routinely uses the PHQ-9 and the GAD-7, but it trains family medicine residents in how to use the clinical relationship to skillfully probe for behavioral health issues.

The region is ready to move to a new level of identifying other screens that can be used by trained staff to detect less routine mental health conditions (e.g., not only depression, suicidality and anxiety, but also psychosis or eating disorders), and less routine physical health conditions in behavioral health settings (e.g., gynecological problems).

**Overall (Provisional) Regional Rating on Integrated, Person-Centered Treatment Planning: Inconsistently Implemented**

This is an area that our use of key informant interviews was not able to assess very well. Our impression is that many programs (e.g., TTBH, UT-RGV) have worked hard to develop one electronic health record that includes information on both physical health and behavioral health. However, we also have the impression that fully integrated treatment planning that is person-centered (which is difficult to achieve) has not yet been widely implemented.

**Overall Regional Rating on Use of Evidence-Based Clinical Models: Inconsistently Implemented**

Many programs either have adopted an evidence-based IBH model (as described in the previous section of this report), or have utilized evidence-based or best practice procedures or practice guidelines – for example, diabetes management protocols at TTBH, or motivational interviewing techniques in FQHCs.

However, in this early stage of the development of IBH in the region (which is true for health care in general) there is still too much reliance on the mere co-location of providers in some settings. There is also a need to develop shared clinical pathways that provide very specific guidance to clinicians on how to collaborate in such a way that, for common co-occurring conditions, is completely integrated and not “siloed” in the practice.
IBH Findings

**IBH Finding 1:** There is a strong commitment to IBH among many providers in the region, with many implementing similar or at least complementary approaches to care. This commitment is shared by Methodist Healthcare Ministries, the Valley Baptist Legacy Foundation, and other important health system leaders in the region, and sets the stage for more intentional collaboration among providers at several different levels.

**IBH Finding 2:** An encouraging array of IBH programming and service delivery has emerged in the RGV, including evidence-based IBH models, such as the Collaborative Care and PCBH models. Exquisitely designed training programs and ambitious integrated programming are developing in some locations.

**IBH Finding 3:** While nearly all sites show evidence of rudimentary aspects of integrated care (including, for example, universal screening and testing for behavioral health or physical health conditions), much more development is needed for the more advanced aspects of integrated care, such as population health management and the development of more precise protocols and shared clinical pathways that can serve to make care truly integrated and well-organized.

**IBH Finding 4:** Not all providers can meet the IBH needs of all people in their settings and, especially given the universally-cited shortage of behavioral health providers, there is a need for cross-provider collaboration to ensure that the right people receive the right care in the right location. As mentioned above, providers now know enough about IBH to systematically collaborate in this way, yet few memoranda of understanding exist between providers and most indicated to us that collaborative efforts have mostly died out or failed.

IBH Recommendations

**IBH Recommendation 1:** While isolated examples of team-based models are evident (for example, the development of an IMPACT program for older adults at the Rio Grande State Center, the PH/BH home for people with diabetes and behavioral health conditions at Su Clinica, and some strong elements of a team-based approach at TTBH), all providers could examine the possibility of developing more team-based care for people with the most challenging co-occurring conditions encountered in their settings.

**IBH Recommendation 2:** Each provider individually, and the region collectively, needs to develop a population health management approach to serving people with co-occurring PH/BH conditions. The Four Quadrant Model, described earlier in this report, can be used as an efficient problem-solving method to begin identifying the number of people falling into each of several clinical sub-populations, the current capacity to meet their needs through the implementation of appropriate IBH models, and the number of new programs (and staff) needed to meet their needs.
• **IBH Recommendation 2.a:** Patient registries and other, simple-to-adopt population health management technologies could be used more widely in the RGV’s IBH programs.

• **IBH Recommendation 2.b:** Some providers have special programs or even whole clinic sites dedicated to specific clinical populations (e.g., women’s health or pediatrics). These sites represent excellent venues for the development of population health approaches that target specific co-occurring behavioral health and physical health needs. Specific models are developing in Texas for key clinical populations, such as the Dallas-area integrated care program for foster care children with complex co-occurring physical health and behavioral health conditions.

**IBH Recommendation 3:** Screening, assessing, and referring people to the appropriate IBH program often will require providers to collaborate. In particular, it would be useful for primary care providers to develop memoranda of understanding (MOUs) with LMHAs (particularly TTBH) that outline target populations; co-location of staff arrangements; referral practices; shared resources, particularly related to telepsychiatry; clinical data sharing protocols; and management of psychiatric crises. The MOUs also should address primary care protocols for shared patients in order to maximize care coordination and minimize duplication of medical care.

**IBH Recommendation 4:** Efforts to implement Recommendation 3, above, could be facilitated by the development of an IBH learning collaborative in the RGV. Providers and training programs, such as the UT-RGV, could use the existing collective impact program, called “Unidos Contra Diabetes,” as a vehicle through which to share best practices and engage in region-wide population health management. Unidos Contra Diabetes focuses heavily on integrated care for people with diabetes and depression, and provides an existing structure within which many RGV providers collaborate. (However, if the region’s leaders and experts in IBH find that the scope and depth required for a learning collaborative is better attended to in a new venue devoted only to IBH, then it might be better to develop such an entity, which could have representation in the Unidos Contra Diabetes in order to ensure proper coordination across the region.)

• **IBH Recommendation 4.a:** An IBH subgroup of Unidos Contra Diabetes should rigorously examine the IBH workforce in the region and make plans for enhancing it. This is already happening through Unidos Contra Diabetes, and many training programs are addressing the need. The group could also track the number of primary care providers – many of whom can be trained through embedded behavioral health specialists and directors of behavioral health – who attain a basic level of IBH competency. In addition, goals for training – and retaining in the region – family physicians, nurse practitioners, psychiatrists, psychiatric nurse practitioners, psychologists, social workers, licensed professional counselors, and licensed substance use disorder counselors should be set and formally tracked by the group.
• **IBH Recommendation 4.b:** The IBH subgroup should also track the prevalence of need for IBH in primary care and specialty behavioral health settings, by age group (child/youth, adult, and older adult), relative to the region’s capacity to meet that need. It should set multi-year goals for increasing the percentage of need met, clarify and periodically update the strategies that will be employed (including workforce related strategies – see above), and track the percentage of need met.

• **IBH Recommendation 4.c.** The IBH subgroup should also track outcomes associated with enhanced IBH in the region, including, for example, suicide rates per capita and by age group, potentially preventable emergency room and hospital visits and readmissions, and other indicators of well-being as measured by the Behavioral Risk Factor Surveillance System (BRFSS) and other ongoing measures in the region.

• **IBH Recommendation 4.d:** Because many providers have, or soon will have, expertise in the implementation of specific evidence-based IBH models, as well as in targeted behavioral health and wellness interventions, the learning collaborative should compile a list of regional expertise, track the implementation of IBH evidence-based models across the region, host an annual IBH conference, and develop a training and consultation calendar or schedule for disseminating and adopting IBH best practices. The group should eventually move beyond a focus on IBH program models (e.g., Collaborative Care and Primary Care Behavioral Health models), and share best practices in implementing shared clinical pathways, such as diabetes-depression care, metabolic syndrome-serious mental illness care, and integrated behavioral medicine approaches to such common maladies as insomnia, headaches, and asthma.

**Adult Criminal Justice System Findings and Recommendations**

**Adult Criminal Justice (ACJ) Findings**

**ACJ Finding 1:** The Mental Health Officer program is a promising practice that is not yet brought to scale across the region.

**ACJ Finding 2:** Regarding crisis response and pre-arrest diversion, across municipalities and county departments there is a lack of a culture of diversion, collaborative policy development, training efforts, and strategic planning, leading to a lack of pre-arrest diversion options and post-arrest connection to care.

**ACJ Finding 3:** Regarding post-booking diversion, across the region, there is a lack of adequate in-jail mental health screening and connection to care.

**ACJ Finding 4:** Regarding jail-based and reentry services, county jailers across the region do not receive specialized mental health training. Additionally, local providers are not engaged with all of the counties they serve to provide in-jail treatment linkage and reentry coordination. This
results in people with complex needs cycling through the system without being linked to community mental health care.

**ACJ Finding 5:** With the exception of specialized caseloads, community mental health services are not informed by risk. Additionally, first responders and mental health providers do not receive information on individuals with complex needs and high levels of service utilization, which leads to a duplication of services without a measurably effective outcome.

**Adult Criminal Justice (ACJ) Recommendations**

**ACJ Recommendation 1:** Consider evolving this promising practice by implementing a modified Mental Health Officer Team (MHOT) model that would be developed by TTBH in partnership with various sheriffs and police departments. Modification could include the incorporation of paramedics and para-medicine first responders to provide appropriate care to individuals in crisis. The reliance on law enforcement to provide mental health first response could be limited to situations that involve public safety. The current model includes financial contributions from law enforcement agencies and other sources, provides assistance during psychiatric crisis for insured and uninsured individuals, and relieves most other officers on routine duty from transporting clients experiencing emergencies. Local para-medicine or ambulance providers could be engaged to participate as the primary mental health crisis response for crises without a clear public safety concern. Because resources within Starr County and its law enforcement agencies are particularly limited, grant funding could be prioritized for the establishment of a MHOT. This would include start-up costs and ongoing operations of the MHOT.

**ACJ Recommendation 2:** Improve the coordination of crisis response services with other community crisis services. Engage all first responders, including medical first responders, to implement a multidisciplinary team approach that would provide services on the crisis scene, manage non-emergency distress calls, link persons to services, and engage in data-driven outreach and preventative services while reducing the need for law enforcement to be the first responders for mental health crisis care. Establish an inter-departmental leadership group to develop a region-wide strategic plan to address front-end diversion needs.

**ACJ Recommendation 3:** Solidify procedures for mental health screening, identification, Magistration, and bonding to be in compliance with Texas Code of Criminal Procedures 16.22 and 17.032.

**ACJ Recommendation 4:** Provide mental health training to county jailers to increase the recognition and response to persons in need of mental health care in the jail. Engage local providers, faith based institutions, and area non-profits to increase jail in-reach services and plan for reentry that links to community care.
ACJ Recommendation 5: Ensure community mental health services are informed by justice system practices. Incorporate the use of risk/need/responsivity models in community mental health agencies for persons with frequent arrests, or on probation or parole, who are not assigned to a specialty case load. Collaborate with local law enforcement and EMS/medical first responders to share information about individuals with complex health needs who have high levels of service utilization. Additionally, collaborate with community corrections to compare cases of crisis services utilization with probation and parole caseloads. For people identified through these collaborations, provide them with engagement services, including those who are not yet enrolled in mental health care.
### Appendix A: List of Participants in the System Assessment

#### Site Visit Participants

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td><strong>County Judges</strong></td>
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<tr>
<td>Erika Velasquez-Ryma</td>
<td>Chief Administrator for Judge Ramon Garcia</td>
<td>Hidalgo County</td>
</tr>
<tr>
<td>Valde Guerra</td>
<td>County Executive Officer</td>
<td>Hidalgo County</td>
</tr>
<tr>
<td>Aurelio Guerra</td>
<td>County Judge</td>
<td>Willacy County</td>
</tr>
<tr>
<td>Eloy Vera</td>
<td>County Judge</td>
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<tr>
<td><strong>Tropical Texas Behavioral Health</strong></td>
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<tr>
<td>Terry Crocker</td>
<td>Chief Executive Officer</td>
<td></td>
</tr>
<tr>
<td>Holly Borel</td>
<td>Associate CEO &amp; COO</td>
<td></td>
</tr>
<tr>
<td>Hilda Garcia</td>
<td>Program Director</td>
<td></td>
</tr>
<tr>
<td>Daniel Gutierrez, MD</td>
<td>Chief Medical Officer</td>
<td></td>
</tr>
<tr>
<td>Steven Vega</td>
<td>Substance Abuse Director</td>
<td></td>
</tr>
<tr>
<td>Juan Animas</td>
<td>Director of TCOOMMI</td>
<td></td>
</tr>
<tr>
<td>Rick Gonzales</td>
<td>Director</td>
<td>Weslaco Clinic</td>
</tr>
<tr>
<td>Monika Flores</td>
<td>Manager</td>
<td>Edinburg Clinic</td>
</tr>
<tr>
<td>Brando Mireles</td>
<td>Manager</td>
<td>Edinburg Clinic</td>
</tr>
<tr>
<td>Monica Rodriguez</td>
<td>YES/Wraparound Manager</td>
<td>Edinburg Clinic</td>
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<tr>
<td>Beatriz Trejo</td>
<td>Chief Financial Officer</td>
<td>Edinburg Clinic</td>
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<tr>
<td>Celia Solis</td>
<td>Controller</td>
<td>Edinburg Clinic</td>
</tr>
<tr>
<td>Coni Aguirre</td>
<td>Chief Administrative Officer</td>
<td>Edinburg Clinic</td>
</tr>
<tr>
<td>Yolanda Paredes</td>
<td>Drop In Center Peer Coordinator</td>
<td>Edinburg Clinic</td>
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<tr>
<td>Cynthia Cash</td>
<td>Family Partner</td>
<td>Edinburg Clinic</td>
</tr>
<tr>
<td>Adam Trejo</td>
<td>Peer Supervisor</td>
<td>Edinburg Clinic</td>
</tr>
<tr>
<td>Rick Gonzales</td>
<td>Supervisor, MH Officer Program</td>
<td>Edinburg Clinic</td>
</tr>
<tr>
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<tr>
<td>John Lung, MD</td>
<td>Family Practitioner</td>
<td>Edinburg Clinic</td>
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<tr>
<td>John Cantu</td>
<td>Primary Care Supervisor</td>
<td>Edinburg Clinic</td>
</tr>
<tr>
<td>Maia Baker</td>
<td>Director of Primary Care</td>
<td>Edinburg Clinic</td>
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<tr>
<td>Jim Banks</td>
<td>Business Development Director</td>
<td>Edinburg Clinic</td>
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<tr>
<td>Dyana Zamora</td>
<td>Service Area Manager</td>
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<tr>
<td>Norma Leija</td>
<td>Peer Supervisor</td>
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<tr>
<td>Romy Zarate</td>
<td>Certified Peer Specialist Peer Provider</td>
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<td>Josephina Romera</td>
<td>RN</td>
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<tr>
<td>Laura Soule</td>
<td>Manager</td>
<td>Harlingen Clinic</td>
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<tr>
<td>Anna Castilo</td>
<td>Supervisor, Veterans Services</td>
<td>Harlingen Clinic</td>
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<tr>
<td>Border Region Behavioral Health Center</td>
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<tr>
<td>Daniel Castillon</td>
<td>Executive Director</td>
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<tr>
<td>Laura Palomo</td>
<td>Director</td>
<td>Adult Behavioral Health Unit</td>
</tr>
<tr>
<td>Alda Rendon</td>
<td>Director of 1115 Waiver</td>
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<tr>
<td>Sandra Maldonado</td>
<td>Manager</td>
<td>Starr Clinic</td>
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<tr>
<td>Rio Grande State Center</td>
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<tr>
<td>Sonia Hernandez-Keeble</td>
<td>Superintendent</td>
<td></td>
</tr>
<tr>
<td>David Moran</td>
<td>Clinical Director</td>
<td></td>
</tr>
<tr>
<td>Blas Ortiz, Jr.</td>
<td>Assistant Superintendent</td>
<td></td>
</tr>
<tr>
<td>Jaime Flores</td>
<td>Mental Health Services Director</td>
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<tr>
<td>Mary Valencia</td>
<td>Outpatient Clinic Director</td>
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<tr>
<td>Tony Zavaletta</td>
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<td>Mary Pat</td>
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<td>Selene Mares</td>
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<td><strong>Valley Baptist Health System</strong></td>
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<tr>
<td>Manuel Vela</td>
<td>President and CEO</td>
<td></td>
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<tr>
<td>Becky Tresnicky</td>
<td>Director, Behavioral Health Services</td>
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<tr>
<td>Celia Solis</td>
<td>Controller</td>
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<tr>
<td>Joe Perez</td>
<td>Vice President of Ministries</td>
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</tr>
<tr>
<td>Daniel Listi</td>
<td>Chief Operating Officer</td>
<td>Valley Baptist Medical Center - Harlingen</td>
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<tr>
<td>David Anthony Saenz, LCSW</td>
<td>Social Services Manager</td>
<td>Valley Baptist Medical Center - Brownsville</td>
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<tr>
<td>Carlo Escobar, LCSW</td>
<td>Manager of IOP Programs</td>
<td>Valley Baptist Medical Center - Brownsville</td>
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<tr>
<td>Alejandro Kudisch, MD</td>
<td>Psychiatrist</td>
<td>Valley Baptist Medical Center - Brownsville</td>
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<tr>
<td>Kenya Walker</td>
<td>Physician Assistant</td>
<td>Valley Baptist Medical Center - Brownsville</td>
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<td><strong>Doctors Hospital at Renaissance</strong></td>
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<tr>
<td>Israel Rocha</td>
<td>CEO</td>
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<tr>
<td>Armour Forse, MD, PhD</td>
<td>Chief Academic Officer</td>
<td>Doctors Hospital at Renaissance</td>
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<tr>
<td><strong>Doctors Hospital at Renaissance – Behavioral Health Center</strong></td>
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<tr>
<td>Linda Resendez</td>
<td>Senior Vice President, Clinical Integration</td>
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<tr>
<td>Krystle Gonzales, BSN, RN</td>
<td>Program Manager</td>
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<tr>
<td>Manuel Amezquita, RN</td>
<td>Clinical Director</td>
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<tr>
<td><strong>Starr County Memorial Hospital</strong></td>
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<tr>
<td>Thalia Munoz</td>
<td>CEO</td>
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<tr>
<td><strong>Behavioral Health Solutions of South Texas</strong></td>
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<tr>
<td>Jose Gonzalez</td>
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<td><strong>South Texas Behavioral Health Center</strong></td>
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<tr>
<td>Joe Rodríguez</td>
<td>Executive Director/CEO</td>
<td></td>
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<tr>
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<tr>
<td>Michael Sauced, LMSW</td>
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<td>Bobby Molina, MHA, MBA</td>
<td>Business Development</td>
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<tr>
<td>Richard Goldberg</td>
<td>CEO</td>
<td>Palms Behavioral Health Corporate Transition Team</td>
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<tr>
<td>Miriam Chambliss, JD</td>
<td>Nurse and Operations Lead</td>
<td>Palms Behavioral Health Corporate Transition Team</td>
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<td><strong>John Austin Peña Memorial Clinic</strong></td>
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<tr>
<td>Eron Manusov, MD</td>
<td>Founding Chair</td>
<td>UT Rio Grande Valley School of Medicine, Dept. of Family and Preventive Medicine</td>
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<tr>
<td>Linda Nelson</td>
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<td><strong>Nuestra Clinica del Valle</strong></td>
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<td>Paula Gomez</td>
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<td><strong>Su Clinica Familiar</strong></td>
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<td>Elena Marin, MD</td>
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<td>Dalia Tovar</td>
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<td><strong>The Wood Group – Respite Program</strong></td>
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<td>COO</td>
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<tr>
<td>Beatrice Garcia</td>
<td>Site Administrator</td>
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<td>Professor Inaugural Dean</td>
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<tr>
<td>Leonel Vela, MD</td>
<td>Senior Associate Dean of Education and Academic Affairs</td>
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<tr>
<td>Arden Dingle</td>
<td>Director of Residency Training Program</td>
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<td>Gabriel de Erausquin</td>
<td>Chair of Psychiatry</td>
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<tr>
<td>Belinda Reininger</td>
<td>Professor of health Promotion and Behavioral Science; Interim Chair Population Health and Behavioral Sciences</td>
<td>UT Rio Grande Valley Medical School; UT School of Public Health</td>
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<td><strong>UTRGV-Doctors Hospital at Renaissance Family Medicine Clinic</strong></td>
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<tr>
<td>Deepu George, MD</td>
<td>Assistant Professor/Clinical; Department of Family and Preventative Medicine; Director of Integrated Care</td>
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<td>Curtis Galke, DO</td>
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<td>Alberto Bernal, MD</td>
<td>First Year Resident</td>
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<td><strong>Law Enforcement</strong></td>
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<td>Ruben Villescas</td>
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<td>Pharr Police Department</td>
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<tr>
<td>Robert Garcia</td>
<td>Crime Analyst and Grant Administrator</td>
<td>Pharr Police Department</td>
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<td>Tobin Lefler</td>
<td>Director</td>
<td>Cameron/Willacy County CSCD</td>
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<tr>
<td>Omar Lucio</td>
<td>Sheriff</td>
<td>Cameron County Sheriff’s Department</td>
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<tr>
<td>Gus Reyna, Jr.</td>
<td>Chief Deputy</td>
<td>Cameron County Sheriff’s Department</td>
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### Valley Baptist Legacy Foundation Rio Grande Valley Behavioral Health Systems Assessment

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<tr>
<td>Arnold Patrick</td>
<td>Executive Director</td>
<td>Hidalgo Adult Probation</td>
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<tr>
<td>Michael Kester</td>
<td>Assistant Chief of Police</td>
<td>Harlingen Police Department</td>
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<tr>
<td>J.E. &quot;Eddie&quot; Guerra</td>
<td>Sheriff</td>
<td>Hidalgo County Sheriff’s Department</td>
</tr>
<tr>
<td>Rey Ramirez</td>
<td>Sergeant</td>
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</tr>
<tr>
<td>Steve Herrera</td>
<td>Captain</td>
<td>Hidalgo County Sheriff’s Department</td>
</tr>
<tr>
<td>Ruben Hinojosa</td>
<td>Captain, Hidalgo County Jail Operations</td>
<td>Hidalgo County Sheriff’s Department</td>
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<tr>
<td>Missy Cruz</td>
<td>LVN, Hidalgo County Jail</td>
<td>Hidalgo County Sheriff’s Department</td>
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<tr>
<td>Ana Moncivias</td>
<td>RN, Hidalgo County Jail</td>
<td>Hidalgo County Sheriff’s Department</td>
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<tr>
<td>Betty Rodriguez</td>
<td>Inmate Rehab Program Specialist</td>
<td>Hidalgo County Sheriff’s Department</td>
</tr>
<tr>
<td>Victor Rodriguez</td>
<td>Police Chief</td>
<td>McAllen Police Department</td>
</tr>
<tr>
<td><strong>Command Staff (Patrol, Fiscal, Training, Investigations, and Special Investigations)</strong></td>
<td>Lieutenant and Captains</td>
<td>McAllen Police Department</td>
</tr>
<tr>
<td>Hon. Larry Spence</td>
<td>Sheriff</td>
<td>Willacy County</td>
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### Additional In-Person and Phone Interview Participants

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<tr>
<th>Name</th>
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<tr>
<td>Eddie Olivarez</td>
<td>Health Director</td>
<td>Hidalgo County Public Health Department</td>
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<tr>
<td>Sister Norma Pimentel</td>
<td>Executive Director</td>
<td>Catholic Charities of the Rio Grande Valley</td>
</tr>
<tr>
<td>Pam Magouirk</td>
<td>COO</td>
<td>Allegian Health Care (MCO)</td>
</tr>
<tr>
<td>Melissa Villafuerte</td>
<td>Medicare Advantage Sales Executive</td>
<td>Allegian Health Care</td>
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<tr>
<td>Orlando Julian</td>
<td>Regional VP of Operations</td>
<td>VBLF Centene (MCO)</td>
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<tr>
<td>Stephanie Contreras</td>
<td>President</td>
<td>NAMI of the Rio Grande Valley</td>
</tr>
<tr>
<td>Name</td>
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<td><strong>In-Person Meetings</strong></td>
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<tr>
<td>Rose Gowen</td>
<td>County Commissioner</td>
<td>Brownsville/ Su Clinica MD</td>
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<tr>
<td>Rosalie Tristan</td>
<td>CASA Coalition Coordinator</td>
<td>Willacy County</td>
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<td><strong>Phone Interviews</strong></td>
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<tr>
<td>Erika Velasquez-Ryma</td>
<td>Chief Administrator Judge Ramon Garcia</td>
<td>Hidalgo County</td>
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<tr>
<td>Jerry Parker</td>
<td>CEO</td>
<td>The Wood Group</td>
</tr>
<tr>
<td>Joseph McCormick, MD, MPH</td>
<td>Chair of Public Health Department</td>
<td>UT School of Public Health - Brownsville</td>
</tr>
<tr>
<td>Jennifer Wood, PhD</td>
<td>Acting Deputy Chief of Staff, Administrative</td>
<td>VA Texas Valley Coastal Bend Health Care System</td>
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<tr>
<td>Pam Magouirk</td>
<td>COO</td>
<td>Alleigan Health Care</td>
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<tr>
<td>Melissa Villafuerte</td>
<td>Enrollment Specialist for Cameron, Hidalgo and Willacy counties</td>
<td>Alleigan Health Care</td>
</tr>
<tr>
<td>Orlando Julian</td>
<td>Regional VP of Operations, McAllen</td>
<td>Centene</td>
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Appendix B: Glossary of Acronyms

ACE: Adverse Childhood Experience
ACT: Assertive Community Treatment
ADA: Americans with Disabilities Act
ADAC: Alcohol and Drug Abuse Counseling
BH: behavioral health
BHLT: behavioral health leadership team
BSN: bachelor of science in nursing
CARF: Commission on Accreditation of Rehabilitation Facilities
CHAMPS: Conversation-Help-Activity-Movement-Participation-Success
CHW: community health worker
CJ: criminal justice
CJCC: criminal justice coordinating committee
COPSD: co-occurring psychiatric and substance use disorder
CQI: continuous quality improvement
CRCG: Community Resource Coordination Group
CRU: Crisis Response Unit
CSCD: Community Supervision and Corrections Department
DA: District Attorney
DBA: doing business as
DFPS: Department of Family and Protective Services
DSRIP: Delivery System Reform Incentive Payment
ED: emergency department
EHR: electronic health record
EMR: electronic medical record
FEP: First Episode Psychosis
FFT: Functional Family Therapy
FPL: federal poverty level
FQHC: federally qualified health center
FTE: full-time equivalent
FY: fiscal year
HHSC: Health and Human Services Commission
HUG: High Utilizer Group
IBH: Integrated Behavioral Health Care with Primary Care
ICT: Integrated Community Treatment
IOP: intensive outpatient (program)
ISD: independent school district
LCDC: licensed chemical dependency counselor
LCSW: licensed clinical social worker
LMHA: local mental health authority
LOC: level of care
LPC: licensed professional counselor
MAT: medication-assisted treatment
MCO: managed care organization
MCOT: Mobile Crisis Outreach Team
MH: mental health
MHA: Mental Health America
MHMR: mental health and mental retardation
MMF: Midland Memorial Foundation
MMHPI: Meadows Mental Health Policy Institute
MRT: Moral Reconciliation Therapy
MST: Multisystemic Therapy
MVPN: Military Veterans Peer Network
NAIP: Network Adequacy Improvement Program
NAMI: National Alliance on Mental Illness
NOMS: National Outcomes Measurement System
OSAR: Outreach, Screening, Assessment and Referral
PA: physician assistant
PBIS: Positive Behavioral Interventions and Support
PCP: primary care physician
PD: police department
SRS: Safe and Responsive Schools
PTSD: Post-Traumatic Stress Disorder
QPR: Question, Persuade, Refer (program)
ROSC: recovery-oriented system of care
RTC: residential treatment center
SA: substance abuse
SAMHSA: Substance Abuse and Mental Health Services Administration
SE: Supported Employment
SED: serious emotional disturbance
SH: Supported Housing
SHS: specialty health system
SMI: serious mental illness
SNOP: Special Needs Offender Program
SOS: Signs of Suicide (program)
START: Skills Training Aggression Replacement Therapy
SUD: substance use disorder
TBI: Trust-based Relational Interventions
TCOOMMI: Texas Correctional Office on Offenders with Medical or Mental Impairments
TDCJ: Texas Department of Criminal Justice
TJJD: Texas Juvenile Justice Department
TMACT: Tool for Measurement of Assertive Community Treatment
TRAS: Texas Risk Assessment System
TRY: Top Rank Youth
VA: Veterans Administration
WRAP: Wellness Recovery Action Planning
YES: Youth Empowerment Services (Waiver)