NUECES COUNTY HOSPITAL DISTRICT
BOARD OF MANAGERS
Board of Managers - Regular Meeting
Tuesday, October 20, 2020 at 12:00 PM

AGENDA

1. WELCOME

2. ROLL CALL OF BOARD OF MANAGERS MEMBERS:

___ John B. Martinez, J.D., Chairman
___ Sylvia Tryon Oliver, Vice-Chairman
___ Belinda Flores, RN
___ Vishnu V. Reddy, M.D.
___ Daniel W. Dain
___ John E. Valls
___ Mariana Garza, J.D.

3. **CALL TO ORDER, ESTABLISHMENT OF QUORUM, MEETING POSTING CONFIRMATION, AND CLOSED MEETING NOTICE**

A. Call to order.

B. Establish quorum.

C. Confirm posting of Meeting's public notice in accordance with Texas Open Meetings Act, Texas Government Code, Chapter 551.

D. Public notice is hereby given that the Board of Managers may elect to go into Closed Meeting session(s) at any time during the meeting to discuss any matter(s) listed on the agenda when so authorized by the provisions of the Open Meetings Act, Texas Government Code, Chapter 551.

4. **PUBLIC COMMENT** - Persons wishing to comment on any item(s) on the agenda or any subject within the Board's responsibilities must sign-in on the "Agenda Item Request to Speak" form provided at the entrance of the Board meeting room at least five (5) minutes prior to commencement of the meeting. Commenters shall limit their comments to three (3) minutes, except that Commenters addressing the Board through a translator shall limit their comments to six (6) minutes. See the "Public Comment" section of the preceding General Information page for additional information.

5. **CONSENT AGENDA** - See the "Consent Agenda" section of the preceding General Information page for an explanation of the Consent Agenda and for additional information.

A. Approve Board of Managers meeting minutes of:
   1. September 15, 2020 Regular;
   2. September 24, 2020 Special; and
   3. September 29, 2020 Special.

B. Receive summary payment information on Nueces County health care disbursements for Fiscal Year 2020 year-to-date:
   1. Salaries, benefits, supplies, and intergovernmental transfers at/for Corpus Christi/Nueces County Public Health Department;
   2. Emergency medical services provided in unincorporated areas of Nueces County;
   3. Supplemental and jail diversion program funding for Nueces Center for Mental Health and Intellectual Disabilities;
   4. Medical services provided at County correctional facilities:
      a. Nueces County Jail; and
      b. Nueces County Juvenile Detention Center;
   5. Funding for alcohol and drug abuse treatment programs:
      a. Cenikor (Charlie's Place);
      b. Council on Alcohol and Drug Abuse; and
      c. Palmer Drug Abuse Program;
   6. Funding for diabetes prevention and supporting programs;
   7. Public health grants; and
   8. Legal and professional fees. *(Finance Committee)*

C. Receive reports relating to Nueces Aid Program enrollment for month-ended September 30, 2020. *(Finance Committee)*

D. Receive fiscal year-to-date Specified Annual Percentage-related revenue reports; revenue receipts pursuant to CHRISTUS Spohn Health System Corporation Amended and Restated Membership Agreement, Section 5.03. *(Finance Committee)*

E. Receive summary imputed claims information on medical and hospital care provided to the Nueces Aid Program population consistent with the CHRISTUS Spohn Health System Corporation Amended and Restated Membership Agreement for fiscal year-to-date period-ended September 30, 2020. *(Finance Committee)*

F. Receive summary report of year-to-date intergovernmental transfers made in support of local and other healthcare providers participating in Medicaid supplemental payment programs sponsored by the Texas Health and Human Commission. *(Finance Committee)*
   1. Texas Healthcare Transformation and Quality Improvement Program (Medicaid 1115 Waiver):
      a. Delivery System Reform Incentive Payment (DSRIP) pool; and
      b. Hospital Uncompensated Care (UC) pool.
   2. Disproportionate Share Hospitals (DSH) program;
   3. Network Access Improvement Program (NAIP);
   4. Uniform Hospital Rate Increase Program (UHRIP); and

5. Graduate Medical Education (GME). *(Finance Committee)*

G. Receive monthly statement of escrow amounts deposited and/or withdrawn by CHRISTUS Spohn Health System Corporation; deposits pursuant to and consistent with Schedule 1 to CHRISTUS Spohn Health System Corporation Amended and Restated Membership Agreement; receive statement for month-ended September 30, 2020. *(Finance Committee)*

6. **REGULAR AGENDA:**

A. **Finance Committee:**

1. Receive and approve Quarterly and Annual Investment Reports:
   a. Quarterly Investment Report for fiscal quarter-ended September 30, 2020 and ratify related investment transactions; and
   b. Annual Investment Report for fiscal year-ended September 30, 2020. ***(ACTION)***

B. **Social Determinants of Health and Health Equity:**

1. Receive information on the role of social determinants of health in promoting health and health equity. ***(INFORMATION)***

2. Discuss and consider approval of Statement of Work (SOW) with Accenture, LLP relating to the provision of and access to proprietary and COVID-19 related data supporting identification of Nueces County's social determinants of health; SOW includes provision of cloud-based social determinants data sets and development of geographical and population-based dashboards in conjunction with Texas Health Institute. SOW accompanies Texas Department of Information Resources Contract No. DIR-TSO-4062 relating to cloud services and related services; and authorize Administrator to finalize details and execute SOW. ***(ACTION)***

3. Discuss and consider approval of an Agreement with Texas Health Institute relating to provision of project management, subject matter expert, environmental and policy scan, community stakeholder engagement services, and recommendations to guide Accenture, LLP's social determinants of health dashboard framework and metrics; and authorize Administrator to finalize details and execute Agreement. ***(ACTION)***

C. **Community Mental Health Initiatives:**

1. Receive Meadows Mental Health Policy Insitute's Nueces County Comprehensive Behavioral Health Community Needs Assessment Final Report September 2020. ***(INFORMATION)***

2. Receive presentation from The Police Assisted Addiction and Recovery Initiative (PAARI) relating to support and resources to help law enforcement agencies create non-arrest pathways to treatment and recovery. ***(INFORMATION)***

3. Receive presentation from Cloud 9® TeleBehavioral Healthcare on technology for law enforcement, fire, and emergency medical services to connect to remote mental health clinicians and/or medical practitioners to jointly treat patients experiencing mental health crisis in the community. ***(INFORMATION)***

D. **COVID-19 Pandemic:**

1. Receive update on establishment of a COVID-19-related Alternate Care Site for post-acute care at Corpus Christi Medical Center-Northwest located at 13725 Northwest Boulevard, Corpus Christi, Texas. ***(INFORMATION)***

E. **Legislation:**

1. Discuss and consider adoption of legislative agenda for 87th (2021) Texas Legislative Session. ***(ACTION)***

F. **Board of Managers Business:**

1. Adopt Calendar Year 2021 Board of Managers Meeting dates and times. ***(ACTION)***

G. **Local Provider Participation Fund:**

1. Receive information on establishment of Nueces County Hospital District LPPF. ***(INFORMATION)***

H. **Purchasing:**

1. Adopt Board of Managers Order granting professional services exemption from the competitive purchasing requirements of Texas Local Government Code, §262.023 for acquisition of Quality Assessment, Utilization Review, and Coding Review Services from the Texas Medical Foundation for Calendar Years 2021, 2022, and 2023; exemption authorized by Local Government Code, §262.024(a)(4). ***(ACTION)***

2. Adopt Board of Managers Order granting professional services exemption from the competitive purchasing requirements of Texas Local Government Code, §262.023 for acquisition, from Texas Health Institute, of project management, subject matter expert, environmental and policy scan, community stakeholder engagement services, and recommendations to guide Accenture, LLP's social determinants of health dashboard framework and metrics for Calendar Years 2021 and 2022; exemption authorized by Local Government Code, §262.024(a)(4). ***(ACTION)***

I. **Administrator's Actions:**

1. Receive information on Administrator's action(s) performed as part of his duties directing the affairs of the District and/or as required by the Board of Managers; duties established pursuant to Texas Health and Safety Code, §281.026(e):
   a. Extension of due date for Deliverable No. 7 of Professional Services Contract with Meadows Mental Health Policy Institute; due date for consultations extended to March 31, 2021. ***(INFORMATION)***

7. **ADMINISTRATOR'S BRIEFING:**

A. Next Board of Managers and Board Committee meetings (all meetings' dates, times, and locations subject to change):

1. Finance Committee: November 17, 2020, 11:00 AM in NCHD Board of Managers Meeting Room at 555 North Carancahua Street, Room 950-A, Corpus Christi, Texas 78401;
2. Board of Managers: November 17, 2020, 12 Noon in NCHD Board of Managers Meeting Room at 555 North Carancahua Street, Room 950-A, Corpus Christi, Texas 78401. ***(INFORMATION)***

8. **ADJOURN**

VG-12-2020-2020000483

Nueces County
Kara Sands
Nueces County Clerk

Instrument Number: 2020000483

Public Notice

PUBLIC NOTICES

Recorded On: October 16, 2020 12:02 PM

Number of Pages: 8

" Examined and Charged as Follows: "

Total Recording: $0.00

STATE OF TEXAS
Nueces County
I hereby certify that this Instrument was filed in the File Number sequence on the date/time printed hereon, and was duly recorded in the Official Records of Nueces County, Texas

Kara Sands
Nueces County Clerk
Nueces County, TX

Kara Sands

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NUECES COUNTY HOSPITAL DISTRICT

Kara Sands
Nueces County Clerk
901 Leopard St #201
Corpus Christi, TX 78401

Main: (361)888-0580

Receipt: 20201016000104
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Seq	Item	Document Description	Number	Number Of	Amount	Serial Number
1	Public Notice	PBN	2020000483	8	$0.00	

Order Total (1) $0.00

Seq	Payment Method	Transaction Id	Comment	Total
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Total Payments (1) $0.00

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NUECES COUNTY HOSPITAL DISTRICT

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May 2018 | Issue Brief

Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity

Samantha Artiga and Elizabeth Hinton

Key Findings

Social determinants of health are the conditions in which people are born, grow, live, work and age that shape health. This brief provides an overview of social determinants of health and emerging initiatives to address them. It shows:

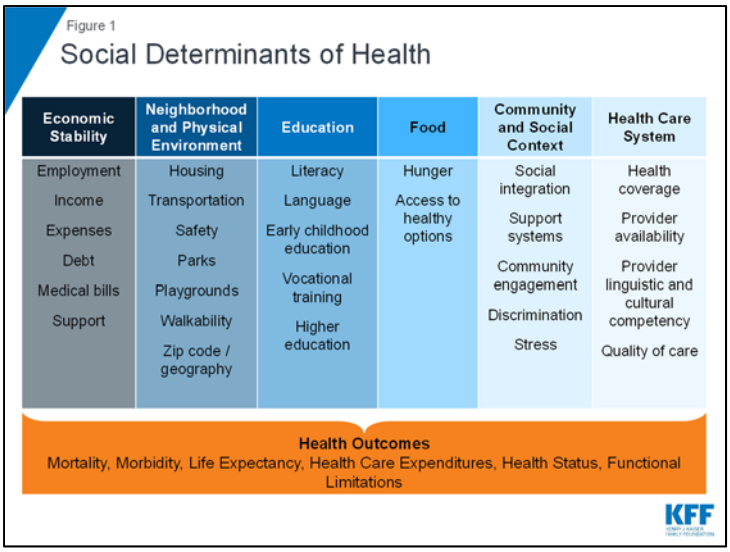
- **Social determinants of health include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care.** Addressing social determinants of health is important for improving health and reducing longstanding disparities in health and health care.
- **There are a growing number of initiatives to address social determinants of health within and outside of the health care system.** Outside of the health care system, initiatives seek to shape policies and practices in non-health sectors in ways that promote health and health equity. Within the health care system, there are multi-payer federal and state initiatives as well as Medicaid-specific initiatives focused on addressing social needs. These include models under the Center for Medicare and Medicaid Innovation, Medicaid delivery system and payment reform initiatives, and options under Medicaid. Managed care plans and providers also are engaged in activities to identify and address social needs. For example, 19 states required Medicaid managed care plans to screen for and/or provide referrals for social needs in 2017, and a recent survey of Medicaid managed care plans found that almost all (91%) responding plans reported activities to address social determinants of health.
- **Many challenges remain to address social determinants of health, and new directions pursued by the Trump Administration could limit resources and initiatives focused on these efforts.** The Trump Administration is pursuing a range of new policies and policy changes, including enforcing and expanding work requirements associated with public programs and reducing funding for prevention and public health. These changes may limit individuals' access to assistance programs to address health and other needs and reduce resources available to address social determinants of health.

Introduction

Efforts to improve health in the U.S. have traditionally looked to the health care system as the key driver of health and health outcomes. However, there has been increased recognition that improving health and achieving health equity will require broader approaches that address social, economic, and environmental factors that influence health. This brief provides an overview of these social determinants of health and discusses emerging initiatives to address them.

What are Social Determinants of Health?

Social determinants of health are the conditions in which people are born, grow, live, work and age.[1] They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care (Figure 1).



Addressing social determinants of health is important for improving health and reducing health disparities.[2] Though health care is essential to health, it is a relatively weak health determinant.[3] Research shows that health outcomes are driven by an array of factors, including underlying genetics, health behaviors, social and environmental factors, and health care. While there is currently no consensus in the research on the magnitude of the relative contributions of each of these factors to health, studies suggest that health behaviors, such as smoking, diet, and exercise, and social and economic factors are the primary drivers of health outcomes, and social and economic factors can shape individuals' health behaviors. For example, children born to parents who have not completed high school are more likely to live in an environment that poses barriers to health such as lack of safety, exposed garbage, and substandard housing. They also are less likely to have access to sidewalks, parks or playgrounds, recreation centers, or a library.[4] Further, evidence shows that stress negatively affects health across the lifespan[5] and that environmental factors may have multi-generational impacts.[6] Addressing social determinants of health is not only important for improving overall health, but also for reducing health disparities that are often rooted in social and economic disadvantages.

Initiatives to Address Social Determinants of Health

A growing number of initiatives are emerging to address social determinants of health. Some of these initiatives seek to increase the focus on health in non-health sectors, while others focus on having the health care system address broader social and environmental factors that influence health.

Focus on Health in Non-Health Sectors

Policies and practices in non-health sectors have impacts on health and health equity. For example, the availability and accessibility of public transportation affects access to employment, affordable healthy foods, health care, and other important drivers of health and wellness. Nutrition programs and policies can also promote health, for example, by supporting healthier corner stores in low-income communities,[7] farm to school programs[8] and community and school gardens, and through

broader efforts to support the production and consumption of healthy foods.[9] The provision of early childhood education to children in low-income families and communities of color helps to reduce achievement gaps, improve the health of low-income students, and promote health equity.[10]

"Health in All Policies" is an approach that incorporates health considerations into decision making across sectors and policy areas.[11] A Health in All Policies approach identifies the ways in which decisions in multiple sectors affect health, and how improved health can support the goals of these multiple sectors. It engages diverse partners and stakeholders to work together to promote health, equity, and sustainability, and simultaneously advance other goals such as promoting job creation and economic stability, transportation access and mobility, a strong agricultural system, and improved educational attainment. States and localities are utilizing the Health in All Policies approach through task forces and workgroups focused on bringing together leaders across agencies and the community to collaborate and prioritize a focus on health and health equity.[12] At the federal level, the Affordable Care Act (ACA) established the National Prevention Council, which brings together senior leadership from 20 federal departments, agencies, and offices, who worked with the Prevention Advisory Group, stakeholders, and the pubic to develop the National Prevention Strategy.

Place-based initiatives focus on implementing cross-sector strategies to improve health in neighborhoods or communities with poor health outcomes. There continues to be growing recognition of the relationship between neighborhoods and health, with zip code understood to be a stronger predictor of a person's health than their genetic code.[13] A number of initiatives focus on implementing coordinated strategies across different sectors in neighborhoods with social, economic, and environmental barriers that lead to poor health outcomes and health disparities. For example, the Harlem Children's Zone (HCZ) project focuses on children within a 100-block area in Central Harlem that had chronic disease and infant mortality rates that exceeded rates for many other sections of the city as well as high rates of poverty and unemployment. HCZ seeks to improve the educational, economic, and health outcomes of the community through a broad range of family-based, social service, and health programs.

Addressing Social Determinants in the Health Care System

In addition to the growing movement to incorporate health impact/outcome considerations into non-health policy areas, there are also emerging efforts to address non-medical, social determinants of health within the context of the health care delivery system. These include multi-payer federal and state initiatives, Medicaid initiatives led by states or by health plans, as well as provider-level activities focused on identifying and addressing the non-medical, social needs of their patients.

FEDERAL AND STATE INITIATIVES

In 2016, Center for Medicare and Medicaid Innovation (CMMI), which was established by the ACA, announced a new "Accountable Health Communities" model focused on connecting Medicare and Medicaid beneficiaries with community services to address health-related social needs. The model provides funding to test whether systematically identifying and addressing the health-related social needs

of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will affect health costs and reduce inpatient and outpatient utilization. In 2017, CMMI awarded 32 grants to organizations to participate in the model over a five-year period. Twelve awardees will provide navigation services to assist high-risk beneficiaries with accessing community services and 20 awardees will encourage partner alignment to ensure that community services are available and responsive to the needs of enrollees.[14]

Through the CMMI State Innovation Models Initiative (SIM), a number of states are engaged in multi-payer delivery and payment reforms that include a focus on population health and recognize the role of social determinants. SIM is a CMMI initiative that provides financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that aim to improve health system performance, increase quality of care, and decrease costs. To date, the SIM initiative has awarded nearly $950 million in grants to over half of states to design and/or test innovative payment and delivery models. As part of the second round of SIM grant awards, states are required to develop a statewide plan to improve population health. States that received Round 2 grants are pursuing a variety of approaches to identify and prioritize population health needs; link clinical, public health, and community-based resources; and address social determinants of health.

- **All 11 states that received Round 2 SIM testing grants plan to establish links between primary care and community-based organizations and social services.**[15] For example, Ohio is using SIM funds, in part, to support a comprehensive primary care (CPC) program in which primary care providers connect patients with needed social services and community-based prevention programs. As of December 2017, 96 practices were participating in the CPC program. Connecticut's SIM model seeks to promote an Advanced Medical Home model that will address the wide array of individuals' needs, including environmental and socioeconomic factors that contribute to their ongoing health.
- **A number of the states with Round 2 testing grants are creating local or regional entities to identify and address population health needs and establish links to community services.** For example, Washington State established nine regional "Accountable Communities of Health," which will bring together local stakeholders from multiple sectors to determine priorities for and implement regional health improvement projects.[16] Delaware plans to implement ten "Healthy Neighborhoods" across the state that will focus on priorities such as healthy lifestyles, maternal and child health, mental health and addiction, and chronic disease prevention and management.[17] Idaho is creating seven "Regional Health Collaboratives" through the state's public health districts that will support local primary care practices in Patient-Centered Medical Home transformation and create formal referral and feedback protocols to link medical and social services providers.[18]
- **The Round 2 testing grant states also are pursuing a range of other activities focused on population health and social determinants.** Some of these activities include using population health measures to qualify practices as medical homes or determine incentive payments, incorporating use of community health workers in care teams, and expanding data collection and analysis infrastructure focused on population health and social determinants of health.[19]

MEDICAID INITIATIVES

Delivery System and Payment Reform

A number of delivery and payment reform initiatives within Medicaid include a focus on linking health care and social needs. In many cases, these efforts are part of the larger multi-payer SIM models noted above and may be part of Section 1115 Medicaid demonstration waivers.[20] For example, Colorado and Oregon are implementing Medicaid payment and delivery models that provide care through regional entities that focus on integration of physical, behavioral, and social services as well as community engagement and collaboration.

- In Oregon, each Coordinated Care Organization (or "CCO") is required to establish a community advisory council and develop a community health needs assessment.[21] CCOs receive a global payment for each enrollee, providing flexibility for CCOs to offer "health-related services" – which supplement traditional covered Medicaid benefits and may target the social determinants of health.[22] Early experiences suggest that CCOs are connecting with community partners and beginning to address social factors that influence health through a range of projects. For example, one CCO has funded a community health worker to help link pregnant or parenting teens to health services and address other needs, such as housing, food, and income.[23] Another CCO worked with providers and the local Meals on Wheels program to deliver meals to Medicaid enrollees discharged from the hospital who need food assistance as part of their recovery.[24] An evaluation conducted by the Oregon Health & Science University's Center for Health Systems Effectiveness released in 2017 found CCOs were associated with reductions in spending growth and improvement in some quality domains.[25] According to the evaluation, most CCOs believed health-related flexible services were effective at improving outcomes and reducing costs.[26]
- Similarly, in Colorado, the Regional Collaborative Organizations (RCCOs), which are paid a per member per month payment for enrollees, help connect individuals to community services through referral systems as well as through targeted programs designed to address specific needs identified within the community.[27] A study published in 2017 comparing Oregon's CCO program to Colorado's RCCO program found that Colorado's RCCO program generated comparable reductions in expenditures and inpatient care days.[28]

Several other state Medicaid programs have launched Accountable Care Organization (ACO) models that often include population-based payments or total cost of care formulas, which may provide incentives for providers to address the broad needs of Medicaid beneficiaries, including the social determinants of health.[29]

Some state Medicaid programs are supporting providers' focus on social determinants of health through "Delivery System Reform Incentive Payment" (DSRIP) initiatives. DSRIP initiatives emerged under the Obama Administration as part of Section 1115 Medicaid demonstration waivers. DSRIP initiatives link Medicaid funding for eligible providers to process and performance metrics, which may involve addressing social needs and factors. For example, in New York, provider systems may implement

DSRIP projects aimed at ensuring that people have supportive housing. The state also has invested significant state dollars outside of its DSRIP waiver in housing stock to ensure that a better supply of appropriate housing is available.[30] In Texas, some providers have used DSRIP funds to install refrigerators in homeless shelters to improve individuals' access to insulin.[31] The California DSRIP waiver has increased the extent to which the public hospital systems focus on coordination with social services agencies and county-level welfare offices.[32] To date, data on the results of DSRIP programs are limited, but a final federal evaluation report is scheduled to for 2019.[33]

Medicaid programs also are providing broader services to support health through the health homes option established by the ACA. Under this option, states can establish health homes to coordinate care for people who have chronic conditions. Health home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, as well as referrals to community and social support services. Health home providers can be a designated provider, a team of health professionals linked to a designated provider, or a community health team. A total of 21 states report that health homes were in place in fiscal year 2017.[34] A federally-funded evaluation of the health homes model found that most providers reported significant growth in their ability to connect patients to nonclinical social services and supports under the model, but that lack of stable housing and transportation were common problems for many enrollees that were difficult for providers to address with insufficient affordable housing and rent support resources.[35]

Housing and Employment Supports

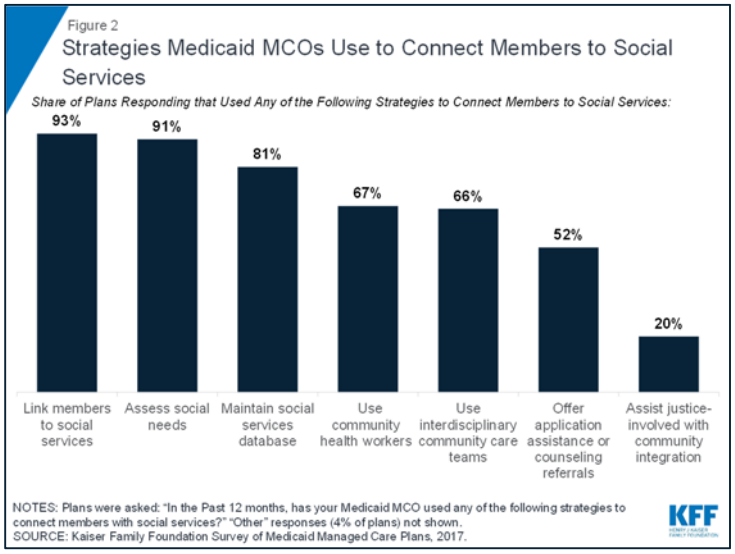
Some states are providing housing support to Medicaid enrollees through a range of optional state plan and waiver authorities. While states cannot use Medicaid funds to pay for room and board, Medicaid funds can support a range of housing-related activities, including referral, support services, and case management services that help connect and retain individuals in stable housing.[36] For example, the Louisiana Department of Health formed a partnership with the Louisiana Housing Authority to establish a Permanent Supportive Housing (PSH) program with the dual goals of preventing and reducing homelessness and unnecessary institutionalization among people with disabilities. Louisiana's Medicaid program covers three phases of tenancy support services for Medicaid beneficiaries in permanent supportive housing: pre-tenancy services (housing search assistance, application assistance etc.), move-in services, and ongoing tenancy services.[37] Louisiana reports a 94% housing retention rate since the program began housing tenants in 2008. A preliminary analysis shows statistically significant reductions in hospitalizations and emergency department utilization after the PSH intervention, and an early independent analysis of the PSH program's impact on Medicaid spending found a 24% reduction in Medicaid acute care costs after a person was housed.[38]

Through a range of optional and waiver authorities, some states are providing voluntary supported employment services to Medicaid enrollees. Supported employment services may include pre-employment services (e.g., employment assessment, assistance with identifying and obtaining employment, and/or working with employer on job customization) as well as employment sustaining services (e.g., job coaching and/or consultation with employers). States often target these services to

specific Medicaid populations, such as persons with serious mental illness or substance use disorders and individuals with intellectual or developmental disabilities. For example, under a Section 1115 waiver, Hawaii offers supportive employment services to Medicaid enrollees with serious mental illness (SMI), individuals with serious and persistent mental illness (SPMI), and individuals who require support for emotional and behavioral development (SEBD).[39]

Medicaid Managed Care Organizations (MCOs)

Medicaid MCOs are increasingly engaging in activities to address social determinants of health. Data from the Kaiser Family Foundation's 50-state Medicaid budget survey show that a growing number of states are requiring Medicaid MCOs to address social determinants of health as part of their contractual agreements (Box 1). In 2017, 19 states required Medicaid MCOs to screen beneficiaries for social needs and/or provide enrollees with referrals to social services and six states required MCOs to provide care coordination services to enrollees moving out of incarceration, with additional states planning to implement such requirements in 2018.[40] Other data from a 2017 Kaiser Family Foundation survey of Medicaid managed care plans show that almost all responding MCOs[41] (91%) reported activities to address social determinants of health, with housing and nutrition/food security as the top areas of focus.[42] The most



Box 1: Examples of States Integrating Social Determinants into Medicaid Managed Care Contracts

- **Arizona** requires coordination of community resources like housing and utility assistance under its managed long-term services and supports (MLTSS) contract. The state provides state-only funding in conjunction with its managed behavioral health contract to provide housing assistance. The state also encourages health plans to coordinate with the Veterans' Administration and other programs to meet members' social support needs.
- The **District of Columbia** encourages MCOs to refer beneficiaries with three or more chronic conditions to the "My Health GPS" Health Home program for care coordination and case management services, including a biopsychosocial needs assessment and referral to community and social support services.
- **Louisiana** requires its plans to screen for problem gaming and tobacco use and requires referrals to Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Louisiana Permanent Supportive Housing program when appropriate.
- **Nebraska** requires MCOs to have staff trained on social determinants of health and be familiar with community resources; plans are also required to have policies to address members with multiple biopsychosocial needs.

common activities plans reported engaging in were working with community -based organizations to link members to social services (93%), assessing members' social needs (91%), and maintaining community or social service resource databases (81%) (Figure 2).[43] Some plans also reported using community health workers (67%), using interdisciplinary community care teams (66%), offering application assistance and counseling referrals for social services (52%), and assisting justice-involved individuals with community reintegration (20%).

PROVIDER ACTIVITIES

Under the ACA, not-for-profit hospitals are required to conduct a community health needs assessment (CHNA) once every three years and develop strategies to meet needs identified by the CHNA. The CDC defines a community health assessment as "the process of community engagement; collection, analysis, and interpretation of data on health outcomes and health determinants; identification of health disparities; and identification of resources that can be used to address priority needs."[44] Under the ACA, the assessment must take into account input from people who represent the broad interests of the community being served, including those with public health knowledge or expertise.

Some providers have adopted screening tools within their practices to identify health-related social needs of patients. For example, according to a survey of nearly 300 hospitals and health systems conducted by the Deloitte Center for Health Solutions in 2017, nearly 9 in 10 (88%) hospitals screen patients to gauge their health-related social needs, though only 62% report screening target populations in a systematic or consistent way.[45] These hospitals are mostly screening inpatient and high-utilizer populations.[46] The National Association for Community Health Centers, in coordination with several other organizations, developed the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool to help health centers and other providers collect data to better understand and act on their patients' social determinants of health. Other organizations and entities have created screening tools, including Health Leads, a non-profit organization funded by the Robert Wood Johnson Foundation, which has developed a social needs screening toolkit for providers and CMMI, which released an Accountable Health Communities screening tool to help providers identify unmet patient needs.[47]

Looking Ahead

The ACA provided a key opportunity to help improve access to care and reduce longstanding disparities faced by historically underserved populations through both its coverage expansions and provisions to help bridge health care and community health. To date, millions of Americans have gained coverage through the coverage expansions, but coverage alone is not enough to improve health outcomes and achieve health equity. With growing recognition of the importance of social factors to health outcomes, an increasing number of initiatives have emerged to address social determinants of health by bringing a greater focus on health within non-health sectors and increasingly recognizing and addressing health-related social needs through the health care system.

Within the health care system, a broad range of initiatives have been launched at the federal and state level, including efforts within Medicaid. Many of these initiatives reflect new funding and demonstration authorities provided through the ACA to address social determinants of health and further health equity. They also reflect a broader system movement toward care integration and "whole-person" delivery models, which aim to address patients' physical, mental, and social needs, as well as a shifts towards payments tied to value, quality, and/or outcomes.

Although there has been significant progress recognizing and addressing social determinants of health, many challenges remain. Notably, these efforts require working across siloed sectors with separate funding streams, where investments in one sector may accrue savings in another. Moreover, communities may not always have sufficient service capacity or supply to meet identified needs. Further, there remain gaps and inconsistencies in data on social determinants of health that limit the ability to aggregate data across settings or to use data to inform policy and operations, guide quality improvement, or evaluate interventions.[48] Within Medicaid, the growing focus on social determinants of health raises new questions about the appropriate role Medicaid should play in addressing non-medical determinants of health and how to incentivize and engage Medicaid MCOs in addressing social determinants of health.[49]

The Trump Administration is pursuing policies that may limit individuals' access to assistance programs to address health and other needs and reduce resources to address social determinants of health. The Administration has begun phasing out DSRIP programs,[50] is revising Medicaid managed care regulations,[51] and has signaled reductions in funding for prevention and public health. It has also announced plans to change the direction of models under the CMMI.[52, 53, 54] The Administration also is pursuing approaches to enforce and expand work requirements in public programs,[55] including Medicaid.[56] CMS asserts that this policy is designed to "improve Medicaid enrollee health and well-being through incentivizing work and community engagement" and that state efforts to make participation in work or other community engagement a requirement for Medicaid coverage may "help individuals and families rise out of poverty and attain independence."[57] In guidance, CMS has specified that states implementing such programs will be required to describe strategies to assist enrollees in meeting work requirements (e.g., linking individuals to job training, childcare assistance, transportation, and other work supports), but that states may not use federal Medicaid funds for supportive services to help people overcome barriers to work.[58] Data show that most nonelderly Medicaid adults already are working or face significant barriers to work, leaving a small share of adults to whom these policies are directed.[59] However, eligible individuals could lose Medicaid coverage due to difficulty navigating documentation and administrative processes associated with these requirements.[60]

This brief updates an earlier version that was produced with Harry J. Heiman, formerly with the Satcher Health Leadership Institute at the Morehouse School of Medicine.

Endnotes

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Centers for Disease Control and Prevention

NCHHSTP Social Determinants of Health

Frequently Asked Questions

What is health equity?

Health equity can be defined in several ways. One commonly used definition of health equity is when all people have "the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance'".[1] The U.S. Department of Health and Human Services defines health equity as attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.[2] Achieving health equity, eliminating disparities, and improving the health of all groups is an overarching goal for Healthy People 2020 and a top priority for the Centers for Disease Control and Prevention (CDC).[3]

What are social determinants of health?

Health is influenced by many factors, which may generally be organized into five broad categories known as determinants of health: genetics, behavior, environmental and physical influences, medical care and social factors. These five categories are interconnected.

The fifth category (social determinants of health) encompasses economic and social conditions that influence the health of people and communities.[4] These conditions are shaped by socioeconomic position, which is the amount of money, power, and resources that people have, all of which are influenced by socioeconomic and political factors (e.g., policies, culture, and societal values).[5,6] An individual's socioeconomic position can be shaped by various factors such as their education, occupation, or income. All of these factors (social determinants) impact the health and well-being of people and the communities they interact with.

Several factors related to health outcomes are listed below.

- How a person develops during the first few years of life (early childhood development)
- How much education a person obtains and the quality of that education
- Being able to get and keep a job
- What kind of work a person does
- Having food or being able to get food (food security)
- Having access to health services and the quality of those services
- Living conditions such as housing status, public safety, clean water and pollution
- How much money a person earns (individual income and household income)
- Social norms and attitudes (discrimination, racism and distrust of government)
- Residential segregation (physical separation of races/ethnicities into different neighborhoods)
- Social support
- Language and literacy
- Incarceration
- Culture (general customs and beliefs of a particular group of people)
- Access to mass media and emerging technologies (cell phones, internet, and social media)

All of these factors are influenced by social circumstances. Of course, many of the factors in this list are also influenced by the other four determinants of health.

Why is addressing the role of social determinants of health important?

Addressing social determinants of health is a primary approach to achieving health equity. Health equity is "when everyone has the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance'".[7] Health equity has also been defined as "the absence of systematic disparities in health between and within social groups that have different levels of underlying social advantages or disadvantages—that is, different positions in a social hierarchy".[8] Social determinants of health such as poverty, unequal access to health care, lack of education, stigma, and racism are underlying, contributing factors of health inequities. The Centers for Disease Control and Prevention (CDC) is committed to achieving improvements in people's lives by reducing health inequities. Health organizations, institutions, and education programs are encouraged to look beyond behavioral factors and address underlying factors related to social determinants of health.

A growing body of research highlights the importance of upstream factors that influence health and the need for policy interventions to address those factors—in addition to clinical approaches and interventions aimed at modifying behavior.[9]

The Centers for Disease Control and Prevention (CDC) is committed to achieving improvements in people's lives by reducing health inequities. Health organizations, institutions, and education programs are encouraged to look beyond behavioral factors and address underlying factors related to social determinants of health.

How is the World Health Organization addressing social determinants of health?

The World Health Organization (WHO) created the Commission on Social Determinants of Health to address social determinants of health.[4] The Commission uses the following three principles to guide its work in eliminating health inequities for local communities and nations and throughout the world:

- Improve the conditions of daily life—the circumstances in which people are born, grow, live, work, and age.
- Tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—globally, nationally, and locally.
- Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.[4]

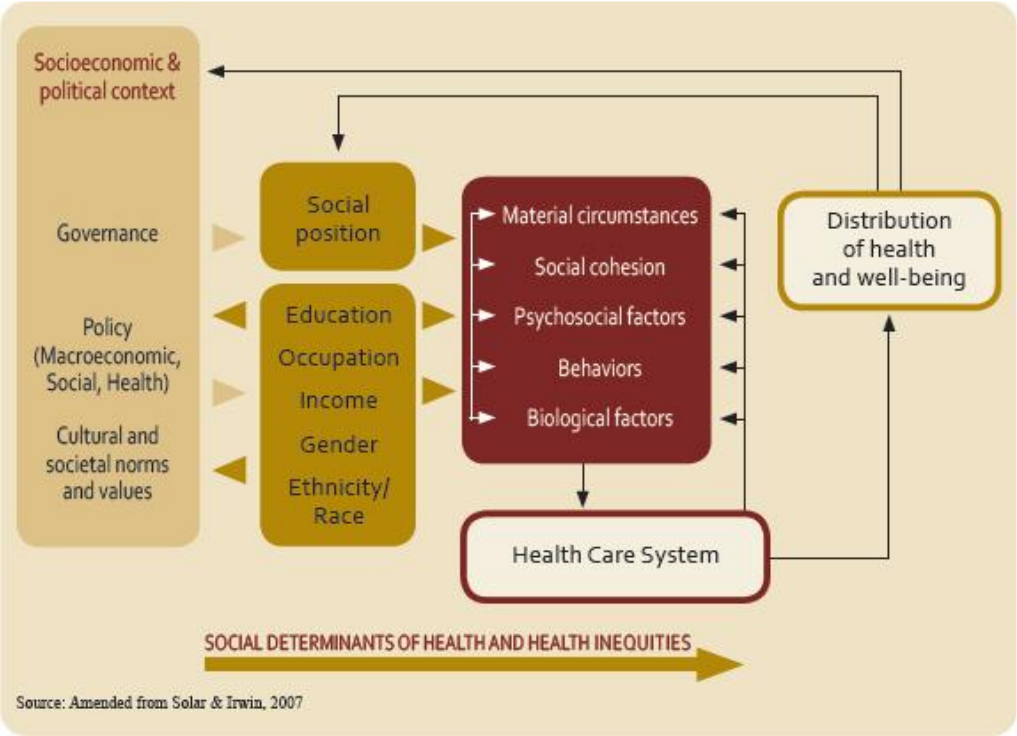

Figure 1. World Health Organization's Social Determinants of Health Conceptual Framework[4]

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The commission created the conceptual framework below that describes relationships among individual and structural variables. The framework represents relationships among variables that are based on scientific studies or substantial

evidence. The framework provides a point from which researchers can take action, such as creating targeted interventions, on social determinants of health.

Where can I find more information about social determinants of health?

More information is available from a variety of sources, including the following publications and web sites.

Websites

- World Health Organization
- U.S. Department of Health and Human Services Office of Minority Health
- Office of Minority Health's National Partnership for Action to End Health Disparities
- National Association of County and City Health Officials (NACCHO) Health Equity and Social Justice
- The Robert Wood Johnson Foundation (RWJF)
- Healthy People 2020

Publications

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How do I contact the Office of Health Equity at CDC's NCHHSTP with other questions?

You can e-mail the Office of Health Equity at OHEinquiries@cdc.gov.

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Page last reviewed: December 19, 2019

All Policies

Advancing Health Equity by Addressing the Social Determinants of Health in Family Medicine (Position Paper)

Introduction

Social determinants of health (SDoH) are the conditions under which people are born, grow, live, work, and age, and include factors such as socioeconomic status, education, employment, social support networks, and neighborhood characteristics.[1] These have a greater impact on population health than factors like biology, behavior, and health care.[2,3] SDoH, especially poverty, structural racism, and discrimination, are the primary drivers of health inequities.[4-6] Reducing health inequities is important because they are pervasive; unfair and unjust; individuals affected have little control over the contributing circumstances; affect everyone; and can be avoided with existing policy solutions.[7]

The purpose of this position paper is to outline prevalent health inequities; describe how social factors impact health; discuss the role family physicians can play in addressing SDoH and reducin health inequities; and state the American Academy of Family Physicians (AAFP) stance on relevan policy interventions.

Definitions

Social Determinants of Health: The conditions under which people are born, grow, live, work, and age.[1]

Structural Determinants of Health Inequities: The social, economic, and political mechanisms which generate social class inequalities in society.[8]

Health Equity: "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."[9]

Health Disparities: "A type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability."[10]

Health Inequities: "A difference or disparity in health outcomes that is systematic, avoidable, and unjust."[10]

Health Inequities

The most prevalent and severe health inequities occur where there is poverty, systematic racism, and discrimination.[6] Some of the most common and well-researched health inequities are experienced between groups based on socioeconomic status, race and ethnicity, sexual orientation and gender expression, as well as geographic location.[11,12] Information is provided in the following sections to help characterize these health inequities. However, this is not intended to be comprehensive or cov all health inequities.

Socioeconomic Status

Socioeconomic status refers to the social and economic factors that influence the position individuals hold in society. This includes factors like occupation, class, education, income, and wealth.[11,12] Individuals with higher socioeconomic status consistently experience better health outcomes than those with lower socioeconomic status, and this occurs across a social gradient.[11] It is not just the very poor who are affected. Research has shown that:

- Nearly as many deaths are caused by social factors as by behavioral or pathophysiological factors.[13,14] One group of researchers found that in the year 2000, more than 244,000 deaths could be attributed to low education (less than some college education); more than 133,000 deaths could be attributed to individual poverty (household annual income of ≤$10,000); and more than 39,000 deaths could be attributed to area poverty (live in a county where ≥20% of the population lives below the poverty line).[13] 26

- The death rate in 2007 was more than 2.5 times greater for individuals without a high school diploma compared to those with at least some college, and the disparity had increased since 1989.[15]
- Income inequality is associated with greater health care expenditures, health care use,[16] and death from cardiovascular disease and suicide.[17]

Race, Ethnicity, and Discrimination

Race and ethnicity are associated with many indicators of health status, even after considering socioeconomic status, behavior, and other characteristics. Systematic, persistent, and long-felt discrimination is thought to be the main contributor.[11] Research has shown that:

- Life expectancy is consistently lower for non-Hispanic black individuals compared to non-Hispanic white and Hispanic individuals of the same sex (Figure 1).[18]
- The infant mortality rate is more than double among infants born to non-Hispanic black wom compared to infants born to non-Hispanic white and Hispanic women (Figure 2).[19]
- Typical drivers of infant mortality do not fully explain the variation. Research has shown that

1. The infant mortality rate is greater among infants born to non-Hispanic black women across age groups and all socioeconomic levels.[20]
2. The infant mortality rate is greater among infants born to non-Hispanic black women across educational levels, and the disparity increases for those with a master's degree or higher. In fact, the infant mortality rate is highest for black women with a doctorate or professional degree.[20]
3. The prevalence of alcohol use during pregnancy is roughly the same among non-Hispanic black and non-Hispanic white women, and non-Hispanic white women are more likely to smoke cigarettes.[20]

Sexual Orientation and Gender Expression

Lesbian, gay, bisexual, and transgender (LGBT) people also experience higher levels of discrimination, stigma, stress, and worse outcomes for a variety of health status indicators. Research has shown that:

- All-cause mortality rates were found to be greater among gay men compared to heterosexual men. However, this was driven almost entirely by differences in HIV-related mortality.[21]
- Current alcohol use was greater among gay and bisexual men compared to heterosexual men, as well as greater among lesbian women compared to heterosexual women.[22]
- Heavy drinking was also greater among lesbian and bisexual women compared to heterosexual women.[22]
- Current smoking was greater among gay men and lesbian women compared to heterosexual men and women.[22]
- Delaying health care due to cost was greater among gay and bisexual men and lesbian and bisexual women compared to heterosexual men and women.[22]
- LGBT individuals are more likely than cisgender or heterosexual people to experience violenc victimization, harassment, and discrimination.[23]

Neighborhood and Place

The physical features of an area can impact people's health. Physical features like air and water quality and climate, as well as housing, parks, and other recreation areas all play a part in physical activity and life expectancy.[11] Research has shown that:

- There is more than a 20-year gap in life expectancy between U.S. counties with the highest and lowest life expectancy and this gap has continued to grow since the 1980s.[24] Life expectancy gaps of up to 25 years have also been identified between different neighborhoods within the same city (Figure 3).[25]
- Improving features of the built environment, such as sidewalks and streetscapes, the density of parks, and recreational facilities have been shown to be associated with greater levels of physical activity in children and adults.[26]

How Social Factors Impact Health

Health equity scholars use a metaphor of a "stream" of causation to illustrate how social factors impact health. The "downstream" factors include issues that medicine and public health typically deal with—morbidity and mortality, access to health care, behavioral risk factors, and living conditions. The questions that arise from this illustration are why are so many people sick and why are there such great differences among groups? The answer lies in the "upstream" factors, which include governance, culture, and societal values. These, as well as economic, social, and public policies, are the factors that lead to long-held social inequities (Figure 4).[8,27] To understand how social factors impact health, it is important to understand how risk factors are shaped upstream, and how differences in living conditions and exposures are physically embodied by individuals.

Upstream Factors: The Structural Determinants of Health Inequities

The structural determinants of health inequities are the social, economic, and political mechanism which generate social class inequalities in society.[8] These are macro-level factors that impact larg numbers of people. Examples of structural determinants of health include the degree that government subsidizes health care or education; decisions about pollution, including minimum standards or where toxic substances are stored or released; and decisions about the built environment, which can benefit or harm communities. These all contribute to social class inequalities. Jim Crow laws and redlining are more specific examples. These laws and corporate policies legislated segregation, restricted access to good housing from black Americans, and reduced their ability to influence governmental decisions or live in a healthy neighborhood. This had a substantial negative impact on the health of black Americans. Data showed that life expectancy and infant mortality improved for black Americans after these policies were eliminated.[24,28]

Downstream Factors: Opportunities and Constraints to Health Promoting Resources

Social factors also influence health by providing or constraining opportunities for people to access resources that promote better health. Individuals with low socioeconomic status are less likely to be able to acquire health care, nutritious foods, good educational opportunities, safe housing, or safe spaces for exercise.[29] Negative health behaviors, like tobacco, alcohol, or explicit drug use are often pervasive in disadvantaged communities. These types of behaviors are then socially patterned in children, who have not fully developed their ability to make rational decisions.[30] These factors are shaped by more upstream factors.

Chronic Stress and Embodiment

The upstream and downstream factors shape the conditions under which people live. Differences in living conditions and opportunities to make healthy decisions result in differentials in exposures and chronic stress. Embodiment is "a concept referring to how we literally incorporate, biologically, the material and social world in which we live..."[31]Social factors are embodied as individuals are exposed to repeated and chronic stress.[32] The autonomic nervous system, the hypothalamic-pituitary-adre axis, and the cardiovascular, metabolic, and immune systems protect the body by responding to internal and external stress. Over time, chronic stress can increase the allostatic load, or the "wear and tear" that accumulates on the body over time. This "wear and tear" has health damaging effects.[32,33]Historically-disadvantaged groups have been found to experience greater allostatic loa more "wear and tear" than more advantaged groups.[34] Embodiment and allostatic load are though explain why social factors are linked with almost every measure of health status throughout time.[31,33]

Call to Action

The AAFP urges its members to become more informed about the impact SDoH have on health and health inequities, and to identify tangible next steps they can take to address their patients' SDoH and reduce health inequities within their scope. The AAFP also urges hospitals and health care systems to consider the SDoH in their strategic plans and to provide their staff, including family physicians, with opportunities to engage with and advocate on behalf of their community to advance health equity. In addition, the AAFP urges health insurers and payors to provide appropriate payment to support health care practices to identify, monitor, assess, and address SDoH.[35]Finally, since health inequities arise outside of the health care sector, the AAFP urges funders, including the federal

government, to provide sufficient funding to address the SDoH and reduce health inequities. In addition to other interventions, this includes robust financial support for the nation's public health infrastructure to support their efforts to facilitate cross-sector community collaboration, strategic planning for health, Health in All Policies, and the core public health functions.[36]

The Role of Family Physicians in Reducing Health Inequities

Family physicians can play an important role in addressing both the upstream and downstream SDoH. They provide high-quality health care for underserved populations more so than other medical specialties.[37] Family physicians can also work with their practice teams and community members to address SDoH in any of the following ways:

- Knowing how patients are affected by SDoH and helping address their needs to improve their health.
- Creating a practice culture that values health equity by addressing implicit bias in your practi and using cultural proficiency and health literacy standards.
- Understanding what health inequities exist within your community and helping raise the prominence of these issues among the public and policymakers.
- Knowing which organizations are working to improve health equity in your community and w your community's health agenda includes.
- Advocating for public policies that address SDoH and reduce health inequities.

The AAFP has created resources to assist family physicians and their health care teams at [The EveryONE Project Toolkit](#).

Policy Recommendations

The AAFP supports the following types of public policies for their ability to address SDoH and reduce health inequities.

- Access to Health Care: The AAFP recognizes that health is a basic human right for every person and that the right to health includes universal access to timely, acceptable, and affordable health care of appropriate quality.[38] All people of the world, regardless of social, economic, or political status, race, religion, gender, or sexual orientation should have access to essential

health care services.[39] The AAFP also urges its members to become involved personally in improving the health of people from minority and socioeconomically disadvantaged groups. The AAFP supports: (1) cooperation between family physicians and community health centers to expand access to care; (2) regulatory and payment policies that encourage the establishment and success of physician practices in underserved areas; (3) programs that encourage the provision of services by physicians and other health care professionals in underserved areas and that meet the unique health needs of those communities; and (4) public policies that expand access to care and address SDoH.[40]

- Health in All Policies: The AAFP supports adoption of a Health in All Policies strategy by all governing bodies at the local, state, and federal levels. Health in All Policies strategy aims to improve the policymaking process by incorporating health implications, evidence-based information, and community input. This is intended to help inform policymakers about how their decisions about laws, regulations, and policies will impact health and health equity.[41]
- Federal Nutrition Programs: The AAFP supports federal nutrition programs as a matter of pu health. Access to affordable and healthy food significantly affects an individual's health, education, and development.[42] Food access also supports medical treatment that requires patients to take medications with food. In 2015, more than 42 million people in the U.S. were living in food insecure households, including more than 13 million children.[43]
- Anti-Poverty Programs: The AAFP supports programs that lift people out of poverty and has issued the position paper, Poverty and Health – The Family Medicine Perspective.[44] Poverty h been defined as the inability to acquire goods and services that are viewed as necessary to participate in society and negatively affects almost every indicator of health status.[12,45] The poverty threshold in the U.S. was $12,752 for an individual under age 65 and $25,094 for a family of four in 2017,[46] with 12.3% of individuals in the U.S. considered living in poverty.[47] Examples of policies that are effective at lifting people out of poverty include: the earned income tax credit, Social Security, unemployment insurance, and rental assistance programs.[48,49]
- Support for the Homeless: The AAFP supports Housing First programs that offer rapid access to permanent, affordable housing integrated with health care and supportive services. Housing First is a model defined by the U.S. Department of Housing and Urban Development (HUD) as a method to "quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry..."

Preconditions and barriers can include, but are not limited to sobriety, treatment, or service participation requirements.[50] Housing impacts health care. Access to safe and affordable housing is a SDoH. Homelessness may exacerbate existing health conditions and lead to the development of new health conditions. Persons who are homeless frequently experience co-occurring severe physical, psychiatric, substance use, and social problems.[51] Health care services are more effective when a patient is housed, and maintaining housing is more likely when comprehensive primary health care services are available. Effective strategies to end homelessness must address this complexity of health conditions and disability faced by persons who are homeless.

- Civil Rights and Anti-Discrimination: The AAFP opposes all discrimination in any form, including, but not limited to, that on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus, or national origin.[52]
- Educational Achievement: The AAFP supports programs that improve equitable access to hi quality education and equitable educational achievement. Education is associated with man health behaviors, and therefore affect health status. Individuals with lower education are mo likely to smoke, have an unhealthy diet, and lack exercise.[53] They also have a lower life expectancy.[54] Despite this, school funding, teacher-to-pupil ratio, and other important indicat of educational quality are not distributed evenly by state and community.[55] All schools shoul have sufficient funding to meet the educational needs of its students and promote success. Special attention should be paid to inner city and rural schools that are often under-resourced and may need increased resources to meet their students' needs. Based on strong evidence showing improved educational, social, and health-related outcomes (especially in low-income or racial and ethnic minority communities) the AAFP supports funding for center-based early childhood education,[56] full-day kindergarten,[57] and out-of-school-time academic programs.[58] The AAFP also supports funding for grants, scholarships, and other means of financial support for low-income college students.
- Built Environment: The AAFP supports improvements to the built environment, such as designing walkable neighborhoods, complete streets, and mixed-use zoning as a means to improve community health.[59] The AAFP also supports equitable improvements to the built environment, with a special emphasis on disadvantaged communities, and community input

into these decisions to ensure that current residents are not displaced or otherwise negatively impacted.[60]

- Home Visitation Programs in Pregnancy and Early Childhood: The AAFP supports home visitation programs in pregnancy and early childhood where trained professionals visit families and provide information and training about health, development, and care of children. These programs offer families the necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.[61]
- Alternate Payment Models: The AAFP supports alternative payment models that ensure SDoH are appropriately accounted for in the payment and measurement design so that practices have adequate support to improve quality and outcomes for all patients, eliminate health disparities, and reduce costs for the health care system.[35]
- Medical Education: The AAFP supports education on SDoH and their impacts on health inequity to be integrated into all levels of medical education. Physicians should be knowledgeable about the impact of SDoH and have the ability to work with patients to address SDoH by tailoring treatment to address patients' barriers to better health.[62]

Conclusion

Social determinants of health have a substantial impact on the health of many Americans and are key driver of health inequities. Family physicians have an important role in addressing both upstre and downstream SDoH and reducing health inequities by providing high-quality health care for the underserved and advocating to raise the prominence of health inequities among the public and policymakers. The AAFP urges its members to work with their practice teams and community members to address SDoH and urges government, health care systems, and public health organizations to develop policies and practices that address SDoH to help reduce health inequities.

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(2019 April BOD)

STATE OF TEXAS
DEPARTMENT OF INFORMATION RESOURCES

CONTRACT FOR SERVICES

Accenture LLP

1. Introduction

A. Parties

This Contract for Services ("Contract") is entered into between the State of Texas ("State"), acting by and through the Department of Information Resources ("DIR") with its principal place of business at 300 West 15th Street, Suite 1300, Austin, Texas 78701, and Accenture LLP ("Vendor"), with its principal place of business at 1501 South Mopac Expressway, Suite 300, Austin, Texas 78746.

B. Compliance with Procurement Laws

This Contract is the result of compliance with applicable procurement laws of the State. DIR issued a solicitation on the Comptroller of Public Accounts' Electronic State Business Daily, Request for Offer (RFO) DIR-TSO-TMP-266, on February 2, 2017, for Cloud Services. Upon execution of this Contract, a notice of award for RFO DIR-TSO-TMP-266 shall be posted by DIR on the Electronic State Business Daily.

C. Order of Precedence

This Contract; Appendix A, Standard Terms and Conditions For Services Contracts; Appendix B, Vendor's Historically Underutilized Businesses Subcontracting Plan; Appendix C, Pricing Index; Appendix D, Statement of Work, Appendix E, ACP Services Agreement; Exhibit 1 Vendor's Response to RFO DIR-TSO-TMP-266, including all addenda; and Exhibit 2, RFO DIR-TSO-TMP-266, including all addenda; are incorporated by reference and constitute the entire agreement between DIR and Vendor. In the event of a conflict between the documents listed in this paragraph, the controlling document shall be this Contract, then Appendix A, then Appendix B, then Appendix C, then Appendix D, Appendix E, Exhibit 1, and finally Exhibit 2. In the event and to the extent any provisions contained in multiple documents address the same or substantially the same subject matter but do not actually conflict, the more recent provisions shall be deemed to have superseded earlier provisions.

2. Term of Contract

The initial term of this Contract shall be two (2) years commencing on the last date of approval by DIR and Vendor, with two (2) optional one-year renewal periods. Prior to expiration of each term, the contract will renew automatically under the same terms and conditions unless either party provides notice to the other party 60 days in advance of the renewal date stating that the party wishes to discuss modification of terms or not renew. Additionally, the parties by mutual agreement may extend the term for up to ninety (90) additional calendar days.

3. A. Service Offerings

Services available under this Contract are limited to Cloud Services and Related Services as specified in Appendix C, Pricing Index. Vendor may incorporate changes to their services offering; however, any changes must be within the scope of the RFO and services awarded based on the posting described in Section 1.B above. Vendor may not add services which were not included in the Vendor's response to the solicitation described in Section 1.B above.

B. Emerging Technologies and Future Acquisitions

DIR recognizes that technology is ever-evolving and advancing. DIR reserves the right to consider the addition of emerging technology such as next generation, enhancements and upgrades for services that are within the scope of Cloud Services. Vendor may propose such services throughout the term of the contract. Pricing and terms will be negotiated upon DIR acceptance. Any determination will be at DIR's sole discretion and any decision will be final. In addition, Texas DIR and Vendor may mutually agree to add future acquisitions of Vendor to the contract. Subsequent terms of the acquisition(s) and pricing will be mutually agreed upon in writing and amended under the contract.

4. Pricing

Pricing to the DIR Customer shall be as set forth in Appendix A, Section 7, Pricing, Purchase Orders, Invoices and Payment, and as set forth in Appendix C, Pricing Index and shall include the DIR Administrative Fee.

5. DIR Administrative Fee

A. The administrative fee to be paid by the Vendor to DIR based on the dollar value of all sales to Customers pursuant to this Contract is three-fourths of one percent (.75%). Payment will be calculated for all sales, net of returns and credits. For example, the administrative fee for sales totaling $100,000 shall be $750.00.

B. All prices quoted to Customers shall include the administrative fee. DIR reserves the right to change this fee upwards or downwards during the term of this Contract, upon written notice to Vendor without further requirement for a formal contract amendment. Any change in the administrative fee shall be incorporated by Vendor in the price to the Customer.

6. Notification

All notices under this Contract shall be sent to a party at the respective address indicated below.

<u>If sent to the State</u>:
Kelly A Parker, CTPM, CTCM
Director, Cooperative Contracts
Department of Information Resources
300 W. 15th St., Suite 1300
Austin, Texas 78701
Phone: (512) 475-1647
Facsimile: (512) 475-4759
Email: kelly.parker@dir.texas.gov

If sent to the Vendor:
Thomas Pettit
Sr. Managing Director
Accenture LLP
1501 S MoPac Expressway, Suite 300
Austin, TX 78746
Phone: (512) 732-5300
Facsimile: (512) 652-7246
Email: thomas.pettit@accenture.com

7. A. Statement of Work and Service Agreement

Services provided under this Contract shall be based on the Appendix D, Sample Statement of Work (SOW) and Appendix E, ACP Services Agreement to this Contract. Customers may negotiate the terms and conditions of a SOW to suit their business needs, so long as the negotiated terms and conditions do not diminish Vendor's commitments set forth in the Appendix D, Sample Statement of Work, Appendix E, ACP Services Agreement, or this Contract.

B. Conflicting or Additional Terms

In the event that conflicting or additional terms in Service Agreements or linked or supplemental documents amend or diminish the rights of DIR Customers or the State, such conflicting or additional terms shall not take precedence over the terms of this Contract.

In the event of a conflict, any linked documents may not take precedence over the printed or referenced documents comprising this contract; provided further that any update to such linked documents shall only apply to purchases or leases of the associated Vendor product or service offering after the effective date of the update; and, provided further, that, if Vendor has responded to a solicitation or request for pricing, no update of such linked documents on or after the initial date of Vendor's initial response shall apply to that purchase unless Vendor directly informs Customer of the update before the purchase is consummated.

In the event that different or additional terms or conditions would otherwise result from accessing a linked document, agreement to said linked document shall not be effective until reviewed and approved in writing by Customer's authorized signatory.

Vendor shall not [without prior written agreement from Customer's authorized signatory,] require any document that: 1) diminishes the rights, benefits, or protections of the Customer, or that alters the definitions, measurements, or method for determining any authorized rights, benefits, or protections of the Customer; or 2) imposes additional costs, burdens, or obligations upon Customer, or that alters the definitions, measurements, or method for determining any authorized costs, burdens, or obligations upon Customer.

If Vendor attempts to do any of the foregoing, the prohibited documents will be void and inapplicable to the contract between DIR and Vendor or Vendor and Customer, and Vendor will nonetheless be obligated to perform the contract without regard to the prohibited documents, unless Customer elects instead to terminate the contract, which in such case may be identified as a termination for cause against Vendor.

The foregoing requirements apply to all contracts, including, but not limited to, contracts between Customer and a reseller who attempts to pass through documents and obligations from its Manufacturer of Publisher.

C. Shrink/Click-wrap License Agreement
Regardless of any other provision or other license terms which may be issued by Vendor after the effective date of this Contract, and irrespective of whether any such provisions have been proposed prior to or after the issuance of a Purchase Order for products licensed under this Contract, or the fact that such other agreement may be affixed to or accompany software upon delivery (shrink-wrap), the terms and conditions set forth in this Contract shall supersede and govern the license terms between Customers and Vendor. It is the Customer's responsibility to read the Shrink/Click-wrap License Agreement and determine if the Customer accepts the license terms as amended by this Contract. If the Customer does not agree with the license terms, Customer shall be responsible for negotiating with the reseller to obtain additional changes in the Shrink/Click-wrap License Agreement language from the software publisher.

8. Authorized Exceptions to Appendix A, Standard Terms and Conditions dated September 29, 2017, for Service Contracts.

A. **Appendix A, Section 4, Intellectual Property Matters**, is hereby replaced in its entirety with the following:

Vendor is providing its commercially available services under the Contract. Unless expressly agreed to in writing, no custom work is authorized or payable under this Contract.

B. **Appendix A, Section 6. C.,** Services Warranty and Return Policies, is hereby replaced in its entirety with the following:

Vendor and Order Fulfiller will adhere to the Vendor's then-currently published policies concerning services warranties and returns. Such policies for Customers will not be materially more restrictive or more costly than warranty and return policies for other similarly situated Customers for the like services.

C. **Appendix A, Subparagraph 3 of Section 7. C., Customer Price,** is hereby replaced in its entirety with the following:

If during the term of this Contract, pricing for the same services available under this Contract is provided by the Vendor at a lower price to: (i) an eligible Customer who is not purchasing those services under this Contract or (ii) to any other similarly situated customer, in either case under the same terms and conditions provided for the State for the same commodities and services under this Contract, then the available Customer Price in this Contract shall be adjusted to that lower price. This requirement applies to services directly contracted by Vendor for a quantity of one (1) under like terms and conditions, and does not apply to volume or special pricing purchases. Vendor shall notify DIR within ten (10) business days and this Contract shall be amended to reflect the lower price.

D. **Appendix A, Section 9A. 2., Acts or Omissions**, is hereby replaced in its entirety with the following:

Vendor shall indemnify and hold harmless the State of Texas and Customers, AND/OR THEIR OFFICERS, AGENTS, EMPLOYEES, REPRESENTATIVES, CONTRACTORS, ASSIGNEES, AND/OR DESIGNEES FROM ANY AND ALL THIRD PARTY LIABILITY, ACTIONS, CLAIMS, DEMANDS, OR SUITS, FOR PERSONAL INJURY, DEATH, DAMAGE TO REAL OR TANGIBLE PERSONAL PROPERTY, OR ASSOCIATED ECONOMIC LOSS AND ALL RELATED COSTS, ATTORNEY FEES, AND EXPENSES arising out of, or resulting from any acts or omissions of the Vendor or its agents, employees, subcontractors, Order Fulfillers, or suppliers of subcontractors in the execution or performance of the Contract and any Purchase Orders issued under the Contract; provided however Vendor's liability for this indemnity shall not exceed in the aggregate five (5) million dollars under the Contract. THE DEFENSE SHALL BE COORDINATED BY VENDOR WITH THE OFFICE OF THE ATTORNEY GENERAL WHEN TEXAS STATE AGENCIES ARE NAMED DEFENDANTS IN ANY LAWSUIT AND VENDOR MAY NOT AGREE TO ANY SETTLEMENT WITHOUT FIRST OBTAINING THE CONCURRENCE FROM THE OFFICE OF THE ATTORNEY GENERAL. VENDOR AND THE CUSTOMER AGREE TO FURNISH TIMELY WRITTEN NOTICE TO EACH OTHER OF ANY SUCH CLAIM.

E. **Appendix A, Section 9 A. 3., Infringements, Subparagraphs (b) and (c)** are hereby replaced in their entirety with the following:

b) Vendor shall have no liability under this section if the alleged infringement is caused in whole or in part by: (i) use of the product or service for a purpose or in a manner for which the product or service was not designed, (ii) any modification or unauthorized use of ACP Services made to the product without Vendor's written approval, (iii) any modifications made to the product by the Vendor pursuant to Customer's specific instructions, (iv) any intellectual property right owned by or licensed to Customer, (v) solely by Customer data, (vi) an adjudicated claim of willful infringement directed at anyone other than Vendor and its affiliates, (vii) a combination of the ACP Services with any other product, service, software, content, data or method not supplied by Vendor which is not required for the functionality of the ACP Services; or a no fee or trial license of the ACP Services, or (viii) any use of the product or service by Customer that is not in conformity with the terms of any applicable license agreement.

c) If Vendor becomes aware of an actual or potential claim, or Customer provides Vendor with notice of an actual or potential claim, Vendor may (or in the case of an injunction against Customer, shall), at Vendor's sole option and expense: (i) procure for the Customer the right to continue to use the affected portion of the product or service, or (ii) modify or replace the affected portion of the product or service with functionally equivalent or superior product or service so that Customer's use is non-infringing. Exclusive remedy. This Section 9 constitutes Customer's sole and exclusive remedy and Vendor's (and its affiliates') entire obligation to Customer with respect to any claim that the ACP Service(s) infringes or misappropriates the intellectual property rights of any third party.

F. **Appendix A, Section 9 I., Security of Premises, Equipment, Data, and Personnel**, is hereby replaced in its entirety with the following:

Vendor and/or Order Fulfiller may, from time to time during the performance of the Contract, have access to the personnel, premises, equipment, and other property, including data, files and /or materials (collectively referred to as "Data") belonging to the Customer. Vendor shall use their best efforts to preserve the safety, security, and the integrity of the personnel, premises, equipment, Data and other property of the Customer, in accordance with the instruction of the Customer. Vendor shall be responsible for damage to Customer's equipment, workplace, and its contents when such damage is caused by its employees or subcontractors working onsite. If a Vendor fails to comply with Customer's security requirements, then Customer may immediately terminate its Purchase Order and related Service Agreement. Cloud vendor's security obligations will be specified in the Appendix E (ACP Services Agreement) and each applicable Service Order.

G. **Appendix A, Section 9. J., Background and/or Criminal History Investigation**, is hereby replaced in its entirety with the following:

Prior to commencement of any services, background and/or criminal history investigation of the Vendor's employees and subcontractors who will be providing services to the Customer under the Contract may be performed by the Customer as agreed to by Vendor and Customer in Purchase Order or SOW. Should any such employee or subcontractor of the Vendor who will be providing services to the Customer under the Contract not be acceptable to the Customer as a result of the background and/or criminal history check, then Customer may immediately terminate its Purchase Order and related Service Agreement or request replacement of the employee or subcontractor in question.

H. **Appendix A, Section 9. K., Limitation of Liability,** is hereby replaced in its entirety with the following:

For any claim or cause of action arising under or related to the Contract:

i) to the extent permitted by the Constitution and the laws of the State, none of the parties shall be liable to the other for punitive, special, or consequential damages, even if it is advised of the possibility of such damages; and

ii) Vendor's liability for damages of any kind to the Customer shall be limited to the total amount paid to Vendor under the Contract during the twelve months immediately preceding the accrual of the claim or cause of action, or for claims subject to Section 9.A.(2) hereof five million dollars. However, this limitation of Vendor's liability shall not apply to third party claims of bodily injury due to tortious negligence; violation of intellectual property rights including but not limited to patent, trademark, or copyright infringement; indemnification requirements under this Contract (except as otherwise provided in Section 9.A.(2) hereof) ; and violation of State or Federal law including but not limited to disclosures of confidential information and any penalty of any kind lawfully assessed as a result of such violation.

I. **Appendix A, Section 9. X., Disclaimer of Implied Warranties**, is hereby added as follows:

In addition any warranties provided in a SOW or Service Agreement, Vendor warrants that all goods it provides will conform to contract specifications and requirements and applicable industry and professional standards; and that it will perform all work in a good and workmanlike manner, conforming to contract specifications and requirements and applicable industry and professional standards. EXCEPT AS EXPRESSLY PROVIDED IN THE APPLICABLE SOW OR THIS CONTRACT, VENDOR, ITS AFFILIATES AND ITS LICENSORS MAKE NO REPRESENTATIONS AND PROVIDE NO WARRANTIES OF ANY KIND, WHETHER EXPRESS, IMPLIED, STATUTORY OR OTHERWISE REGARDING THE SERVICES, WORK PRODUCT, ACP SERVICES OR ANY THE THIRD PARTY COMPONENTS OR CONTENT EMBODIED THEREIN, INCLUDING ANY WARRANTY THAT THE ACP SERVICES WILL BE UNINTERRUPTED, ERROR FREE, OR FREE OF HARMFUL COMPONENTS, OR THAT ANY CONTENT, INCLUDING CUSTOMER DATA OR THIRD PARTY COMPONENTS OR CONTENT, WILL BE SECURE OR NOT OTHERWISE LOST OR DAMAGED, AND INCLUDING ANY IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, OR, AND ANY WARRANTIES ARISING OUT OF ANY COURSE OF DEALING OR USAGE OF TRADE. EACH PARTY, ITS AFFILIATES AND ITS LICENSORS DISCLAIM ALL, AND THE OTHER PARTY AGREES THAT IT IS NOT ENTITLED TO, ANY EQUITABLE OR IMPLIED INDEMNITIES. THESE DISCLAIMERS SHALL ONLY APPLY TO THE EXTENT PERMITTED BY APPLICABLE LAW. VENDOR, ON BEHALF OF ITSELF AND ITS SUPPLIERS, SPECIFICALLY DISCLAIMS ANY EXPRESS OR IMPLIED WARRANTY OF FITNESS OF THE ACP SERVICES FOR HIGH RISK ACTIVITIES.

J. **Appendix A, Section 10. C., Force Majeure,** is hereby replaced in its entirety with the following:

DIR, Customer, or Vendor may be excused from performance under the Contract for any period when performance is prevented as the result of an act of God, strike, war, civil disturbance, epidemic, or court order, provided that the party experiencing the event of Force Majeure has prudently and promptly acted to take commercially reasonable steps that are within the party's control to continue performance and to shorten the duration of the event of Force Majeure. The party suffering an event of Force Majeure shall provide notice of the event to the other parties when commercially reasonable. Subject to this provision, such non-performance shall not be deemed a default or a ground for termination. However, a Customer may terminate a Purchase Order for convenience if it is determined by the Customer that Vendor will not be able to deliver services in a timely manner to meet the business needs of the Customer.

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This Contract is executed to be effective as of the date of last signature.

Accenture LLP

Authorized By: Signature on File

Name: Jon Andrews

Title: Managing Director

Date: 2/11/2019

The State of Texas, acting by and through the Department of Information Resources

Authorized By: Signature on File

Name: Hershel Becker

Title: Chief Procurement Officer

Date: 2/21/2019

Office of General Counsel: Signature on File 2/19/2019

THIS SCOPE OF WORK IS UNDER LEGAL REVIEW AND WILL BE DISTRIBUTED PRIOR TO THE BOARD MEETING.

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Nueces County

Comprehensive Behavioral Health Community Needs Assessment

Final Report

SEPTEMBER 2020

MEADOWS
MENTAL HEALTH
POLICY INSTITUTE

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The Meadows Mental Health Policy Institute (MMHPI) is grateful to the Nueces County Hospital District for its financial support of this work, and the Nueces County Commissioners Court for its support and commitment to improving mental health care in Nueces County. We are especially grateful to Nueces County Judge Barbara Canales, who is a tenacious local champion for transforming the Nueces mental health system and who initiated this assessment, and Dr. Jonny Hipp, Nueces County Hospital District Chief Executive Officer and Administrator, for his guidance during our work. We are also grateful to the nearly 200 people we interviewed either individually or in groups, including two focus groups with officers from the Corpus Christi Police Department and deputies from the Nueces County Sheriff's Office. A complete list of people we interviewed is provided in Appendix A. Appendix B includes a list of the questions we used when conducting interviews.

Executive Summary

In this Executive Summary, we highlight key findings and recommendations from our assessment. This final report integrates community feedback on the initial draft report submitted on June 13, 2020. We presented the draft report to the Commissioners Court and the Nueces County Hospital District (NCHD) Board of Managers and received written comments as well. This final report also contains additional information not provided in the draft report, but does not change substantive recommendations in any material way. A table with recommendations and suggested timelines for initial steps for implementation is provided in Appendix G.

In addition to the data analysis described in the report, we interviewed nearly 200 leaders and other community members in the course of our assessment. These included stakeholders from the criminal justice and health systems; mental health providers; eight local schools, including independent school districts, charter schools, and Catholic schools; philanthropic organizations; multiple divisions within Texas A&M University–Corpus Christi (TAMU-CC); people with lived experience of mental illness; the court system; the juvenile justice system; the child welfare system; and county elected officials and appointed officials, including every member of the Commissioners Court and every member of NCHD. In every case, we found people to be forthcoming about both gaps and opportunities to improve mental health care in Nueces County.

Organization of the Report and Key Recommendations in Summary Form

This Executive Summary is designed to provide the reader with a succinct overview of our key recommendations. Our guiding principle is that the traditional approach of treating the mind and body separately has led to inadequate and often inappropriate care for people with mental illnesses; an overuse of jails, emergency departments, and hospital beds; and a treatment approach to adults with serious mental illnesses and children and youth with serious emotional disturbances that stands in sharp contrast to the integrated care provided people with complex physical health needs. Care for mental illness should be the same as care for physical illness unless clinical needs or public safety warrants a specialty approach, with integration of care the norm and not simply a goal. In Nueces County, as in communities throughout Texas, care remains fragmented, but we provide strategies throughout our report that can lead to integrated care.

We begin with a discussion of Nueces County's advantages, particularly in its elected and appointed officials, and important contextual factors shaping the future of mental health care in the county. Then, to understand the size of the population in need, we provide prevalence figures and comments regarding opportunities to target the relatively small population of people in Nueces County who require the most intensive services, while noting that most

persons in Nueces can be treated in primary care settings. We then provide an analysis of hospital inpatient capacity, as this was the most immediate issue facing NCHD during our assessment. We follow that analysis with recommendations for crisis services across the spectrum, and then discuss gaps in care and strategies to improve access to care. A section on financing follows and we conclude with recommendations for overseeing the implementation of these recommendations in the future.

In the rest of this Executive Summary, we highlight key recommendations in each of these core areas.

Critical Advantages and Contextual Factors in Nueces County

Nueces County is at a critical juncture in mental health care for Nueces County residents. Because of the leadership of its elected officials, there is a unique opportunity in which the county can take major steps to begin the transformation of the Nueces mental health system. COVID-19 and its impact on the health system, and on the mental health of county residents, adds to the urgency of taking advantage of this opportunity. To do so will require a commitment to treating mental illness like a physical illness. The segregated approach to mental health care, still common in most communities, is best illustrated in Nueces County by the soon-to-be-ended provision of inpatient psychiatric care at a hospital building with few other services; the commitment to change is illustrated by the fact that this is not a permanent site and that these beds will be replaced with new inpatient beds that presumably will be located at a facility where complex care needs, including both physical and mental health, can be addressed.

This report is designed to a provide a framework for county leaders to take concrete steps to begin this transformation. We strongly believe that the best mental health care is provided in an integrated health care system and that, as with all illnesses, the earlier we can identify and treat mental illness, the better. This will require major changes in the response to mental health crises by expanding and, in some cases, creating services that evidence shows can reduce hospitalizations and jail bookings, and it requires continuing leadership by elected and appointed officials. Clinical leadership is essential in causing this transformation to occur, but it is not enough without the attention of elected and appointed officials.

Although Nueces County has significant gaps in treatment capacity (discussed in detail in the report), it also has critical advantages that create the opportunity for rapid improvement. These advantages include the following:

- There is strong political leadership from the Nueces County Commissioners Court and Nueces County Court Judge Barbara Canales.

- NCHD recognizes that mental health care is a major issue and it has responded with great attention to the emerging changes in how inpatient psychiatric care will be provided, with CHRISTUS Spohn bringing in a new care provider.
- For the first time, Nueces Center for Mental Health and Intellectual Disabilities (NCMHID) has received funding to purchase private psychiatric beds in the community. NCMHID can now purchase 531 bed days not to exceed $371,500 annually for Nueces County adults, children, and youth. This will enhance the ability of the Nueces County mental health service delivery system to treat people who require inpatient care locally, a factor that should, over time, reduce the overall need for funding for inpatient capacity because of better and more continuous care near family and local resources.
- Resources such as the University of Texas Rio Grande Valley (UTRGV) have been underutilized, but can play a major role in advancing integrated care, particularly for children and youth, through initiatives such as Texas Child Health Access Through Telemedicine (TCHATT) program and the Child Psychiatry Access Network (CPAN) created by the Texas Legislature during the 86th Regular Session in 2019.
- Driscoll Children's Hospital, while it does not provide inpatient psychiatric care, has hired additional child psychiatrists, a child psychologist, and a developmental pediatrician to increase its behavioral health staff, and has also begun depression screening in its clinics that focus on disorders that increase the likelihood of chronic pain. Driscoll potentially could become an increasingly important resource to the community in behavioral health because of these investments.
- Prevalence data illustrate that most Nueces County residents who need mental health care can be treated in primary care settings and that those *most* in need of specialty care (people with first episode psychosis, those who would benefit from intensive services such as Assertive Community Treatment, and others with the most pressing needs) constitute a small enough population that relatively modest investments can have enormous payoffs in better care in the community and reduced use of hospitals and jails to address their needs.

As Nueces County moves forward, there are two critical decisions that will shape mental health care in the county for years to come:

- Whether NCHD (or the county) will expand funding of mental health care in Nueces County beyond those receiving care through the indigent care program. The narrow but critical question of which provider will provide inpatient and related care appears to have been resolved by the recent commitment of CHRISTUS Spohn to maintain services at the current level, through a new subcontractor. The broader question is whether the county will extend its commitment beyond those who are eligible for care under the indigent health care program and, if so, how that expansion will be funded.

The need to address changes that are coming to the availability of the 1115 Transformation Waiver Delivery System Reform Incentive Payment (DSRIP) program funding, which will require Nueces County and participating providers to think creatively – and in an integrated manner – about how Nueces County uses all sources of available behavioral health funding, consider alternative sources for funding to replace reductions in DSRIP funding, and determine whether and how to make up potential gaps in funding, as DSRIP in its current formulation ends in September 2021.

None of this occurs in a vacuum. Until recently no one anticipated the loss of revenue associated with the economic impact from coronavirus disease 2019 (COVID-19). As we note in this report, the impact of the economic shutdown and social isolation on behavioral health needs will be immense, not only in the immediate future but also 18 to 24 months from now and so we have tried to provide recommendations that can be taken in the short run without significant fiscal cost.

Our recommendations can be summed up in these terms:

- Integrated rather than segregated treatment of mental health needs should be the primary goal at every point in the treatment process.
- Nueces County currently has enough licensed psychiatric inpatient capacity between CHRISTUS Spohn and Bayview to meet the needs of Nueces County residents; it will be important to assure the location of replacement/new beds in a facility that can best meet the needs of persons with complex mental health and health conditions. The question of assuring adequate payment mix to ensure the beds are financially viable is a critical question. As noted below, a significant number of patients with commercial insurance are often transferred out of Nueces County; providing treatment to those patients in beds within the county may be part of the answer to the financial viability question.
- Focusing on best practices described in the report and taking advantage of new opportunities presented by the Texas Legislature, particularly in treating children and youth, will pay dividends.
- The best leadership especially in the near term must come from elected and appointed officials with a vision for system transformation and responsibility for funding and oversight.

Prevalence of Mental Illnesses and Emotional Disorders

Recommendation: Prevalence data suggest that Nueces County should emphasize the development of interventions that target the comparatively small number of people with the most intensive needs while emphasizing the use of primary care to treat the majority of people with mental illnesses.

We estimated that approximately 25,000 children and youth in Nueces County have mental health needs (Table 2) and that approximately 15,000 children and youth (or 60%) can be treated in an integrated primary care setting (Table 17). Of those with mental health needs, we estimate that 5,000 children and youth in Nueces County have a serious emotional disturbance (SED) many of whom, but not all, will require care in the specialty behavioral health system. We estimate that approximately 65,000 adults have mental health needs (Table 3) and, of those, approximately 10,000 adults have a serious mental illness (Table 3. We further estimate that among adults with mental health needs, the vast majority (50,000, or 77%) can be treated in integrated care settings (Table 21).

More than half of children and youth with SED and adults with serious mental illnesses (SMI) live in poverty, which complicates access to health care. The Nueces County population is projected to continue to grow among children and youth (26% increase from 2020 to 2050), adults ages 18 to 64 (34%), and especially older adults ages 65 and older (45% projected growth) (Tables 7 and 8). As in all Texas communities, people with mental illnesses have significant co-morbidity with substance use disorders and with complex physical health issues (Tables 4 through 6). This illustrates why it is critical to create services that can treat the whole person, rather than segregating the treatment of mental illnesses and physical illnesses.

Although the overall size of a population in need can be daunting, and Nueces County has large service gaps, our prevalence analysis also showed that relatively few people require the most intensive services. Fortunately, there are evidence-based interventions that can have a significant impact on these cohorts. For example, there are fewer than one dozen children and youth (out of 25,000 with mental health needs) and approximately 30 adults (out of 65,000 with mental health needs) who experience first-episode psychosis each year (Tables 2 and 3). Establishment of a first-episode psychosis program (discussed in the Recommendations for Investment in Children and Youth Care) would result in better lives for these individuals and their families and would relieve Nueces County of the costs that accrue over time as a result of untreated psychosis. Similarly, there are approximately 100 adults in Nueces County that require Assertive Community Treatment (ACT), an intervention that reduces hospital use when done well, and approximately the same number who require Forensic ACT (FACT), a justice-focused version of ACT that reduces jail bookings (Table 3). As discussed in detail in the Access to Care section, these evidence-based approaches to care, which focus on people with the most

intensive needs, can pay dividends across the various systems that otherwise bear the brunt of discontinuous or unavailable care.

Hospital Bed Capacity

Recommendation: The current number of beds licensed to provide inpatient psychiatric care in Nueces County is sufficient, given current use and lengths of stay, to meet the needs of Nueces County residents. However, the provision of inpatient psychiatric care at the old hospital campus location will fortunately be ending, and NCHD has an opportunity, if it chooses to use its contractual relationship with the CHRISTUS Spohn system, to invest in psychiatric inpatient capacity that is part of, or contiguous with, a hospital with the means to provide the full range of services required by people with SMI, including substance use disorders and complex physical health conditions.

A core service and financial issue is the provision of inpatient psychiatric care in Nueces County, particularly care that is financed through NCHD. There is a consensus that the current situation, in which the 7th floor of the otherwise closed and abandoned Memorial Hospital continues to be used for inpatient psychiatric care, is untenable; though this issue will necessarily be resolved when pursuant to existing agreements the hospital is torn down no later than 2023. In addition, CHRISTUS Spohn has given notice of its intent to sever its relationship with Care Integrated Behavioral Health (CIBH) as its behavioral health provider, and its commitment to contract with a new provider of services (Ocean Healthcare). The CHRISTUS and Ocean Healthcare commitment is not dissimilar from a May 20, 202 NCHD proposal to create no fewer than 33 beds with various services including critical components such as an assessment and evaluation center, an adult crisis unit, an adult stabilization unit, a child and adolescent unit, a neuro-geropsychiatric unit, as well as an outpatient unit.

According to American Hospital Association (AHA) data generated by hospital reports of licensed inpatient bed capacity, there are currently 88 licensed inpatient psychiatric beds in Nueces County (56 in Bayview Behavioral Hospital, including 24 beds for children and 32 for adults, and another 32 adult beds at CHRISTUS Spohn).[1]

As our analyses illustrate, the beds currently available in Nueces County typically operate at less than 80% capacity (Table 14) with a one- to six-day length of stay for the majority of patients at both hospitals (Figures 5 and 6). In 2018, 4,069 people were admitted to inpatient psychiatric beds in Nueces County hospitals (3,029 were Nueces County residents and 1,039 were non-residents while another 468 people from Nueces County were admitted to inpatient beds in

[1] Input from interviews we conducted suggested that Bayview Behavioral Hospital (Bayview) operates 61 beds and CHRISTUS Spohn operates 30 for a total of 91 beds (versus 88); however, we relied on the AHA data for our analyses. In any event, the difference is minimal and did not affect our analysis in any material respect.

other counties (Table 12, Table 15). Although there is no formula for determining precisely how many inpatient beds a particular area requires, and many other factors (including available outpatient capacity and crisis response) affect that number, our analysis of admission patterns and lengths of stay concluded that based on historic bed use, including admissions and typical length of stay, the current inpatient capacity at Bayview and CHRISTUS Spohn is sufficient. For example, we were told by some stakeholders that 60 additional psychiatric beds were needed in Nueces County. Adding 60 **additional** beds (as an example) to the inpatient beds operated by CHRISTUS Spohn and Bayview would give Nueces 116 inpatient beds in an environment in which the current 88 licensed beds typically run at less than 80% capacity. In fact, our analyses suggest that maintaining the current number of licensed beds, allocating them appropriately to meet adult and older adult needs, and placing them in a modern setting where access to physical health care and an enhanced outpatient system is readily available, would provide Nueces County with sufficient beds when combined with Bayview's existing capacity for child and adult inpatient care. A single exception in capacity is for children under 12 years of age. While Bayview will admit children on a case-by-case basis, admission decisions include factors other than available beds (e.g. the child's developmental needs, appropriateness with current census). CHRISTUS Spohn, as it creates new inpatient capacity, may use this as an opportunity to expand its capacity to treat this population locally.

Finally, many people admitted for inpatient psychiatric care have complex health conditions, and many people admitted to Nueces County emergency rooms for primary care have secondary psychiatric or substance use disorders (Table 6). This range of need means that to provide integrated care, any new inpatient capacity must have a full array of diagnostic and treatment modalities readily available to identify and treat complex health conditions, including substance use disorders. Co-morbid psychiatric and health conditions require disease management that integrates health, behavioral health, and inpatient and outpatient care. To simply focus on creating inpatient psychiatric care capacity without considering these other factors only continues the legacy of treating the brain and body separately and creates discontinuity of care for both.

Crisis Response

Recommendation: We recommend the creation of an integrated, medically-facing crisis response system that emphasizes medical and mental health response as its key components and includes critical services such as crisis stabilization either through NCMHID or other providers. Although there are elements of crisis response in Nueces County, the response to mental health crises relies heavily on law enforcement and there needs to be more integration of the responses by law enforcement and the NCMHID. In addition, NCMHID lacks critical components of crisis services in its service array.

Because of service gaps, discontinuous care, and the fact that most communities rely too heavily on law enforcement to address mental health crises, the most immediate way to begin restructuring a community's response to mental illness is by focusing on the crisis system. In its current form, crisis response in Nueces County has several critical shortcomings and inefficiencies. Both NCMHID and law enforcement in Nueces County provide responses to mental health crises. For example, NCMHID operates the county's only mobile crisis outreach team (MCOT), which relies heavily on support from a contractor for after-hour services. NCMHID also supports the Crisis Intervention Teams of the Corpus Christi Police Department and Nueces County Sheriff's Office. Although there is some cooperation between these two crisis response efforts, as pointed out both in this report and in a preliminary report we submitted on December 17, 2020, those responses are not truly integrated. In addition, many people we interviewed said they were unaware of NCMHID's crisis capacity and we also learned that MCOT responders do not receive specialized training on the unique needs of children and youth in crisis and their families.

We make several recommendations in our report for developing a more integrated and readily available response to mental health crises for adults, children and youth and veterans in Nueces County. These recommendations include transforming crisis response to a more medically-facing response, consistent with the manner in which we approach crises involving other medical conditions, as well as adding to the current crisis services offered by NCMHID. A failure to address crisis response will result in continued reliance on hospital emergency departments and the jail as the providers of first rather than last resort; therefore, we highly recommend that Nueces County leadership make the transformation of crisis services one of its first order of business.

Access to Care

Recommendation: Nueces County should invest in specific, evidence-based interventions that will enable the early identification of serious mental illness and enable people to live in their communities; create tools to integrate primary health and mental health care, something of particular importance to children and youth; focus on where veterans receive mental health care outside the U.S. Department of Veterans Affairs; and create jail transition programs.

Access to care includes, but should not be limited to, consideration of inpatient capacity. Too often, inpatient capacity is treated as an independent item unrelated to what occurs in the community. This rests in part on a historically limited view of mental illness as either requiring a law enforcement response (because of a conflation of mental illness and dangerousness) or hospitalization (because of an assumption that serious mental illnesses can only be treated in inpatient settings). In addition, access to care can be impeded by socio-economic status, including a lack of insurance or other reimbursement for care, as well as gaps in service capacity, all factors that have an impact on access to care in Nueces County.

We treat the issue of inpatient hospitalization capacity separately, but there are other important ways that access to care can be improved for Nueces County residents.

First, we recommend investment in evidence-based interventions designed to get the most return on investment for those comparatively small number of people who require care in the specialty behavioral health care system. For adults, that involves creating additional capacity to meet the needs of people who would benefit from, but do not currently receive, ACT or FACT. Of the approximately 100 adults who would benefit from ACT (Table 3), only 39 received the service (Table 23) and there is currently no FACT program in Nueces County. We also estimate that approximately 10,000 adults in Nueces County may require care in specialty behavioral health settings, with 7,000 of those individuals living in poverty. Of those in poverty, only 40% (or 2,721) received some level of service (Tables 21 and 22). For children and youth, we recommend implementation of programs created by the Texas Legislature in its 86th Regular Session in 2019. Specifically, the 86th Legislature provided a critical tool for providing psychiatric consultation to primary pediatric offices (where most children receive care) through Senate Bill (SB) 11. SB 11 created the Texas Child Mental Health Care Consortium, which is charged with overseeing five key initiatives, most notably the Child Psychiatry Access Network (CPAN). CPAN provides free psychiatric consultation for pediatric primary care providers and can be an enormous source for better care for children and youth in Nueces County. In addition, Nueces County can take advantage of the Texas Child Access Through Telemedicine (TCHATT) program, also established by SB 11, which provides schools with access to telehealth consultations for behavioral health issues; this would fill an important gap for Nueces County school children.

There is also a large veterans' community in Nueces County (Table 24), with over 25,000 veterans, including more than 9,000 veteran families. These individuals and families face significant barriers to care, problems exacerbated by the fact that Nueces County is covered by the only U.S. Department of Veteran Affairs (VA) health care system in Texas (VA Texas Valley Coastal Bend Health Care System) without its own hospital. As a result, veterans must either negotiate access to care in the health systems in Nueces County (which is reportedly difficult) or travel to VA facilities in San Antonio or Temple for care, disrupting family life and continuity

of care as a result. We recommend that health care providers, funders, and elected officials specifically focus on creating a plan to ease barriers to accessing care for veterans and their families, beginning with a unified strategy for identifying and gathering data on veterans who access care in non-VA health systems in Nueces County. Understanding where and why veterans are accessing, or unable to access, community mental health resources outside of the VA is a critical first step to successfully addressing barriers to care.

Finally, for people involved in the criminal justice system, we recommend a focus on creating jail transition programs that make accessing care in the community easier after release from jail. This is a major service gap in Nueces County that is also implicated in repeated incarceration as untreated mental health conditions can result in behavior that elicits a law enforcement response.

Financing of Care

Recommendation: As the Regional Healthcare Partnership (RHP) 4 Anchor, NCHD could facilitate discussions with providers who are participating in the Nueces County DSRIP program regarding a contingency planning process to determine the DSRIP activities that will continue when funding is no longer available, and identify potential funding sources, strategies to create cross-county quality health outcomes, and collaboration opportunities among the DSRIP providers.

NCHD was designated by the Texas Health and Human Services Commission as the RHP 4 Anchor. Its responsibilities include facilitating learning opportunities for DSRIP providers and providing technical assistance related to DSRIP reporting requirements specific to the providers' achievement metrics and the primary contact for HHSC as it relates to the DSRIP program. Each provider selects their own achievement measures from a list of approved measures prescribed by HHSC. NCHD has no authority to mandate a provider to select a specific measure. Funding for the DSRIP program ceases in September 2021, along with the anchor responsibilities. Providers will be required to submit their final DSRIP reporting no later than September 2022.

With that said, as the RHP 4 Anchor, NCHD can lead the planning for this new world. Planning now would allow elected officials to fully understand the impact of this decrease in revenue on the health care system, including behavioral health care, if Texas does not come to an agreement with the federal government for a DSRIP replacement program. Although our report is specific to behavioral health, all providers should be included as significant reductions in health care services will impact people with and without mental health conditions.

In 2011, the federal government approved Texas' 1115 Transformation Waiver. This has been a major funding mechanism for mental health programs in Nueces County (Tables 25, 26) and localities across Texas. Waiver funds support two objectives: (1) uncompensated care payments

are designed to help offset the costs of uncompensated care; and (2) DSRIP payments "are incentive payments to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served."[2]

Throughout the 1115 Transformation Waiver's lifespan (from 2011 through 2021), the DSRIP value to the 18 counties in the Coastal Bend region of RHP 4 has been over $937 million. Of that, more than $735 million has been allocated to providers located in Nueces County.[3] To date, NCMHID has earned $29,209,552, with an additional $10,362,652 available in the remaining reporting cycles of the waiver.[4] For fiscal year (FY) 2019, this represented 18% of NCMHID's overall budget. However, the current DSRIP funding is slated to end in September 2021 and although the state is considering various alternatives to replace this funding, there are no firm plans in place to do so. As a result, counties such as Nueces County need to consider whether and how such funding might be replaced. For NCMHID, this loss equates to being unable to provide one fifth of the services throughout the center, including mental health programs for adults and youth, and programs serving people with developmental and intellectual disabilities. The loss includes funding cuts for indirect costs such as safety, risk management, training, information technology, support staff, and office space. In short, with the loss of DSRIP funding, NCMHID will not be able to deliver services as they are being delivered today.

In addition, CHRISTUS Spohn corporate member revenue is the major funding source (65%) supporting NCHD and those funds, along with tax levies, are used to fund the intergovernmental transfers for the 1115 waiver, other Medicaid programs, and programs such as jail health and mental health services. These programs provide financial support to Nueces County, CHRISTUS Spohn, and other hospitals and providers in Nueces County. However, under Texas Health & Safety Code § 281.094(a), the NCHD may only use funding sources other than tax levies to fund health care services, including mental health services, for people who do not qualify for the county indigent health care program. Major reductions in available DSRIP funding will have a negative impact on funding available in Nueces County for mental health services. Although NCHD currently has available cash reserves and enjoys the authority to issue bonds, decisions to potentially expand the county commitment to fund mental health care is limited to funding sources other than tax levies (e.g., through cash reserves or new bonds) and is a major decision that will drive mental health care in Nueces County for decades. As NCHD

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[2] Texas Health and Human Services. (n.d.). *Waiver overview and background resources*. https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-overview-background-resources

[3] RHP 4 providers located in Nueces County are Corpus Christi Medical Center, Spohn Health System, Nueces County Public Health District, Driscoll Children's Hospital, and NCMHID.

[4] RHP 4 Coastal Bend. (2019, November 20). *DY 9 RHP plan updated*. https://www.nchdcc.org/pdf/RHP-4-DY-9-Plan-Update-FINAL-Provider-Public_Mtgs-2019.11.20.pdf

engages in contingency planning for the county, the potential impact of DSRIP reductions should be considered in the Board's long-term financial planning.

Given the complexities of changes to DSRIP funding and decisions regarding inpatient psychiatric care, we recommend that these financing issues be considered as a single set of issues. If programs that currently keep people out of the hospital disappear, if their funding is severely reduced, or if their programming is not expanded to meet need if funding stays intact, the result will be a significant impact on bed capacity. Conversely, if new beds are financed and constructed without reference to the impact of changes in funding on community programs, Nueces County elected and appointed leadership may be saddled with unnecessary costs for decades to come because of overbuilt inpatient capacity that requires continuous maintenance and support.

Leadership for Change and Transformation

Recommendation: We recommend the creation of a broad-based planning group, with elected political leadership, to oversee transformation of the Nueces County mental health system.

In an effort to plan for improved mental health care, many communities have created behavioral health leadership groups that typically include elected officials, behavioral health and social service providers, and others such as advocates, peers, and family members. Although these planning groups can have a favorable impact, health providers and leaders are often underrepresented, if represented at all.

Given the many needs of the Nueces County system, and given the political leadership of the current County Commission, we recommend the creation of a leadership group that focuses on, but is not restricted to, behavioral health leaders and advocates, composed of elected officials, health *and* behavioral health leaders and providers, and representatives of the veterans' community, school districts, law enforcement, and others to provide an integrated approach to improving treatment for mental illness in Nueces County. We believe NCHD should have a leadership role in this group. However, given its constitutional and statutory commitment for the county indigent health care program, other elected officials and providers of care will also need to step forward to lead. We also recommend adoption or refinement of existing planning mechanisms for criminal justice, children and youth, and veterans services, which would be implemented under the auspice of the overall planning group, with ultimate direction from the Commissioners Court as it deems appropriate.

This Executive Summary has provided major findings and recommendations. We provide more detail in the pages that follow.

Overview and Background of Assessment

In September 2019, Nueces County and Nueces County Hospital District (NCHD) engaged the Meadows Mental Health Policy Institute (MMHPI) to conduct a comprehensive behavioral health community needs assessment (needs assessment) to inform the county's efforts to improve mental health services for its residents and its local capacity to meet the need. We (MMHPI) were asked to provide a ''comprehensive needs assessment for Nueces County that can serve as the basis for a systemic approach to providing services for mental illnesses and substance use disorders, initially in Nueces County, but ultimately across the larger Coastal Bend region."

The executed contract between MMHPI, Nueces County, and NCHD established deadlines for various deliverables, some of which were modified by mutual agreement of the parties:

- October 2019 – conduct an onsite meeting and host a project kick-off meeting.
- October 2019 – submit a detailed work plan for the community needs assessment.
- December 2019 – submit a preliminary report on the prevalence and hospital emergency department utilization study.
- December 2019 – submit a preliminary report on criminal justice diversion issues.
- June 2020 – submit a draft report of the community needs assessment.
- July 2020 – submit a final report of the community needs assessment (extended at the request of NCHDB to permit additional comment).
- September 2020 – submit a final report of the community needs assessment.
- Through December 2020 – provide consultation to implement recommendations.

As provided in the contract with NCHD and Nueces County, we committed to an iterative process to provide Nueces County stakeholders with multiple opportunities to offer feedback on our findings and recommendations. As part of this process, we submitted a draft preliminary prevalence report on December 4, 2019, that detailed the hospital capacity and bed use for people with psychiatric diagnoses. We provided an opportunity for stakeholder feedback and delivered a final preliminary prevalence report on December 13, 2019. We submitted a draft preliminary criminal justice report on December 17, 2019, incorporated feedback from local criminal justice stakeholders and partners, and will deliver a final preliminary criminal justice report after submission of this draft report. Finally, John Petrila, Senior Executive Vice President of Policy, presented our preliminary findings and recommendations to NCHD Board of Managers on December 17, 2019, and to the Nueces County Commissioners Court on December 18, 2019. Subsequent to the December presentations, we conducted additional interviews, discussed findings with key stakeholders, and received information regarding recent discussions in Nueces County about the future of inpatient psychiatric hospitalization. Interviews and information gathering continued through the week of June 8th. A draft report was submitted to Judge

Barbara Canales and Dr. Jonny Hipp on June 13, 2020, with revised drafts in response to comments submitted on July 13 and July 23. A presentation of key findings was given to a joint meeting of the Commissioners Court and NHCD Board of Managers on July 15, 2020. Recommendations from the revised draft of the comprehensive mental health needs assessment were discussed at the NCHD Board of Managers meeting on August 18, 2020. Finally, a presentation was given to the Nueces County Opioid Task Force on August 20, 2020.

Data Sources

We have interviewed nearly 200 leaders and other community members. These included stakeholders from the criminal justice system; health systems; mental health providers; eight local schools, including independent school districts, charter schools, and Catholic schools; philanthropic organizations; multiple divisions within Texas A&M University–Corpus Christi (TAMU-CC); people with lived experience of mental illness; the court system; the juvenile justice system; the child welfare system; and county elected officials and appointed officials.

We also utilized various data sources, including hospital data, and employed a number of analytic techniques, including prevalence estimates and system utilization, to inform our recommendations. We explain source data and methodology techniques in detail in Appendices C, D, and E. We incorporated information from prior reports, including prior research conducted in the region by MMHPI such as the *July 2018 CHRISITUS Spohn Health System Proposal*; the *2018 San Antonio State Hospital Redesign: Stakeholder Engagement Report and Strengths, Weaknesses, Opportunities and Threats Analyses*; the *2020–2022 CHRISTUS Spohn Health System Community Health Needs Assessment*; the *2019 Driscoll Health System Community Health Needs Assessment*; and the *County Health Rankings and Roadmaps*.

We also visited treatment and service sites, including but not limited to the Nueces County Jail, Nueces Center for Mental Health and Intellectual Disabilities (NCMHID, the local mental health authority), the City of Corpus Christi Detention Center, the Council on Alcohol and Drug Abuse – Coastal Bend, Nueces County Juvenile Justice Center (including the detention center), the 7th floor of Memorial Hospital, and the Robert N. Barnes Regional Treatment Facility.

A Note on COVID-19

COVID-19 will continue to have an impact into the foreseeable future. Although policymakers and providers have, by necessity, focused on the spread of the virus and its impact on inpatient facilities, our work during COVID-19 and in the aftermath of Hurricane Harvey suggests that the impact on mental health of not only the virus, but also the accompanying economic shutdown, accelerating unemployment, and impact of social isolation, will be felt in obvious ways (for example, in rising suicide and substance abuse overdose deaths associated with rising

unemployment) and in other significant ways such as increases in depression and post-traumatic stress disorders that will occur months after the current situation eases.[5, 6]

We also have created a variety of resources on the impact of and response to COVID-19, which may be useful to various parties in Nueces County.[7]

Framing Our Findings and Recommendations

Several principles guided our needs assessment:

- Identification and treatment of mental illness should occur at the earliest possible moment and should be provided, whenever possible, in the general health care system, from the initial response to a crisis through the use of outpatient and inpatient care, with specialty care reserved for those whose needs cannot be addressed by the general health care system. In practice, this means that traditional reliance on law enforcement response to mental health crises should be shifted, to the degree possible, to the medically-facing response used for all other health crises.
- Many people with diagnoses of mental illnesses have complex physical health needs and, conversely, many people with complex physical health needs suffer from mental illnesses such as depression that can compromise care. Given this, emergency assessment and hospitalization of people with mental illness diagnoses should occur, whenever possible, in settings that can assess and treat both physical and mental health conditions. This has implications for decisions made by NCHD in contracting for inpatient psychiatric services for people who qualify for the Nueces Aid Program.
- It is particularly important to identify and provide treatment for children, youth, and families at the earliest possible point because untreated mental illnesses and emotional disturbances can have cascading effects on the child or youth's health, school performance, and other measures that, if left unaddressed, are associated with greater risks of entry into the juvenile justice and adult criminal justice systems.
- Although many communities believe they need more psychiatric inpatient beds, there is no formula for determining how many beds or what types of beds a community may need. The need for beds is dependent on multiple factors, including crisis response, community programs that buffer against hospital need, and related factors. As our analysis indicates, Nueces County has major gaps in crisis response and community

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[5] Meadows Mental Health Policy Institute. (2020, April 28). *Projected COVID-19 MHSUD impacts, volume 1: Effects of COVID-induced economic recession (COVID recession) – April 28, 2020, full version*. https://www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDImpacts.pdf

[6] Meadows Mental Health Policy Institute. (2017, November 30). Hurricane / Tropical Storm Harvey impact on child and youth mental health.

[7] Meadows Mental Health Policy Institute. (n.d.). *Mental health resources during a pandemic.* https://www.texasstateofmind.org/covid-19/

treatment alternatives and addressing these gaps in service should have an impact on the overall number of inpatient beds that the community requires.

No community in Texas or the nation has a system that seamlessly incorporates all of these principles. Like most communities, the need for mental health care in Nueces County is often identified by law enforcement at the point of crisis and delivered primarily by specialists responding to a crisis. This reliance on law enforcement occurs routinely only with mental health crises, and not with physical health crises. Mental health care is fragmented and segregated in many instances from the health care system: Too often, the mental health system in Nueces County, as in much of Texas, looks like the system depicted in the current mental health system diagram in the following figure (Figure 1), when it should look as much as possible like the system depicted in the second – and ideal – mental health system diagram (Figure 2). Most of our recommendations focus on ways to better integrate care as we move from reliance on a segregated specialty system. We also have developed a more detailed framework for the ideal system for children and youth. For those interested specifically in those issues, the framework and its description can be found in Appendix H.

Figure 1: The Current Mental Health Care System

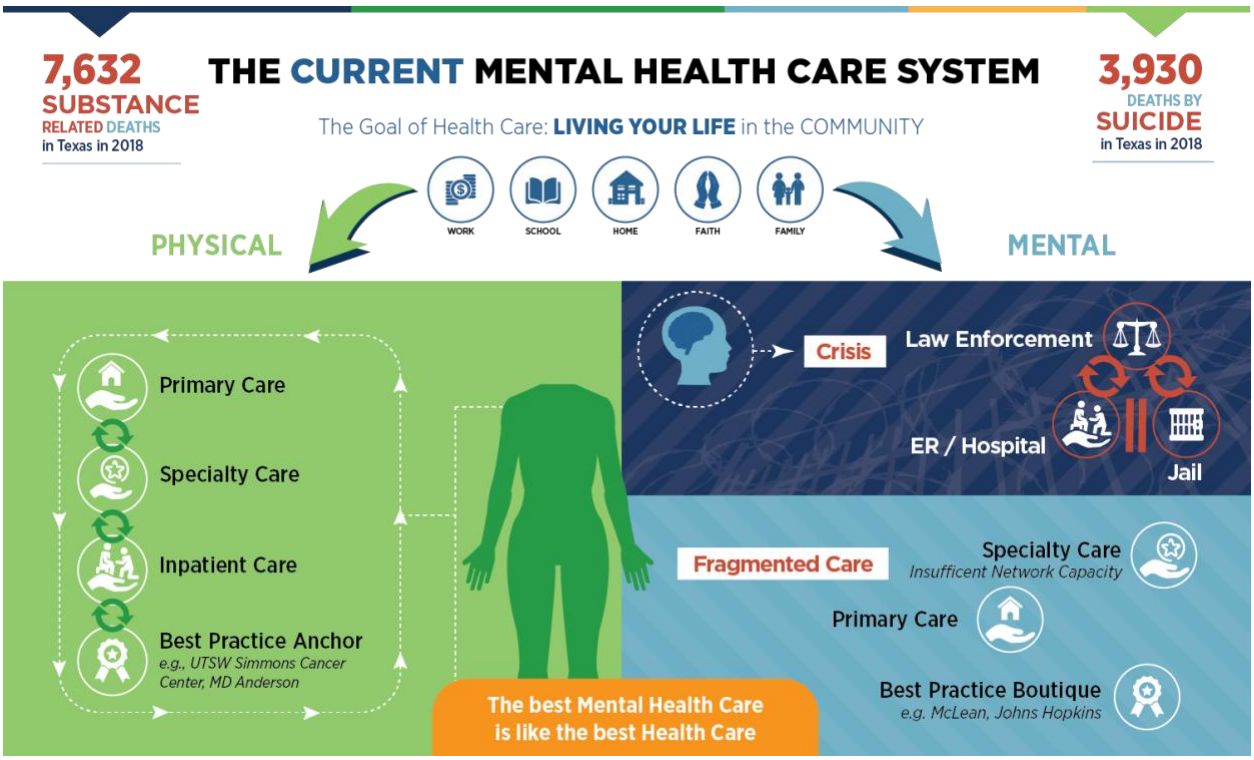
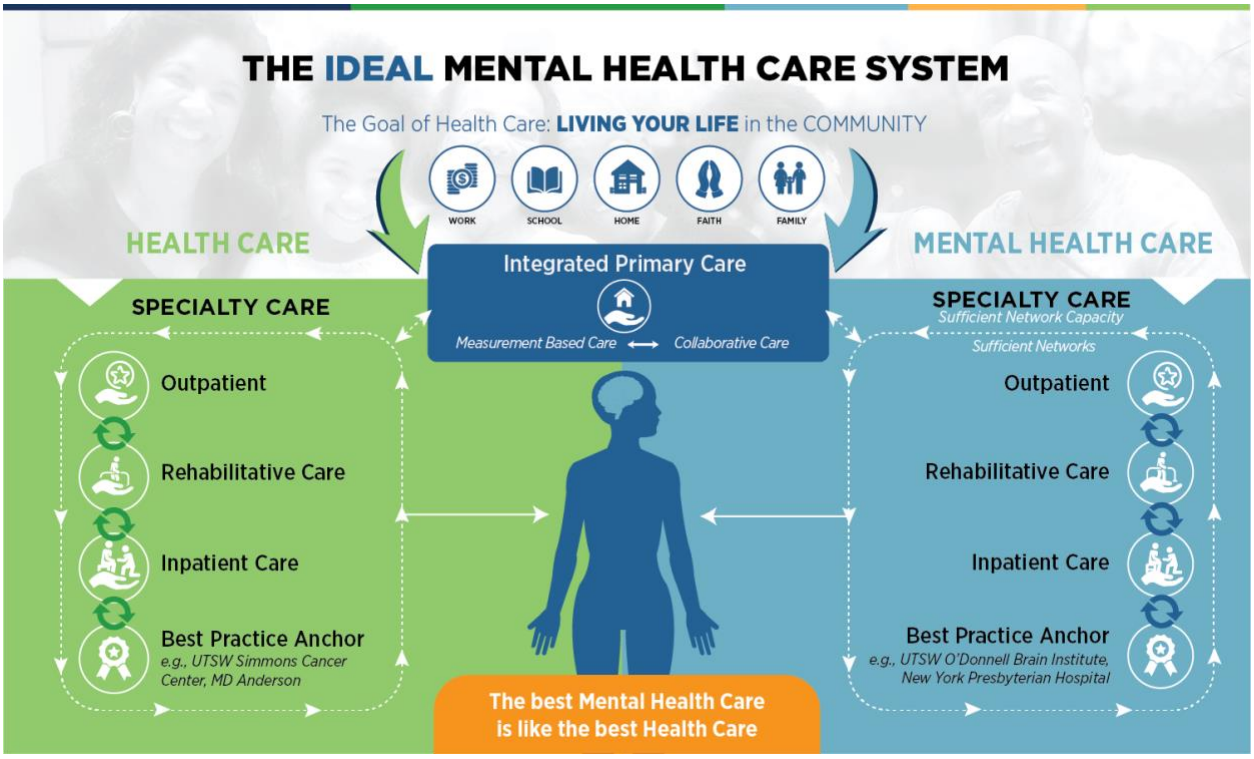


Figure 2: The Ideal Mental Health System



Contextual Issues Affecting Mental Health Care in Nueces County

Leadership is committed to transforming mental health care in Nueces County

As noted in the Executive Summary, Nueces County has several important advantages as it reexamines mental health care for its residents. None is more important than its elected and appointed leadership. In interviews, each of the county commissioners expressed a strong commitment to improving mental health care in Nueces County. Although they differed in their emphasis on what issues were most important, each expressed the view that mental health was an issue that had to be addressed. From the beginning of her term, County Judge Barbara Canales has made improving mental health care a major priority and the community has an enormous stake in where CHRISTUS Spohn locates new inpatient beds to replace those in the old Memorial building when that building is demolished. There are other mental health providers, including the Nueces Center for Mental Health and Intellectual Disabilities (NCMHID), Care Integrated Behavioral Health (CIBH), Bayview Behavioral Hospital, and increasingly Driscoll Children's Hospital, with a strong commitment to creatively improving care in Nueces County.

Social Determinants of Health in Nueces County

Traditionally, communities often have looked at health care, including mental health care, as a function of the resources available to provide care. Although those resources are critically important, the social determinants of health and the community context in which people live

also have an impact on health, development, and morbidity. The social determinants of health are the conditions in which people are born, grow, live, work, and age.[8]

One way to capture data about these social determinants of health is through the County Health Rankings and Roadmaps (CHRR), a collaboration between the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation. The CHRR uses a model of community health that is based on the factors that influence how long and well people live, and uses more than 30 measures that examine health outcomes (length of life and quality of life) and the health factors (health behaviors – 30%, clinical care – 20%, social and economic factors – 40%, and physical environment – 10%) that will impact health in the future.[9]

On overall health, Nueces County ranked in the bottom half (123rd) of the 244 Texas counties that have rankings in the CHRR.[10] Nueces County ranked higher than other Texas counties, indicating better than average results on length of life outcomes (ranked 78th out of 244 Texas counties) and access to clinical care (ranked 23rd), but very low in social and economic determinants of health (ranked 187th out of 244 Texas counties).[11] The CHRR also provides "areas of strength" for health factors for Nueces County, identifying that the county has a higher ratio of primary care physicians per population (provider-to-population ratio in Nueces County is one physician per 1,210 residents) than Texas overall (1:1,640 providers-to-population residents) and higher access to exercise opportunities (95% of the population has access to exercise facilities) than even the top performing counties in the country.[12] In addition, the CHRR notes "areas to explore," which are summarized in the following table.

Table 1: County Health Rankings and Roadmaps – "Areas to Explore" for Nueces County

CHRR "Areas to Explore"		
	Nueces County	Texas
Percentage of adult obesity	33%	30%

[8] World Health Organization. (n.d.). *About social determinants of health*. http://www.who.int/social_determinants/sdh_definition/en/
[9] University of Wisconsin Population Health Institute. (2020). County Health Rankings Model. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model
[10] University of Wisconsin Population Health Institute. (2020). Nueces (NUE) County, Texas. County Health Rankings & Roadmaps. Retrieved June 5, 2020, from https://www.countyhealthrankings.org/app/texas/2020/rankings/nueces/county/outcomes/overall/snapshot
[11] University of Wisconsin Population Health Institute. (2020). Nueces (NUE) County, Texas. County Health Rankings & Roadmaps.
[12] University of Wisconsin Population Health Institute. (2020). Nueces (NUE) County, Texas. County Health Rankings & Roadmaps.

CHRR "Areas to Explore"	Nueces County	Texas
Percentage of ninth-grade cohort that graduates in four years	90%	95%
Percent unemployed[13] (note that these are pre-COVID figures)	4.7%	3.9%
Number of reported violent crime offenses/100,000 population[14]	685	420

Nueces County has several core attributes that address these health outcomes, health factors, and the social determinants of health. Nueces County is supported by academic institutions that are deeply committed to the community. Texas A&M University–Corpus Christi has a number of programs that focus on the community including Texas A&M Coastal Bend Health Education Center and the Antonio E. Garcia Arts & Education Center. Del Mar College is a comprehensive community college that offers certificates and associates degrees, with a focus on community in its vision, mission, and core values. The University of Texas Rio Grande Valley also serves as a hub for Nueces County for the Child Psychiatry Access Network, which is discussed in more detail later.

In addition, Nueces County is supported by a number of outstanding health systems:

- CHRISTUS Spohn provides health care services at three hospital campuses in Nueces County that comprise CHRISTUS Spohn Hospital Corpus Christi: the Shoreline campus, the Memorial campus, and the South campus.[15] It also provides health care services to residents of Nueces County who live in poverty or do not have insurance through a contract with NCHD.[16]
- The Corpus Christi Medical Center is a health care system of six campuses, which includes Bayview Behavioral Hospital, a behavioral health facility that provides comprehensive psychiatric services.[17]
- The Driscoll Health System includes the Driscoll Children's Hospital, which is a hospital focused on children and is the only such hospital south of Houston and San Antonio. The

[13] This number does not reflect the impact of the "COVID-19 Recession."
[14] The 2020 county health rankings used data from 2014 and 2016 for this measure, so it may not reflect more current data.
[15] CHRISTUS Spohn Health System. (2020). *Community health needs assessment 2020–2022*. https://www.CHRISTUShealth.org/-/media/files/homepage/giving-back/chna/CHRISTUSspohnhealthneedsassessment2019.ashx?la=en
[16] Hipp, J. F. (2017, November 14). *About Nueces County Hospital District*. Nueces County Hospital District. http://www.nchdcc.org/about.cfm
[17] Bayview Behavioral Hospital. (n.d.). *About us*. https://bayviewbehavioralhospital.com/about/index.dot

Driscoll Health system also operates a health plan and has physician practices and clinics and specialty centers throughout Nueces County and South Texas.[18]

These health systems also provide important insights from the community needs assessments they conduct, and many of their findings mirror the CHRR for Nueces County. Consider, for example, the most recent community health needs assessment (2020–2022) by the CHRISTUS Spohn Health System (which used later data than the CHHR noted above):

- Community safety, as measured through violent crime, has implications for population health, including mental health, and was substantially higher in Nueces County (617.7 violent crimes per 100,000 people) than the overall violent crime rates in Texas (406 per 100,000 people).
- Nueces County had the highest rates of obesity (33.0%) and physical inactivity (28.5%) in comparison to surrounding counties and Texas (28.0% and 24.0%, respectively).[19]

Moreover, the community needs assessments for both the CHRISTUS Spohn Health System and Driscoll Health System emphasize the importance of mental health, including these findings:

- Mental and behavioral health is considered the number one community health need.
- The burden of morbidity and mortality resulting from mental illness represents a significant and growing concern in the report area.[20]
- Data indicate that mental health issues are among the most frequent primary and secondary diagnoses in the target population.[21]

Beyond these health systems, Nueces County also has a number of organizations such as Cenikor (formerly Charlie's Place Recovery Center) that provide health/mental health services that would not otherwise be available. The importance of these organizations came up repeatedly during our interviews within the context of Nueces County's tradition of taking care of itself given its distance from other places and resources.

The region's academic institutions, health systems, and NCMHID all serve to provide the necessary infrastructure to create integrated care for people with mental illnesses and complex medical needs. In addition, multiple stakeholders are interested in mental health, including

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[18] Driscoll Children's Hospital. (2019, November 19). *Driscoll Health System receives Press Ganey Guardian of Excellence Award*. https://www.driscollchildrens.org/about-us/driscoll-health-system-receives-press-ganey-guardian-of-excellence-award

[19] CHRISTUS Spohn Health System. (2020).

[20] CHRISTUS Spohn Health System. (2020).

[21] Araiza, I., & Stoker-Garcia, B. (2019). *2019 Driscoll Health System community health needs assessment*. Driscoll Health System. https://www.driscollchildrens.org/wp/wp-content/uploads/2020/01/DHS-CHNA-2019-REPORT.-FINAL.pdf

leadership from all key sectors and, importantly, political leaders. These factors create a tremendous opportunity for positive change.

Prevalence and the Impact of Co-Morbid Health Conditions

Recommendation: Nueces County should emphasize the development of interventions that target the comparatively small population of people with the most intensive needs.

Prevalence estimates provide an essential foundation for thinking about service needs, gaps, and investments. Tables 2 and 3 provide 12-month prevalence data for mental health disorders and related information for children, youth, and adults in Nueces County. Appendices D and E provide details on the methodology we used to generate these estimates; endnotes provide information about specific items in the tables.

We estimate that approximately 25,000 children and youth and approximately 65,000 adults in Nueces County have mental health disorders (Tables 2 and 3), the vast majority of whom can be treated in integrated health care settings and who do not require specialty behavioral health care (Tables 17, 21). Although there are significant gaps in services in the Nueces County area, underneath the aggregate numbers of people suffering from mental illnesses, targeted investments in services for those most in need can have a dramatic impact.

First, there is no question that poverty is an important factor in Nueces County. Of the approximately 5,000 children and youth we estimated to have serious emotional disturbances in Nueces County (Table 2 below), approximately 2,000 (or 40%) live in poverty. The same is true for the approximately 10,000 adults with serious mental illnesses (Table 3 below), with approximately 7,000 of them (or 70%) living in poverty. Poverty can complicate access to care and is one of the most important social determinants associated with reduced health status. About 2,000 (or 1 in 10) children and youth with behavioral health needs require specialty rehabilitation care, including 200 with the most intensive needs who are at risk for out-of-home or out-of-school placement. Currently, specialty rehabilitative care in Nueces County is limited to the public sector, just as it is throughout Texas and much of the rest of the nation. However, there are local system strengths to build upon. For example, the Nueces County Juvenile Justice Center offers one of only a few Multisystemic Therapy programs in the state. Multisystemic Therapy is an evidence-based, intensive, family- and community-based treatment for youth with complex clinical, social, and educational problems (e.g., violence, drug abuse, and school expulsion). The existing Multisystemic Therapy infrastructure can be expanded to other high-need children and youth in the county.

Second, despite significant gaps in services in Nueces County, there is a relatively small number of people who require the types of intensive services that can buffer against hospitalization and jail bookings. We estimate that approximately 100 people in Nueces County can benefit from

Assertive Community Treatment (ACT), which is associated with reduced hospitalization, and another 100 can benefit from Forensic ACT (FACT), which is associated with jail bookings (Table 3). Although there are significant gaps between need and access, as the discussion in the section on Access to Care describes in more detail, investment in these programs, using evidence-based tools, could have a significant impact on resolving the issue of how many licensed inpatient beds Nueces County requires in addition to providing the type of intensive services that people with the most serious mental illnesses and emotional disorders require.

Third, there are significant needs among children and youth in Nueces County given the number who have three or more adverse childhood experiences (ACES) (Table 2). However, as the section on Recommendations for Investment in Children and Youth Care describes, there are opportunities to provide services in schools and other sectors that can ameliorate the impact of such experiences for the approximately 9,000 children and youth with those experiences.

Fourth, although there are fewer than a dozen children and youth (out of 25,000 with mental health needs) (Table 2), and fewer than 30 adults (out of 65,000 with mental health needs) (Table 3) who suffer from first episode psychosis each year, we strongly recommend the establishment of a first-episode psychosis program to reach these individuals as early in their illness as possible (see Recommendations for Investment in Children and Youth Care below for more detail). This, in turn, will have an impact on the need for and use of hospital beds. As noted in the executive summary and below, the Texas Legislature has provided the opportunity to dramatically improve the availability of psychiatric consultation to schools and primary pediatric offices.

Table 2: Twelve-Month Prevalence of Mental Health Disorders in Children and Youth in Nueces County (2018)

Mental Health Condition – Children and Youth Prevalence[i]	Age Range	Nueces County
Total Population	**6–17**	**60,000**
Population in Poverty[ii]	6–17	30,000
All Mental Health Needs (Mild, Moderate, and Severe)[iii]	**6–17**	**25,000**
Mild	6–17	15,000
Moderate	6–17	5,000
Severe – Serious Emotional Disturbance (SED)[iv]	6–17	5,000
SED in Poverty[v]	6–17	2,000
At Risk for Out-of-Home/Out-of-School Placement[vi]	6–17	200
Specific Disorders – Children and Youth[vii]		

Mental Health Condition – Children and Youth Prevalence[i]	Age Range	Nueces County
Depression[viii]	12–17	4,000
Bipolar Disorder[ix]	12–17	700
Post-Traumatic Stress Disorder	12–17	1,000
Schizophrenia[x]	12–17	2,000
First Episode Psychosis (FEP) Incidence – New Cases per Year[xi]	12–17	10
Obsessive-Compulsive Disorder – Children/Youth[xii]	6–17	1,000
Eating Disorders[xiii]	12–17	300
Self-Injury/Harming Behaviors[xiv]	12–17	3,000
Conduct Disorder	12–17	2,000
Number of Deaths by Suicide[xv]	0–17	<10
Specific Disorders – Children Only		
All Anxiety Disorders – Children[xvi]	6–11	3,000
Depression/All Mood Disorders – Children	6–11	300
Children and Youth with Adverse Childhood Experiences (ACEs)[xvii]		
Population with 1 or 2 ACEs	0–17	30,000
Population with 3 or More ACEs	0–17	9,000

Table 3: Twelve-Month Prevalence – Mental Health Disorders for Adults in Nueces County (2018)

Mental Health Condition – Adults	Nueces County
Total Adult Population	**270,000**
Population in Poverty[xix]	90,000
All Mental Health Needs (Mild, Moderate, and Severe)[xx]	**65,000**
Mild	25,000
Moderate	25,000
Severe – Serious Mental Illness [xxi]	10,000
Serious Mental Illness in Poverty[xxii]	7,000
Complex Needs Without Forensic Need (ACT)[xxiii]	100
Complex Needs with Forensic Need (FACT)[xxiv]	100
Specific Diagnoses	
Major Depression[xxv]	20,000
Bipolar I Disorder[xxvi]	1,000

Mental Health Condition – Adults	Nueces County
Post-Traumatic Stress Disorder[xxvii]	9,000
Schizophrenia[xxviii]	1,000
First Episode Psychoses (FEP) Incidence – New Cases per Year (Ages 18–34)[xxix]	30
Number of Deaths by Suicide[xxx]	53

Substance use is also a significant issue in Nueces County. As Tables 4 and 5 illustrate, many people have co-occurring mental illness and substance use disorders, and many people admitted to Nueces County emergency departments with serious physical health issues have secondary psychiatric or substance use disorders (Table 6). These are complex health conditions that require treatment providers, especially those providing inpatient care, to be able to address not only the psychiatric disorder but also the co-occurring conditions. This has implications for developing new inpatient capacity as Nueces County moves to a different model for providing inpatient psychiatric care for people who are uninsured; it is essential to think about serious mental illness for many people as one of a number of conditions which in the aggregate are highly complex and require integrated care at every point.

Finally, except in rare situations involving threats to public safety or self, or acute symptomology that cannot be relieved in the community, these disorders can all be managed in community settings, *if adequate community services exist.*

Table 4: Prevalence of Substance Use Disorders (SUD) Among Youth Ages 12 to 17 (2018)[xxxi, xxxii]

Population	Nueces
Total Population	**30,000**
Total Population in Poverty	15,000
Any Substance Use Disorder	**1,000**
SUD in Poverty[xxxiii]	400
Comorbid Psychiatric and Substance Use Disorders[xxxiv]	400
Needing but Not Receiving Treatment for Substance Use Disorder[xxxv]	900
Alcohol-Related SUD	**400**
Needing but Not Receiving Treatment for Alcohol Use Disorder [xxxv]	400

Population	Nueces
Illicit Drug-Related SUD	**700**
Needing but Not Receiving Treatment for Illicit Drug Use Disorder [xxxv]	700
Number of Drug-Related Deaths in 2018[xxxvi]	**<10**
Number of Alcohol-Induced Deaths in 2018[xxxvii]	**N/A**

Table 5: Prevalence of SUD Among Adults in Nueces and Surrounding Counties (2018)[xxxviii, xxxix]

Population	Nueces
Total Population	**270,000**
Total Population in Poverty	90,000
Any Substance Use Disorder	**20,000**
SUD in Poverty[xl]	8,000
Comorbid Psychiatric and Substance Use Disorders[xli]	10,000
Needing but Not Receiving Treatment for Substance Use Disorder[xlii]	15,000
Alcohol-Related SUD	**15,000**
Needing but Not Receiving Treatment for Alcohol Use Disorder	15,000
Illicit Drug-Related SUD	6,000
Needing but Not Receiving Treatment for Illicit Drug Use Disorder	5,000
Number of Drug-Related Deaths in 2017[xliii]	52

Table 6: Medical Emergency Department (ED Visits) in Nueces County with Co-Occurring Psychiatric and Substance Use Disorders (COPSD) – All Ages (Calendar Year 2018)

Rank	Primary Physical Health Diagnoses with the Most Secondary Psychiatric Diagnoses		Primary Physical Health Diagnoses with the Most Secondary SUD Diagnoses		Primary Physical Health Diagnoses with the Most COPSD Diagnoses	
	Top Physical Health Diagnoses	Visits	Top Physical Health Diagnoses	Visits	Top Physical Health Diagnoses	Visits
1	Throat/Chest Pain	1,171	Throat/Chest Pain	250	Throat/Chest Pain	97
2	Abdominal/Pelvic Pain	820	Other Sepsis	164	Abdominal/Pelvic Pain	69
3	Dorsalgia	441	Abdominal/Pelvic Pain	124	Other Sepsis	45

Rank	Primary Physical Health Diagnoses with the Most Secondary Psychiatric Diagnoses		Primary Physical Health Diagnoses with the Most Secondary SUD Diagnoses		Primary Physical Health Diagnoses with the Most COPSD Diagnoses	
	Top Physical Health Diagnoses	Visits	Top Physical Health Diagnoses	Visits	Top Physical Health Diagnoses	Visits
4	Other Sepsis	386	Cellulitis/Acute Lymphangitis	123	Cellulitis/Acute Lymphangitis	33
5	Other Disorders of the Urinary System	314	Cutaneous Abscess	97	Cutaneous Abscess	33
6	Other COPD	263	Nausea/Vomiting	81	Epilepsy/Seizures	26
7	Other Joint Disorder	257	Alcoholic Liver Disease	81	Acute Pancreatitis	24
8	Headache	253	Open Head Wound	77	Skull/Facial Fracture	22
9	Cellulitis/Acute Lymphangitis	234	Acute Pancreatitis	69	Narcotics and Psychodysleptics	22
10	Type 2 Diabetes	234	Heart Attack	69	Open Head Wound	21

It is also worth noting that, while not a focus in our assessment, Nueces County is one of the harder hit counties in Texas by the national opioid epidemic. According to the 2019 County Health Rankings, the drug overdose mortality rate for Nueces County is 19 deaths per 100,000 population, compared to the overall rate for Texas of 10 deaths per 100,000.[22] The Nueces County Commission has created the Opioid Task Force to address this issue through prevention, education, and intervention.

A Note on Projected Growth

By the year 2050, the population of all age groups in Nueces County is expected to increase, with the population of adults over the age of 65 growing at the fastest rate. Based on these projections, the underlying need for behavioral health services for children and youth in Nueces County should show modest growth through 2050; however, the need for behavioral health services for older adults may increase disproportionately to other age groups.

[22] University of Wisconsin Population Health Institute. (2020). Drug overdose deaths in Texas. County Health Rankings & Roadmaps. Retrieved March 29, 2020, from https://www.countyhealthrankings.org/app/texas/2019/measure/factors/138/data

Table 7: Estimated Population of Children and Youth in Nueces County – 2020 through 2050[xliv]

Year	Children Ages 6 to 11		Youth Ages 12 to 17		All Children/Youth Ages 6 to 17	
	Population	Percentage of Change from 2020	Population	Percentage of Change from 2020	Population	Percentage of Change from 2020
2020	**30,707**		**31,424**		**62,130**	
2025	33,491	9%	32,739	4%	66,230	7%
2030	35,370	15%	35,770	14%	71,140	15%
2035	36,072	17%	37,935	21%	74,007	19%
2040	36,298	18%	38,896	24%	75,194	21%
2045	37,076	21%	39,126	25%	76,202	23%
2050	38,488	25%	39,792	27%	78,280	26%

Table 8: Estimated Population of Adults in Nueces County – 2020 through 2050[xlv]

Year	Adults Ages 18 to 64		Older Adults Ages 65 and Older		All Adults Ages 18 and Older	
	Population	Percentage of Change from 2020	Population	Percentage of Change from 2020	Population	Percentage of Change from 2020
2020	**225,561**		**52,691**		**278,252**	
2025	234,708	4%	60,388	15%	295,095	6%
2030	245,143	9%	66,104	25%	311,247	12%
2035	260,802	16%	67,549	28%	328,351	18%
2040	276,705	23%	69,081	31%	345,786	24%
2045	291,719	29%	71,133	35%	362,852	30%
2050	302,858	34%	76,313	45%	379,171	36%

Psychiatric Bed Capacity

Recommendation: The current number of beds licensed to provide inpatient psychiatric care in Nueces County is sufficient, given current use and length of stay, to meet the needs of Nueces County residents. It now appears that the CHRISTUS Spohn system, working with Oceans Healthcare, has committed itself to providing inpatient psychiatric care that will be part of, or contiguous with, a hospital with the means to provide the full range of services required by people with serious mental illnesses, including substance/alcohol use disorders and complex physical health conditions.

Nueces County is at a crossroads in the provision of inpatient psychiatric care. The antiquated and unsupportable practice of providing inpatient care for uninsured people on the 7th floor of an otherwise abandoned hospital will end by necessity when the building is demolished, which should occur in or prior to 2023. In addition, CHRISTUS Spohn has given notice of its intention to end its relationship with Care Integrated Behavioral Health (CIBH) as its subcontracted mental health provider and replace it with a relationship with Oceans Healthcare, maintaining at least its current allocation of inpatient psychiatric beds. It is critical that these new beds be located in or contiguous to an inpatient hospital with the capacity to treat the full range of complex health conditions.

The CHRISTUS Spohn proposal appears to be congruent with the recommendation by NCHD from May 20, 2020, to adopt a plan (titled Mental Health-Behavioral Health: Required Elements of Nueces County Program) to build a new hospital facility "dedicated to mental and behavioral health" with "no less than 33" new beds with "a preference that the facility be located within close proximity of an emergency department and the Nueces County Jail." The plan would obligate a provider of care to ensure the availability of inpatient beds to all NCHD patients at all times and additional beds "will be used to provide community-wide care to insured and uninsured patients as Provider determines appropriate in its discretion". The proposal also stipulates that the provider will make available an assessment and evaluation center, an Adult Crisis Unit, and an Adult Stabilization Unit at the facility, as well as a Child/Adolescent Unit and a Neuro-Geropsychiatric Unit, as well outpatient services "in close proximity to the Facility". The proposal states that "NCHD will not contribute funds toward its construction, operation or maintenance as it will be built on privately owned property." The provider is obligated to ensure the availability of beds to all NCHD patients and "additional beds will be used to provide community-wide care to insured and uninsured patients as Provider determines appropriate in its discretion". This proposal illustrates a strong understanding that mental health care must encompass more than psychiatric inpatient beds.

We note the terms of NCHD's plan (prepared and adopted before the CHRISTUS Spohn decision to maintain its presence in psychiatry and mental health) because it is consistent with CHRISTUS Spohn's intent, including maintaining but not significantly adding to the number of inpatient beds in the county, with ancillary services focused on specialty care and ambulatory care. Because the number of necessary beds has been a continuing source of discussion during our assessment, we provide an analysis of potential inpatient capacity needs, based on a variety of factors, including historic use of existing beds, length of stay, and flow of patients into and out of Nueces County. Our analysis concludes that even with the major gaps that currently exist in community services, there is sufficient inpatient capacity in Nueces County to meet the needs of Nueces County residents, including those who currently receive inpatient care outside of the county. This means that replacing beds currently operated by CHRISTUS Spohn with an additional 33 beds would essentially substitute newly built capacity for old; but adding 33 beds

to those operated by CHRISTUS Spohn and Bayview would likely result in excess capacity. Our analysis follows.

Factors Affecting Inpatient Bed Need Capacity in Nueces County

There is no formula for determining how many inpatient psychiatric beds a community requires. Inpatient care for mental illnesses, like inpatient care for any illness, should only occur in situations when it is essential, and not as a default because of a lack of capacity in ambulatory treatment. In addition, it is important to consider what types of beds (acute or long-term) are needed and for whom (geriatric, adults, or children) as well as their location (general hospital or free-standing psychiatric hospital). In our analysis, we relied on factors such as current inpatient capacity; historical bed use; how many Nueces residents receive inpatient care in Nueces County – and outside the county – through admission to a Nueces County emergency department; the number of non-Nueces County residents receiving inpatient care in Nueces County facilities, regardless of emergency department use; and length of inpatient stay.

Current Inpatient Bed Availability

Our analysis assumes the following:

- There are 88 licensed inpatient psychiatric beds in Nueces County
- Those beds typically operate at approximately 75-80% capacity
- If inpatient use continues at historic levels, and even assuming that patients from Nueces County who are currently treated in other counties are treated instead in Nueces County, the current licensed capacity is sufficient to meet inpatient needs.

A full analysis follows:

According to American Hospital Association (AHA) data that were generated by hospital reports of licensed inpatient bed capacity, there are currently 88 licensed inpatient psychiatric beds in use in Nueces County (56 in Bayview, including 24 beds for children and 32 for adults, and another 32 adult beds in CHRISTUS Spohn). These are the figures we used in our analyses in these reports. Input from interviews we conducted suggested that Bayview operates 61 beds and CHRISTUS Spohn operates 30 beds for a total of 91 beds (versus 88); however, we relied on the AHA data for our analyses. In any event, the difference is minimal and did not affect our analysis in any material respect.

In addition, Nueces County is in the San Antonio State Hospital (SASH) catchment area for adults. In calendar year (CY) 2018, 39 Nueces County residents were admitted to SASH, none through Nueces County emergency departments, suggesting that most if not all of these admissions were forensic admissions for people admitted to SASH through the criminal justice process. In addition, SASH frequently places a moratorium on admissions because of staff

shortages and consistently maintains a waitlist. In a 2018 San Antonio State Hospital assessment, stakeholder interviews across the SASH catchment area revealed that SASH is simply inaccessible to many communities, especially for people admitted through civil commitment processes. In fact, many stakeholders suggested that increased forensic capacity has been one of the main reasons why community providers can no longer access – or have so much difficulty accessing – beds for a civil commitment placement.

Admissions to Licensed Psychiatric Beds Through Nueces Emergency Departments

Many but not all people are admitted to inpatient psychiatric care through emergency departments. We consider flow from emergency departments to inpatient beds first.

A number of Nueces County emergency departments accept psychiatric admissions. People who visited emergency departments and were then placed in a psychiatric bed were more often placed in local beds when they lacked commercial insurance; those whose care was funded through commercial insurance were more often placed outside of Nueces County. This is a reversal of the usual practice in many communities where hospitals strive to retain financially resourced patients. Among the people who were hospitalized in a psychiatric bed after visiting a Nueces County emergency department, more than half were hospitalized locally (Table 9). As noted, those who were funded through Medicaid, other government funds, or were self-funded were more often hospitalized locally, whereas people who were funded through Medicare or commercial insurance were more often hospitalized outside of Nueces County (Table 9).

Table 9: Admissions to Psychiatric Hospitals from Nueces Emergency Departments (ED), All Ages, by Payer (CY 2018)

Admissions from Nueces EDs to Psychiatric Beds[xlvi]	Total Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Total Admissions from Nueces EDs	**418**	**32%**	**13%**	**8%**	**13%**	**33%**
to Non-Local Psychiatric Bed	173	23%	15%	5%	6%	50%
to Local Psychiatric Bed	245	38%	12%	10%	18%	21%
CHRISTUS Spohn – Corpus Christi ED						
to Non-Local Psychiatric Bed	11	9%	27%	9%	0%	55%
to Local Psychiatric Bed	15	20%	27%	0%	27%	27%
CHRISTUS Spohn Hospital Corpus Christi – Shoreline ED						
to Non-Local Psychiatric Bed	12	25%	17%	0%	8%	50%
to Local Psychiatric Bed	79	29%	15%	9%	28%	19%

Admissions from Nueces EDs to Psychiatric Beds[xlvi]	Total Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
CHRISTUS Spohn Hospital Corpus Christi – South ED						
to Non-Local Psychiatric Bed	9	11%	33%	11%	0%	44%
to Local Psychiatric Bed	22	23%	23%	5%	23%	27%
Corpus Christi Medical Center – Bay Area ED						
to Non-Local Psychiatric Bed	43	14%	12%	0%	14%	58%
to Local Psychiatric Bed	17	18%	35%	6%	24%	18%
Corpus Christi Medical Center – Doctors Regional ED						
to Non-Local Psychiatric Bed	31	19%	29%	3%	3%	45%
to Local Psychiatric Bed	24	4%	4%	67%	21%	0%
Corpus Christi Medical Center – Northwest ED						
to Non-Local Psychiatric Bed	21	24%	19%	10%	10%	38%
to Local Psychiatric Bed	4	25%	25%	0%	0%	50%
Driscoll Children's Hospital ED						
to Non-Local Psychiatric Bed	39	33%	0%	8%	3%	56%
to Local Psychiatric Bed	82	70%	0%	0%	5%	26%

While approximately 80% of all admissions to licensed psychiatric beds for Nueces County residents occur in Nueces County hospitals (primarily CHRISTUS Spohn and Bayview) only about 60% of patients (totaling 245 patients) admitted to a licensed psychiatric bed after admission to an emergency department in Nueces County are cared for in Nueces County; the other approximately 40% (totaling 173) are transferred outside of Nueces County.

Table 10: Summary of Admissions to Psychiatric Hospitals from Nueces County Emergency Departments, by Age (CY 2018)

County of Admission	Total Admissions	Adults (Age 18 to 64)	Older Adults (Age 65 and Older)	Youth (Age 12 to 17)
Bell	2	1	N/A	1
Bexar	44	31	2	7
Brazos	3	1	N/A	2
Cameron	46	30	4	12
Collin	3	2	N/A	1
Dallas	11	5	N/A	5

County of Admission	Total Admissions	Adults (Age 18 to 64)	Older Adults (Age 65 and Older)	Youth (Age 12 to 17)
Denton	2	1	N/A	1
El Paso	3	N/A	N/A	2
Fort Bend	2	N/A	N/A	2
Grayson	3	2	N/A	1
Harris	11	2	2	6
Hidalgo	23	15	1	5
Montgomery	1	1	N/A	N/A
Nueces	245	140	18	81
Potter	1	1	N/A	N/A
Tarrant	10	4	N/A	6
Travis	5	4	N/A	1
Williamson	3	1	N/A	2
Total Admissions to Nueces Hospitals from Nueces EDs	**245**	**140**	**18**	**81**
Total Admissions to Non-Local Hospitals from Nueces EDs	**173**	**101**	**9**	**54**
Total Admission to Nueces Hospitals and Non-Local Hospitals from Nueces EDs	**418**	**241**	**27**	**135**

Number and Residence of Inpatient Admissions Regardless of Portal

When one considers all admissions to Nueces County inpatient beds, Medicaid is a major payer for care for children and youth, but much less so for adults, not surprising given eligibility standards in Texas for Medicaid. In calendar year 2018, there were 4,068 admissions to Nueces County inpatient psychiatric beds. All children and youth admissions (969) occurred at Bayview, while adult admissions were more closely split between CHRISTUS Spohn (1,680) and Bayview (1,419).

Table 11: Admissions to Psychiatric Beds at Nueces County Hospitals, by Age Group and Payer (CY 2018)[xlvii]

Age Group	Total Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Bayview Behavioral Hospital						
All Ages	**2,388**	**41%**	**13%**	**9%**	**16%**	**19%**
Adults (Age 18 to 64)	1,336	22%	18%	13%	25%	21%
Older Adults (Age 65 and older)	83	4%	90%	0%	0%	5%
Youth (Age 12 to 17)	906	71%	0%	4%	4%	20%
Children (Age 6 to 11)	63	78%	2%	10%	3%	8%
CHRISTUS Spohn – Corpus Christi						
All Ages	**1,680**	**22%**	**22%**	**4%**	**28%**	**24%**
Adults (Age 18 to 64)	1,495	25%	14%	4%	32%	26%
Older Adults (Age 65 and older)	185	1%	86%	3%	0%	10%

It is noteworthy that of the 4,068 admissions to Nueces County hospital beds, 1,039 (or 26%) were from outside of Nueces County, including 850 admissions to Bayview (35% of its total) and 189 admissions to CHRISTUS Spohn (11% of its total). These figures illustrate Bayview's place in a larger market as a provider of children's psychiatric services.

Table 12: Admissions to Nueces Psychiatric Beds by Local Versus Non-Local Residents (CY 2018)[xlviii]

Hospital	Total Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Bayview Behavioral Hospital						
Total Admissions	**2,388**	**41%**	**13%**	**9%**	**16%**	**19%**
Admissions of Nueces Residents	1,538	44%	14%	2%	19%	19%
Non-Local Admissions	850	36%	11%	22%	10%	20%
CHRISTUS Spohn – Corpus Christi						
Total Admissions	**1,680**	**22%**	**22%**	**4%**	**28%**	**24%**
Admissions of Nueces Residents	1,491	23%	20%	3%	29%	24%
Non-Local Admissions	189	13%	38%	7%	18%	24%

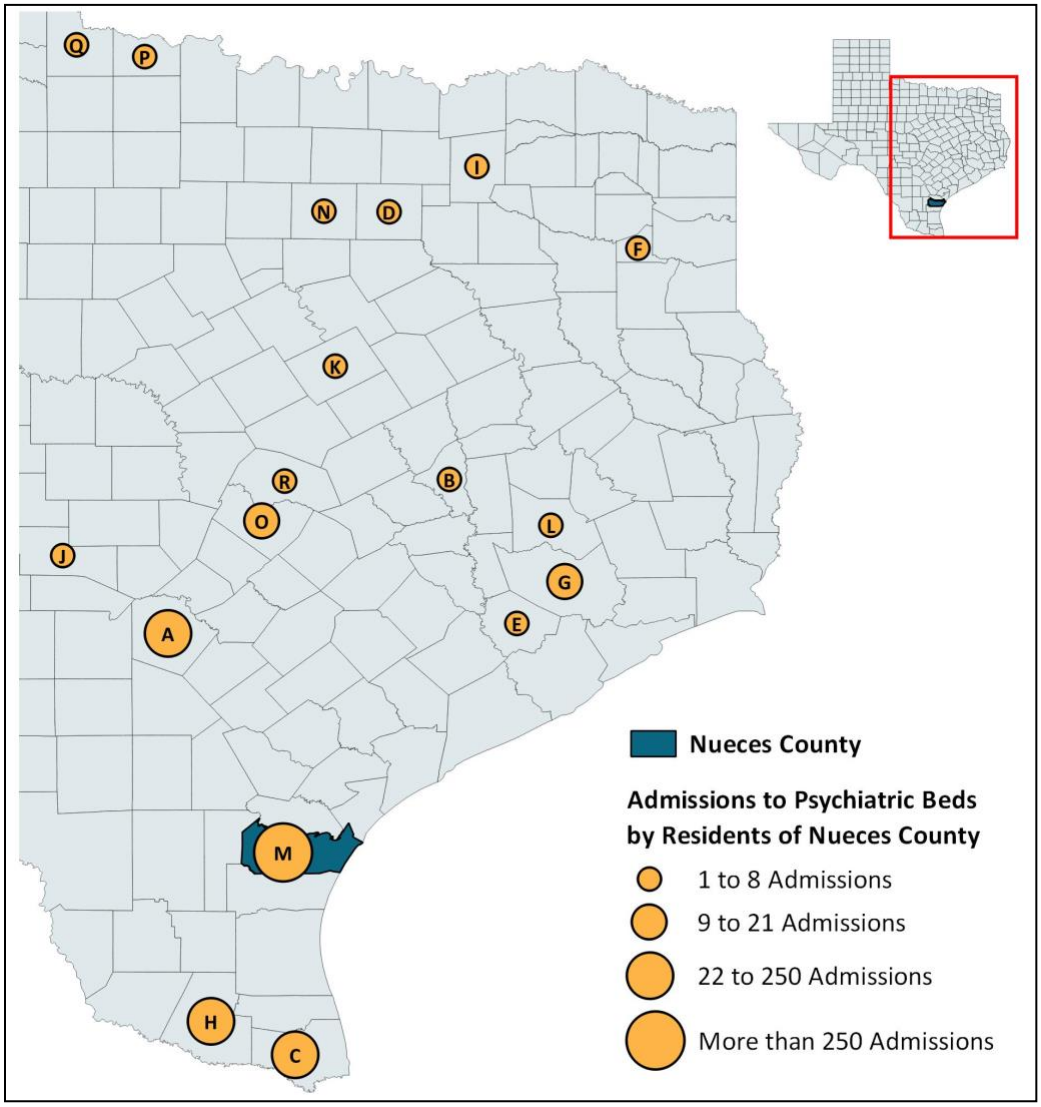
At the same time, 522 Nueces residents (411 adults, 111 children and youth) were admitted to non-local hospitals, with just over 50 admitted to state hospitals (Table 13). However, because most admissions to state hospitals are for people requiring competency restoration, they are largely omitted from considerations of determining bed capacity. If a Nueces County hospital decided to create a hospital-based competency restoration program, the analysis of that program's needs would then be incorporated. One important factor in providing care closer to home for Nueces County residents is that NCMHID will have funds to purchase private psychiatric inpatient beds in the community for the first time in its contract with the Texas Health and Human Services Commission. NCMHID indicated that the draft Texas Health and Human Services Commission contract for fiscal year 2020 will provide it with funding to purchase 923 bed days for 300 admissions for Nueces County adults, children, and youth. The Texas Health and Human Services Commission sets a limit on how much a local mental health authority can pay per bed per day, which cannot exceed $700 a day. Despite rate limitations, this will provide access for some people who are in need of inpatient services that are closer to their home community and support better continuity of care to ongoing community-based services.

Table 13: Summary Table – Residents of Nueces County, Admissions to Psychiatric Beds, by Age (CY 2018)

Map Label	County and Hospital	All Ages	Adults	Children and Youth
A	Bexar	250	198	52
B	Brazos – Rock Prairie Behavioral Health	<6	<6	N/A
C	Cameron	91	67	24
D	Dallas – Methodist Richardson Medical Center	<6	<6	N/A
E	Fort Bend – Westpark Springs	<6	<6	N/A
F	Gregg – Oceans Behavioral Hospital of Longview	<6	<6	N/A
G	Harris	21	21	N/A
H	Hidalgo	110	79	31
I	Hunt – Glen Oaks Hospital	<6	<6	N/A
J	Kerr – Kerrville State Hospital	<6	<6	N/A
K	McLennan – DePaul Center	<6	<6	N/A
L	Montgomery	<6	<6	N/A
M	Nueces	3,041	2,383	658
N	Tarrant – Sundance Hospital	<6	<6	<6
O	Travis	20–24	19	<6

Map Label	County and Hospital	All Ages	Adults	Children and Youth
P	Wichita – North Texas State Hospital	<6	<6	N/A
Q	Wilbarger – North Texas State Hospital-Vernon	6	6	N/A
R	Williamson	8–12	7	<6
Total Admissions		**3,563**	**2,794**	**769**
Admissions to Local Nueces County Hospitals		**3,041**	**2,383**	**658**
Admissions to Non-Local Hospitals		**522**	**411**	**111**
Admissions to State Hospitals		**53–57**	**52**	**<6**

Map 1: Residents of Nueces County – All Admissions to Psychiatric Beds (CY 2018)



Nueces County Psychiatric Inpatient Capacity is Typically Available

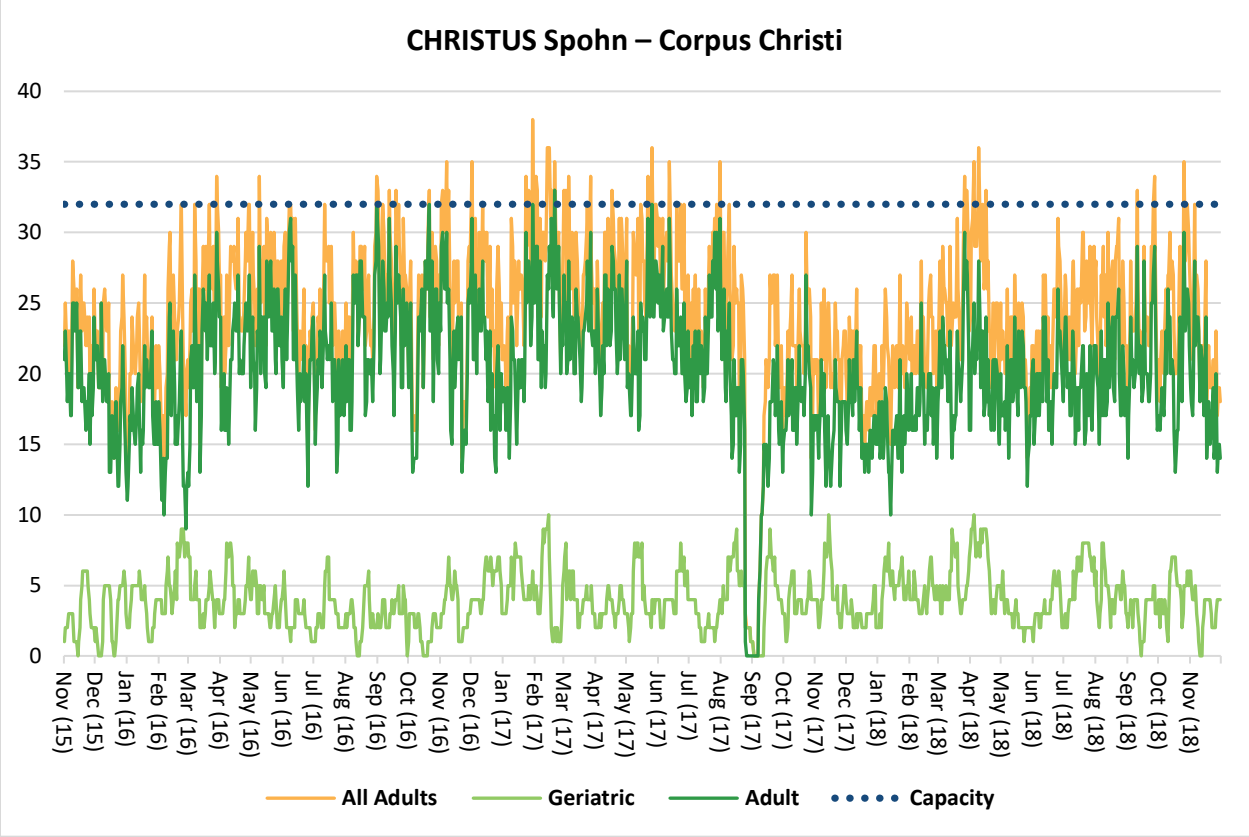
As noted, a number of stakeholders reported that Nueces County needs more inpatient beds, with 60 beds typically cited (though without quantitative data to substantiate that assertion). However, data on bed use from 2016–2018 showed open capacity most of the time (Table 14). Note that nationally, occupancy rates in hospitals for all purposes run at approximately 65%.

Table 14: Average Daily Psychiatric Utilization and Capacity – Nueces County (CY 2018)[xlix]

Type of Utilization	CHRISTUS Spohn Hospital – Corpus Christi	Bayview Behavioral Hospital
Adult Utilization		
Average Daily Utilization	24	23
Utilization as a Percentage of Capacity	75%	71%
Percentage of Days with Available Beds	94%	81%
Child and Youth Utilization		
Average Daily Utilization	N/A	17
Utilization as a Percentage of Capacity	N/A	70%
Percentage of Days with Available Beds	N/A	87%

The time series charts in Figures 3 and 4 show a day-by-day analysis for each hospital between November 2015 and November 2018. Figure 3 reveals that CHRISTUS Spohn – Corpus Christi occasionally operated beyond its capacity, though, as Table 14 shows, the vast majority (94%) of days had bed availability.

Figure 3: CHRISTUS Spohn – Corpus Christi Daily Utilization Versus Capacity (January 2016 – November 2018)



At Bayview Behavioral Hospital, 23 adults and 17 children and youth, on average, occupied beds each day (a total of 40 across age groups), compared to 56 available beds. Thus, although many of the beds were being occupied (71% overall, as shown in Table 14), the hospital was not usually operating at or over capacity. Figure 4 presents the points throughout the time period when utilization exceeded capacity. Despite the periods when the hospital exceeded capacity, beds were available most days (81% to 87%, depending on age group; see Table 14). Based on data beginning in November 2015, the time series graph (Figure 4) shows a trend in increased bed utilization over time, with the greatest utilization and concentrations of days operating at capacity during the end of 2018. However, that increase also appears to have stabilized by the end of November 2018.

Figure 4: Bayview Behavioral Hospital Daily Utilization Versus Capacity (January 2016 – November 2018)

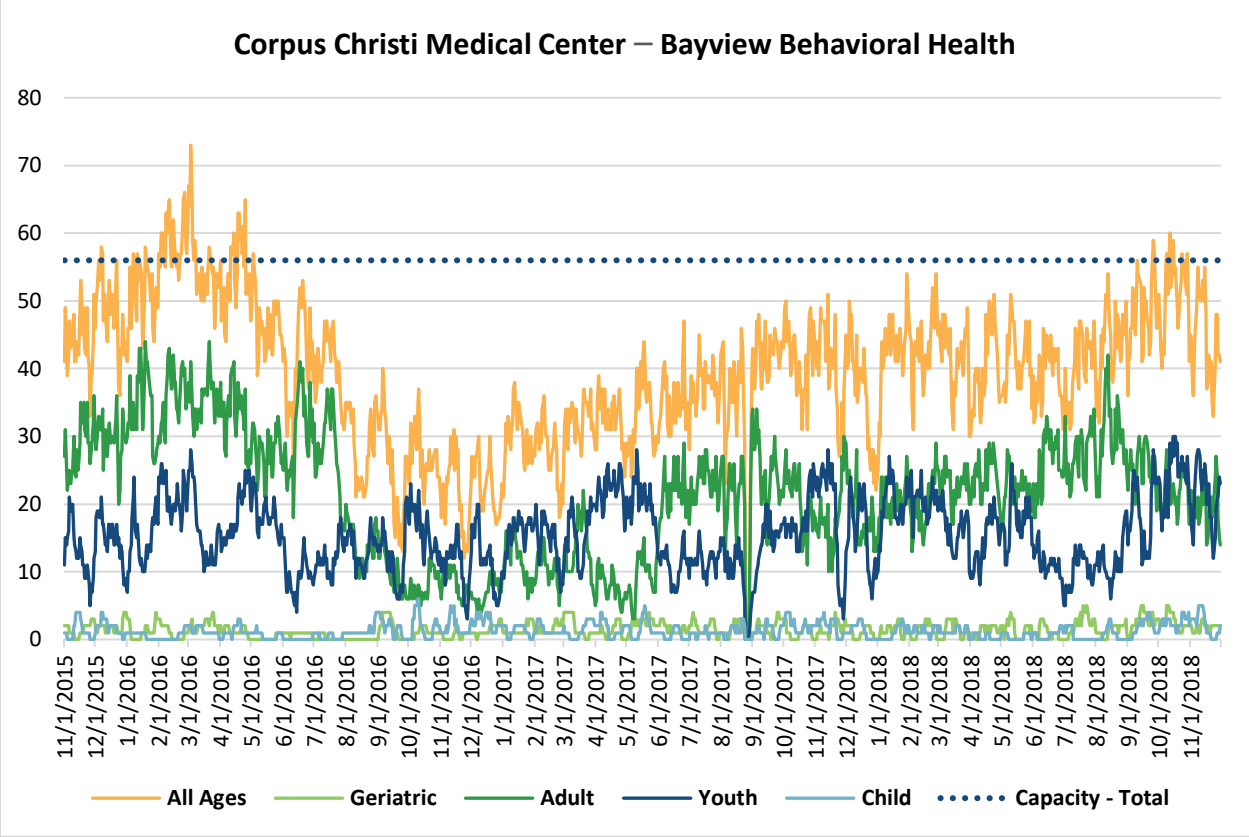
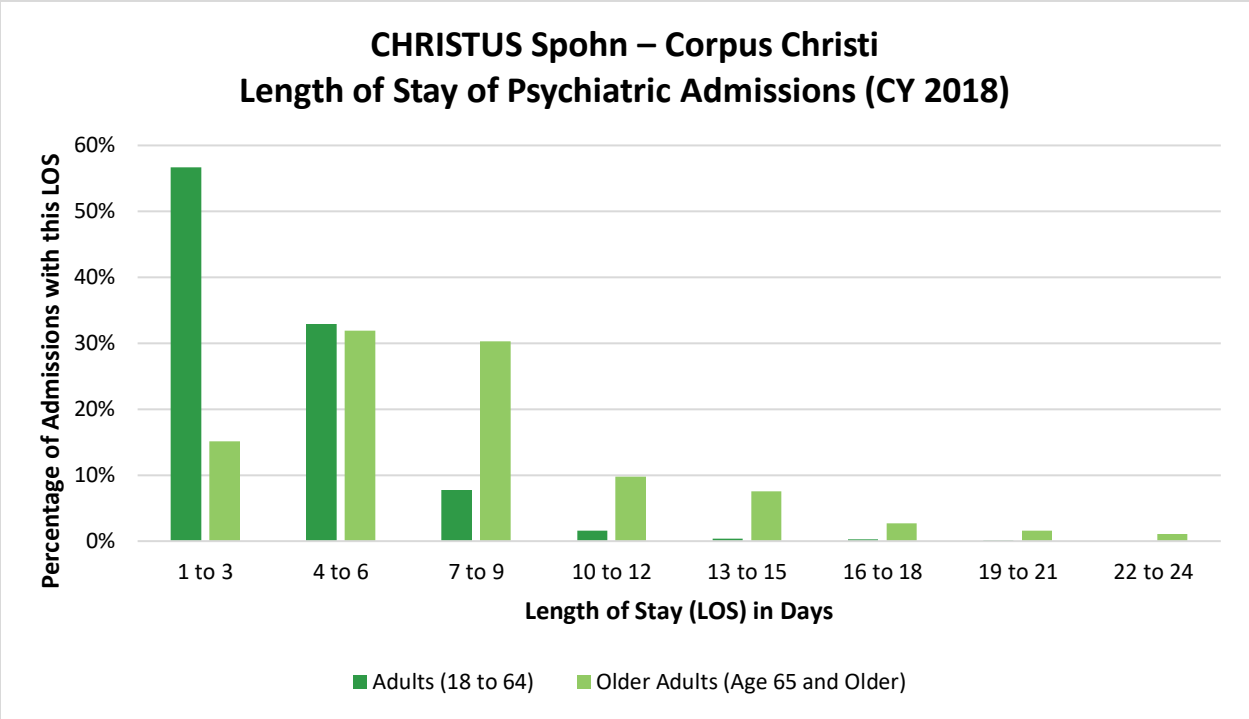


Figure 5 shows the lengths of stay at CHRISTUS Spohn – Corpus Christi, by age group, for calendar year 2018. Most adults between the ages of 18 and 64 had a length of stay of just one to three days. Older adults above age 64 stayed for somewhat longer, but still fewer than 10% stayed for longer than two weeks. CHRISTUS Spohn does not report any utilization data for children or youth. The length of stay analysis at CHRISTUS Spohn – Corpus Christi showed rapid stabilization and discharge for adults.

Figure 5: CHRISTUS Spohn – Corpus Christi Length of Stay Details[l]

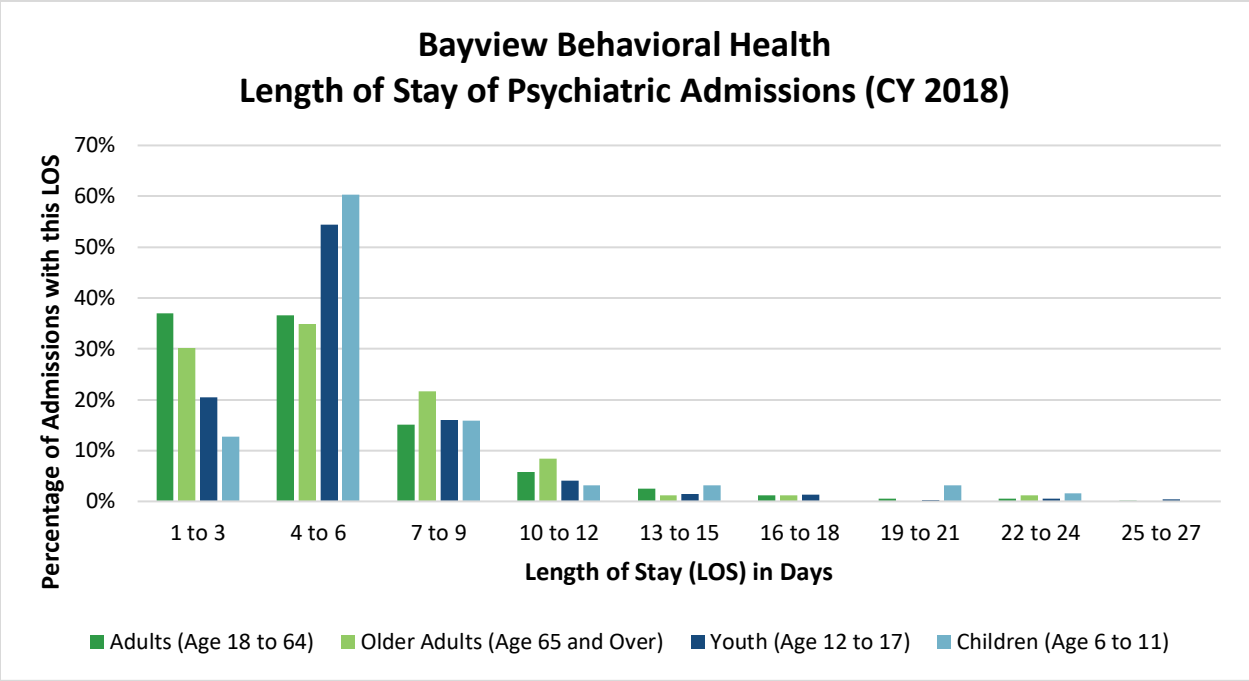


The average length of stay graph for Bayview Behavioral Hospital, as shown in Figure 6, shows a more muted difference between adults and older adults, but with somewhat longer lengths of stay for the older population. Many children and youth had lengths of stay between four and six days, with some utilization of more than two weeks.

The extended length of inpatient stays for older adults may reflect a lack of stepdown to skilled nursing facilities, forcing older patients to remain hospitalized beyond what is medically necessary. Or it may reflect conditions in older populations that are more difficult to stabilize. Chart reviews and analysis of the availability of skilled nursing facilities could help clarify if inpatient bed use in Nueces County hospitals may be reduced for older patients with mental illnesses.

Extended lengths of stay for some children and youth at Bayview Behavior Hospital also warrant further investigation. These cases are relatively rare, but in other Texas hospitals, extended hospitalization has occasionally occurred for children and youth involved with the foster care system who were unable to be placed with families. Because of the disruption caused by extended inpatient episodes, these cases should be reviewed to rule out systemic problems in the child welfare system that result in longer inpatient stays for children.

Figure 6: Bayview Behavioral Hospital Length of Stay Details[li]



Public perception that "more beds" are needed is often shaped by the reality that, in a disjointed and uncoordinated system, like that in Nueces County, people present at emergency departments, inpatient units, and jails while they are in crisis. This creates a perception that eliminating these individual crises is best addressed by adding more inpatient psychiatric beds. However, regardless of how many beds a community has, lengths of stays are typically short (usually a number of days) and people do return to the community. The need for emergency department, jail, and inpatient bed capacity is shaped by the integration or expansion of existing crisis services and other initiatives, bringing intensive outpatient programs to scale, and the availability of services (including inpatient) that can treat complex physical health needs, including substance use disorders (SUD). As we note in the Recommended Priorities for Service Investment in Adult Care: ACT and Forensic ACT section, Nueces County either lacks or has insufficient capacity in important services such as Assertive Community Treatment (ACT) and Forensic ACT (FACT) that can buffer against hospitalization and jail bookings. And as we note in the Crisis Response Across Populations section, the use of telehealth in Nueces County could also be expanded considerably to provide assessment, consultation, and treatment in a non-inpatient setting, particularly (though not only) with children and youth and their families.

The treatment of complex health needs often associated with serious mental illnesses should occur in settings where comorbid conditions (physical health issues, substance use issues) can be treated with the psychiatric illness. That is more difficult to accomplish in freestanding settings such as the floor in Memorial Hospital currently devoted to inpatient care (and which will be replaced). As Tables 4, 5 and 6 above illustrate, many people with primary physical

health issues have significant psychiatric or substance use conditions as a secondary diagnosis and many people with primary psychiatric diagnoses have physical health issues as well.

Overall Nueces Bed Needs Considering Multiple Historic Factors

As noted, in calendar year 2018, 3,029 Nueces County residents and 1,039 non-residents were admitted to inpatient psychiatric beds in Nueces County hospitals (Table 12 above). In addition, 468 Nueces residents were admitted to inpatient hospital beds outside of Nueces County (this excludes 54 Nueces residents admitted to state hospitals since those admissions are generally for forensic admissions by court order). Therefore, in considering "how many beds" are needed for Nueces, it is useful to consider whether there is existing capacity to treat *all* Nueces County residents (other than forensic admissions) who were admitted to inpatient care regardless of admission to Nueces facilities or elsewhere. To do so, we used an average length of stay that was above the average length of stay (LOS) - 5 days - for inpatient admissions in Nueces County hospitals. Recall that the *current* bed capacity in Nueces is 88 licensed inpatient psychiatric beds (including 24 beds for children at Bayview and 64 beds for adults, 32 each at Bayview and CHRISTUS Spohn). For Bayview Behavioral Hospital, 64% of psychiatric inpatient LOS are 5 days or fewer. At Christus Spohn Corpus Christi, 76% of patients stay for 5 days or less.

Calculating Potential Need Based on Historic Use

Adult Bed Needs

In calendar year 2018, there were 2,832 adult admissions for adults ages 18 to 64 and 268 admissions of adults ages 65 and older to the 64 licensed inpatient psychiatric beds in Nueces County hospitals (Table 15). Assuming a 5-day LOS per admission (which exceeds the median LOS for all hospitals in Nueces County and is the median LOS for Bayview), 43 inpatient beds would have been sufficient to account for all admissions (against a current licensed inpatient capacity of 64 adult beds in Nueces). To permit inpatient beds to operate at 75% capacity and allow 25% of beds to be open on an average day, 54 beds would be needed to accommodate all admissions.

If we include the 359 admissions of adults (ages 18-64) and older adults (65+) from Nueces County to non-local hospitals and assume that *all* Nueces residents other than those admitted for forensic purposes to state hospitals will be treated in Nueces County, the 5-day LOS average would require 49 inpatient beds for adults and older adults combined. Allowing 25% of beds to remain open on an average day, 61 beds would be needed to accommodate all local and non-local admissions, still below the current allotment of 64 adult beds.

Children and Youth Bed Needs

In calendar year 2018, there were 63 admissions of children ages 6 to 11 and 906 admissions for youth ages 12-17 to Bayview Hospital (Table 15). Assuming an average LOS of 5 days per

admission, 13 inpatient beds would have been sufficient to account for all child and youth resident admissions Bayview (and note that Bayview operates 24 beds for children and youth currently). To leave at least 25% of beds open on an average day, 17 beds are needed to accommodate all local admissions. If we include admissions to non-local hospitals by Nueces County residents and allocate 25% beds to be open, the 5-day LOS assumption would require 20 inpatient beds. In other words, if all Nueces County children and youth were treated in Nueces County facilities alone and none were transported for care out of Nueces County, the current number of beds would be sufficient for a 5-day LOS (a LOS that exceeds the current norm).

Table 15: Calculation of Psychiatric Bed-Days for Nueces County Hospitals (Local Residents and Non-Local Residents) (CY 2018)[lii]

Hospital	Total Psychiatric Admissions	Psychiatric Bed Days for 5 Day Average Length of Stay	Number of Beds Needed for Five Day Average LOS, Full Capacity[liii]	Psychiatric Beds Days for Five Day Average LOS at 75% Capacity	Number of Beds Needed for Five Day Average LOS at 75% Capacity
Bayview Behavioral Hospital					
All Ages	2,389	11,945	34	14,931	42
Children (Age 6 to 11)	63	315	1	394	1
Youth (Age 12 to 17)	906	4,530	12	5,663	16
Adults (Age 18 to 64)	1,337	6,685	18	8,356	23
Older Adults (Ages 65 and older)	83	415	2	519	2
CHRISTUS Spohn – Corpus Christi					
All Ages	1,680	8,400	23	10,500	29
Adults (Age 18 to 64)	1,495	7,475	20	9,344	26
Older Adults (Ages 65 and older)	185	925	3	1,156	3
Nueces Resident Admissions to Non-Local Hospitals					
All Ages	468	2,340	9	2,925	10
Children (Age 6 to 11)	29	145	1	181	1
Youth (Age 12 to 17)	80	400	2	500	2
Adults (Age 18 to 64)	337	1,685	5	2,106	6

Hospital	Total Psychiatric Admissions	Psychiatric Bed Days for 5 Day Average Length of Stay	Number of Beds Needed for Five Day Average LOS, Full Capacity[liii]	Psychiatric Beds Days for Five Day Average LOS at 75% Capacity	Number of Beds Needed for Five Day Average LOS at 75% Capacity
Older Adults (Ages 65 and older)	22	110	1	138	1
Nueces Admissions Combined					
All Ages	4,537	22,685	66	28,356	**81**
Children (Age 6-11)	92	460	2	575	**2**
Youth (Age 12 to 17)	986	4,930	14	6,163	**18**
Adults (Age 18-64)	3,169	15,845	43	19,806	**55**
Older Adults (Ages 65 and older)	290	1,450	6	1,813	**6**

It may be that population trends, changes in practice, unmet need and other factors counsel the creation of additional inpatient capacity in Nueces County. However, historic use suggests that current capacity is generally sufficient, even with significant gaps in the current community care system, and could accommodate even those admissions of Nueces County residents that currently occur in other counties and do so without disrupting the ability of people from other counties to find care in Nueces County. In addition, the plan adopted by NCHD (the Mental Health-Behavioral Health: Required Elements of Nueces County Program, noted above) before the CHRISTUS Spohn decision to continue its commitments with NCHD, recognizes that inpatient capacity alone is not enough: the stipulation that there must be triage capacity, the use of telemedicine, adult crisis and stabilization capacity and an outpatient clinic acknowledges that providing multiple levels of assessment and treatment are necessary. As elements such as those suggested by NCHD and recommendations in this report are implemented, the need for inpatient treatment as a last resort (as it is for health care generally) is more likely to diminish, rather than grow.

Crisis Response Across Populations

Recommendation: We recommend the creation of an integrated, medically-facing crisis response system that emphasizes medical and mental health response as its key components and includes critical services such as crisis stabilization either through NCMHID or other providers. Although there are elements of crisis response in Nueces County, the response to mental health crises relies heavily on law enforcement and there needs to be more integration of the responses by law enforcement and the NCMHID. In addition, NCMHID lacks critical components of crisis services in its service array.

Crisis services are critical for people with significant behavioral health needs. For many, the onset of a crisis may be the first interaction with the mental health system. When crisis services are unavailable or ineffective, other services from the community safety net such as law enforcement and hospital emergency departments must fill the gap, sometimes in ways that may contribute to further traumatization. Getting crisis services "right" is critical to identifying and assessing need as well as linking people to services at the earliest point possible. Crisis services can offer tools and supports that help people not only to move through crises but also to engage in their recovery and successful community living. The "right" crisis services include a continuum of services that aim to de-escalate the crisis in a safe setting, relying on a client-centered approach that is respectful and provides the person with supports to minimize the crisis.

However, crisis services alone, regardless of their effectiveness in mediating crises, need to be part of a larger continuum of care that, to the maximum extent possible, supports people in their recovery and efforts to lead successful lives in the community. Crisis services ideally include a continuum of services specifically created with the intention to stabilize and improve the individual's symptoms and facilitate their engagement in treatment in the least restrictive setting possible.

The Meadows Mental Health Policy Institute has developed several recommendations for the components of a crisis service continuum. While few communities have each of these components, they do provide a framework for the development of specific services. These include:[23]

- Crisis stabilization/observation beds (23- to 48-hour units);
- Short-term crisis residential and crisis stabilization services (extended observation units);
- Crisis triage/assessment centers and crisis urgent care centers;
- Emergency medical services (EMS);

[23] Meadows Mental Health Policy Institute. (2016, December). *Behavioral health crisis services: A component of the continuum of care*. Commissioned by St. David's Foundation. https://www.texasstateofmind.org/wp-content/uploads/2017/01/MMHPI_CrisisReport_FINAL_032217.pdf

- Mobile crisis services/mobile crisis outreach teams;
- Crisis telehealth services;
- Crisis hotlines that are available 24 hours a day, seven days a week (24/7);
- Warm lines;
- Psychiatric advanced directives;
- Peer crisis services; and
- Transportation.

In addition, a local mental health authority (LMHA) can provide the following types of crisis services per their contract with the Texas Health and Human Services Commission. HHSC describes these services in its "Community Support Guide for Alternatives to Inpatient Mental Health Treatment."[24] However, NCMHID currently only provides a handful of potential services, as listed below.[25]

NCMHID Provided Services

- Crisis Hotline 24/7 (Adults and Children/Youth)
- Mobile Crisis Outreach Team (Adults and Children/Youth)
- Crisis Respite Services (Adult only)
- Community Inpatient Hospital Services (Adult only)
- Walk-in Crisis Services

Potential Additional Services Per HHSC Contract

- Walk-In Crisis Services
- Extended Observation Unit
- Crisis Residential Services
- Psychiatric Emergency Service Centers
- Crisis Stabilization Unit (CSU)

The following table lays out the crisis funding across various LMHA's to provide a financial perspective on the cost and percentage of crisis expenses in different parts of Texas.

[24] Texas Health and Human Services Commission. (2018). *A community support guide for alternatives to inpatient mental health treatment*. Medical and Social Services Division: Behavioral Health Services. https://hhs.texas.gov/sites/default/files/documents/services/mental-health-substance-use/community-suport-guide-alt-inpatient-mh-treatment.pdf#page26

[25] Texas Health and Human Services. (n.d.). *Community mental health contracts: Information item V – crisis service standards*. https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts

Table 16: Crisis Funding Outlook Across Local Mental Health Authorities[26]

Local Mental Health Authority	Total All Crisis Expenses	Adults Specific Crisis Components *	Child Specific Crisis Components *	Crisis, Transitional, & Intensive Ongoing Services*	Total All Crisis Local Funding	% of Total Local Funding Per Total Expenses
Burke Center	5,716,273	OP, SE	OP, SE	R, OP, SE	2,148,566	37.59%
Nueces County	2,008,601	R, SE, O	SE	OP, SE, O	400,513	19.94%
Permia Care	3,882,633	OP, SE	OP	R, OP, SE	523,862	13.49%
Heart of Texas Region	5,225,984	N/A	N/A	R, OP, SE, O	618,624	11.84%
Border Region	1,624,624	SE	SE	R, OP	985,965	60.69%
Authority of Brazos Valley	2,365,745	SE	SE	R, OP	172,264	7.28%
StarCare Specialty Health	1,398,979	R	R	OP, SE, O	433,210	30.97%

Key*	
OP	Outpatient
SE	Screening & Eligibility
O	Other
R	Residential/Inpatient

In 2014, NCMHID worked with the community to develop a plan for expanding crisis continuum services to adults in Nueces County, but these services were not selected by the Texas Health and Human Services Commission for funding. The stakeholders who worked with Nueces County and signed letters of support included the Corpus Christi Police Department, the City of Corpus Christi, Cenikor (formerly Charles's Place Center of Recovery), Corpus Christi Metro Ministries, and the Corpus Christi Salvation Army. Although this plan was not funded, it could be used as a starting point for the community to develop a crisis continuum plan for adults, children, and youth in Nueces County. Some of the adult crisis continuum services that were set forth in the application were:

[26] Information in this table was found in the MH Report III Quarter 4 reports for 2019. Data provided by Texas Health and Human Services Commission via Open Records Request on December 18, 2019 from https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts
(personal communication, received on January 8, 2020).

- Expanding current county crisis services,
- Establishing 10 sober beds,
- Adding an extended observation unit,
- Adding additional crisis respite beds, and
- Providing a walk-in crisis clinic.

The following section provides detailed recommendations for improving crisis response resources in Nueces County building on the approach in the 2014 plan, but mindful as well that crisis services in Nueces County are significantly underdeveloped.

The Current Crisis Response System and Recommendations

Creation of a Medically-Facing Crisis Response Team

The crisis response system in Nueces County, as it is currently structured, is overly reliant on hospital emergency departments and law enforcement to respond to a crisis, as well as unnecessary inpatient utilization instead of community-based interventions. There are several actions that Nueces County can take to quickly improve crisis response. Note that many Texas communities, including Dallas, Austin, Abilene, Houston, and others are considering innovative crisis response teams that are medically-facing and that rely on teams composed of a paramedic (to provide medical screening), a mental health professional (to respond to immediate mental health issues), and law enforcement (to secure the scene, as appropriate) rather than relying on law enforcement alone, or mental health providers alone, to respond to a crisis.

Early returns on this integrated approach are promising, with a reduction in arrests and emergency department stays, and resolution of many situations in the community (instead of in emergency rooms or jails). For example, as outlined in our final report regarding our work on the Dallas County Smart Justice Project, a three-year project funded by the W.W. Caruth Jr. Foundation at the Communities Foundation of Texas,[27] the City of Dallas deployed a multidisciplinary response team called the Rapid Integrated Group Healthcare Team (RIGHT) Care. This unit is a collaborative partnership between the Dallas Police Department, Dallas-Fire Rescue, and Parkland Health and Hospital System – whose service area was identified as the geographic areas of greatest need – to respond to mental health-related 911 calls for service. RIGHT Care provides on-site clinical assessment and linkage to appropriate care at the point of intervention for people who have mental health needs and are experiencing a mental health crisis in the community.

[27] Meadows Mental Health Policy Institute. (2020). Dallas County smart justice project: Year three end-of-year report – final report.

RIGHT Care has reduced the burden on law enforcement in responding to 911 mental health calls in the Dallas community and has fundamentally altered intervention practices in the South Central Patrol Division, where it has been implemented since 2018. Key highlights of success include:

- From implementation through December 15, 2019, RIGHT Care has had 5,514 total interactions with individuals. Of these interactions, 1,972 resulted in diverting people from arrest or involuntary hospitalization and connecting them instead to treatment or services.
- The total time of redeployment back to service for Dallas Police Department's (DPD) officers over all 46 and 46A RIGHT care calls equaled 127 weeks (46 and 46A calls represent DPD's calls for service related to mental health issues). DPD has saved over one-and-a-half full-time police officer positions added back to patrol time since the beginning of the program.

We recommend this approach highly, particularly with its integration of a paramedic, mental health professional, and law enforcement. We are happy to provide additional information to Nueces County officials if they are interested. In the interim, we have specific recommendations for the bifurcated crisis response system that currently exists in Nueces County. These recommendations follow.

Improving NCMHID Hotline and Mobile Crisis Outreach

NCMHID, Nueces County's LMHA, is the only provider of community-based crisis services in the county. As the LMHA, NCMHID is contractually responsible for providing a 24/7 crisis hotline and mobile crisis outreach team (MCOT). A crisis hotline is a needed community resource that provides information, support, referrals, and screening to members of the community who are experiencing a mental health crisis. NCMHID currently subcontracts the hotline management to Avail Solutions. According to data provided by NCMHID, at least 50% of the calls to its hotline are categorized as "other," which means that half the people calling the crisis line are not experiencing a mental health crisis.

NCMHID also provides the county's only MCOT. An MCOT must have the ability to mobilize in response to a crisis to ensure that the crisis is treated in a familiar setting such as the person's home, school, or community. Often when a person is in a familiar and safe setting, the crisis can be de-escalated in the community without the need for more restrictive settings such as a hospital or jail. The team also can facilitate connections to community resources as well as coordination with existing services, as opposed to an emergency department, which typically is not as connected to community resources.

Throughout our assessment, many of the community providers who refer to emergency departments stated they were not aware of the crisis services offered by NCMHID. According to NCMHID leadership and community stakeholders, NCMHID's MCOT only mobilizes during standard business hours and it subcontracts its after-hours crisis response to Avail Solutions. If a crisis occurs outside of standard business hours — or on a holiday or weekend —Avail Solutions responds. And although NCMHID would appear to have ensured continuity of its services through this contract, Avail Solutions will only go to designated safe places — emergency rooms, schools, juvenile justice facilities, or the Avail Solutions offices. If a person cannot be safely transported to one of those locations, the police will be called for transport. This contradicts the ultimate goal of crisis services, which is to reduce criminal justice interventions, use of emergency rooms, and inpatient hospitalization. In addition, NCMHID's current operations do not meet the goals of an MCOT,[28] which are to provide rapid evaluation, stabilization, and resolution to a crisis *wherever the individual is located, including at home or in the community.*[29] Therefore, in order to meet model fidelity and community need, NCMHID will need to develop a more responsive solution to addressing crises that occur after business hours in the community.

Given the need to realign and redistribute resources, it is noteworthy that NCMHID's fiscal year (FY) 2019 total crisis expenditures for providing crisis response services in Nueces County were approximately $2 million.[30] A thorough review by NCMHID of existing costs and expenses may locate areas for more efficient use of funds. Although NCMHID's implementation of best practices in its crisis services delivery may initially cost more than its current operating budget, NCMHID can achieve potential efficiencies and better outcomes for people experiencing a behavioral health crisis through improved operations. For example:

- NCMHID could potentially decrease spending and improve clinical outcomes by bringing after-hours crisis response in-house or co-locating crisis staff at emergency departments during peak times.
- A majority of hotline calls are not crisis related; therefore, restructuring the flow and amount of calls coming through the hotline may permit redirection of these funds to support direct crisis intervention instead.
- NCMHID should consider renegotiation of its current contract with Avail Solutions or in-house responders to establish a per-episode fee for after-hours crisis response rather than the current flat rate arrangement.

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[28] Texas Health and Human Services. (n.d.). *Community mental health contracts: Information item V – crisis service standards*.

[29] Italics added to highlight the ways NCMHID appears to be out of compliance with its current crisis response contract.

[30] Details regarding the NCMHID fiscal year budget were discussed during conversations with NCMHID leadership.

Once key aspects of the plan are in place, NCMHID should develop a plan for strategic outreach to community-based organizations, including hospital systems, to improve the community's knowledge of the services it offers, including the best use of the MCOT services. Developing and implementing a plan to inform community organizations and hospital systems about NCMHID's available crisis services and how to use them can be accomplished in a relatively short amount of time, likely three to four months. However, an important aspect of the outreach plan will be to integrate these strategies into ongoing operations to ensure community-wide education on a regular schedule, rather than a one-time occurrence. Although implementing a community outreach strategy will be a low-cost intervention, changing after-hours crisis response will require a moderate to significant budget allocation.

Although NCMHID is responsible for providing community-based crisis services for Nueces County, including a crisis hotline and an MCOT, as provided in Chapter 534 of the State Health and Safety Code,[31] it will take a coordinated response among all community stakeholders to address the countywide need for an appropriate response to mental health crises that reduces the need for emergency room visits and inpatient psychiatric hospital stays, and uses public funding resources efficiently. Nueces County leaders could examine alternative models of crisis response approaches such as those embodied in RIGHT Care or the Bexar County's approach to emergency navigation for possible implementation in Nueces County.

Law Enforcement Crisis Response

Both NCMHID and the Corpus Christi Police Department provide crisis response services. As noted above, NCMHID is contractually responsible for providing a 24/7 crisis hotline and MCOT. The Corpus Christi Police Department has a Crisis Intervention Team program staffed by a dedicated, full-time Corpus Christi Police Department officer who works Mondays through Fridays during the day and is supported by Corpus Christi Police Department officers hired by NCMHID in an off-duty capacity to work the evening and weekend shifts.

As we pointed out in our December 2019 report on criminal justice issues, hiring off-duty Corpus Christi Police Department officers to staff the program has been a challenge for NCMHID. Stakeholders we interviewed reported that off-duty officers may be reluctant to participate in the Crisis Intervention Team because they fear they would not have the employment protections afforded to on-duty officers such as workers' compensation coverage for injuries sustained in the performance of their duties (e.g., officer-involved shooting,

[31] Texas Health and Safety Code, Title 7. Mental Health and Intellectual Disability, Subtitle A. Services for Persons with Mental Illness or an Intellectual Disability, Chapter 534, Community Services, Attachment A01 Performance Contract Notebook [MH/PCN] (2015 & rev April 2, 2020). https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/community-mh-contracts/performance-contract-notebook-program-attachment.pdf

incidents resulting in injuries to citizens or officers, and complaints) or non-duty related injuries such as slips and falls or workplace accidents.

Immediate Recommendations to Enhance the Corpus Christi Police Department Crisis Intervention Team

- We recommend that officers be considered on-duty while working on the Crisis Intervention Team. This will ensure all officers working with the Crisis Intervention Team are consistently operating under the same policies and procedures; increase the number of officers who are available to work on the Crisis Intervention Team; and ensure that officers are classified as on-duty and afforded all the rights and protections as any other officer working a shift.
- Staff the Corpus Christi Police Department Crisis Intervention Team with on-duty officers in lieu of the off-duty officers currently hired by NCMHID. The existing agreements between Corpus Christi Police Department and NCMHID can be restructured to allow the Corpus Christi Police Department to be reimbursed for either permanent full-time equivalent officers (FTEs) or city-sanctioned overtime.
- Dedicate one FTE departmental staff member for Crisis Intervention Team oversight. The job responsibilities for this position would include oversight of program fidelity, training, data collection, scheduling, community meetings and engagement, referrals, and outreach.
- Employ at least one permanent FTE officer who is assigned to each shift, Mondays through Fridays (7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m.).[32]
- Cultivate a cadre of 10 to 12 officers who are interested in working with the Crisis Intervention Team. Ideally, these officers would be drawn from various shifts and different patrol districts. Identify officers among this cadre who would be scheduled on the weekends and could backfill the lead FTE(s) on days and evenings, Mondays through Fridays, when necessary. Training a cadre of officers from different patrol districts would reinforce the commitment to the Crisis Intervention Team program, allow those officers to share experiences related to mental health crisis calls, and provide expertise and resources when the Crisis Intervention Team lead is unavailable.
- Align work hours between Corpus Christi Police Department and NCMHID case managers who work with the Crisis Intervention Team.
- Patrol in an unmarked police vehicle. This vehicle should be equipped with concealed emergency lights and siren and all necessary police communications (mobile digital computer and radio) and in-car video equipment.

[32] As evidenced in our work in other communities, we have found that the primary need for a co-response model is Mondays through Fridays (7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m.). When making budget considerations, those are the most effective hours to staff a co-response or multi-disciplinary team.

- Allow NCMHID case managers to respond to an incident in a NCMHID vehicle when a police officer or deputy is unavailable.
- Provide NCMHID case managers a distinct uniform to wear.
- Provide NCMHID case managers a concealable, ballistic protective vest (minimum level of protection should be at least National Institute of Justice Level II or greater) similar to the vests issued to officers and deputies.

Through our interviews with Corpus Christi Police Department training staff, we believe it would take approximately two to three months to identify and train new officers for the program. Additionally, we have found that organizational staffing changes take approximately one month to accommodate new work schedules that could possibly impact personnel changes. To accommodate these changes, the Corpus Christi Police Department can consider reallocation of existing funds or budgeted positions. Federal and state funding opportunities and annual Bureau of Justice Assistance grants available through the Council of State Governments may also be available to fund personnel for co-responder models.[33]

The creation of a new Nueces County Sheriff's Office Crisis Intervention Team is an opportunity for the Corpus Christi Police Department, Nueces County Sheriff's Office, and NCMHID to collaborate to create a Crisis Intervention Team Standard Operating Procedure (SOP) that will be distributed to all police officers, sheriff's deputies, and diversion staff.

Immediate Recommendations for Shared Policy, Procedures, and Documentation

Given the number of parties involved in these efforts, we recommend that the Corpus Christi Police Department, Nueces County Sheriff's Office, and NCMHID create shared policies and procedures, including:

- Develop a SOP to include several elements such as:
  - A formal explanation of the Crisis Intervention Team program and its goals,
  - A clear explanation of the roles and responsibilities for each Crisis Intervention Team member (law enforcement and case managers),
  - Client/consumer interaction and referral records management system documentation procedures, and
  - Data collection instructions and a data/metric reporting schedule.
- Develop a shared and formal training for all officers, deputies, and case managers working on the Crisis Intervention Team and the MCOT.

[33] Regarding physical resources, utility khaki pants, polo shirts, and outer jackets are easily acquired items and should cost $100 per set. Ballistic vests may cost $800 and acquisition usually takes nearly two months once an order is placed with a vendor. Using the Corpus Christi Police Department procurement contract could shorten this projected delivery time. Acquiring a vehicle and installing an equipment "police package" can take up to three months. A completely equipped police vehicle costs approximately $45,000. Some of these costs may be covered through grant requests under the Justice Assistance Grant program previously mentioned.

- Create a social service (or other appropriate title) referral element in the records management system for the Crisis Intervention Teams to appropriately route incidents to the lead Crisis Intervention Team officer within a department.

Written documents should be available within two months and approved by all stakeholders within three months. The initial alignment of policies, processes, and workflows recommended here should not cost anything other than existing staff time.

A Note on Emergency Detention Orders and Related Processes

Although we recommend that Nueces County create a medically-facing crisis response system for mental health crises, the stakeholders we interviewed also indicated that there was some uncertainty in the community about when and how law enforcement officers are permitted to take a person into custody for emergency detention under Chapter 573, Health and Safety Code.[34] This uncertainty is highlighted by the use of emergency detentions within the Crisis Intervention Team program. Under the current procedure, when an NCMHID case manager is on the scene, the Corpus Christi Police Department Crisis Intervention Team officer often defers emergency detention decision-making to the NCMHID case manager and uses a judge's or magistrate's authority for emergency apprehension and detention under Subchapter B of Chapter 573. In contrast, an on-duty officer, without a NCMHID case manager, does not hesitate to execute an emergency detention order when the circumstances merit such action. There should be a concrete plan to ensure access to inpatient care when needed and that there is a warm hand-off to community-based care.

Immediate Recommendations for Consensus on the Use of Emergency Detention Orders and Related Processes

Criminal justice stakeholders, courts, NCMHID, and local hospitals should develop a consensus on the use of the emergency detention options offered in Chapter 573, Health and Safety Code. This process should begin immediately and produce written documentation within two months. There is no specific cost for this recommendation other than existing staff time to bring stakeholders together and quickly develop shared processes. The written document should include:

- Protocols for law enforcement to use the provisions of the Chapter 573 for Apprehension by Peace Officer Without Warrant,
- Protocols for law enforcement and hospitals to obtain emergency detention orders,
- Protocols for connecting people released from care to NCMHID and other community supports for ongoing treatment,

[34] Texas Health and Safety Code, Title 7. Mental Health and Intellectual Disability, Subtitle, C. Texas Mental Health Code, Chapter 573. Emergency Detention. (1991 & rev 2019). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.573.htm

- Access by defense attorneys to people held under emergency detention orders and reports on their client's treatment progress to advocate for the patient to receive appropriate treatment in the least restrictive setting.

Crisis Response for Children and Youth

There are particular gaps in the crisis response for children and youth. The NCMHID MCOT does not have a particular focus on children and, aside from the MCOT, the only alternative to inpatient hospitalization is the partial hospitalization and intensive outpatient program offered at Bayview for youth ages 12 to 17 years, in which approximately 20 youth participate. Although this program is valuable, it is a more intensive intervention within the continuum of care and, in and of itself, insufficient to provide crisis services to children and youth. Additionally, the MCOT crisis team does not have a separate team that responds to the needs of children and youth. A separate team for children and youth would be ideal, but many LMHAs do not have separate MCOT teams because the cost can be prohibitive. They can, however, train current staff in crisis response best practices for children and youth. At this time, no additional training is offered for Nueces County MCOT staff.

Further, the county's 2014 community plan to expand crisis continuum services did not include a component that specifically addressed the needs of children and youth. Also, the continuum of crisis services available to adults, while limited, is more comprehensive than the services available for children and youth. Since it takes time and funding to implement many best practices in crisis response, our primary recommendation is for the community to expand on the 2014 report to include a crisis continuum plan for children and youth. When funding for crisis services becomes available, whether it is through the Health and Human Services Commission or another funder, a critical component of the application is the ability to show how the additional funds will support current efforts. Not only will having a documented plan provide the community with a roadmap towards implementing the ideal crisis care framework, it will also improve the community's likelihood of securing funding in an application process that requires documentation of current efforts.

Immediate Recommendations to Improve Crisis Care Continuum for Children and Youth

NCMHID should:

- Implement a training for all MCOT responders in best practices for crisis response for children and youth.
- Expand the 2014 community plan to include a vision for crisis services for children and youth that includes expanding services that are currently available through the crisis care continuum.

Implementing a training for all MCOT responders that addresses best practices in crisis response for children and youth can be accomplished in approximately three months. Again, planning should include the need to incorporate training into ongoing education and training requirements to ensure this knowledge is integrated into the overall operations, as opposed to a one-time occurrence. We recommend the Think:Kids Collaborative Problem-Solving Approach.[35] This program teaches skills related to problem solving, flexibility, and frustration tolerance and focuses on building healthy relationships and teaching children and youth the skills they need to succeed. In order to implement Think:Kids to fidelity, training and certification must be received through the model developers. Funding to train MCOT responders would require a moderate budgetary allocation.

Expanding the 2014 community plan to include a vision for crisis services for children and youth can be accomplished in approximately six to 12 months. A full description of a crisis response system can be found in the MMHPI document on crisis response noted above,[36] but plan components for children and youth should include a number of elements, including:

- A mobile crisis team for children, youth, and families that has the capacity to provide limited ongoing in-home supports, case management, and direct access to out-of-home crisis supports (for a national example, see Wraparound Milwaukee's Mobile Urgent Treatment Team/MUTT); [37]
- Screening, assessment, triage, ongoing consultation, time-limited follow-up care, and linkages to transportation resources, supported by protocols and electronic systems to communicate results across professionals and systems to determine the appropriate level of services;
- 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, including an array of options such as:
  - In-home respite options,
  - Crisis foster care (placements ranging from a few days up to 30 days),
  - Crisis respite (one to 14 days),
  - Crisis stabilization (15 to 90 days), with capacity for 1:1 supervision;
  - Acute inpatient care, and
  - Linkages to a full continuum of empirically supported practices

[35] Massachusetts General Hospital Department of Psychiatry. (2020). *Think:Kids CPS certification program*. http://www.thinkkids.org/train/certification/
[36] Meadows Mental Health Policy Institute. (2016, December).
[37] For more information, see http://wraparoundmke.com/programs/mutt/

We suggested an extended timeframe for completion to account for the time it would take to include necessary partners in the process. Funding to expand the 2014 community plan would also be small, though it would require the time of key staff members across multiple organizations. Implementation of a community plan, however, will require a significant budget allocation requiring funding from multiple sources, including billing, hospital systems, juvenile justice, child welfare, education, and philanthropy.

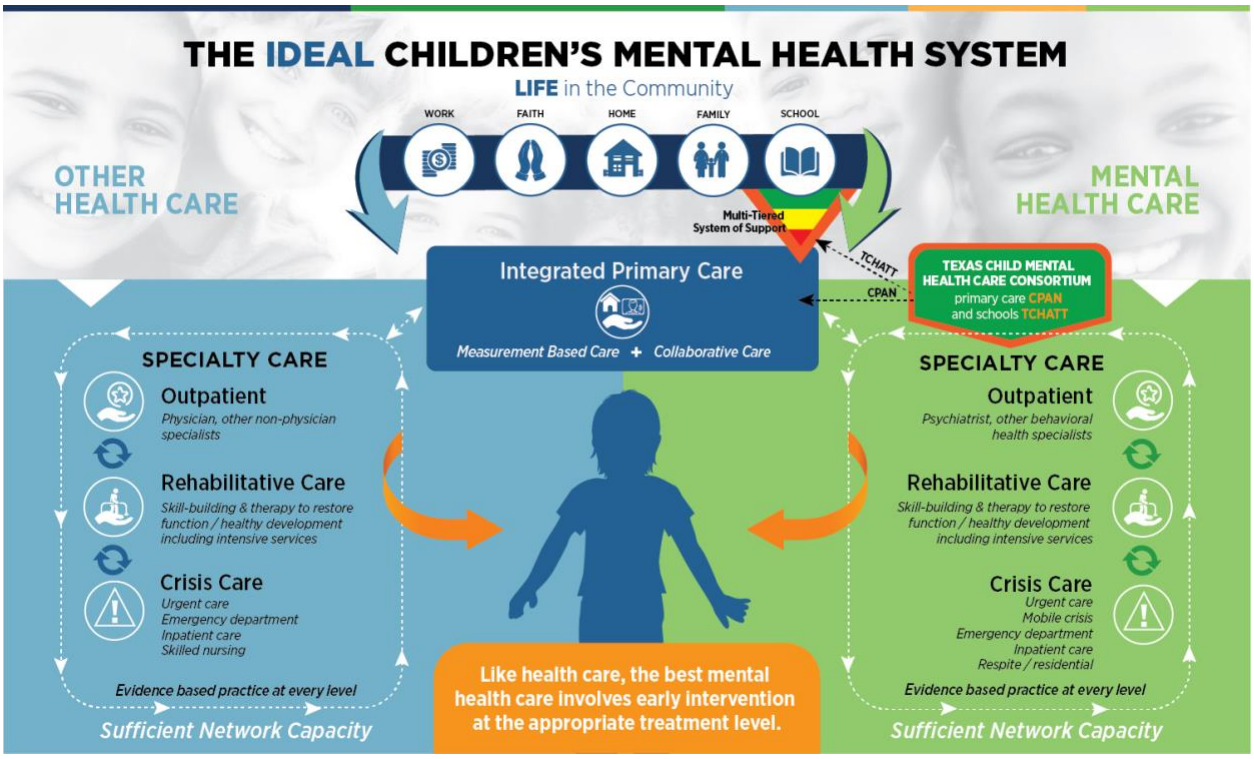
Access to Community Care Is Currently Limited: Local Mental Health Authority Utilization

Recommendation: Nueces County should invest in specific, evidence-based interventions that will enable the early identification of serious mental illness and enable people to live in their communities; create tools to integrate primary health and mental health care, something of particular importance to children and youth; focus on where veterans receive mental health care outside the U.S. Department of Veterans Affairs; and create jail transition programs.

Children and Youth

The ideal mental health system for children and youth is similar to that for adults, as Figure 7 below illustrates.

Figure 7: The Ideal Children's Mental Health System



This ideal system has five components:

- **Life in the Community** (Component 0), depicted at the top of the figure, includes the range of community settings where children and families spend their time. Health needs – including diseases affecting the brain, such as mental health disorders, as well as other pediatric health conditions, both chronic (like diabetes) or acute (like orthopedic accidents) – occur in the social context of life: home, family, schools, faith communities, foster care, juvenile justice settings, and other places where children, youth, and their families spend their time. The types of health care services that occur here are prevention and early intervention as well as supports for children, youth, and families with more severe needs who require interventions in their home and community. This includes services embedded in other child-serving organizations, including schools (note the symbol for multi-tiered systems of supports, or Multi-tiered Systems of Support, which is the primary framework we describe in the report for organizing the full range of needed school-based mental health supports, from prevention to treatment).
- **Integrated Primary Care** (Component 1) includes the health settings where all children should receive routine medical care and where the vast majority of children and youth with mild-to-moderate mental health needs should receive mental health care. The family doctor's office is in the center of the diagram above because this represents the best place to detect any health need early and successfully provide routine care. Integrating mental health treatment into pediatric primary care settings is an essential strategy for increasing access to mental health services for children and youth, treating those with most mild-to-moderate conditions, and creating referral pathways for those in need of more specialized and intensive care.[38]
- **Specialty Outpatient Care** (Component 2) is the level of the system that most people tend to think of when imagining mental health care: a mental health (or other behavioral health) specialist such as a psychiatrist, psychologist, social worker, therapist, counselor, or nurse practitioner providing care in a clinic or office. However, research shows that such care is only needed for children and youth with moderate-to-severe needs in a well-functioning system with adequate primary care supports routinely available to the family doctor. Specialty care is essential for both assessing more complex conditions and providing ongoing care for conditions like bipolar disorder, post-traumatic stress, severe depression, and other more complex disorders that require specialized interventions beyond the capacity of integrated primary care. This includes the typical example of a clinician in an office as well as more novel approaches using telehealth, such as the new Texas Child Health Access Through Telemedicine (TCHATT) program for underserved Texas schools that launched in May 2020.[39] We estimate that about one quarter of children and youth with mental health conditions (around 6,000

[38] Straus, J. H., Sarvet, B. (2014). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs, 33*(12), 2153–2161. https://doi.org/ 0.1377/hlthaff.2014.0896

[39] Additional information on the Texas Child Health Access Through Telemedicine Program can be found on page 55.

children and youth in Nueces County, including 3,000 children and youth with serious emotional disturbance living in poverty) need treatment by such specialists each year.

- **Specialty Rehabilitative Care** (Component 3) includes the broad range of evidence-based services necessary to address more severe and functionally impairing conditions, such as early onset psychosis and severe behavioral impairment that, if untreated, too often can lead to severe problems at home or school and even involvement in the juvenile justice system. Such care needs to address both the underlying clinical needs and the severe functional impairment in multiple life domains associated with it. About 2,000 children and youth in Nueces County suffer from these more severe and often chronic needs and impairments each year. This includes the approximately 300 children and youth with the most severe needs receiving intensive home and community-based services, who face the greatest risk for out-of-home or out-of-school placement each year.
- **Crisis Care** (Component 4) is essential to effectively respond to the acute needs of children, youth, and their families that can flare up at any level of care. Crisis services are not intended for ongoing care, nor are they substitutes for routine, ongoing care. However, even with optimal levels of the right kinds of prevention, primary care, specialty, rehabilitation, and intensive services, any health condition can become acute at times and require urgent intervention to respond to crises that can jeopardize a child or youth's safety and functioning. Crisis care ideally includes mobile teams that respond to urgent needs outside of the routine delivery of care as well as a continuum of time-limited out-of-home placement options ranging from crisis respite to acute inpatient or residential care. In addition to preventing a sometimes-dangerous escalation of a mental health condition, crisis services also create connections between the crisis care continuum and ongoing care.

Additional detail on the five components that together constitute our Mental Health Systems Framework for Children and Youth as a whole can be found in Appendix H.

As previously noted, most children and youth can be treated in the primary care system and those with serious emotional disorders (SED) and serious mental illnesses (SMI) generally can be treated in community settings. However, in Nueces County, access to community services has been quite limited. Pediatric and behavioral health care are not routinely integrated in Nueces County, which is a missed opportunity for early detection and treatment of pediatric mental health concerns. Pediatric care, where the family doctor provides ongoing, routine care for children, youth, and their caregivers, is the front line for health care delivery and the place where families are most likely to get the help they need for their children. This is the setting where childhood development is evaluated, most illnesses detected, and early identification and effective referral and coordination for more complex health needs optimally provided. About two thirds of Nueces County children and youth suffering from mild-to-moderate

anxiety, depression, attention issues, and other behavior challenges each year (about 15,000 of 25,000 total children and youth in Nueces County) could have their needs adequately addressed in such settings, if detected early and treated with adequate supports to the primary care provider (such as the Child Psychiatry Access Network – or CPAN – a program that was launched in May 2020 by the newly-created Texas Child Mental Health Care Consortium that was established by the Texas Legislature and all 12 state-funded medical schools in 2019), particularly if the clinical setting offers collaborative care (which pays for a behavioral health specialist in the primary care office, either in person or through telehealth). [40,41,42,43,44]

There are a few examples of integrated pediatric and behavioral health care, but their scope and reach are extremely limited. The Coastal Bend Wellness Foundation offers integrated care within their federally qualified community health center. Within the organization, primary care providers screen for mental and behavioral health needs using the Patient Health Questionnaire-9 (PHQ-9). If potential mental health concerns are identified through the PHQ-9, patients are referred to services in-house between providers. Whenever possible, providers also do a "warm handoff," walking the individual to the mental health provider's office for immediate assistance. Providers share information and communicate across teams through their electronic health record. Coastal Bend Wellness Foundation also has a monthly clinic management meeting where members of the team can consult with one another on the client's progress or additional needs. To further support behavioral health integration within the organization, Coastal Bend Wellness Foundation is hiring a licensed clinical social worker to help with case management and ensure that clients are connected with the mental and behavioral health services they need and help eliminate barriers to accessing services.

TAMU-CC also has a program called the Texas Counselors and Healthcare Integration Project (Tex-CHIP), that provides integrated behavioral healthcare within medically underserved communities. Tex-CHIP is funded by a four-year grant from the Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services, and provides the opportunity for future behavioral health counselors to specialize in integrated care by

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[40] We estimate that about two out of three children and youth with mental health needs have conditions that can be successfully managed in an integrated primary care setting. This translates to around 15,000 children and youth in Nueces County.

[41] Shippee, N. D., Mattson, A., Brennan, R., Huxsahl, J., Billings, M. L., & Williams, M. D. (2018). Effectiveness in regular practice of collaborative care for depression among adolescents: A retrospective cohort study. *Psychiatric Services, 69*(5), 536–541. https://doi.org/10.1176/appi.ps.201700298

[42] Kolko, D. J., Campo, J., Kilbourne, A. M., Hart, J., Sakolsky, D., & Wisniewski S. (2014). Collaborative care outcomes for pediatric behavioral health problems: A cluster randomized trial. *Pediatrics, 133*(4), e981–992.

[43] Richardson, L. P., Ludman, E., McCauley, E., Lindenbaum, J., Larison, C., Zhou, C., Clarke, G., Brent, D., & Katon, W. (2014). Collaborative care for adolescents with depression in primary care: a randomized clinical trial. *JAMA, 312*(8), 809–816. https://doi.org/10.1001/jama.2014.9259.

[44] Additional information on the Child Psychiatry Access Network can be found on page 53.

offering internships in these settings. As of February 2020, TAMU-CC has 28 students placed throughout 15 integrated care facilities, nine of which serve children and youth.

In addition, as Driscoll Children's Hospital increases its psychiatric footprint, it offers an opportunity for community-based care for children who require care in specialty behavioral health settings.

The following tables draw from data received from the Texas Health and Human Services Commission (HHSC). HHSC provided data on children and adults served by local mental health authorities (LMHAs) in fiscal year (FY) 2018. In Tables 17 and 19, we provide estimates of the number of children, youth, and adults who need care, broken out by treatment category.

Table 17 reports the total number of children and youth with any behavioral health need, with estimates of the number of children and youth who are best served in different care settings. The majority of children and youth with behavioral health needs can be met in an integrated care setting (15,000 of approximately 25,000 total). About one in four children and youth need specialty care settings (6,000), including 2,000 with SED living in poverty who could benefit from care through the LMHA. Finally, about 2,000 (or 1 in 10) children and youth with behavioral health needs require rehabilitation or intensive care, including 200 with the most intensive needs who are at risk for out-of-home or out-of-school placement and would require the most intensive services.

Table 17: Children and Youth in Need by Care Setting (2018)

Children and Youth – Community Care Need by Setting[liv]	
Integrated Primary Care[lv]	**15,000**
Specialty Behavioral Health Care[lvi]	**6,000**
Children and Youth in Poverty Needing Specialty Behavioral Health Care[lvii]	2,000
Mental Health Rehabilitation/Intensive Care[lviii]	**2,000**
Intensive Services[lix]	200

Tables 18 and 19 provide an overview of the number of children and youth served by NCMHID (the local mental health authority), including breakouts for the number served at each level of care (LOC). In comparison to the 2,000 children and youth in poverty who need specialty care, as reported above, 695 children and youth received ongoing care through the NCMHID.

Additionally, of the approximately 2,000 needing rehabilitation and intensive services, 53 received YES Waiver[45] and four received intensive family services through NCMHID.

These estimates indicate a large gap in care for children and youth with serious emotional disturbances (SED) who are living in poverty. The largest need is for rehabilitation and intensive services, but many children and youth with SED are also not receiving ongoing specialty outpatient care. To close this gap, it is important to incorporate the previous population growth estimates. Table 7 identifies a 7% estimated growth rate in the population of children and youth by 2025. Absent other factors, the number of children and youth with SED is likely to grow at this same rate.

Table 18: Children and Youth with SED in Poverty Who Were Served by the LMHA (FY 2018)[lx]

Nueces Center for Mental Health and Intellectual Disabilities				
Total Child and Youth Population in Poverty[lxi]	Children and Youth with SED in Poverty[lxii]	Children and Youth Served in Ongoing Treatment[lxiii]	Exact Percentage	Percentage of Children and Youth Served by NCMHID with Medicaid[lxiv]
30,000	2,000	695	28%	91%

Table 19: Children and Youth Levels of Care Analysis (FY 2018)[lxv]

Treatment Category	Level of Care	Nueces County	
		Number Served	% of Total Served[lxvi]
Outpatient	Medication Management	53	8%
	Targeted Services	379	55%
Rehabilitation	Complex Services	149	21%
	Intensive Family Services	4	1%
	Early Onset Psychosis Services	0	0%
	Young Child Services	45	6%
	YES Waiver	53	8%
	Transition-Age Youth	0	0%
Crisis	Residential Treatment Centers	0	0%

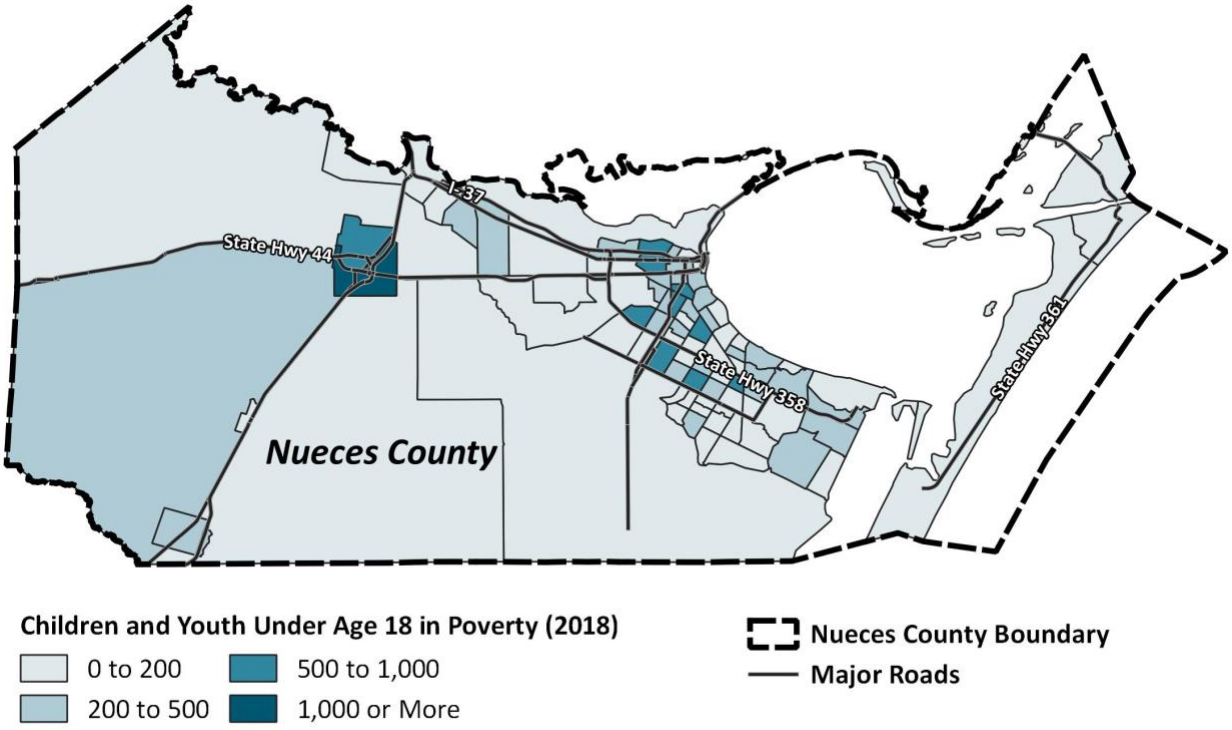
[45] The Youth Empowerment Services Waiver is a 1915(c) Medicaid program that helps children and youth with serious mental, emotional, and behavioral difficulties. The YES Waiver provides intensive services that are delivered within a strengths-based team planning process called Wraparound. See: https://hhs.texas.gov/services/mental-health-substance-use/childrens-mental-health/yes-waiver

Treatment Category	Level of Care	Nueces County	
		Number Served	% of Total Served[lxvi]
	Crisis Services	9	1%
	Crisis Follow Up	3	0%
Total Served		695	100%

In addition, the geographic location of services and where children and youth in poverty live are often unrelated.

Map 2 shows counts of children and youth in poverty by census tract, with dark blue areas signifying regions with high counts of children and youth in poverty as compared to the overall county. The region near Corpus Christi/Robstown has tracts with high counts of children and youth in poverty, whereas Port Aransas has lower counts of children and youth in poverty.

Map 2: Children and Youth Under Age 18 in Poverty by Census Tract (2018)[lxvii]

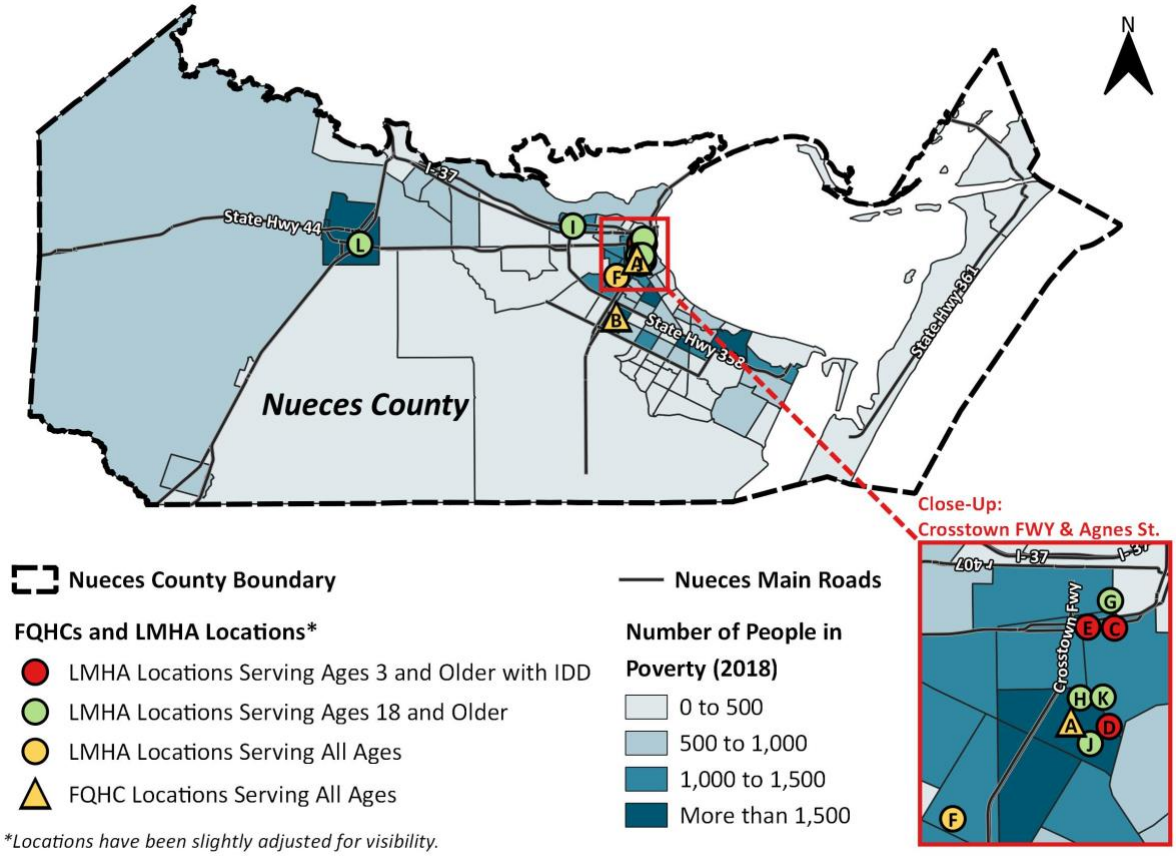


Map 3 shows the locations of federally qualified health centers (FQHCs) and the local mental health authority (LMHA) in Nueces County and also the 2018 counts of people in poverty by census tract, which serves as the base for the map.[lxviii] These providers generally serve people who are living in poverty, and therefore, service locations should reflect where people in poverty live.

The census tracts with the most people living in poverty are located in the blue areas on the left side of the map (west Nueces County) and in central Nueces County (Corpus Christi). The majority of providers are concentrated in a small geographic area (Corpus Christi). Providers serving children and youth with intellectual or developmental disabilities (IDD) appear to be located only in central Nueces County (Corpus Christi).

When compared to the map above which shows the areas with high counts of children and youth in poverty, it is evident that children and youth or people with IDD who are in need of services and who do not live in the central region of Nueces County may have difficulty accessing providers that are located beyond the areas where they live.

Map 3: Federally Qualified Health Centers (FQHCs) and Local Mental Health Authority (LMHA) Locations in Nueces County



Recommendations for Investment in Children and Youth Care

There are significant opportunities in Nueces County to improve care for children and youth, providing early treatment for psychosis, extending the reach of psychiatric consultation into primary care, and improving the mental health of children in schools. Providers can also look examples of integrated primary care available at LMHAs in Texas. Tropical Texas Behavioral

Health is the LMHA for Hidalgo, Cameron, and Willacy counties in Texas. Tropical Texas Behavioral Health established primary care clinics inside their mental health clinics because many of their patients who had chronic, co-morbid medical conditions were unable or unwilling to access primary care services in the community. Tropical Texas Behavioral Health integrated primary care clinics provide medical care including diagnosis and treatment of illness, conditions and diseases children and youth, linked to their mental health services. Primary care nursing staff provides medication training to educate the child, youth, and family on the diagnosed chronic medical condition, symptomatology, medications and possible side effects, and the interaction with their co-occurring mental illness. Tropical Texas Behavioral Health has seen an increase in the quality of care and coordination of care to their patients. Bluebonnet Trails Community Services, the LMHA located in Round Rock, added medical and dental healthcare to their services to increase access and better coordinate care. Their family health centers and practices offer access to a full array of services, including medical, dental, mental health, developmental health and substance abuse services. Bluebonnet Trails Community Services utilizes collaborative healthcare teams to provide and coordinate care that meets patients' various needs.

Below we focus on opportunities including those created by the Texas Legislature.

Implement a Coordinated Specialty Care Model – First Episode Psychosis

Nueces County has the opportunity to create a program to address the needs of the small number of youth who experience a first episode psychosis every year. Coordinated Specialty Care is a treatment approach that differs from treatment-as-usual because rather than waiting for people who are experiencing psychosis to find their way to treatment (something that typically only happens years after the first manifestation of psychotic symptoms), a team of specialists works actively with a variety of community partners to identify youth and young adults with emerging psychoses and to recruit them into treatment.

Recent research on the Coordinated Specialty Care model in the United States, as well as previous research in other countries, indicates it tends to reduce overreliance on expensive inpatient services, has great potential not only to preserve a person's health, social functioning, and quality of life,[46] but also to save communities and employers money in the long term.

[46] Ruggeri, M., Bonetto, C., Lasalvia, A., Fioritti, A., de Girolamo, G., Santonastaso, P., Pileggi, F., Neri, G., Ghigi, D., Giubilini, F., Miceli, M., Scarone, S., Cocchi, A., Torresani, S., Faravelli, C., Cremonese, C., Scocco, P., Leuci, E., Mazzi, F., Pratelli, M., … GET UP Group (2015). Feasibility and effectiveness of a multi-element psychosocial intervention for first-episode psychosis: Results from the cluster-randomized controlled GET UP PIANO trial in a catchment area of 10 million inhabitants. *Schizophrenia Bulletin, 41*(5), 1192–1203. https://doi.org/10.1093/schbul/sbv058

Coordinated Specialty Care models, as described by experts, are models that early research suggests can lead to positive, cost-effective outcomes.[47, 48, 49]

Steps should be taken to expand the capacity within Assertive Community Treatment team to help integrate a First Episode Psychosis – Coordinated Specialty Care model. At the heart of the Coordinated Specialty Care model is a multi-disciplinary team of specialists that works with a very small caseload of consumers to help them find the right medication and treatment, individualized to their needs. The team also provides a variety of evidence-based psychosocial services to help people learn how to manage their illnesses and achieve their most important goals, particularly in the areas of education and employment.[50]

Recommendation: Expand Child and Adolescent Psychiatry Capacity

An initiative that will help Nueces County address the shortage of child psychiatrists and concerns about overmedication and misdiagnosis is the Child Psychiatry Access Network (CPAN). Senate Bill (SB) 11 (86th Regular Session, 2019) established the Texas Child Mental Health Care Consortium to foster collaboration on pediatric mental health care among medical schools in Texas.[51] As described in SB 11, the Texas Child Mental Health Care Consortium is responsible for overseeing five key initiatives, one of which is CPAN. The CPAN program will support pediatric primary care providers by providing them with a no-cost psychiatric consultation for patients with a mental health concern. A similar program established in Massachusetts currently supports over 95% of the pediatric primary care providers in the state and suggests that two thirds of behavioral health care could be provided in pediatric settings with the right integration supports.[52] Through CPAN, pediatricians and other primary care providers can access child psychiatric and mental health consultation services through regional "hubs" supported by Texas medical schools. The hub that includes Nueces County is located at The University of Texas Rio Grande Valley (UTRGV).

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[47] Craig, T. K., Garety, P., Power, P., et al. (2004, November 4). The Lambeth Early Onset (LEO) Team: Randomised controlled trial of the effectiveness of specialised care for early psychosis. *BMJ, 329*(1067). doi:10.1136/bmj.38246.594873.7C

[48] Liffick, E., Mehdiyoun, N. F., Vohs, J. L., Francis, M. M., & Breier, A. (2016, October 3). Utilization and cost of health care services during the first episode of psychosis. *Psychiatric Services, 68*(2):131–136. doi:10.1176/appi.ps.201500375

[49] Srihari, V. H., Tek, C., Kucukgoncu, S., et al. (2015, February 2). First-episode services for psychotic disorders in the U.S. public sector: A pragmatic randomized controlled trial. *Psychiatric Services, 66*(7):705–712. doi:10.1176/appi.ps.201400236

[50] Becker, D. R., & Drake, R. E. (2003). *A working life for people with severe mental illness*. Oxford University Press.

[51] Senator Jane Nelson filed SB 10, which ultimately passed as a component of Senator Larry Taylor's SB 11.

[52] Straus, J. H., & Sarvet, B. (2014). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs, 33*(12), 2153–2161.

Providers in Nueces County report a shortage of mental health providers available to treat children and youth with mental health needs, which is a reality felt by many across Texas and the nation. This shortage has resulted in an overburdened health system that is stretching to deliver mental health services to more people than it is reasonably able to serve. Consequently, many children and youth receive fewer services than they need or wait weeks or months to access services, resulting in worsening and increased acuity of symptoms.

With CPAN on the horizon, mental health leaders in Nueces County should collaborate to maximize opportunities presented through the initiative. Over the long term, UTRGV's CPAN hub will help address the shortage of mental health providers in Nueces County by offering pediatric primary care providers with support in meeting their patients' mental health needs, including clinical consultation, care coordination assistance, and continuing education. This, in turn, can help improve diagnosis and prescription practices at the primary care level. UTRGV's CPAN hub will also include a referral network of specialty outpatient providers it can share with pediatric primary care providers.

CPAN will also expand the use of integrated pediatric primary care. With more children and youth being treated by their pediatrician, resources within specialty outpatient care can be focused on those with moderate to severe mental health needs. Studies on models similar to CPAN have shown a reduction in the medications prescribed to children and youth seeking mental health treatment. For example, in 2017, following the implementation of Seattle Children's Partnership Access Line (PAL), prescriptions of antipsychotic prescriptions for children enrolled in Washington State's Medicaid program decreased by nearly half.[53] This study also reported that children with a history of foster care placements experienced a 132% increase in outpatient mental health visits after the consultation call.[54] This is likely due to physicians knowing about and using the hub for referrals when a mental health need was identified during an office visit.

Immediate Recommendations for CPAN

The first step in implementing CPAN is to register all Nueces County pediatric primary care providers (pediatricians, family medicine physicians, physician assistants, nurse practitioners, and nurses) to participate with the UTRGV CPAN hub. This should include pediatric primary care providers who are contracted to provide medical services for the Nueces County Robert N. Barnes Regional Juvenile Facility post-adjudication center.

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[53] Barclay, R. P., Penfold, R. B., Sullivan, D., Boydston, L., Wignall, J., & Hilt, R. J. (2017, April). Decrease in statewide antipsychotic prescribing after implementation of child and adolescent psychiatry consultation services. *Health Services Research, 52*(2), 561–578.

[54] Hilt, R. J., Romaire, M. A., McDonell, M. G., Sears, J. M., Krupski, A., Thompson, J. N., & Trupin, E. W. (2013, February). The partnership access line evaluating a child psychiatry consult program in Washington State. *JAMA Pediatrics, 167*(2), 162–168.

CPAN launched on May 18, 2020. Therefore, pediatricians and primary care providers should develop a relationship with the UTRGV CPAN hub as soon as possible. When mental health needs are identified, pediatricians and primary care providers can access the CPAN hub's referral network to refer their patients to community services and supports to address the mental and behavioral health needs identified. Likewise, specialty outpatient providers should prepare for the implementation of CPAN by developing relationships with the hub to be included on its referral list. Through the UTRGV CPAN referral network, pediatricians and primary care providers will be better equipped to refer their patients to community services and supports that specifically address the behavioral health needs of children and youth. Toward this end, in May 2020, MMHPI, which has existing relationships with CPAN members, helped facilitate a meeting between the NCMHID and the UTRGV CPAN hub; however, Nueces County pediatric primary care providers should develop a relationship with the UTRGV CPAN hub as soon as possible.

Recommendation: Adopt the Texas Child Health Access Through Telemedicine Program

Community and school leaders should actively engage with UTRGV to push for a plan to expand Texas Child Health Access Through Telemedicine (TCHATT) to Nueces County. In addition to CPAN, SB 11 established the Texas Child Health Access Through Telemedicine (TCHATT) program, which will also be implemented by UTRGV. TCHATT is a statewide program that gives schools access to mental health providers via telemedicine and telehealth to help children and youth with urgent mental health needs. The urgent assessments and short-term stabilization care that will be available through TCHATT will increase community-wide urgent care capacity. It will also require linkages for follow-up care to specialty outpatient mental health providers. Although TCHATT will be offered statewide, it will not be provided in every Texas independent school district (ISD) or in every school in the ISDs served by the program due to the limited funding allocated to the regional "hubs" supported by Texas medical schools. At this time, the UTRGV hub has no target date to implement TCHATT in any Nueces County schools. Given the lack of both psychiatric and specialty outpatient and rehabilitative providers, it is critical that Nueces County students have access to the telemedicine services that will be available through TCHATT. Additional funding is expected for new TCHATT school-based programs in August 2020.

Immediate Recommendations for TCHATT

Community and school leaders should engage UTRGV as soon as possible to push for an implementation date in Nueces County.

Recommendation: Create a Collaborative of Educational Entities to Create an Inventory of Trainings and Resources

Untreated child and youth mental health conditions are linked to higher rates of school absence and reduced rates of timely course completion and graduation.[55] Student mental and behavioral health concerns not only affect the student experiencing the concern, they also have an impact on the people that surround them. Students with unaddressed mental and behavioral health symptoms can also disrupt the learning environment for other students.[56]

In Nueces County, there are 12 independent school districts (ISDs) and 3 charter schools that serve 61,348 children and youth. Schools are a natural setting for linking families to access health and mental health services. As highlighted in the previous section, many factors, such as poverty, contribute to the complexity of mental health issues. The school districts in Nueces County have many excellent practices but currently work in silos, using limited resources to serve students and families. Every district we interviewed shared remarkable best practice work, but few were aware of what other districts were doing. In addition, it was unclear if districts had begun using information from the Nueces County Opioid Task Force education subcommittee that was created by the Nueces County Commissioners Court. The Nueces County Commissioners Court created the Opioid Task Force in late July 2019 to address the opioid epidemic in Nueces County. Its education subcommittee convenes a monthly meeting of community members, including representatives from Calallen ISD, Corpus Christi ISD, Flour Bluff ISD, Gregory Portland ISD, Tuloso Midway ISD, West Oso ISD, Catholic Schools, Texas A&M Corpus Christi, IWA, It's Your Life Foundation, New Life Refuge, and Methodist Healthcare Ministries. The education subcommittee explores the role mental and behavioral health plays in addiction.

It is also unclear if districts had begun using information from the Suicide Prevention Task Force, which conducts focus groups with youth and makes recommendations to improve suicide prevention measures in the region's schools. This task force is a local effort led by Cissy Reynolds-Perez, assistant superintendent of West Oso ISD, and Scott Eliff, Corpus Christi ISD superintendent, who were appointed to the task force by lawmakers.[57] This task force has been conducting focus groups with youth and making recommendations to improve suicide prevention measures in the region's schools.

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[55] Blackorby, J., & Cameto, R. (2004). Changes in school engagement and academic performance of students with disabilities. In Office of Special Education, U.S. Department of Special Education, Special education elementary longitudinal study. Menlo Park, CA: SRI International.

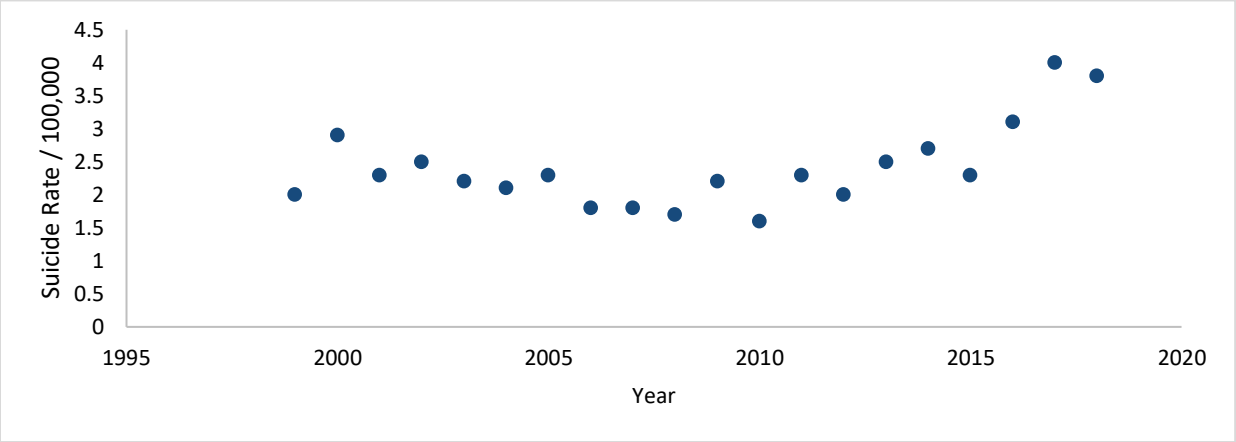
[56] Gottfried, M. A., Egalite, A., & Kirksey, J. J. (2016). Does the presence of a classmate with emotional/behavioral disabilities link to other students' absences in kindergarten? https://www.sciencedirect.com/science/article/pii/S0885200616300205?via=ihub

[57] The MMHPI team has attempted to schedule an interview with members of the Suicide Prevention Task Force. However, because of the COVID-19 outbreak, it has been difficult to set up a time to interview them.

Information learned from both of these task forces should be integrated into this recommended formal collaborative.

According to the Centers for Disease Control and Prevention (CDC), suicide is the second leading cause of death among American youth and rates of death from suicide are now at their highest levels ever across the country.[58] In an attempt to map suicide trends in Nueces County, we queried the Centers for Disease Control and Prevention's (CDC) mortality database.[lxix] Because the number of deaths attributed to suicide for children and adolescents between the ages of 6 and 17 years did not exceed 10 deaths in any single year, data were suppressed under federal law.[59] As a substitute, we instead mapped the suicide mortality trends across the state of Texas for children and youth ages six to 17 (Graph 1) which demonstrate an upward trend in suicide mortality beginning in 2016, adjusted for the growing population. The state-wide average rate of deaths by suicide per 100,000 is 2.4; the rate in Nueces County is slightly higher (2.6 per 100,000). Overall, between 1999 and 2018, Nueces County has had 31 deaths from suicide among youth ages 6 to 17 years.

Graph 1: Rate of Deaths by Suicide Among Children and Youth Ages six to 17 in the State of Texas



Furthermore, although COVID-19's impact does not specifically target child and youth, it is still relevant to the community because the economic fallout from efforts to suppress the transmission of the virus will continue to have an impact on deaths by suicide and substance use and mental health disorders in all ages. In Texas, MMHPI's models project that – absent an increase in preparedness to detect and treat depression and addiction – every five percent

[58] Centers for Disease Control and Prevention (CDC) WISQARS Leading Causes of Death Reports, in 2017. Retrieved from: https://webappa.cdc.gov/sasweb/ncipc/leadcause.html

[59] The Public Health Service Act (42 U.S.C. 242m(d)) requires that no data are presented for death or birth counts of 9 or fewer are presented by sub-national geography. Therefore, any demographic groups with less than ten deaths are reported as <10.

annual increase in the unemployment rate could result in 300 additional lives lost to suicide each year and 425 additional lives lost to drug overdoses.[60]

As such, we recommend that school district behavioral and mental health leads, the Region 2 Education Service Center (ESC), including their new mental health support staff member funded by House Bill 19 (86th Legislature, Regular Session), community mental health providers, and school members from the regional Opioid and Suicide Prevention Task Forces develop a formal collaborative team to inventory training and resources available to students and families across all systems, ensure that districts are aware of all available services, and then prioritize one or two gaps to collectively address. This effort will contribute to the development of a comprehensive array of services available to districts and establish a formalized system for improving prevention, intervention, and crisis supports in schools. This formal collaborative can leverage information learned through the Opioid Task Force and Suicide Prevention Task Forces.

In addition to leveraging information learned from recent task force efforts, Nueces County needs a central point of contact when developing this formal collaborative. The Region 2 ESC, a school district, community provider, or organizing entity with established expertise in this area could take the lead. We recommend Region 2 ESC as they are well-recognized within the community, they work with all districts, and they have behavioral and mental health staff to provide leadership. Furthermore, as noted above, HB 19 requires the local mental health authority to place a mental health support staff member in Region 2 ESC and this position can further support these efforts. This formalized collaborative team can be supported by the Texas Education Agency, which is currently providing resources to support ESCs and schools with implementing improved mental health practices. They can also connect with other entities or ESCs doing similar work to learn from them, such as the Region 4 ESC, which convenes a leadership network of Superintendents, School Behavioral Health District Coordinators, and counselors monthly to disseminate timely information regarding federal, state and local updates and share best practices. Finally, all members of the formal collaborative team should actively participate in order to ensure success. Taken together, these factors would help Region 2 ESC with the responsibility of coordinating a new committee.

Schools should also use the Multi-tiered System of Support and the Interconnected Systems Framework to develop a robust set of mental and behavioral health supports in schools. Multi-tiered System of Supports is a comprehensive framework for delivering practices and systems for enhancing student academic and behavioral outcomes through a three-tier system. This

[60] Frasquilho, D., Matos, M. G., Salonna, F., Guerreiro, D., Storti, C. C., Gaspar, T., & Caldas-de-Almeida, J. M. (2016, February 3). Mental health outcomes in times of economic recession: A systematic literature review. *BMC Public Health, 16*, 115. https://doi.org/10.1186/s12889-016-2720-y

framework brings together the two long-established, research-supported school practices of Response to Intervention (RTI) and Positive Behavioral Interventions and Supports (PBIS), linking both the academic needs RTI aims to address with the behavioral support identified within the PBIS framework. Multi-tiered System of Support includes universal promotion strategies for all students (Tier 1), targeted services and supports for a smaller group of students experiencing or at risk of experiencing a mental and behavioral health challenge (Tier 2), and specialized and individualized services for the small number of students with complex mental and behavioral health needs that Tier 1 or Tier 2 programs cannot adequately meet (Tier 3).[61]

The Interconnected System Framework could be used in partnership with community providers to help students gain access to Tier 3 services. The Interconnected System Framework brings together various frameworks, including MTSS, in a community-based, collaborative framework that enhances all approaches and extends the array of mental health supports for students and families through collaboration between schools and community providers. The Interconnected System Framework helps expand Multi-tiered System of Support by including community providers in key components, such as decision making, selection and implementation of evidence-based practices, monitoring, and ongoing coaching.

As a way to empower students, the Texas Education Agency Long-Range Plan[62] recommends an integrated and data-driven academic and nonacademic Multi-tiered Systems of Support model on every campus to identify and connect all students with appropriate support services, including supports for behavioral health, mental health, and intrapersonal and interpersonal effectiveness. Region 2 ESC already provides some support in these areas as evidenced by their website. However, the ESC has the potential to help their districts fully implement best practice frameworks like Multi-tiered Systems of Support and Interconnected Systems Framework with fidelity by training, coaching and helping districts identify a standard data collection system to drive decision-making. The ESC is positioned to provide training in these areas to meet mandates set forth by the 86th Legislature and to develop the community relationships needed to sustain Tier 2 and 3 supports, including the use of evidence-based programs and crisis support. Collaborating with community providers can help develop partnerships to link these types of services and supports into schools.

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[61] American Institutes for Research. (2017, September*). Mental health needs of children and youth: The benefits of having schools assess available programs and services*. https://www.air.org/sites/default/files/downloads/report/Mental-Health-Needs-Assessment-Brief-September-2017.pdf

[62] Texas Education Agency. (n.d.). *86th Texas Legislature enacts many LRP recommendations*. https://tea.texas.gov/About_TEA/Leadership/State_Board_of_Education/LRP/86th_Texas_Legislature_enacts_many_LRP_recommendations

Immediate Recommendations for Schools

Develop a formal collaborative team to create an inventory of trainings and resources that are available to students and families across all jurisdictions, ensure that districts are using all available services, and address one or two identified gaps, such as the need for intensive services and supports and crisis intervention.

In addition, Region 2 ESC should lead local efforts to convene necessary educational entities to coordinate efforts with the Texas Education Agency and connect with other entities and ESCs doing similar work.

This work should begin immediately. Once a leader (Region 2 ESC, a school district, a community provider, or even a contracted service with established expertise in this area) is identified, the first meeting can be scheduled, and the group can begin its work. This recommendation has no cost but does require a commitment of time and resources. The formalized collaborative team can be supported by the Texas Education Agency, which is currently providing resources to support ESCs and schools in implementing improved mental health practices.

Recommendations to Improve Mental Health Care in the Child Welfare System

In state fiscal year 2019, 773 children and youth in Nueces County were in foster care. Children and youth in foster care have complex needs and challenges that require dedicated resources and coordinated attention. Half of the children who were in foster care in Nueces County were under the age of six. These challenges stem from problems in their homes that lead to foster care involvement, in addition to trauma associated with being removed and placed in unfamiliar settings. Providing children and youth in foster care with access to a continuum of high quality mental and behavioral health services could promote positive outcomes such as safety and child well-being. In comparison to the entire child population, many children and youth in foster care also experience complex medical conditions, and most are at risk for heightened behavioral health challenges. In the last five years, the removal rate in Nueces County was higher than the statewide average, as Table 20 below illustrates:

Table 20: Statewide and Nueces County Number of Removals per 1,000 Child Population (2015–2019)[lxx]

Fiscal Year	Statewide rate per 1,000 child population	Nueces County rate per 1,000 child population
2019	2.51	3.24
2018	2.81	3.75

Fiscal Year	Statewide rate per 1,000 child population	Nueces County rate per 1,000 child population
2017	2.72	4.37
2016	2.64	4.07
2015	2.40	3.57

The Texas child welfare system is in the midst of a historical transformation based on the Department of Family and Protective Services' (DFPS) incremental rollout of the Community-Based Care model across the state. Under Community-Based Care, foster care and case management functions previously administered centrally through Child Protective Services (CPS) at DFPS will transition to a regional single source continuum contractor that is responsible for contracting with child placement agencies, coordinating and delivering services to children and youth in foster care and their foster families, developing foster care capacity, and engaging the community to achieve positive outcomes for children, youth, and families being served.

In the first stage of implementation, single source continuum contractors are responsible for developing a network of foster care providers and community supports that allow children and youth to remain in their communities and connected to their families. In the second stage, the single source continuum contractors' responsibilities expand to include case management, kinship, and reunification services. In the final phase, single source continuum contractors are expected to meet specific performance metrics and payments will be tied to outcomes.

Local stakeholders noted severe challenges in the child welfare system, including lack of child and adolescent psychiatrists, lack of crisis and inpatient services, and the over-medication of children. Nueces County community leaders and key child welfare providers should establish a formal collaborative effort focused on strengthening the local foster care system and include access to mental health as a key focus. A collaborative effort would help build on strengths in the child welfare system and identify unmet needs and underused resources for children, youth, and families involved with the foster care system. Bringing together community leaders, individuals working on behalf of the foster care system, and individuals who work with children and youth in foster care – including school representatives – would be especially strategic and timely given new policies that will affect key services in the next few years, including community-based care and the federal Family First Prevention Services Act.

The 2018 passage of the federal Family First Prevention Services Act requires changes and presents new opportunities to achieve better outcomes for children and families involved with the state's child welfare system. The Family First Prevention Services Act was designed to help keep families intact by expanding access to evidence-based prevention services, including

mental health and substance use disorder treatment services as well as skill-based and other in-home interventions to strengthen families. It also seeks to improve the well-being of children and youth already in foster care through new regulations and incentives designed to minimize placements in congregate care settings, such as residential treatment centers or general residential operations. Most provisions of the Family First Prevention Services Act requirements went into effect in October 2019; however, Texas is one of many states to request a two-year delay in implementation. Although there are many unknowns regarding the eventual implementation of the Family First Prevention Services Act, Senate Bill (SB) 355 (86th Legislature, 2019) requires DFPS to create a strategic plan to implement Community-Based Care and foster care prevention services under the Family First Prevention Services Act.

Nueces County can use the eventual transition to Community-Based Care as an opportunity to collaborate to strengthen the foster care system. Groups in Houston, Dallas, and Austin have used the inevitable transition to Community-Based Care as an opportunity to come together for regional planning to not only to prepare for Community-Based Care, but also make strategic decisions to strengthen the system as a whole.

Local leaders and child welfare providers in Nueces County (DFPS Region 11) should come together now to begin addressing three core components: (1) community engagement, (2) an environmental scan of child welfare services and supports in Region 11, including identifying community strengths and areas for systems change, and (3) a review of regional and national best practices and financial sustainability models. Each of these core components builds on each other to support key stakeholders in developing a planning document that ensures the delivery of high quality, trauma-informed services for children, youth, and their families. This project will engage system partners, assess current services and supports, and assist the community in adopting a shared vision that drives the development of a community-based plan to improve the lives of children, youth, and their families. The planning document should address state and federal regulations and also begin to address gaps we identified in the child welfare system during this assessment. DFPS intends to announce the catchment areas in which it intends to roll out Community-Based Care in December 2020.

Immediate Recommendations for Child Welfare

Local leaders and child welfare providers in Nueces County (DFPS Region 11) should immediately develop a baseline understanding of the community's capacity to serve its children and youth in foster care, identify community strengths and areas for systems change, and initiate considerations for reimagining Region 11's foster care system in alignment with the Community-Based Care model. This will help bring providers and stakeholders together to create a child welfare system that works in a more interdisciplinary way. The community can identify connected priorities and problem solve as a group. Furthermore, this type of

preparation will provide the community with greater influence over how Community-Based Care rolls out and the outcomes for this transition.

This recommendation does require a commitment of time and resources from Nueces County community leaders and key child welfare providers. Nueces County could engage with a third-party organization for an 18-month planning project to support collaboration among community leaders, key stakeholders, and interested community partners in laying the initial foundation for Community-Based Care in Region 11. We have supported this type of work in other parts of the state, including a past project in Harris County and a current project in North Texas.

Adults

As shown in Table 21, most adult mental health needs can be adequately met in an integrated care setting (50,000 adults of the 65,000 with any mental health need). Of the remaining adults who need care in a specialty setting, we estimate that about 7,000 with serious mental illnesses who are living in poverty would benefit from care through the LMHA. In contrast, just 2,721 adults received ongoing care through the LMHA, representing 40% of estimated need. The population of adults in Nueces County is estimated to grow by 6% by 2025 (Table 8, above). The number of adults in need of ongoing specialty care is likely to grow proportionately.

Table 21: Adults in Need, by Care Setting (FY 2018)

Adults – Community Care Need by Setting[lxxi]	
Adults with Mental Health Conditions[lxxii]	**65,000**
Needs that Can Be Met in Integrated Care[lxxiii]	**50,000**
Needs that Require Specialty Setting[lxxiv]	**10,000**
In Poverty Needing Specialty Care[lxxv]	7,000
Complex Needs without Forensic Need (ACT)[lxxvi]	100
Complex Needs with Forensic Need (FACT)[lxxvii]	100
Adults with Substance Use Disorders[lxxviii]	**20,000**
Needs that Can Be Met in Integrated Care[lxxix]	**8,000**
Needs that Require Specialty Setting[lxxx]	**10,000**

Table 22: Number of Adults with SMI in Poverty Who Received Outpatient Services from the Nueces Center for Mental Health and Intellectual Disabilities (NCMHID) (FY 2018)[lxxxi]

Adults	NCMHID
SMI in Poverty[lxxxii,lxxxiii]	7,000

Adults	NCMHID
All Levels of Care Served	2,721
% in Need Served	40%

Table 23: Adult Levels of Care Analysis (FY 2018)[lxxxiv]

Treatment Category	Level of Care	Nueces County	
		Number Served	% of Total Served by Any Service[lxxxv]
Outpatient	Medication Management	0	0%
	Skills Training	2,039	75%
	Medications and Therapy	11	0%
Rehabilitation	Medication and Case Management	210	8%
	ACT (ACT)	39	1%
	Early Onset Psychosis Services	0	0%
	Transition-Age Youth	2	0%
Crisis	Crisis Services	182	7%
	Crisis Follow Up	238	9%
Total Served		**2,721**	**100%**
	Total Non-Crisis Served	2,301	85%
	Total Crisis Served	420	15%

Recommended Priorities for Service Investment in Adult Care: ACT and Forensic ACT

We reviewed a full range of programmatic options consistent with the input from Nueces County, local stakeholders, providers, and NCMHID representatives and focused on the primary objective to reduce use of the jail, emergency departments, and inpatient hospitalization by people with severe mental illnesses. As part of our examination of the community-based crisis continuum, we took a particularly close look at the functioning of the Assertive Community Treatment (ACT) team. The ACT team provides the highest level of community-based care to people with serious mental illnesses who are vulnerable to homelessness, hospitalization, and

criminal justice system involvement, and can reduce hospitalization and sustain community tenure.[63, 64, 65]

We estimated that 100 people in Nueces County should be served by ACT (Table 22). NCMHID reported that it is deemed an urban ACT with a potential capacity of up to 100 people, but only 39 are currently enrolled (Table 23) because of its decision to only staff up to a 40-person capacity. This gap between capacity, need, and number of people served has serious ramifications for other resources in Nueces County such as inpatient beds because ACT can sustain community tenure for people with serious mental illnesses and reduce hospitalizations.

Based on input from local stakeholders and NCMHID, one possible reason for this is that the ACT team does not currently engage in assertive outreach to people who decline ACT services or reach out to hospitals and the criminal justice system to locate those with the greatest use of these systems. NCMHID reported that historically it has not engaged in such outreach to system partners since the ACT team primarily receives referrals from within its own system and has filled program capacity (at currently staffing levels) through in-house referral alone. However, people who are most in need of ACT services often require assertive engagement and outreach prior to agreeing to receive the full array of ACT services. Fortunately, state-mandated criteria for services were clarified in 2017 (Broadcast MSG0761) to permit pre-enrollment outreach in order to help teams better prioritize care for people most in need of services.[66]

Recommendations for Improving ACT in Nueces County

ACT can be improved in several ways, which in turn would have positive impacts across the mental health system in Nueces County.

- NCHMID should implement the 24-hour on-call rotation that is an expected component of ACT. This is a fidelity requirement for ACT teams and should be available to ACT team

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

[64] Cuddeback, G. S., et al. (2013). Fidelity to recovery-oriented ACT practices and consumer outcomes. *Psychiatric Services, 64*(4), 318–323. Unpublished research also has shown positive correlations between fidelity to the TMACT model and both increased client retention on the team and better employment outcomes. Monroe-DeVita, M. (2016). *TMACT fidelity review orientation, part II*. Unpublished slide presentation received through personal communication from the author, April 21, 2016.

[65] Coldwell, C. M., Bender, & W. S. (2007). The effectiveness of assertive community treatment for homeless populations with severe mental illness: a meta-analysis. *The American Journal of Psychiatry, 164*(3):393–399. doi:10.1176/ajp.2007.164.3.393

[66] Miller, J., & Strickland, R. (2017, March 15). Broadcast MSG0761: Assertive Community Treatment fidelity tool: Using the Tool of Measurement of Assertive Community Treatment as an alternative to the Dartmouth Assertive Community Treatment Scale [Memorandum]. Texas Health and Human Services Commission.

staff.[67, 68] This component is one of the wraparound services that is integrated into treatment to de-escalate crises within the community and is one of the main tenets of the ACT model to divert people from unnecessary hospitalization and incarceration. Because this is a requirement of the ACT model, there should be no budgetary allocation needed. This step will require a cultural and organizational shift for the ACT team to recognize this new responsibility as well as for leadership to understand that the ACT team should function and respond differently than other programs within the agency. It will also decrease the dependence on the MCOT and Avail Solutions crisis response.

- The ACT team should enhance its functioning to better meet the needs of people with serious mental illnesses in Nueces County by prioritizing enrollment of people with the most serious and complex mental health needs who have been cycling through costly services, particularly hospitalization**.** To be financially sustainable, these interventions need to target people who are using enough care in order for NCMHID to achieve sufficient savings to justify the intensity and cost of care.[69, 70] As we have discussed with NCMHID representatives, these interventions also need to be managed so that people are stepped down assertively to lower levels of care as soon as they are stabilized to the point where they can reliably engage in less intensive interventions. This should include clear protocols, which are shared with system partners, that identify when to step people down to lower levels of care in order to free up limited ACT capacity for people with high needs, as well as protocols that ensure coordination with system partners who also serve people receiving ACT services to avoid prematurely stepping them down to a lower level of care. In order to accomplish this, the team should realign its work with contemporary ACT standards to ensure that the highest quality of services is delivered.

In addition, an analysis of the utilization of services should be conducted pre- and post-enrollment in ACT . While one year pre- and post-enrollment is a reasonable comparison point, project participants would ideally be followed two to three years post-discharge to discern the project's impact on hospital and jail use over time. To achieve this, the agencies and organization enrollees will need to share data prior to enrollment. Metrics that can be used to measure the impact of ACT (and FACT, below) include:

- **Tool for Measurement of ACT fidelity metric OS-7** – Current Tool for Measurement of ACT fidelity standards include a provision requiring that the team actively recruits new consumers who could benefit from ACT, including assertive outreach to referral sites for

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[67] Monroe-DeVita, M., Moser, L. L., & Teague, G. B. (2013). *The Tool for Measurement of Assertive Community Treatment (TMACT).*

[68] Teague, G. B., Bond, G. R., & Drake, R. E. (1998). *Dartmouth Assertive Community Treatment Scale (DACTS).*

[69] Latimer, E. A. (1999). Economic impacts of Assertive Community Treatment: A review of the literature. *The Canadian Journal of Psychiatry, 44*(5), 443–454. https://doi.org/10.1177/070674379904400504

[70] Morrissey, J. P., Domino, M. E., & Cuddeback, G. S. (2013, April 1). Assessing the effectiveness of recovery-oriented ACT in reducing state psychiatric hospital use. *Psychiatric Services, 64*(4):303–311. doi:10.1176/appi.ps.201200095

regular screening and planning for new admissions to the team. The team should start tracking the number of consumers being actively engaged, in addition to members enrolled on the team.

- **Inpatient utilization (number of admissions and number of days)** – This is critical to document the cost-effectiveness of the ACT team, as well as other additional projects developed by the collaborative.
- **Emergency department utilization (number of visits)** – This is also critical to document the cost-effectiveness of the ACT team, as well as other additional projects developed by the collaborative.
- **Jail utilization (number of bookings and number of days)** – This is the most important metric pertinent to measuring a reduction in the misuse of county jail services for those experiencing mental health crises.
- **Percentage of people with serious mental illness and Adult Needs and Strengths Assessment determination of Level of Care 4 who receive a face-to-face ACT service within 48 hours of discharge/release from jail –** This will measure the team's responsiveness.

Recommendation for Creating Forensic Assertive Community Treatment (FACT)

Forensic Assertive Community Treatment (FACT), a derivative of ACT designed for people with mental illnesses with higher risk for criminal recidivism, has been shown by research to reduce jail recidivism rates for people with serious mental illnesses and at a high risk for recidivism who frequently cycle through the criminal justice system and local emergency and hospital services.[71] Best practice FACT is based on best practice ACT principles (Tool for Measurement of ACT), but the FACT team also includes a forensic specialist and all staff are specially trained to focus on factors that increase a person's risk for recidivism (called "criminogenic risk"). Currently, people involved in the criminal justice system receive the same treatment as those who are not involved in the criminal justice system, which is not best practice for forensic services. Without a specialized forensic component, the program's participants are likely to experience reincarceration as ACT has not been shown to be effective in reducing arrests and jail time.[72]

- We recommend adding dedicated forensic expertise to the ACT team and establishing, at a minimum, a specialized track within the team with its own caseload based on FACT principles. Stand-alone jail-based case management is not in and of itself a best practice, but a FACT team needs formal linkages to the jail for which it provides diversion. This

[71] Cusack, K. J., Morrissey, J. P., Cuddeback, G. S., Prins, A., & Williams, D. M. (2010). Criminal justice involvement, behavioral health service use, and costs of forensic assertive community treatment: A randomized trial. *Community Mental Health Journal, 46*(4), 356–363. https://doi.org/10.1007/s10597-010-9299-z

[72] Beach, C., Dykema, L., Appelbaum, P., Deng, L., Leckman-Westin, E., Manuel, J., McReynolds, L., & Finnerty, M. (2013). Forensic and non-forensic clients in assertive community treatment: A longitudinal study. *Psychiatric Services, 64*(5), pp.437–444.

position can provide outreach and engagement more broadly (since not everyone leaving the jail will be need Forensic ACT services), though as this position's duties expand, the dedicated FACT capacity of the team would diminish. Overall, alignment of this position with the FACT team would increase the team's capacity to engage people leaving the jail and be more supportive of best practices.

- Development of FACT capacity should be part of the rapid improvements to the current jail diversion workflow as listed on page 76 of this report. Integrating FACT into an overall jail diversion system should better leverage existing resources and improve overall outcomes. Pre-booking diversion services could be enhanced by creating a collaborative relationship between the forensic component of the ACT team and existing jail diversion resources. A dedicated forensic specialist could be part of the response to existing notifications generated during the jail booking process and begin to assertively engage candidates for ACT or FACT. The workflow improvement process should identify other opportunities for a forensic resource to engage with persons in need of services. Therefore, we recommend that NCMHID's ACT team take responsibility for specific tasks for assertive engagement through in-reach to the jail, local hospitals, and emergency departments. This position should be tasked with prioritizing people who are most in need of services while providing ongoing engagement with potential program participants until they accept services.

Recommendation to Assure a Better "Fit" for Services: Incorporate the Risk-Needs-Responsivity Model and Criminogenic Risk Assessment

Just as matching ACT services to people who repeatedly cycle through restrictive and expensive services can maximize outcomes such as reduced hospital and emergency department use, matching FACT services to people who have a moderate to high criminal risk score can reduce jail use and criminal justice system involvement. Forensic ACT also requires tailoring intensive wraparound services and interventions to target criminogenic thinking and actions. The fidelity model that was created by MMHPI and the University of California, Berkeley[73] combines best practices in Risk-Need-Responsivity principles and ACT to support a model that is practical to implement in real-world settings.

FACT teams also need to closely coordinate services with community supervision when implementing Risk-Need-Responsivity principles,[74] which involves assessing and reducing various aspects of criminogenic risk – criminal thinking, substance use, and associating with criminal companions, for example – by matching interventions to each person's specific constellation of risk factors. The primary driver of criminogenic risk is history of involvement

[73] Meadows Mental Health Policy Institute. (2017). *Smart justice FACT fidelity scoring guide*.
[74] Skeem, J., et al. (2014). Offenders with mental illnesses have criminogenic needs, too: Toward recidivism reduction. *Law and Human Behavior, 38*(3), 212–224.

with the criminal justice system (e.g., recidivism), but there are multiple factors involved in this risk and the team and its system partners will require training in using the model and incorporating the principles into their practice of identifying and managing cases. But the investment should be worthwhile, as research on FACT has shown that incorporating Risk-Need-Responsivity principles into case assignment and care planning can reduce both psychiatric hospitalizations and jail use among people who previously were caught in patterns of frequently cycling through the criminal justice system and local emergency and hospital services.[75]

Recommendation to Improve Referrals to Inpatient Care for Veterans

Service members, veterans, and their family members make up a significant and important part of Nueces County with a population of over 25,000 veterans, including more than 9,000 veteran families. The Nueces County mental health system for veterans has several strengths that support veterans accessing and receiving mental health care. We were particularly impressed with the U.S. Department of Veteran Affairs (VA) and how they have leveraged two of the most progressive integrated mental health and case management programs in the community. Between the Primary Care Mental Health Integration program and the Intensive Community Mental Health Recovery program, the VA staff have created a solid foundation for eligible veterans seeking VA care and were consistently referred to as a well-respected member of the veterans' mental health system. The VA does not always experience this level of appreciation or support in other communities.

The university was another high point in the mental health care for veterans. We were encouraged by the enthusiasm and effort put forth by the members of the veterans' services at Texas A&M University-Corpus Christi (TAMU-CC), and their dedication to caring for student veterans. For example, the student counseling center's veteran advocate has created an innovative approach to engaging and curating community partners by hosting training that includes free continuing education units (CEU). By adding aspects of military culture to the CEU presentations, community providers are also exposed to military-specific language and artifacts they can use in their practices.

Table 24 provides the prevalence of mental health conditions and substance use disorders for the veteran population of Nueces County.

[75] See, for example: Cusack, K. J., et al. (2010). Criminal justice involvement, behavioral health service use, and costs of forensic assertive community treatment: A randomized trial. *Community Mental Health Journal, 46*(4), 356–363.

Table 24: Nueces County Prevalence of Mental Health and Substance Use Disorders in the Population of Veterans (2018)[lxxxvi]

Mental Health Conditions or Substance Use Disorders	Male	Female	Total (Rounded so Total Number is Not Sum of Male and Female)[lxxxvii]
Total Veteran Population	25,000	2,000	25,000
Mental Health Condition	**Total Prevalence**		
Any Mental Illness	3,000	600	4,000
Serious Mental Illness	700	200	900
Major Depression	1,000	300	1,000
Substance Use Disorder	**Total Prevalence**		
Alcohol Use Disorder	2,000	100	2,000
Illicit Drug Use	2,000	300	2,000
Nonmedical Use of Psychotherapeutics	700	100	900
Nonmedical Use of Pain Relievers	600	100	700

Some veterans receive care through the three U.S. Department of Veterans Affairs (VA) facilities located in Nueces County - the Corpus Christi Outpatient Clinic, Corpus Christi Specialty Outpatient Clinic, and the Vet Center.

The table below illustrates the last three fiscal years of VA expenditures in Nueces County and the unique veteran population served.

Table 25: VA Expenditures in Nueces County by Fiscal Year[76]

Fiscal Year	Unique Patients Receiving VA Care	Nueces County Veterans Served[77]	VA Spending on Medical Care[78]
2016	7,066	26%	$54,211,000
2017	7,094	26%	$67,476,000

[76] U.S. Department of Veterans Affairs. Summary of Expenditures by State for Fiscal Year 2016,2017,2018. Retrieved from: https://www.va.gov/VETDATA/Expenditures.asp
[77] The Percentage of Nueces County Veterans Served is based on the VA's estimation of the total veteran population in Nueces county for each fiscal year, which experienced small fluctuations year to year.
[78] Mental health spending is included in the overall cost of medical care, breakouts of costs are unavailable.

Fiscal Year	Unique Patients Receiving VA Care	Nueces County Veterans Served[77]	VA Spending on Medical Care[78]
2018	7,219	27%	$76,661,000

At the same time, however, approximately half of the veteran population receives care outside of the VA[79] and, for these veterans, local hospitals play an essential role. The VA Valley Coastal Bend Health Care System is the only VA health care system in Texas that does not have a hospital, forcing veterans who cannot access care at local hospitals to leave their families and support networks to travel to VA hospitals in other parts of Texas (i.e., Temple or San Antonio) to receive care. Community providers such as CHRISTUS Spohn and Bayview should play a central role in collecting data on veteran mental health care for veterans that seek care locally and help create a transparent and efficient process for referring veterans to inpatient care as well as their subsequent discharges. Nueces County can further support coordinated care for veterans by making it a priority of the veteran collaborative subcommittee or entity (as recommended in the Leadership section) to examine the current process and help eliminate artificial barriers to veterans accessing care in the community.

For outpatient care, NCMHID provides services to veterans and families who are otherwise unable, unwilling, or ineligible for VA services. NCMHID screens potential clients with a questionnaire that asks about the client's prior military service and service history of immediate family members. However, NCMHID is currently transitioning to an electronic health record, and the military screening tool in use is paper based, so no summary data on veterans utilizing MCMHID services were available.

Additionally, the Military Veteran Peer Network coordinator for Nueces County is housed at NCMHID. The Military Veteran Peer Network coordinator is funded by the State of Texas through the LMHA and trained by the Texas Veterans Commission's Veterans Mental Health Program to provide peer-to-peer support through training, technical assistance, and connection to a statewide network of military trauma-affected veteran peer support. While the premise of the Military Veteran Peer Network program is to build large cohorts of veteran peers in communities in order to connect with local veterans in need, our interviews discovered that there is little evidence of a Military Veteran Peer Network coordinator's presence in the community. The training reports we received from the Texas Veterans Commission for Nueces County in state fiscal year 2019 were concerning, as the numbers of veterans and providers trained in state certified curriculum for Military Veteran Peer Network Basic Training, Suicide

[79] U.S. Department of Veterans Affairs. (2016, December). *Unique veteran users profile FY 2015*. https://www.va.gov/vetdata/docs/SpecialReports/Profile_of_Unique_Veteran_Users_2015.pdf

Awareness, and Military Informed Care combined for less than 30 trainees total. An additional point of concern was the lack of Military Veteran Peer Network services provided to justice-involved veterans. Of the almost 900 veterans involved in the justice system last fiscal year (2019), just over 50 were connected with Military Veteran Peer Network services. This is an important gap in services as peer-based services for justice involved veterans have demonstrated correlative effectiveness in addressing risk factors and helping to reduce recidivism when paired with behavioral therapies and veteran treatment courts.[80]

The reported numbers for one-on-one peer support and general assistance referrals provided more optimism and offered context for a program that focuses on the individual veteran or family member. The Texas Veterans Commission's report for Military Veteran Peer Network in Nueces County conveyed over 650 one-on-one peer support sessions and almost 180 general assistance referrals.[81] However, the reporting system for Military Veteran Peer Network relies on the individual coordinator to categorize and report their interactions and does not account for the duplication of veterans or family members. Due to possibility of over reporting or underreporting, it is difficult to determine the efficiency of veterans accessing mental health programs through coordinator referrals.

Immediate Recommendations for Veterans Who Receive Care in the Non-Veterans System

Development of a unified strategy for gathering data on the provision of mental health care for veterans in non-VA health systems in Nueces County would be a critical first step that would ensures Nueces County will make informed, data-driven decisions for continuing to improve access and delivery of care to its veteran population. In addition, examination of the inpatient care referral processes from VA facilities to community providers to eliminate artificially extended wait times and unnecessary duplication of admissions paperwork. Without a local hospital in the VA health care system, veterans in Nueces County should be able to turn to community resources without encountering additional obstacles to care.

Justice-Involved Veterans

According to Veterans Re-Entry Search Services data provided by the Veterans Mental Health Department of the Texas Veterans Commission; veterans make up approximately 5.75% of the total jail population. The table below breaks down veterans in jail by quarter in the state fiscal year 2019.

[80] Criminal Justice Policy Review. (February 10, 2016). The Availability and Utility of Services to Address Risk Factors for Recidivism in Justice Involved Veterans. Retrieved from: https://journals.sagepub.com/doi/abs/10.1177/0887403416628601

[81] Texas Veterans Commission Veteran Mental Health Department (personal communication, 2020).

Table 26: Veterans Re-Entry Search Services Query – Nueces County (FY19)

Veterans Re-Entry Search Services Query – Nueces County SFY 2019[82]			
State Fiscal Quarter 2019	Number of Veterans in Jail	Number of Nonveterans in Jail	Percentage of Veterans in Jail
Q1	212	3,476	6%
Q2	243	4,080	6%
Q3	205	3,559	5.8%
Q4	214	4,112	5.2%

Veterans involved with the justice system are asked at initial intake and during the medical screening about veteran status and subsequently verified through Veterans Re-Entry Search Services. However, not every veteran self identifies, and we were unable to ascertain whether or not the entire jail roster is screened daily to identify veterans who do not willingly disclose veteran status.

After veterans are identified, and their status is verified, they are screened for eligibility to participate in veteran's treatment court as an alternative to traditional criminal prosecution. Nueces County is just one of 39 counties in Texas to hold a veteran's treatment court. The current veteran's treatment court is presided over by Judge Jack W. Pulcher and serves over 30 veterans. Eligibility for participating is limited to certain types of offenses (no felonies or felony deferred adjudications), and the district attorney must approve the veteran's application. Additionally, the veteran's justice outreach coordinator at the VA is an integral partner in the veteran court process. The veteran's justice outreach coordinator helps coordinate eligibility and access to VA services and treatments that are required to complete the program. In the months preceding this needs assessment, the veteran's justice outreach coordinator position at the VA was vacant, which limited the coordination efforts between county staff and the VA. Data for veterans served through Judge Pulcher's veterans treatment court were unavailable. Through the course of interviews, we discovered that summary records were not readily available for cases before recent staff changes. However, a plan is in place to contract with a web-based tool called Reliatrax to streamline processes, bridge communication gaps between clients, counselors, and partners, and improve data retention and accuracy. As one of the only veteran treatment courts in Texas to leverage a technology solution to track every veteran identified in jail and more efficiently connect them to supportive services, this is a promising initiative.

[82] Texas Veterans Commission Veteran Mental Health Department (personal communication, 2020).

During focus groups with Corpus Christi Police Department officers, it became apparent that not all officers - particularly those on the night shift - knew that the VA homeless program could be leveraged as a resource for identifying and verifying the veteran status of Corpus Christi's homeless population. While the VA has become a reliable resource for officers during regular office hours, the night shift will have to explore alternatives for veteran identification and verification like the VA's Veterans Re-Entry Search Services and SQUARES web-based platforms. Veterans Re-Entry Search Services is a secure web site that enables correctional and other criminal justice system entities to identify inmates or defendants who have served in the United States military. Veterans Re-Entry Search Services requires certain demographic information to be submitted (name, date of birth, social security number, gender, et cetera) in order to identify records of military service. SQUARES is another VA web application that provides external homeless service organizations reliable, detailed information about veteran eligibility. Shelters in the area, like the Salvation Army of Corpus Christi, have a memorandum of understanding with the VA and have access to SQUARES. Similar to Veterans Re-Entry Search Services, SQUARES also require a set of demographic information to be entered to identify and verify veteran status.

Justice-Involved Veterans Recommendation

Nueces County support the veteran's treatment courts pilot use of Reliatrax for one year. At a considerably small expense ($3.00/client or $3,600/annually), Nueces County can become a leader among Texas veteran treatment courts in capturing justice-involved veteran data and coordinating services with the VA and local veteran service organizations. Valuable data regarding service utilization, dispositions, and community engagement can shape the future of veteran's treatment court in Nueces County and has the potential to become a state model for data collection. The veteran's treatment court has received TVC funding through a veteran treatment court grant program as has the Nueces County Community Supervision and Corrections Department.

Recommendation to Improve Jail Diversion Workflow for Justice-Involved Adults

During our site visits and interviews, we consistently heard of opportunities to remove barriers to increase the number of people diverted from jail and expedite their release from jail once admitted. We have provided a high-level workflow for current jail diversion efforts in Figure 8 on the following page. Opportunities that merit immediate attention include:

- Prioritize access to psychiatrists for people in jail who need a new or updated diagnosis to be considered for diversion.
- Expand the ability to transport people directly from jail to treatment or other services.
- Establish dedicated times on the Magistrate Court docket for mental health cases, with on-site resources to connect people to service.

- Coordinate among existing data systems to identify people who need mental health services, but who bond out of jail before completing the assessment process.
- Expand the effective processes for engaging people in the formal jail diversion program to other releases.

These rapid process revisions could be facilitated by a jail operations team, which should include the staff who are directly working on jail diversion. The team could quickly form on an ad-hoc basis and begin working on the identified priorities. As the work progresses, the team could determine if a more formal structure is needed. Many jail diversion programs across the state hold regularly scheduled collaborative meetings, including programs in Dallas, Bexar, Travis, and Tarrant counties.

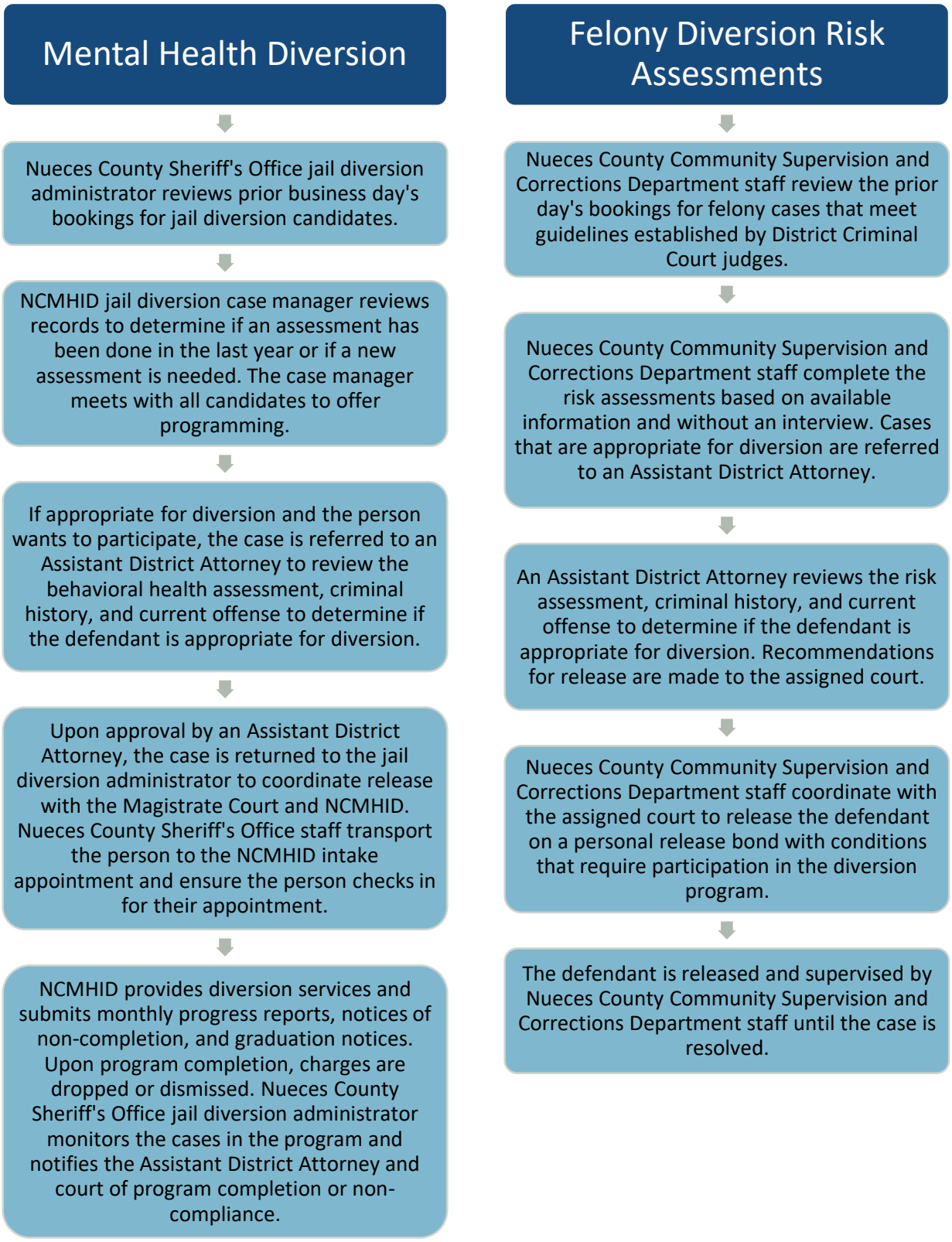
Immediate Recommendations for Work Flow

Rapidly revise existing jail diversion work flows based on current opportunities. See Appendix F for an example of the Dallas Sheriff's Office, Jail and Magistrate workflow.[83]

The ad-hoc team could organize quickly and have an initial meeting within 30 days or less. There would be no additional cost for the team to organize and begin to work on improvements to the workflow. As the team progresses, they would identify opportunities that may require funding and would be expected to show the benefits of these opportunities in terms of cost and for the system and people who receive services.

[83] Fabelo, Dr. T., Oshatz, L., & Tyler, J. (2017). *Early Identification, Diversion and Connection to Treatment of Justice Involved Mentally Ill Persons: Implementation and Impact Analysis*. Justice Center: The Council of State Government.

Figure 8: Workflow of Current Jail Diversion Efforts in Nueces County[84]



People Experiencing Homelessness

Overview

The issue of homelessness must be addressed by evaluating access to healthcare and support services. This is true across the populations that constitute the focus of our work in Nueces County, including adults in the criminal justice system, veterans, and children and youth who have behavioral health needs. Housing is a social determinant of health[85] and safe housing is associated with longer life.[86] Conversely, homelessness is associated with an increased risk for arrest and emergency department admissions as well as health issues.[87] In addition, The Department of Housing and Urban Development's (HUD) 2018 Annual Homeless Assessment Report (2018 AHAR) to Congress,[88] estimated that about one in five people among the approximately 550,000 people who are homeless nationally (about 110,000) have a severe mental illness–this is five times the rate of severe mental illness in the general population. Most of those people also suffer some level of co-morbid substance use disorder, and approximately 90,000 more people among this group (15%) suffer from chronic substance use disorders.[89] Overall, two in five people who are homeless are affected by severe mental health and substance use disorders.

We have reviewed available data on homelessness in Nueces County and we also interviewed key stakeholders and providers.[90] In this section of the report we address several topics including: an explanation of how the community response to homelessness is organized; describe the current prevalence of homelessness in Nueces County in the context of state and

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[84] This workflow chart was created by MMHPI staff to provide a high-level workflow diagram based on the information gathered from interviews with criminal justice stakeholders and partners between October 2019 and March 2020.

[85] Social determinants of health, including economic stability, education, health, access to health care, and the social and community context in which people live, have an impact on health, development, and morbidity.

[86] Wahoiak, L. (2016, September). Healthy, safe housing linked to healthier, longer lives: Housing a social determinant of health. The Nation's Health, 46 (7) 1–19.

[87] National Association of State Mental Health Program Directors. (2017). The role of permanent supportive housing in determining psychiatric inpatient bed capacity. Retrieved October 28, 2019 from https://www.nasmhpd.org/sites/default/files/TAC.Paper_.4.Housing_in_Determining_Inpatient_BedCapacity_Final.pdf

[88] The U.S. Department of Housing and Urban Development Office of Community Planning and Development. (2018). The 2018 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-in-time estimates of homelessness. Retrieved October 28, 2019, from https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf

[89] U.S Department of Housing and Urban Development. (2018, November 13). HUD 2018 continuum of care homeless assistance program homeless populations and subpopulations. Retrieved October 28, 2019, from https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2018.pdf

[90] It should be noted that we have not interviewed the president of the Homeless Issues Partnership, Inc. (HIP) for this final version of our needs assessment. There was an interview scheduled, however it was canceled due to an unexpected personal emergency and was not rescheduled.

national prevalence; and finally, provide an overview of current services and the community's efforts to reduce homelessness. Within this framework, we note findings and recommendations. Our primary focus is on connecting housing with appropriate health services and specific intersection points across systems that can be leveraged for improved outcomes. We do not address the very complex issues of affordable housing in general and developing more housing stock. These complex issues must be included in any comprehensive plan to eliminate homelessness, but are beyond the scope of this report.

Organization of Community Response to Homelessness

The bulk of federal funding to address homelessness comes through HUD's Homeless Assistance Grants.[91] HUD requires that communities establish a formal Continuum of Care collaborative to conduct strategic planning according to specific guidelines and to apply for HUD's Homeless Assistance Grants, which are only awarded through the Continuum of Care process. Nueces County does not have its own Continuum of Care but is part of the Balance of State system managed by the Texas Homeless Network.[92,93] Homeless Issues Partnership, Inc (HIP) is the formal Homeless Coalition required to access Continuum of Care funds. The group meets monthly to discuss homeless issues and must approve any funding applications through the Continuum of Care process. According to HUD data, the 2019 Continuum of Care funding for Nueces County is:[94]

- $162,398 to the Salvation Army of Corpus Christi for Rapid Re-housing; and
- $144,269 to the Salvation Army of Corpus Christi for a 12-bed permanent supportive housing project.

Corpus Christi city leadership has enhanced city efforts to increase housing and support services. For example, in 2019 a new Homeless and Workforce Housing Division comprised of three employees within the Housing and Community Development Department was created. The division is working on homelessness and increasing access to affordable housing.

For our needs assessment, we interviewed the homelessness and housing administrator, who had been on the job for four months and we were encouraged by the city's actions to increase

[91] Continuum of Care 101. (2009). HUD's Homeless Assistance Programs, 90.
[92] Texas Homeless Network (THN) is a non-profit membership-based organization helping communities strategically plan to prevent and end homelessness. THN works to end homelessness in Texas by collaborating with all communities, large and small, across the state to build systems to achieve this goal. We coordinate local and national advocacy efforts, data collection and research, host an annual statewide conference, and serve as the host agency for the Texas Balance of State Continuum of Care (CoC) where we assist in the coordination of programs and funding.
[93] Who We Are – Texas Homeless Network. (n.d.). Retrieved March 27, 2020, from https://www.thn.org/who-we-are/
[94] Awards and Allocations—HUD Exchange. (n.d.). Retrieved March 27, 2020, from https://www.hudexchange.info/grantees/allocations-awards/

housing and support services. For example, the city has dedicated funds from a 1/8 percent sales tax that can be used for housing. The fund had built a balance of $1.7M that has been allocated to a new facility for the Salvation Army of Corpus Christi that is under construction and a 52-unit new affordable housing development with embedded wrap-around services that was primarily funded from Hurricane Harvey relief funds administered by the General Land Office of the State of Texas. City staff reported that the dedicated sales tax is projected to generate $500,000 annually, depending on the strength of the local economy. The City of Corpus Christi receives funds directly from HUD for three programs: Community Development Block Grant, Home Investment Partnership Program, and Emergency Solutions Grant. Only the Emergency Solutions Grant funding typically supports people experiencing homelessness. The 2019 funding breakdown for each program is as follows:[95]

- Community Development Block Grant: $1,650,526;
- Home Investment Partnership Program: $1,055,648; and
- Emergency Solutions Grant: $228,067

National and State Homeless Prevalence Estimates

HUD's 2018 Annual Homeless Assessment Report (2018 AHAR) to Congress,[96] reported just over 550,000 people in the United States experienced some type of homelessness on a given day. Approximately two thirds (65%) were in sheltered locations such as emergency shelters or transitional housing programs, and about one third (35%) were in unsheltered locations such as living on the street, in abandoned buildings, or other places not deemed suitable for human habitation.[97] This represented an increase in the number of people who were homeless on a given night by 0.3% from 2017 to 2018.[98]

The 2018 AHAR states that Texas had 25,310 people who were homeless in 2018 on any given day, an increase of 1,762 (or 7.5%) from 2017. The 2018 AHAR also reported that approximately one third (7,638) of homeless Texans lived in rural parts of the state.[99] According to the same report, the number of people in Texas who were homeless on any given day declined between 2010 to 2017 by 14,478 people, or 36.4%.

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[95] Awards and Allocations—HUD Exchange. (n.d.).

[96] The U.S. Department of Housing and Urban Development Office of Community Planning and Development. (2018). The 2018 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-in-time estimates of homelessness. Retrieved October 28, 2019, from https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf

[97] The U.S. Department of Housing and Urban Development Office of Community Planning and Development. (2018).

[98] The U.S. Department of Housing and Urban Development Office of Community Planning and Development. (2018).

[99] HUD defines rural areas as places where the population predominantly resides in urban clusters that are more than 10 miles from an urbanized area or in Census-defined rural territories. The U.S. Department of Housing and Urban Development Office of Community Planning and Development. (2018), (p. 18).

Nueces County Homeless Prevalence

The Point in Time[100,101] count for Nueces County on January 23, 2020, identified 830 people experiencing homelessness. This was an increase of 450 people over the 2019 Point in Time[102] count of 380. There were 391 people identified as sheltered and 265 were unsheltered. There were 174 people who were observed but did not provide information. The 2020 Point in Time count also found increases in homelessness in these populations:

- Chronically homeless (over one year): 99 in 2020 vs. 53 in 2019;
- Children: 61 in 2020 vs. 26 in 2019; and
- Veterans: 65 in 2020 vs. 37 in 2019.

Note that the Housing and Urban Development 2018 AHAR count is a point-in-time count for a particular day; aggregate numbers are much higher. For example, in Texas, public school data reported to the U.S. Department of Education during the 2016–2017 school year showed that an estimated 115,000 public school students experienced homelessness over the course of the year. [103] Of that total, just under 5,000 students were unsheltered, just over 11,000 were in shelters, about 8,000 more were in hotels or motels, and the vast majority (about 90,000) were doubled up in residences more suited for a single family dwelling.[104] The Point in Time counts do not capture all people experiencing homelessness, therefore the Point in Time data should be seen as the lowest possible number that should be anticipated in any community. In our interviews with local homelessness providers and advocates, the local population was estimated to be closer to 1,200 to 1,500.

Nueces County Services for People Experience Homelessness

Housing Units

The 2019 Housing Inventory Count published by the Texas Homeless Network[105] reported 772 available housing units for people experiencing homelessness in Nueces County, distributed as follows:

- Emergency Shelters: 471;
- Veteran's Vouchers and Units: 129;
- Transitional Housing: 98;

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[100] Texas Homeless Network, Balance of State Continuum of Care data. Retrieved March 25, 2020 from https://www.thn.org/texas-balance-state-continuum-care/data/pit-count-and-hic/

[101] The Point-in-Time (PIT) count is a count of sheltered and unsheltered people experiencing homelessness on a single night in January.

[102] Homeless-Issues-Partnership-Inc-Combined-Report.pdf. (n.d.). Retrieved March 27, 2020, from https://www.thn.org/wp-content/uploads/2019/03/Homeless-Issues-Partnership-Inc-Combined-Report.pdf

[103] National Center for Homeless Education (NCHE). (n.d.). Texas. Retrieved October 28, 2019, from http://profiles.nche.seiservices.com/StateProfile.aspx?StateID=51

[104] National Center for Homeless Education (NCHE). (n.d.).

[105] Texas Homeless Network, Balance of State Continuum of Care data.

- Rapid Re-Housing: 62; and
- Permanent Supportive Housing: 12.

Healthcare and Support Services

NCMHID receives funding from the Projects for Assistance in Transition from Homelessness (PATH) program. PATH services to identify homeless individuals who have a mental illness and links them to ongoing mental health services and resources. Services include outreach screening, diagnostic assessment, treatment and assistance with housing needs. All NCMHID services are available to people experience homelessness, within the confines of specific program requirements and limits on available resources.

Local Shelters

For our needs assessment, we interviewed three local homeless shelters who vary in the services they provide and funding structure. We recognize that Nueces County has many more shelters available to the community,[106] however, the shelters we interviewed provide a vast majority of the services in the community.

Good Samaritan Rescue Mission (Good Samaritan) is the largest shelter[107] in Corpus Christi with 233 beds and the Salvation Army of Corpus Christi has 124 beds. These two shelters provide most of the emergency shelter capacity for the community. Purple Door operates a 65-bed shelter for people experiencing homelessness due to domestic violence.

Good Samaritan is a faith-based non-denominational shelter that serves adults without children and does not accept any government funding. A volunteer retired physician is on site every other week. Good Samaritan staff manage medications other than inhalers and medications are dispensed four times daily. Residents are expected to manage when to take their medications and obtain refills. Good Samaritan collaborates with other providers and NCMHID case managers visit to check on people in their care, but there is no on-site behavioral healthcare.

The Salvation Army of Corpus Christi provides a comprehensive range of services to people experiencing homelessness. and serves as the coordinated entry point for homeless services.[108] People needing housing begin at the Salvation Army's emergency shelter with an assessment of their needs. The assessment leads to a referral to housing and related support services. In most

[106] Homelessness Snapshot for Leadership Corpus Christi—October 2019. (n.d.). Retrieved March 27, 2020, from https://www.slideshare.net/lizawisner/homelessness-snapshot-for-leadership-corpus-christi-october-2019
[107] GOOD SAMARITAN: Rescue mission has grown into area's largest shelter. (n.d.). Retrieved March 27, 2020, from https://www.kristv.com/news/homeless-corpus-christi-crisis-on-our-streets/good-samaritan-rescue-mission-has-grown-into-areas-largest-shelter
[108] Coordinated Access Information Flyer accessed 3/25/2020 from https://e067abf4-3fdd-4876-b029-f4ad6a1cf30f.filesusr.com/ugd/c59d4d_de3e95e61f6e4e8c85ef8006987ef2e2.pdf

cases, the initial housing offered is emergency shelter. The Salvation Army of Corpus Christi also has funds for homeless prevention (i.e., rent to avoid eviction), rapid rehousing for people newly homeless, transitional housing for veterans, and a permanent supportive housing project for disabled people who are also considered chronically homeless. The Salvation Army of Corpus Christi is building a new facility that will be Americans with Disabilities Act (ADA) accessible and allow more people with special needs to be served.

Findings and Recommendations

Rapid Response Needed to Provide Services to People Experiencing Homelessness

Our interviews with staff at Good Samaritan and the Salvation Army of Corpus Christi identified several common challenges to providing services to people experiencing homelessness, including:

- There are not enough services for people experiencing homelessness who are also mentally ill. This is especially true for people who need assistance in accessing care and following treatment plans and people with a history of violent offenses and/or inappropriate behavior.
- There is a need for increased access to healthcare, both urgent and routine care, for people in shelters. Improved coordination with hospitals and other providers is also needed when discharging people who are experiencing homelessness. Shelter staff report that people often present for shelter who need more medical care and support than they can provide.
- Staff report an increase in people with chronic health conditions who require long term supportive care that shelters are not able to provide.
- There is a need for improved coordination among providers. We found in our interviews that providers are not aware of all the services that are available and how to access those services. Shelter providers specifically cited confusion by the Corpus Christi Police Department's crisis intervention team about who is appropriate for what shelters and services.
- Emergency shelters are not functioning as part of a coordinated system of community-based crisis interventions services designed to reduce reliance on emergency departments, jails and other public resources.

Rapid Response Needed to Provide Services to People Experiencing Homelessness Recommendation

Shelter providers should be included in efforts to develop a strategic planning process that we have recommended in the Leadership section of this report. While that effort begins, the emergency shelter providers should rapidly connect with other key providers to ensure access to existing services and resources. Although the HIP provides a place for standing meetings among providers, we learned that Good Samaritan—the largest shelter in Nueces County—

does not attend these meetings because the meetings emphasize HUD funding, which they do not pursue nor accept. Therefore, we recommend that HIP expand its focus or alternatively an ad-hoc meeting could be quickly convened by the Salvation Army of Corpus Christi in its role as the coordinated entry point. The following providers, at a minimum, should be included in this rapid coordination process:

- NCMHID staff to ensure access to mental health services that are available currently;
- Crisis intervention team leaders to coordinate admission criteria; and
- City of Corpus Christi leadership to leverage existing support and services.

Financial Considerations

Recommendation: As the Regional Healthcare Partnership 4 Anchor, NCHD could facilitate discussions with providers who are participating in the Nueces County Delivery System Reform Incentive Payment (DSRIP) program regarding a contingency planning process to determine the DSRIP activities that will continue when funding is no longer available, and identify potential funding sources, strategies to create cross-county quality health outcomes, and collaboration opportunities among the DSRIP providers. Planning now would allow elected officials to fully understand the impact on the health care system if Texas does not come to an agreement with the federal government for a DSRIP replacement program. The DSRIP funding terminates in September 2021. Although our report is specific to behavioral health, all providers should be included as significant reductions in health care services will impact people with and without mental health conditions.

Health care financing is obviously complicated and financing of care in Nueces County is no exception. The multiple factors involved in financial support for behavioral health services make it difficult to predict the future with certainty, but there are factors the county should consider soon as it plans for the future of the behavioral health system in Nueces County. In this section, we highlight financial considerations related to:

- COVID-19,
- Texas 1115 Transformation Waiver,
- DSRIP, and
- Nueces County Hospital District funding.

COVID-19

As we were writing our recommendations for this report, the COVID-19 pandemic reached Texas. Although it is too early to understand the depth of the short-term and the nature of the long-term financial ramifications, it is clear the pandemic will factor into how health care services are financed at the federal, state, and local levels. As noted above, there are likely to be long-term impacts on mental health, particularly from the economic disruptions in response to the virus. It is also reshaping, perhaps temporarily, the way services are delivered in the community, with a growing use of telehealth and the provision of virtual services.

Financing

Communities may be faced with declining revenues, depending on how long the economic impacts of COVID-19 affect communities. The 2021 Texas Legislature will be balancing multiple funding issues with decreased revenue because of efforts to mitigate the spread of COVID-19 and declining oil prices.

Service Delivery

Regulatory changes that allow telephone and telehealth services to be reimbursed by Medicaid, Medicare, and commercial insurance are currently considered temporary service options, but they may become permanent, which could potentially have a beneficial impact on practice in Nueces County. However, provider shortages may increase as some independent physician practices lose ground or close because of COVID-19.

1115 Transformation Waiver: DSRIP

Overview

In December 2011, the Centers for Medicare and Medicaid Services (CMS) approved Texas' 1115 Transformation Waiver. Waiver funds support two objectives: (1) uncompensated care payments were designed to help offset the costs of uncompensated care; and (2) DSRIP, which "are incentive payments to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served."[109]

According to the Texas Health and Human Services Commission (HHSC), "DSRIP is locally driven, based on community needs, and as an incentive payment program, offers flexibility to: (1) innovate to deliver better care and improve health outcomes; and (2) deliver services not traditionally billable to insurance but that can improve health. Major DSRIP focus areas include:

- Behavioral health;
- Primary care;
- Patient navigation, care coordination, and care transitions, especially for complex populations;
- Chronic care management; and
- Health promotion and disease prevention."[110]

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[109] Texas Health and Human Services. (n.d.). *Waiver overview and background resources*. https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-overview-background-resources

[110] Texas Health and Human Services Commission. (2019, September 30). *Draft Delivery System Reform Incentive Payment (DSRIP) transition plan*. https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/draft-dsrip-transition-plan-cms.pdf

The impact of DSRIP – and possible changes to it – on behavioral health systems throughout the state cannot be overstated. DSRIP has been a major financial force in closing gaps in care and launching innovative solutions to what had been long-standing community problems. From a federal government perspective, the DSRIP program was never intended to be a long-term financial opportunity for states and their provider communities. Its goal was to transform the health care delivery system and improve health outcomes.

In May 2016, Texas and CMS agreed to an extension of the waiver. Then, in December 2017, CMS approved a five-year renewal to September 2022. Both the extension and the renewal continued the uncompensated care pool and the DSRIP program pool. From October 2013 to September 2017, providers received over $15 billion in DSRIP funds and served 11.7 million people.[111]

Under the waiver, payment eligibility requires participation in one of the state's 20 regional healthcare partnerships (RHPs). RHP participants include governmental entities providing public funds known as intergovernmental transfers (IGTs); Medicaid providers, including hospitals and physician groups; local community mental health authorities; public health departments; and other stakeholders. Nueces County is one of 18 counties in RHP 4, also known as the Coastal Bend region.[112] Each RHP has one anchoring entity, which "acts as a primary point of contact for HHSC in the region and is responsible for seeking regional stakeholder engagement and coordinating development of a regional plan."[113] NCHD anchors RHP 4 and its responsibilities include facilitating learning opportunities for DSRIP providers and providing technical assistance related to DSRIP reporting requirements specific to the providers' achievement metrics. In the DSRIP program, each provider selects their own achievement measures, as determined by HHSC and CMS guidelines. NCHD has no authority to mandate a provider to select a specific achievement goal. These anchor responsibilities will cease when the DSRIP program is terminated in September 2021.

Regional DSRIP Behavioral Health Funding

In the first phase of the waiver (2011–2017), providers reported on projects, including outcome measures. RHP 4 projects ranged from expanding access to care by adding clinicians or clinic hours to establishing residency programs to developing community health worker programs. Given the project-focused nature of the waiver during that period, we can determine the DSRIP payments providers received for behavioral health initiatives. For providers located in Nueces

[111] Texas Health and Human Services Commission. (2019, September 30).
[112] The 18 counties of RHP 4 are Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, and Victoria.
[113] Texas Health and Human Services. (n.d.). *Waiver overview and background resources*. https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-overview-background-resources

County, behavioral health projects included increasing the number of psychiatric nurse practitioners, expanding and enhancing tele-psychiatry services, integrating primary care with behavioral health services, and increasing access to peer support services. In phase one of the waiver, Nueces County providers received $82,077,916 for behavioral health-related projects; in total, the RHP 4 region received over $126 million for behavioral health-related projects in the first round of the waiver.

Table 27: Regional Healthcare Partnership 4 Behavioral Health Payments Earned (2011-2019)

Regional Healthcare Partnership 4	Payments Earned[88]
Nueces Center for Mental Health and Intellectual Disabilities (NCMHID)	$22,384,801
Providers Located in Nueces County	$59,693,115
Nueces County	$82,077,916
Other RHP 4 LMHAs	$28,067,895
Other RHP 4 Providers not in Nueces County	$16,469,693
Other RHP 4 Counties	$44,537,588
RHP 4 Total Behavioral Health Funds	$126,615,504

A "significant transition occurred"[114] during phase two of the waiver (2017–2021), with funding shifting to system-wide activities intended to achieve provider-selected outcome measure bundles. Under phase two, the waiver shifted from project "clients" (e.g., an integrated care clinic serving 225 people) to "all patients in the provider system measured for health care quality achievement."[115] In the all-patients methodology, larger provider system changes are measured, such as follow up after hospitalization for mental illness or care planning for dual diagnoses across all patients in the providers' system of care.

Total Regional DSRIP Funding

Through the 1115 transformation waiver's lifespan (from 2011 through 2021), the DSRIP value to the 18 counties in the Coastal Bend region of RHP 4 has been over $937 million. Of that, more than $735 million has been allocated to providers located in Nueces County. [116] To date, NCMHID has received $29,209,552, with an additional $10,362,652 available in the remaining

[114] Texas Health and Human Services Commission. (2019, September 30).
[115] Texas Health and Human Services. (n.d.). *Health information technology (health IT) strategic plan: Draft DSRIP revised transition plan – Submitted to CMS (4/13/2020).* https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-renewal
[116] RHP 4 Providers located in Nueces County are Corpus Christi Medical Center, Spohn Health System, Nueces County Public Health District, Driscoll Children's Hospital, and NCMHID.

reporting cycles of the waiver. For fiscal year (FY) 2019, this represented 18% of the NCMHID overall budget. This funding is woven throughout the NCMHID budget and impacts all programs and administrative functions.

Table 28: Regional Healthcare Partnership 4 Total Funding (2011–2021)

Providers	Demonstration Years (DY) 2 – 8 Payments Earned to date[lxxxix]	DY 9 – 10 Project Values[xc]	Total Valuation
All RHP 4 Providers	$690,855,441	$246,940,368	$937,795,809
All Providers Located in Nueces County	$537,625,400	$197,461,590	$735,086,990
NCMHID	$29,209,552	$10,362,652	$39,572,204

Post DSRIP

As noted above, the current waiver is set to expire in September 2022; however, the current funding pool ends in September 2021. In October 2019, HHSC submitted a draft DSRIP transition plan[117] to CMS, describing how the state will further develop its delivery system reform efforts without DSRIP funding. In the draft transition plan, HHSC acknowledged that DSRIP enabled more coordination across physical health, behavioral health, and public health care. In addition to analyzing stakeholder proposals, HHSC is currently exploring new programs, policies, and other strategies that use Medicaid resources and financing structures "to build on DSRIP's successes in increasing access to care and delivering cost-effective care for Texans."[118] At this time, there is no clear understanding if this transition plan or new funding will be available to providers. The DSRIP funding is interwoven throughout the county's system of care and the impact of eliminating DSRIP funding, will be significant for providers.

Nueces County Hospital District Funding

NCHD has a constitutional and statutory responsibility for indigent health care in Nueces County. Chapter 281 of the Texas Health and Safety Code[119] requires the hospital district to expend tax funds for furnishing medical and hospital care for people in poverty or without insurance who reside in the district, along with a provision to allow contracting with a school district to provide nursing services and assistance to district employees and students (section 281.0465). The statue also provides the hospital district authority to issue bonds to provide hospital facilities. In addition, Chapter 61 of the Texas Health & Safety Code provides authority, duties and responsibilities for indigent health care.

[117] Texas Health and Human Services Commission. (2019, September 30).
[118] Texas Health and Human Services Commission. (2019, September 30).
[119] Health and Safety Code, Title 4. Health Facilities, Subtitle D. Hospital Districts, Chapter 281. Hospital Districts in Counties of at least 190,000 (1989 & rev 2019). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.281.htm

Section 281.094 of the Health and Safety Code provides for the use of non-tax funds by NCHD: "With the approval of the Nueces County Commissioners Court, the board of Nueces County Hospital District may use funds made available to the district from sources other than a tax levy to fund health care services, including public health services, mental health and mental retardation services, emergency medical services, health services provided to people confined in jail facilities, and for other health related purposes." In addition, any NCHD funds can be used for indigent health care and intergovernmental transfers for the non-federal share of Medicaid payments.

Funding for NCHD comes from two primary sources: property tax revenue (35%) and CHRISTUS Spohn corporate member revenue (65%). Property taxes are based on the effective tax rate directed by the Commissioners Court. The CHRISTUS Spohn corporate member revenue is a more complicated arrangement. The revenues that come to the hospital district through this arrangement are a percentage of CHRISTUS Spohn's Nueces County facilities' net patient revenue, excluding any federal funds. According to interviews with NCHD staff, NCHD has approximately $70 million in cash assets, with no debt.

The majority of NCHD expenditures are related to intergovernmental transfers (89%) that support multiple components of the 1115 Transformation Waiver and other Medicaid programs. The intergovernmental transfers support four CHRISTUS Spohn hospitals, along with the city/county health department, Corpus Christi Medical Center, and Driscoll Children's Hospital.

Table 29: Intergovernmental Transfers (IGT) Provided by NCHD (FY 2020)

Provider	IGT Amount Provided by NCHD FY Ending 9/30/20
CHRISTUS Spohn Corpus Christi	$64,100,311
CHRISTUS Spohn Alice	$5,243,320
CHRISTUS Spohn Beeville	$3,965,540
CHRISTUS Spohn Kleberg	$3,823,315
City/County Health Department	$1,208,100
Corpus Christi Medical Center	$19,776,918
Driscoll Children's Hospital	$13,581,977
DeTar Healthcare	$2,600,478
All Other Providers in Nueces Service Delivery Area	$185,155

NCHD FY 2020 budget includes expenditures to support behavioral health services in the county. In addition to budget items in the following table, NCHD's membership agreement with CHRISTUS Spohn also provides for Spohn's provision of inpatient psychiatric services for people who are uninsured.

Table 30: NCHD FY 2020 Budget – Behavioral Health Related Budget Items

Behavioral Health Related Budget Items	Budget
NCMHID	$969,129
NCMHID Jail Diversion Program	$2,500,000
Alcohol and Drug Rehabilitation Center (Cenikor)	$55,000
Council on Alcohol and Drug Abuse	$28,714
Palmer Drug Abuse Program	$5,000

It is evident from this brief narrative that Nueces County has a huge stake in the transformation of the 1115 waiver program as well as potential reductions in state and local revenue support for programs because of the economic impact of COVID-19. In our view, NCHD is best equipped to lead an integrated analysis of the overall financial impact of these changes as well create specific responses to them.

Leadership

Recommendation: We recommend the creation of a broad-based planning group, with elected political leadership, to oversee transformation of the Nueces County mental health system.

Nueces County benefits from strong commitment from its elected and appointed leaders to transform mental health care in the county. It is essential that these leaders continue to be involved in shaping that transformation. The core recommendation to accomplish this is for Nueces County leaders to empower a formal leadership group and charge it with improving mental health care in the county. Issue-specific work groups could then be coordinated under the umbrella of the core group to focus on improving care in specific sectors, such as the hospital/crisis services system and adult needs more broadly, the criminal justice system, the service delivery system for children and youth, and services for service members, veterans, and their families. We first describe our recommendation for the core group, then discuss more population-specific issues and recommendations that should be prioritized and addressed by the more focused work groups.

Recommendation: Creation of a Leadership Group Not Restricted to Behavioral Health and Led by Elected Officials

It is essential for a formal leadership team to "own" and "drive" the changes needed for the mental health system in Nueces County. Many communities in Texas and elsewhere have created behavioral health workgroups. We have come to believe that approach is too narrow given the importance of integrating mental health care within general health care. It is especially important in Nueces County where the Commissioners Court has exercised key leadership and where NCHD plays a significant role through its membership agreement with CHRISTUS Spohn. Given the many needs of the Nueces County system and given the political leadership of the current Commissioners Court, we recommend the creation of a leadership group that comprises elected officials, health and behavioral health leaders and providers, and representatives of the veterans' community, school districts, law enforcement, and others to provide an integrated approach to improving treatment for mental illnesses in Nueces County. This leadership group would provide overall direction and integration of efforts across the entire spectrum of systemic transformation work.

Ultimately, it is up to Nueces County to decide how to create a governing structure to implement system reform, including identifying participants, establishing the degree of formal authority exercised by the group, and deciding how it defines and performs its role. However, it is also important that the leaders of local health systems and elected officials are members of such a group. The group should include principals (not staff) from all major stakeholders, including elected officials. This group should be a place where local leaders meet to discuss data and make policy decisions, and where work groups can report up to a centralized group. During our time in Nueces County, we identified many areas where local leaders and sectors were already collaborating, and that collaboration should be taken to the next level to transform the mental health system.

As it will be difficult for a group of leaders to implement change over time and across populations and systems, we recommend that additional workgroups or subcommittees be convened under the auspices of the leadership group to focus on the crisis response system; the criminal justice system; and the systems that serve service members, veterans, and their families. We will specifically focus on the need for workgroups for service members, veterans, and their families, criminal justice, homelessness, and philanthropy. Child, youth and family collaboratives have been discussed in the Access to Community Care sections of this report and we refer the reader to those sections for details regarding those collaboratives. We did not include the need for a general child, youth and family collaborative here because we did not determine that there was a need. Rather, the child, youth and family collaboratives should focus on specific sectors such as Schools and Child Welfare.

Recommendation: Creation of a Service Members, Veterans, and Families Leadership Workgroup

Our assessment revealed that the organizations providing mental health services for service members, veterans, and their families were operating well at the program level. We noted, however, that many of these organizations were unable to act on potential opportunities to partner with or collaborate with other organizations due to lack of authority.

Engaging the leaders of these organizations in a service members, veterans, and families leadership workgroup would allow them to provide recommendations to the leadership group. This workgroup would also provide direction and a platform for recognizing and acting on synergies for mental health care across systems for the benefit of service members, veterans, and families.

Immediate Recommendations for Service Members, Veterans, and Families

Create a service members, veterans, and families leadership workgroup.

The initial meeting of the service members, veterans, and families leadership workgroup should be held within three months after the submission of this final report. Meetings should be held quarterly and be timed to match the leadership group's schedule (quarterly or semiannual) of focusing on issues pertaining to service members, veterans, and families.

Recommendation: Criminal Justice Planning Capacity

Feedback from the interviews we conducted confirmed that the criminal justice system in Nueces County faces many of the same challenges as other Texas counties. There are multiple elected officials, agencies, and staff that make up the county's criminal justice system. Each has its own statutory authority and responsibility, processes, and expectations for outcomes. Although we are impressed by the local commitment to improved coordination, we believe Nueces County has the opportunity to implement best practices and learn from other communities to translate that commitment into sustained action.

It is our experience that communities are more successful in improving outcomes when two resources are in place. First, there needs to be a formal planning body that includes all system stakeholders and decision-makers, often called a criminal justice coordinating committee (CJCC). Most communities start a CJCC by utilizing the *Guidelines for Developing a Criminal Justice Coordinating Committee*, which was developed by the National Institute of Corrections in 2002.[120]

[120] National Institute of Corrections. (2002, January). *Guidelines for developing a criminal justice coordinating committee*. U.S. Department of Justice. https://s3.amazonaws.com/static.nicic.gov/Library/017232.pdf

We learned during our interviews that key leadership in Nueces County is interested in establishing a CJCC. We strongly support Nueces County establishing a CJCC and recommend that it follow the guidelines referenced above, along with other best practices, as the CJCC is established. Our experience in other counties that have established a CJCC is that the commissioners court often approves the CJCCs charter and by-laws and the county judge or a commissioner provides leadership oversight.

Second, there should be a dedicated criminal justice planning staff member to support the CJCC. Staff dedicated to planning activities can facilitate CJCC meetings; provide the data, research, and analysis for decision makers; distribute information; and manage timelines for action. In December 2012, the National Institute of Corrections released a technical assistance document, *Staffing a Local Criminal Justice Coordinating Committee*, that explains the benefits of having planning staff and provides guidance on how to structure the position.[121] A new, dedicated, and appropriately qualified person likely needs to be hired. It is important that this position require experience in managing criminal justice systems. The employee should not represent any component of the criminal justice system and be housed within a county department that is not directly part of this system. This employee's role should support a data-driven decision-making process by the CJCC. Dallas, Tarrant, Harris, Bexar, and Travis counties all have similar positions, which have been crucial to efforts to manage jail populations, connect people to services, and improve outcomes throughout the system. In some of these counties, there are separate criminal justice planning departments. In other counties, staff are attached to the county budget officer, commissioners court administration, or directly to the county judge. The cost for this position would depend on the pay level the county establishes for this position.

A starting point for the CJCC is to formally map the local criminal justice system according to the Sequential Intercept Model (SIM).[122] The SIM is a planning tool that organizes the criminal justice system into six phases, or intercepts, beginning with a person's first contact with the criminal justice system. These intercepts are (0) community services such as crisis lines, (1) arrest, (2) booking and preliminary arraignment, (3) time spent in the courts and jail, (4) community reentry, and (5) community corrections (services in the community to prevent re-offense). The SIM framework has been used in jurisdictions across the United States and is an

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[121] National Institute of Corrections. (2012, December). Staf*fing a local criminal justice coordinating committee*. U.S. Department of Justice. https://s3.amazonaws.com/static.nicic.gov/Library/026308.pdf

[122] The sequential intercept model is described in a 2006 paper by Mark Munetz and Patricia Griffin. It has since become a basic planning tool used by communities across the United States. The paper can be found here: Muntez, M. R., & Griffin, P. A. (2006, April). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services, 57*(4), 544–549. https://www.ncbi.nlm.nih.gov/pubmed/16603751

excellent tool for organizing diversion planning across the many systems that may have contact with an individual at each of the various intercepts.

Our experience in other communities that have established criminal justice coordinating committees is that long-term success begins with work on a small number of focused issues. For example, the CJCC in Dallas County started by resolving problems between local law enforcement and the county jail about custody of detainee property and transportation to the county jail from the city jails. We recommend that the Nueces County CJCC's initial charge be focused on a few key components of the local system where there are opportunities for rapid improvement, as follows:

- **Alternatives to jail:** Expand existing alternatives to incarceration and create new ones. Opportunities could include increasing releases from the City Detention Center, expanding the use of "cite and release" provisions in state law, and developing drop-off centers for law enforcement to use for lower-level offenders who need a connection to community services.
- **Incorporate risk assessments into bail decisions:** Build upon the existing collaboration between the Nueces County Community Supervision and Corrections Department and the felony courts to provide risk assessments to all magistrates for consideration in setting bail.
- **Develop pre-trial supervision capacity:** Providing supervision to people awaiting trial protects the public safety by using a monitoring system that is based on a person's level of risk and providing connections to community supports. The county's Office of Commissioner Court Administration has limited resources for responding to pre-trial inquiries and providing notices of court dates. Additional staff resources would permit more robust supervision.

Immediate Recommendations for Criminal Justice

Nueces County Commissioners Court should:

- Establish a Nueces County CJCC, following best practices, with a formal charter and by-laws approved by the Commissioners Court; and
- Hire a criminal justice planning staff member to support the CJCC and its work, who would then be assigned to the appropriate department or elected official(s).
    - The cost for this position would depend on the pay level the county establishes for this position.

Recommendation: Community-Wide Strategic Planning that Addresses Homelessness[123]

Corpus Christi city leadership has enhanced city efforts to increase housing and support services. A new Homeless and Workforce Housing Division comprised of three employees within the city's Housing and Community Development Department was created in 2019. Corpus Christi's commitment of resources and general prioritization of homelessness provides an opportunity to strengthen community collaboration and planning around homelessness.

We learned during our interviews that the Homeless Issues Partnership, Inc. (HIP)[124, 125] functions as a community housing coalition to meet the requirements for federal Department of Housing and Urban Development (HUD) funds. Although HUD is an important part of a comprehensive funding strategy, it cannot be the only funding a community relies on to meet the needs for housing and support services. Corpus Christi's newly added city staff are valuable resources in community planning, coordinating efforts, and leveraging funding for more housing and services. Additional support from city staff can help the community determine if HIP can be more effective in accessing HUD's Continuum of Care Program[126, 127] funds and increase its scope in the broader community response to homelessness. It is also important that the homeless system participate in broader community planning efforts.
Nueces County should quickly determine if HIP can become the locus for community-wide strategic planning to eliminate homelessness. Nueces County needs an effective, data-driven planning body and HIP should be able to assume responsibility for this body more quickly than starting a new group. Staff from Corpus Christi's newly created Homelessness and Workforce Housing Division can lead this process and provide leadership and administrative support to HIP.

Immediate Recommendation for Addressing Homelessness

Homeless response stakeholders and partners should:

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[123] We have not interviewed the president of HIP for this final version of our needs assessment. There was an interview scheduled; however, it was canceled because of an unexpected personal emergency and was not rescheduled.
[124] Homeless Issues Partnership, Inc. (HIP) is a non-profit organization and Corpus Christi's homeless coalition, which meets on a monthly basis to discuss homeless issues in the area, services offered by agencies, and barriers to services, and it works towards achievable solutions.
[125] City of Corpus Christi. (n.d.). *Homeless Issues Partnership, Inc. (HIP).* https://www.cctexas.com/departments/housing-and-community-development/homeless-programs/hip
[126] The Continuum of Care (CoC) Program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers and state and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness.
[127] HUD Exchange. (n.d.). *Continuum of Care (CoC) Program*. https://www.hudexchange.info/programs/coc/

- Review HIP membership and participation and include any key stakeholders, providers, and funders who are not currently engaged;
- Support HIP's creation of additional workgroups to address specific issues, such as challenges shared by emergency shelter providers;
- Support HIP in endorsing and supporting Corpus Christi's priority of ending veteran's homelessness by housing at least the 65 veterans identified in the 2020 Point-in-Time Count;[128]
- Support HIP in endorsing and supporting Corpus Christi's priority of developing a functioning Homeless Management Information System that all providers will use; and
- Prepare for the next HUD Continuum of Care Program funding opportunity.

Recommendation: Local Philanthropy

Our interviews with local philanthropy revealed considerable interest in the issues raised by this assessment and a willingness to support implementation that fits their funding priorities. This willingness may, however, be impacted by COVID-19.

Immediate Recommendations for Local Philanthropy

- Provide local philanthropy with a copy of this report.
- Convene a meeting with local philanthropy after the final report is released to identify areas of funding interest.
- Reconvene local philanthropy to review and discuss the philanthropy implementation support plan every quarter for one year.

[128] The Point-in-Time (PIT) count is a count of sheltered and unsheltered people experiencing homelessness on a single night in January.

Appendix A: Key Informant Interviews

Elected Officials

Name	Title	Organization
Barbara Canales	Judge	Nueces County
Carolyn Vaughn	Commissioner	Nueces County
Joe A. Gonzalez	Commissioner	Nueces County
John Marez	Commissioner	Nueces County
Brent Chesney	Commissioner	Nueces County

Nueces County Hospital District

Name	Title	Organization
John Martinez	Board Member	Nueces County Hospital District
John Valls	Board Member	Nueces County Hospital District
Daniel Dain	Board Member	Nueces County Hospital District
Dr. Vishnu Reddy	Board Member	Nueces County Hospital District
Sylvia Tryon-Oliver	Board Member	Nueces County Hospital District
Pamela L. Bower	Board Member	Nueces County Hospital District
Belinda Flores	Board Member	Nueces County Hospital District
Jonny Hipp	Administrator/Chief Executive Officer	Nueces County Hospital District
Belinda Chism	Assistant Administrator	Nueces County Hospital District

Nueces Center for Mental Health and Intellectual Disabilities (NCMHID) Board[129]

Name	Title	Organization
Tony C. Diaz	Board Member	NCMHID
John E. Jackson	Board Member	NCMHID
Linda Fallwell-Stover	Board Member	NCMHID
Lind G. Frost	Board Member	NCMHID

[129] NCMHID board members who have been interviewed but do not appear in this table have been listed in the section and table corresponding to their employment rather than board member capacity.

Health Care and Behavioral Health Care Providers

Name	Title	Organization
Kenneth Waller	Chief Executive Officer	Amistad Community Health Center, Inc.
Kathy Garcia	Outreach Director	Bayview Behavioral Hospital
Heather Freeman	Director of Admissions and Assessment	Bayview Behavioral Hospital
Courtney Sanchez	Outreach Director	Bayview Behavioral Hospital
Rlynn Wickel	Vice President – Behavioral Health Services	Bayview Behavioral Hospital
Chris Nicosia	Chief Financial Officer	Bayview Behavioral Hospital
David Barrera	Program Director	Care Integrated Behavioral Health
Dr. Praderio	Chief Medical Officer	Care Integrated Behavioral Health
Dr. Sunil Reddy	Chairman and Chief Executive Officer	Care Integrated Behavioral Health
Dr. Osbert Blow	President	Christus Spohn Health System
Reginald (Reggie) Allen	Vice President, Clinical/Business Operations Transformation	Christus Spohn Health System
Amy Granberry	Vice President Client Engagement and Recovery Management	Cenikor Foundation/Charlie's Place-Corpus Christi
Alison Johnson	Director of Community Health Outreach	Coastal Bend Wellness Foundation
Lindsey Prado	Director of Behavioral Health	Coastal Bend Wellness Foundation
Meredith Grantham	Chief Operations Officer	Coastal Bend Wellness Foundation
Catherine Taylor	Director of Admissions and Placement	Corpus Christi State Supported Living Center
Melissa Sweeting	Executive Director	Council on Alcohol and Drug Abuse Coastal Bend
Ernest Buck	Chief Medical Advisor	Driscoll Health Plan
Mary Dale Peterson	Executive Vice President and Chief Operating Officer; Education, Public Relations and Delegate to Texas Medical Association	Driscoll Health System; Nueces County Medical Society

Name	Title	Organization
John Ramirez	Crime Victim Services Program Manager	Family Counseling Services
Kristi Phillips	Interim Executive Director/Director of Clinical Programs	Family Counseling Services
Maria Graciano	Play Therapy Supervisor	Family Counseling Services
Mary Alvarez	Psychotherapist	Family Counseling Services
Diane Lowrance	Former Director	Nueces Center for Mental Health and Intellectual Disabilities
Mike Davis	Chief Executive Officer	Nueces Center for Mental Health and Intellectual Disabilities
Andrea Vela	Director of Youth Services	Nueces Center for Mental Health and Intellectual Disabilities
Mark Hendrix	Director – Adult Mental Health Services	Nueces Center for Mental Health and Intellectual Disabilities
Rene Mendiola	Chief Financial Officer	Nueces Center for Mental Health and Intellectual Disabilities
Victoria Rodriquez	Associate Director	Nueces Center for Mental Health and Intellectual Disabilities
America Conreras	Director of Resiliency and Recovery Services	Nueces Center for Mental Health and Intellectual Disabilities
Andrea Kovarik	Director of Access Services	Nueces Center for Mental Health and Intellectual Disabilities
Sasha Michaud	Jail Diversion Case Manager	Nueces Center for Mental Health and Intellectual Disabilities
JP Welsh	Military Veteran Peer Network Coordinator	Nueces Center for Mental Health and Intellectual Disabilities
Troy Martinez	Forensic Psychologist	Private Practice; Contracts for Forensic Competency Evaluations
Nathan Hoover	Senior Director, Behavioral Health Services	Superior Health Plan
Jesse Stakes	Clinical Director	Superior HealthPlan
Jody Wilder	Health Services Administrator	Wellpath; Jail Medical Provider
Valerie Davis	Director of Nurses	Wellpath; Jail Medical Provider

Coalitions/Nonprofit Organizations

Name	Title	Organization
Hilary Watt	Principal Officer	Coastal Bend Regional Advisory Council on Behavioral Health
Gilda Ramirez	Vice President	Corpus Christi United Chamber of Commerce
Ernest Scholze	General Manager	Good Samaritan
Julia Wijsman	Head Housing Manager	Good Samaritan
Carole Murphrey	Executive Director and Chaplain	Good Samaritan
Esmeralda Hernandez	Mental Health and Disability Coordinator, Birth to Five Head Start Program	Nueces County Community Action Agency
Irma Shutt	Family Community Partnership Technician, Birth to Five Head Start Program	Nueces County Community Action Agency
Claudio Escobedo	Family Community Partnership Coordinator, Birth to Five Head Start Program	Nueces County Community Action Agency
Marita Rafael	President	Nueces County Medical Society
Paulette Shaw	Executive Director	Nueces County Medical Society
Zehra Surani	Chair, Community Education Committee; Executive Director	Nueces County Opioid & Drug Task Force; It's Your Life Foundation
Brian Permenter	Counseling Manager	Purple Door
Francis Wilson	President and Chief Executive Officer	Purple Door
Gustavo Perez	Business Administrator	Salvation Army of Corpus Christi
Patrick Gesner	Commanding Officer	Salvation Army of Corpus Christi
Donna Hurley	Vice President of Community Impact	United Way of the Coastal Bend
Libby Avery	President and Chief Executive Officer	United Way of the Coastal Bend

Government

Name	Title	Organization
Annette Rodriguez	District Director of Public Health	City of Corpus Christi
Barton Bailey	Homeless & Housing Administrator	City of Corpus Christi
Rebecca Rach	Social Services Director	Nueces County Department of Social Services
Juan (JJ) Delacerda	Veteran Services Officer	Nueces County

Higher Education

Name	Title	Organization
Joshua Watson	Addictions Counseling Program Coordinator	Texas A&M University–Corpus Christi
Sarah Skelton	Student Counseling Center Psychologist	Texas A&M University–Corpus Christi
Chris Giles	Assistant to the Vice President & Director of Strategic Projects	Texas A&M University–Corpus Christi
Art Montiel	Veteran Resource Center Coordinator	Texas A&M University–Corpus Christi

Philanthropy

Name	Title	Organization
Belinda Perez Perea	Program Manager for Children and Family Services Department and the Parents as Teachers Program	Catholic Charities of Corpus Christi, Inc.
Karen W. Selim	Chief Executive Officer	Coastal Bend Community Foundation
Sylvia Whitmore	Chief Executive Officer	The John G. and Marie Stella Kenedy Memorial Foundation
Gloria Hicks	Vice President and Director	The John G. and Marie Stella Kenedy Memorial Foundation

Community Member

Name	Title	Organization
Debra Rodriguez	Local Immigration Attorney	Law Offices of Rodriguez and Moretzsohn

Veterans

Name	Title	Organization
Diane McGough	Fleet and Family Support Center Director	Naval Air Station Corpus Christi
Christie Esquivel	Clinical and Advocacy Program, Counselor	Naval Air Station Corpus Christi
Andrea Gutierrez	Family Advocacy Program Victim Advocate	Naval Air Station Corpus Christi
Arturo Corona	Counseling, Advocacy, and Prevention Supervisor	Naval Air Station Corpus Christi
Patricia Hamilton	Clinical and Advocacy Program, Counselor	Naval Air Station Corpus Christi
Carolyn Scrivano-Martin	Behavioral Health Interdisciplinary Program Coordinator	VA Texas Valley Coastal Bend Health Care System
Carrie Myers	Homeless Veteran Program Manager	VA Texas Valley Coastal Bend Health Care System
Ashley McClelland	Veteran Center Director	Vet Center

Criminal Justice/First Responders

Name	Title	Organization
Walter Garcia	Fire Captain	Corpus Christi Fire Department
Robert Rocha	Fire Chief	Corpus Christi Fire Department
Andrew Cortez	Battalion Chief	Corpus Christi Fire Department
Amber Lopez	Fire Fighter	Corpus Christi Fire Department
Kenneth Erben	Assistant Chief of Operations	Corpus Christi Fire Department
Keane Monroe	City Detention Center Manager	Corpus Christi Municipal Court
Mike Markle	Police Chief	Corpus Christi Police Department
Mark Schauer	Assistant Chief of Police	Corpus Christi Police Department

Name	Title	Organization
Amber Buckelew	Crisis Intervention Team Officer	Corpus Christi Police Department
Skyler Barker	Patrol and Swat Police Officer	Corpus Christi Police Department
Denise Pace	Senior Officer	Corpus Christi Police Department
Brandi Moss	Captain	Corpus Christi Police Department
Marilee Roberts	Court Administrator	Nueces County
Melissa Madrigal	Chief Magistrate	Nueces County
Amanda Delacerda	Veterans Treatment Court Coordinator	Nueces County
Renee Southerland	MSW Graduate Intern	Nueces County Commissioners Court
The Honorable Timothy J. McCoy	Judge	Nueces County Court at Law 5
Jenny Dorsey	Assistant District Attorney for Jail Diversion and Outpatient Competency Programs	Nueces County District Attorney
Robyn Perez	Jail Liaison/Court Coordinator	Nueces County Magistrate Court
William Shull	Director	Nueces County Community Supervision and Corrections Department
Nancy Ruedo	Community Supervision and Corrections Department Officer	Nueces County Community Supervision and Corrections Department
Alana Hobbs	Senior Pre-Trial Release Officer	Nueces County Community Supervision and Corrections Department
Cheryl Davis	Mental Health Supervisor	Nueces County Community Supervision and Corrections Department
J.C. Hooper	Sheriff	Nueces County Sheriff's Office
Debra Dumesnil	Jail Diversion Program Administrator	Nueces County Sheriff's Office
John Galvan	Chief Deputy	Nueces County Sheriff's Office
Roland Martinez, Jr.	Lieutenant	Nueces County Sheriff's Office
Dennise Moore	Deputy	Nueces County Sheriff's Office
Diana Leal	Deputy	Nueces County Sheriff's Office

Foster Care/Child Welfare

Name	Title	Organization
Ashleigh Wilkes	Executive Director	A World for Children
Marni Morgan	Statewide Program Administrator	A World for Children
Gilbert Garcia	Treatment Director	A World for Children
Liddy Vargas	Director of Programs	Agape Ranch
Susan Klaus	Founder/Executive Director	Agape Ranch
Diana Booth	Communications Director	CASA of the Coastal Bend
Page Hall	Executive Director	CASA of the Coastal Bend
Seana Towler	Program Director	CASA of the Coastal Bend
Tara O'Connell	Regional Director, Region 11	Child Protective Services
Clarissa Mora	Executive Director	Children's Advocacy Center of the Coastal Bend
Henry Martinez	Program Director	Circles of Care
Frank Lopez	Clinical Director	Upbring
Krystale Bezio	Chief Program Officer	Upbring

Juvenile Justice

Name	Title	Organization
Carl Coyle	Chief Executive Officer	Liberty Resources
Jennifer Martin	Regional Director	Liberty Resources
Homer Flores	Chief Juvenile Probation Officer	Nueces County Juvenile Justice Center
John Milam	Deputy Director of Special Programs	Nueces County Juvenile Justice Center
Miles Toren	Assistant Chief	Nueces County Juvenile Justice Center
Claudia Schmidt Ikonomopoulos	Mental Health Services Supervisor; Former Chair	Nueces County Juvenile Justice Center; Community Resource Coordination Group

School Districts/School-Based Programs

Name	Title	Organization
Sonya Durrwachter	Director of Special Education	Calallen Independent School District
Kimberley James	Chief of Staff	Corpus Christi Independent School District
April Esparza	Diocesan Health Services Coordinator	Office of Catholic Schools
Stephanie Bonilla	Victim Assistance Coordinator	Diocese of Corpus Christi
Allison Schaum	Assistant Superintendent for Curriculum & Instruction	Flour Bluff Independent School District
James Crenshaw	Principal	Flour Bluff Independent School District
Sharon McKinney	Superintendent of Schools	Port Aransas Independent School District
Heather McQueen	Program Coordinator	Region 2 Education Service Center
Joanne Ferguson	Associate Director for Curriculum, Instruction & Accountability	Region 2 Education Service Center
Karen Turner	Associate Director for Early Childhood Education	Region 2 Education Service Center
Linda Riddle	Administrator	Region 2 Education Service Center
Norma Torres-Martinez	Deputy Director for Instructional Services	Region 2 Education Service Center
Veronica Treviño	Education Specialist	Region 2 Education Service Center
Liz Hanna	Principal	Richard Milburn Alternative High School
Jeanine Kidwell	Superintendent/Principal	Seashore Charter
Jo Milette	Counselor	Seashore Charter
Dr. Cissy Reynolds-Perez	Assistant Superintendent	West Oso Independent School District

Appendix B: Key Informant Interview Questionnaire

Key Informant Interview Questions

1. **What are your goals for this assessment?**

2. **What are the primary strengths the community has in meeting the mental health needs of the community?**
   a. Why are these components of the system working well?
   b. How do these components affect service delivery?
   c. Are there any changes that could be made to improve these components?

3. **What are the community's primary weaknesses and gaps in meeting the mental health needs of the community?**
   a. Why are these components within the system of care not working?
   b. How do these inadequacies affect service delivery?
   c. What problems do these inadequacies create for you within your role in the service system?
   d. From your perspective, what strategies or solutions could be used to overcome these inadequacies?
   e. How would these solutions improve service provision to all populations treated within Nueces County?

4. **What are one or two things that would most significantly improve the community's ability to meet the mental health needs of the community?**
   a. Which services/capacity could be added and what would it take to do so?

5. **What other general comments would you like to offer?**

6. **When thinking of your community leaders and elected officials, who do you believe is someone that should provide feedback to this assessment?**

Appendix C: Qualitative Data Collection Methods

Engagement Process

The Meadows Mental Health Policy Institute (MMHPI) worked with Nueces County Judge Canales and Nueces County Hospital District CEO and Administrator Dr. Jonny Hipp to identify an initial list of local stakeholders for key informant interviews. Through an environmental scan of local organizations conducted by MMHPI staff, news sources, and recommendations made during key informant interviews, we ultimately interviewed nearly 200 local stakeholders to identify issues relevant to the mental health needs in Nueces County. We also conducted three focus groups, one with nearly 15 Corpus Christi Police Department officers from the Delta (downtown/Northside) and Adam (far West side) districts who worked the day shift, one with nearly 20 Nueces County Sheriff's Office deputies, and another with nearly 10 Nueces County Sheriff's Office supervisors.

The key areas of stakeholder engagement included nonprofit, law enforcement, and legal representatives; hospitals and mental health providers; NCMHID; higher education; government; and school districts.

Each key informant interview (individual or small group) or larger focus group session was moderated or co-led by project leads from MMHPI; notes were taken by MMHPI staff.

- **Guide Questions:** MMHPI staff created an interview framework (see Appendix B) as a guide for one-on-one sessions. Often our MMHPI content experts went beyond this guide to ask more focused questions, gaining further information as deemed most appropriate by the interviewer. These questions became more focused as the interview permitted. Open-ended questions covered local, systemic, and institutional issues and experiences in various areas – from local innovative programming developed to divert people from hospitalization and incarceration to changes in the collaborative efforts of mental health-engaged agencies over time. We also added questions to further identify needed system changes, gaps in services, and resources that might be expanded or used strategically in an improved service system.
- **Key Informant Interviews:** We conducted key informant interviews from October 2019 through June 2020. All interviews were conducted by phone or in person. The information we gathered from these interviews is interspersed and detailed throughout the body of this report.
- **Focus Group Interviews**: We held focus groups for stakeholders who we felt could share information best in a group format: one group with officers from the Corpus Christi Police Department, one with deputies from the Nueces County Sheriff's Office, and one with Nueces County Sheriff's Office supervisors.

- **Iterative Engagement Opportunities – Core Parties Collaborative Planning Meetings:** As provided in the contract with Nueces County Hospital District and Nueces County, we committed to an iterative process to provide Nueces County stakeholders with multiple opportunities to offer feedback on our findings and recommendations. As part of this process, we provided opportunities for feedback on the preliminary reports we submitted in December 2019 and presented our initial findings and recommendations to Nueces County Hospital District and Nueces County Commissioners Court in December 2019. We received feedback on the draft needs assessment and incorporated feedback for this final report, which will be delivered in September 2020.

Appendix D: Hospital Data Methodology

We drew our data for emergency department and inpatient psychiatric bed use from the Texas Health Care Information Collection (THCIC). THCIC comprises inpatient, emergency department, and outpatient discharge records for hospitals operating throughout Texas. Each discharge record included details on the client's age, length of stay, county of residence, charges (which reflect the nominal amount billed for each service), primary payer type, and source of admission, among other variables. To analyze the many sources of funding included in records, payer types were grouped into one of five categories for the purposes of this analysis: Medicaid, Medicare, Other Governmental Payer, Self-Pay, and Commercial Insurance.

These THCIC discharge records were used to analyze psychiatric inpatient and emergency department utilization in Nueces County and across Texas, as depicted in the maps and data tables in this report. Although we currently have data from 2015 through the fourth quarter of calendar year (CY) 2018, the data in the maps and tables are limited to a single full year of data – January 2018 through December 2018, with the exception of the daily utilization graphs, which report utilization as far back as January 2016. Discharge records were either reported by age group or aggregated across all age groups, as described in the table titles.

Hospital capacity data were obtained from the American Hospital Association's (AHA) 33rd Annual Survey of Hospitals (for year 2017). We reported the number of beds that are staffed for use by each hospital. However, if the hospital reported an alternate number of available beds in the most recent in-person interviews, we used that reported capacity in lieu of the AHA reported capacity.

Appendix E: Prevalence Estimation Methodology

Introduction

We utilized the work of Dr. Charles Holzer to provide meaningful estimates based on the most rigorous and contemporary epidemiological sources available regarding overall numbers (prevalence) for serious emotional disturbances (SED) and serious mental illnesses (SMI).[130] In 2014, Dr. Holzer worked on behalf of MMHPI to estimate the prevalence of SMI in Texas counties, using 2012 and earlier data.[131] We believe that Dr. Holzer's original SED and SMI estimates and our adaptation of his data, findings, and methodologies to more recent Texas populations provide the most practically relevant estimates available. The method, described in more detail below, uses statistical formulas that apply national prevalence findings to Texas population and demographic data.

Estimating the prevalence of specific mental illnesses such as bipolar disorder, depression, or schizophrenia in different age groups (e.g., children, youth, adults) is a more complicated endeavor – one requiring us to incorporate the best available national studies of the prevalence of those specific disorders. In cases where these more specific epidemiological sources are used, these are always cited and, in all cases, represent what we judge to be the best available, sufficiently contemporary source.

Holzer and "Horizontal Synthetic Estimation"

Beginning with his work at the University of Florida in the 1970s, Holzer drew connections between established data (drawn largely from census data), demographics, and the careful study of how these factors correlated with various needs among populations.[132] Holzer derived principles about these connections as presented in the Mental Health Demographic Profile System (MHDPS). This system matched demographic data from the Florida Health Survey with community demographics and known needs for mental health services, creating a model for estimating need in places and situations in which survey data were not available.

The method, which those in the MHDPS team termed "Horizontal Synthetic Estimation," evolved as Holzer refined his work. A crucial step came in the 1980s, following the National

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[130] Charles E. Holzer III, PhD, is an esteemed psychiatric epidemiologist who has worked and published in behavioral science for forty years. His CV is available at http://172.10.175.217/about_us/faculty/holzer/vita/vita2009/cehvita20090126.htm

[131] In 2014, MMHPI hired Dr. Holzer to perform a revised county-level prevalence estimate throughout Texas. Dr. Holzer licensed the study and methodology to MMHPI on an ongoing basis. If referencing prevalence estimates from this report, please include this citation: Holzer, C., Nguyen, H., & Holzer, J. (2016). *Texas county-level estimates of the prevalence of severe mental health need in 2015*. Meadows Mental Health Policy Institute.

[132] Unless otherwise cited, the information presented is from Dr. Holzer's web page at http://172.10.175.217/estimation/estimation.htm

Institute of Mental Health's Epidemiologic Catchment Area (ECA) program, the largest psychiatric epidemiological study in the United States at the time. Holzer used ECA findings to develop a series of prevalence estimates for the Texas Department of Mental Health and Retardation, a project that led to several similar projects, including estimates in Colorado, Ohio, and Washington State. Following the 1990 Census and the 1993 National Comorbidity Survey (NCS), Holzer developed estimates in other states, including Colorado, Wyoming, and Nebraska, among others, and included county-level prevalence estimates.

Holzer's method represented a departure from less-precise methods. First, he argued, the extant approaches that relied on service utilization mistakenly assumed that local mental health systems served all people with mental health needs. He also criticized some forms of indirect estimation, such as those that used social indicators (crime levels, poverty, divorce, etc.), with no reference to actual data on mental illnesses.

Holzer argued that if prevalence estimates and their correlates with demographic characteristics from national epidemiological studies were applied to state and county populations, he could provide more precise estimates of mental health need. He used statistical methods that analyzed survey data from the 2001–2003 Collaborative Psychiatric Epidemiology Surveys (CPES)[133] to estimate the relationships between seven socio-demographic characteristics (i.e., age, sex, race/ethnicity, marital status, education, poverty, housing status) and SED and SMI prevalence rates.[134] He then applied these rates to the most up-to-date, available county- or state-level American Community Survey (ACS)[135] population and demographic data, which include estimates of the number of people who can be categorized by the same seven socio-demographic characteristics.

MMHPI Adaptation of Holzer's Methodology and Data

In 2014, MMHPI hired Dr. Holzer to perform a revised county-level estimate throughout Texas using 2012 Three-Year ACS data (the most recently available data at the time). Dr. Holzer then licensed the methodology to MMHPI for use in estimating prevalence in Texas. From this work, and by using Dr. Holzer's findings, especially his 2012 estimates of the MMHPI-commissioned study of Texas, we have developed a new series of 2018 estimates utilizing the 2017 ACS Five-Year dataset and the 2018 population estimates. These data were the most current at the time of our analysis.

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[133] The CPES is a collaboration that includes the NCS-R, NLAAS, and NSAL combined. See http://172.10.175.217/estimation/documentation/CPES/cpes.htm

[134] Detailed information on Dr. Holzer's method is available at http://172.10.175.217/estimation/estimation.htm

[135] The ACS is an extension of the U.S. Census Bureau. It is an ongoing statistical survey that gathers significant data that, among other things, track shifting demographic data. The use of ACS data helps to align the Holzer estimates with the most up-to-date information on key demographic information.

Estimating the Prevalence of Specific Disorders

In estimating the prevalence of specific disorders, we draw on the most recent national prevalence studies conducted by psychiatric epidemiologist Ron Kessler and colleagues, as well as on reviews of prevalence studies that target specific disorders. The two primary national studies are the National Comorbidity Survey Replication (NCSR)[136] and the National Comorbidity Survey Replication-Adolescent Supplement (NCSR-A).[137] These studies provide national estimates of specific disorders. We then apply these estimates to the Texas populations of the same age groups (all adults ages 18 and older and youth ages 12–17, respectively).

The national studies did not include all disorders of interest. For example, because of its very low prevalence rate, schizophrenia was not included in the NCSR. In cases of missing diagnoses in the NCSR or NCSR-A, we relied on what we determined to be the best available reviews of epidemiological studies specific to each diagnosis.[138]

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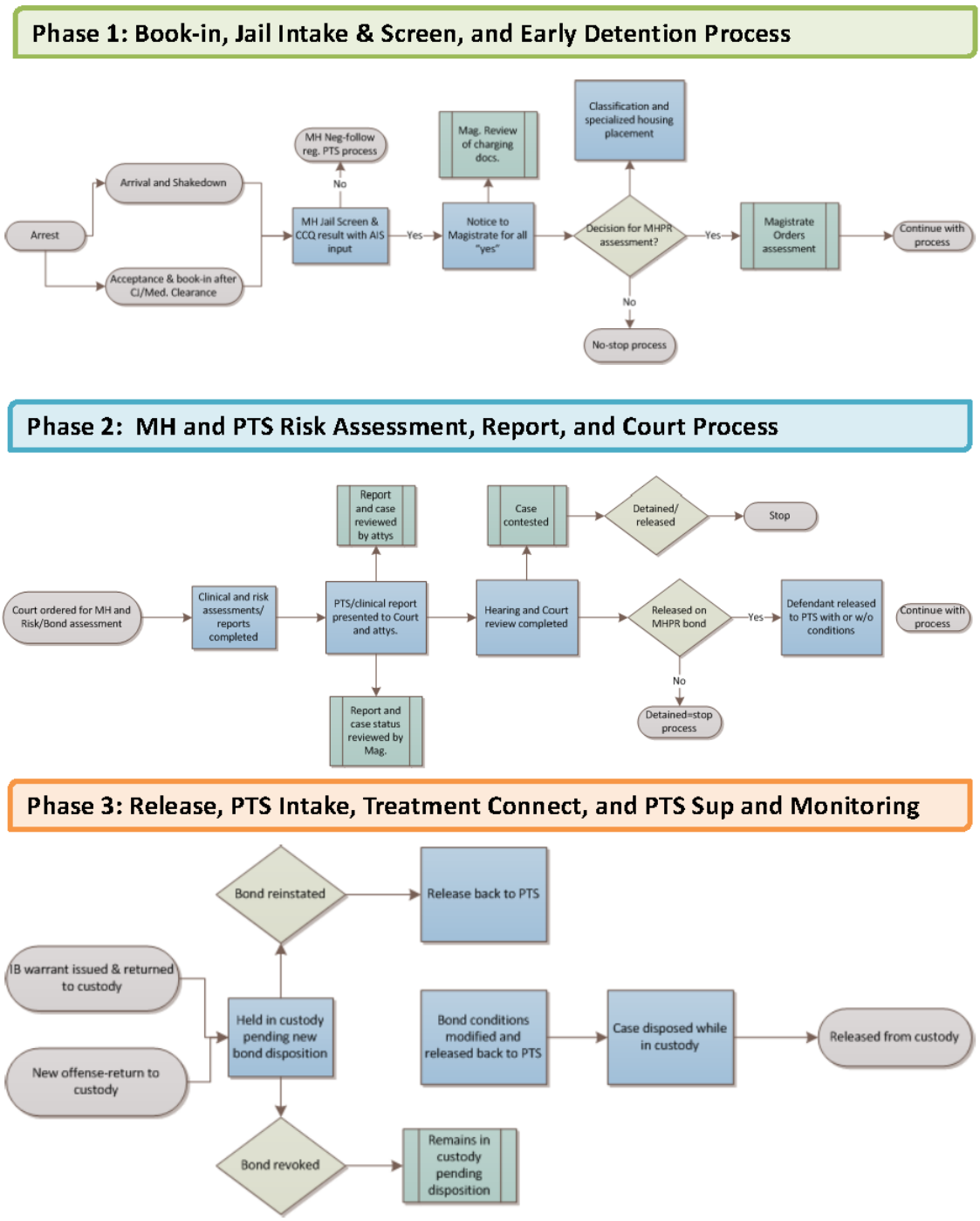
[136] Kessler, R.C., et al. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617–627.

[137] Kessler, R.C., et al. (2012). Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 381–389.

[138] See, for example, McGrath, J., et al. (2008). Schizophrenia: A concise overview of incidence, prevalence, and mortality. *Epidemiological Reviews, 30*, 67–76.

Appendix F: Dallas Sheriff's Office, Jail, and Magistrate Workflow Example



CSG Justice Center: Completion of Process Tasks and Preliminary Quantitative Analysis 18

Appendix G: Timeline of Recommendations for Implementation

Timeline of Recommendations for Implementation		
Entity	**General**	**Timeline to Completion of Recommendation**
The community at large	Prevalence and the Impact of Co-Morbid Health Conditions Nueces County should emphasize the development of interventions that target the comparatively small population of people with the most intensive needs.	Ongoing
NCHD and local hospital system	Psychiatric Bed Capacity NCHD should use its contractual relationship with the CHRISTUS Spohn and its partner Oceans Healthcare to assure that inpatient capacity is part of, or contiguous with, a hospital with the means to provide the full range of services required by people with serious mental illnesses, including substance/alcohol use disorders and complex physical health conditions.	3 – 9 months

Timeline of Recommendations for Implementation		
Entity	**Crisis Response**	**Timeline to Completion of Recommendation**
NCMHID, law enforcement, and community providers at large	Create an integrated, medically facing crisis response system which emphasizes medical and mental health response as its key components and the addition of critical services such as crisis stabilization either through NCMHID or other providers. • NCMHID should complete a thorough review of their existing costs and expenses to locate any areas in which they might use funds more efficiently in order to add additional community-based crisis continuum services. • Develop and implement a plan to outreach to community organizations and hospital systems about the crisis services available and how to use them. • Improve the crisis hotline and mobile crisis outreach team (MCOT) as required in Chapter 534	3 – 4 months

Timeline of Recommendations for Implementation		
Entity	**Crisis Response**	**Timeline to Completion of Recommendation**
	of the State Health and Safety Code. Consider structuring the MCOT as a multidisciplinary response team similar to a model in Dallas, which is a partnership between the police department, which staffs a Crisis Intervention Team-trained officer; the Fire Department, which staffs a paramedic; and the local county hospital which staffs a social worker.	
Corpus Christi Police Department and NCHMID	Law Enforcement Crisis Response Immediate improvements to the current crisis response system Corpus Christi Police Department Crisis Intervention Team • We recommend that officers be considered on-duty while working on the Crisis Intervention Team. This will ensure all officers working with the Crisis Intervention Team are consistently operating under the same policies and procedures; increase officers available to work on the Crisis Intervention Team; and ensure that officers are classified as on-duty and afforded all the rights and protections as any other officer working a shift. • Staff the Corpus Christi Police Department Crisis Intervention Team with on-duty officers in lieu of the off-duty officers currently hired by NCMHID. The existing agreements between Corpus Christi Police Department and NCMHID can be restructured to allow the Corpus Christi Police Department to be reimbursed for either permanent full-time equivalent officers (FTEs) or city-sanctioned overtime. • Dedicate one full-time equivalent departmental staff member for Crisis Intervention Team oversight. The job responsibilities for this position would include oversight of program fidelity, training, data collection, scheduling, community	3 – 4 months

Timeline of Recommendations for Implementation		
Entity	**Crisis Response**	**Timeline to Completion of Recommendation**
	meetings and engagement, referrals, and outreach. • Employ at least one permanent FTE officer who is assigned to each shift, Mondays through Fridays (7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m.).[139] • Cultivate a cadre of 10 to 12 officers who are interested in working with the Crisis Intervention Team. Ideally, these officers would be drawn from various shifts and different patrol districts. Identify officers among this cadre who would be scheduled on the weekends and could backfill the lead FTE(s) on days and evenings, Mondays through Fridays, when necessary. Training a cadre of officers from different patrol districts would reinforce the commitment to the Crisis Intervention Team program, allow those officers to share experiences related to mental health crisis calls, and provide expertise and resources when the crisis intervention team lead is unavailable. • Align work hours between Corpus Christi Police Department and NCMHID case managers who work with the Crisis Intervention Team. • Patrol in an unmarked police vehicle. This vehicle should be equipped with concealed emergency lights and siren and all necessary police communications (Mobile Digital Computer and radio) and in-car video equipment. • Allow NCMHID case managers to respond to an incident in a NCMHID vehicle when a police officer or deputy is unavailable. • Provide NCMHID case managers a distinct uniform to wear.	

[139] As evidenced in our work in other communities, we have found that the primary need for a co-response model is Mondays through Fridays (7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m.). When making budget considerations, those are the most effective hours to staff a co-response or multi-disciplinary team.

Timeline of Recommendations for Implementation		
Entity	**Crisis Response**	**Timeline to Completion of Recommendation**
	• Provide NCMHID case managers a concealable, ballistic protective vest (minimum level of protection should be at least National Institute of Justice Level II or greater) similar to the vests issued to officers and deputies.	
Corpus Christi Police Department, Nueces County Sheriff's Office, and NCMHID	Law Enforcement Crisis Response Immediate improvements to the current crisis response system Shared Policy, Procedures and Documentation among law enforcement CIT programs • Develop a SOP to include several elements such as: – A formal explanation of the crisis intervention team program and its goals; – A clear explanation of the roles and responsibilities for each Crisis Intervention Team member (law enforcement and case managers); – Client/Consumer interaction and referral Records Management System (RMS) documentation procedures; and – Data collection instructions and a data/metric reporting schedule. • Develop a shared and formal training for all officers, deputies, and case managers working on the Crisis Intervention Team and the MCOT. • Create a social services referral element in RMS for the Crisis Intervention Teams to appropriately route incidents to the lead crisis intervention team officer within a department.	2 – 3 months
Criminal justice stakeholders, courts, NCMHID, and local hospitals	Law Enforcement Crisis Response Immediate improvements to the current crisis response system Emergency Detention Orders and Related Processes. • Develop a consensus on the use of the emergency detention options offered in Chapter 573, Health and Safety Code Criminal.	2 months

Timeline of Recommendations for Implementation		
Entity	**Crisis Response**	**Timeline to Completion of Recommendation**
	The written document should include: • Protocols for law enforcement to use the provisions of the Chapter 573 for Apprehension by Peace Officer Without Warrant. • Protocols for law enforcement and hospitals to obtain emergency detention orders. • Connecting people released from care to NCMHID and other community supports for ongoing treatment. • Access by defense attorneys to people held under emergency detention orders and reports on their client's treatment progress to advocate for the patient to receive appropriate treatment in the least restrictive setting.	
NCMHID	Crisis Response for Children and Youth • Implement a training for all MCOT responders in best practices for crisis response for children and youth. • Expand the 2014 community plan to include a vision for crisis services for children and youth that includes expanding services available through the crisis care continuum.	3 months 6 – 12 months

Timeline of Recommendations for Implementation		
Entity	**Access to Community Care**	**Timeline to Completion of Recommendation**
NCMHID	Improve Assertive Community Treatment (ACT) in Nueces County for Children and Adults • NCHMID should implement the 24-hour on-call rotation that is an expected component of ACT. • The ACT team should enhance its functioning to better meet the needs of those with serious and complex mental health needs in Nueces County by prioritizing enrollment for people with the most serious and complex mental health needs who	3 months

Timeline of Recommendations for Implementation		
Entity	**Access to Community Care**	**Timeline to Completion of Recommendation**
	have been cycling through costly services, particularly hospitalization. • Incorporate components of the Coordinated Specialty Care Model for first episode psychosis into the ACT program.	12 months 6 – 12 months
	Create Forensic ACT • Add dedicated forensic expertise to the ACT team and establishing, at a minimum, a specialized track within the team with its own caseload. • Develop pre-booking diversion services by creating a collaborative relationship between the Forensic ACT component of the ACT team and the Inmate Processing Unit (IPU).	12 months 12 months
	Incorporate Risk-Needs-Responsivity Model and Criminogenic Risk Assessment • Forensic ACT teams also need to closely coordinate services with community supervision and implement Risk-Need-Responsivity principles,[140] which involves assessing and reducing various aspects of criminogenic risk – criminal thinking, substance use, and associating with criminal companions, for example – by matching interventions to each person's specific constellation of risk factors.	

[140] Skeem, J. et al. (2014). Offenders with mental illnesses have criminogenic needs, too: Toward recidivism reduction. *Law and Human Behavior, 38*(3), 212-224.

Timeline of Recommendations for Implementation		
Entity	**Access to Community Care**	**Timeline to Completion of Recommendation**
NCMHID and pediatric primary care providers who are contracted to provide medical services for the Nueces County Robert N. Barnes Regional Juvenile Facility post-adjudication center.	Expand Child and Adolescent Psychiatry Capacity • Register all Nueces County pediatric primary care providers (Pediatricians, Family Medicine Physicians, Physician Assistants, Nurse Practitioners and Nurses) to participate with the UTRGV CPAN hub.	1 – 2 months
Community and school leaders	Adopt the Texas Child Health Access Through Telemedicine (TCHATT) Program in some schools in Nueces County. • Community and school leaders should engage UTRGV as soon as possible to discuss implementation of TCHATT in identified schools in Nueces County.	Immediately
School districts in Nueces County, Region 2 Education Service Center (ESC), community mental health providers, and members from the regional Opioid and Suicide Prevention Task Forces	Local education partners should develop a formal collaborative team to inventory training and share resources available to students and families in Nueces County to ensure all students in the county have access to the full range of services available. This collaborative can: • Ensure that districts are using all available services, and • Address one or two identified gaps, such as the need for intensive services and supports and crisis intervention.	2 – 3 months
Local leaders and child welfare providers in Nueces County (DFPS Region 11)	Collaborate to Improve Mental Health Care In the Child Welfare System • Develop a baseline understanding of the community's capacity to serve its children and youth in foster care, identify areas for systems change, and initiate considerations for reimagining	Nueces County could engage with a third-party organization for an 18-month planning project.

Timeline of Recommendations for Implementation		
Entity	**Access to Community Care**	**Timeline to Completion of Recommendation**
	Region 11's foster care system as part of community-based care.	
Health care systems, NCMHID, and the U.S Department of Veteran (VA) Texas Valley Coastal Bend Health Care System and Corpus Christi VA Clinic	Improve Veterans Referral to Inpatient Care • Develop a unified strategy for gathering data on mental health care for veterans in non-VA health systems in Nueces County. Collecting data on mental health care for veterans in the community is an essential step and ensures Nueces County will make informed, data-driven decisions for continuing to improve access and delivery of care to its veteran population. The VA Texas Valley Coastal Bend Health Care System and Corpus Christi VA Clinic should be considered strategic collaborative partners for gathering and sharing data. • Examine inpatient care referral processes from VA facilities to community providers for artificially extended wait times and unnecessary duplication of admissions paperwork. Without a local hospital in the VA health care system, veterans in Nueces County should be able to turn to community resources without encountering additional obstacles to care.	3 – 12 months; should be informed by the Service Members, Veterans, and Families Leadership Advisory Committee 3 – 6 months; should be informed by the Service Members, Veterans, and Families Leadership Advisory Committee
Nueces County	Justice Involved Veterans • Support the veteran's treatment courts pilot use of Reliatrax for one year	Immediately
Jail operations team, which should include the staff who are directly working on jail diversion.	Improve Jail Diversion Work Flow • Rapidly revise existing jail diversion work flows based on current opportunities. • Prioritize access to psychiatrists for those people in jail needing a new or updated diagnosis to be considered for diversion. • Expand the ability to transport people directly from jail to treatment or other services. • Establish dedicated times on the Magistrate Court docket for mental health cases with on-site resources to connect people to service.	The ad-hoc team can organize quickly and have an initial meeting within 30 days or less. The team can begin revising the diversion process at the initial meeting and provide monthly updates to County leadership.

Timeline of Recommendations for Implementation		
Entity	**Access to Community Care**	**Timeline to Completion of Recommendation**
	• Coordinate among existing data systems to note people who need mental health services, but who bond out of jail before completing the assessment process. • Expand the effective processes for engaging people in the formal jail diversion program to other releases.	
Shelter providers, NCMHID, CIT leaders and City of Corpus Christi leadership	Rapid response needed to provide services to people experiencing homelessness • NCMHID staff to ensure access to mental health services that are available currently; • Crisis intervention team leaders to coordinate admission criteria; and • City of Corpus Christi leadership to leverage existing support and services.	Immediately

Timeline of Recommendations for Implementation		
Entity	**Financial Considerations**	**Timeline to Completion of Recommendation**
Nueces County Hospital District (leading Nueces County DSRIP participating providers)	Convene and facilitate a contingency planning process to determine how providers will reduce expenses to compensate for significant decreases in DSRIP revenue.	Within 3 months

Timeline of Recommendations for Implementation		
Entity	**Leadership**	**Timeline to Completion of Recommendation**
Nueces County Leaders including the Nueces County Commissioners Court and Nueces County Hospital District	Create a Leadership Group Not Restricted to Behavioral Health • Composed of elected officials, health and behavioral health leaders and providers, as well as representatives of the veterans' community, school districts, law enforcement, and others to provide an integrated approach to improving treatment for mental illness in Nueces County. This leadership group will provide overall direction and integration of efforts across the entire spectrum of systemic transformation work.	6 months to convene initial meeting
Leadership Group	Creation of a Service Members, Veterans, and Families (SMVF) Leadership Workgroup • Create a service members, veterans, and families leadership workgroup.	6 months to convene initial meeting; SMVF Leadership Advisory Committee to meet within 2 months of creation with ongoing quarterly meetings thereafter.
Nueces County Commissioners Court	Criminal Justice Planning Capacity • Establish a Nueces County Criminal Justice Coordinating Committee following best practices with a formal Charter and by-laws approved by the Commissioners Court. • Hire a criminal justice planning staff member to support the Committee and its work, with staff assigned to the appropriate department or elected official(s).	6 months to convene initial meeting, then develop Charter and by-laws 3 months to hire staff person

Timeline of Recommendations for Implementation		
Entity	**Leadership**	**Timeline to Completion of Recommendation**
Homeless response stakeholders and partners	Homelessness Community-wide Strategic Planning Immediate Recommendation for Addressing Homelessness • Review HIP membership and participation and include any key stakeholders, providers and funders who are not currently engaged. • The HIP should support additional workgroups to address specific issues, such as challenges shared by emergency shelter providers. • The HIP should endorse and support the city priority of ending veteran's homelessness by housing at least the 65 veterans identified in the 2020 Point in Time Count. [141] • The HIP should endorse and support the city priority of developing a functioning Homeless Management Information System that all providers will use. • Prepare for the next HUD Continuum of Care funding opportunity.	3 months for HIP to complete review of membership and recommended priorities and to produce a brief written plan for next steps.
Local philanthropy leaders	Engage Local Philanthropy • Convene a meeting with local philanthropy after release to and identify areas of funding interest. • Reconvene local philanthropy to review and discuss philanthropy implementation support plan every quarter for one year.	Immediately. Within 1 month after final report release. Quarterly after initial meeting.

[141] The Point-in-Time (PIT) count is a count of sheltered and unsheltered people experiencing homelessness on a single night in January.

Appendix H: The Mental Health Systems Framework for Children and Youth

Health care systems are an integral part of the lives of every child, youth, and family, but they are only a part of life. Although this may seem like an obvious and core truth, unfortunately too many health systems are designed without recognizing this truism and they instead focus simply on the care they are attempting to deliver as the overarching concern. But health needs — including diseases affecting the brain, such as mental health disorders, and other health conditions — occur in the context of life: home, family, faith, work, and school.

Some services might be perceived as mental health services, but are not. Because schools, the foster care system, and the juvenile justice system play such integral roles in identifying and addressing the mental health needs of children and youth, we often mistakenly infer that they are a segment of the mental health care delivery system. In the Mental Health Systems Framework for Children and Youth (framework), mental health services are integrated within these systems and then are well-coordinated with the broader health system.

In addition to clarifying the roles of various service providers within the overall mental health care delivery system, it is critical to ensure that children and youth are served at the appropriate level of care. However, current mental health systems in every community in Texas and across the nation are often disjointed and misaligned, lacking the structure for easy navigation by those in need.

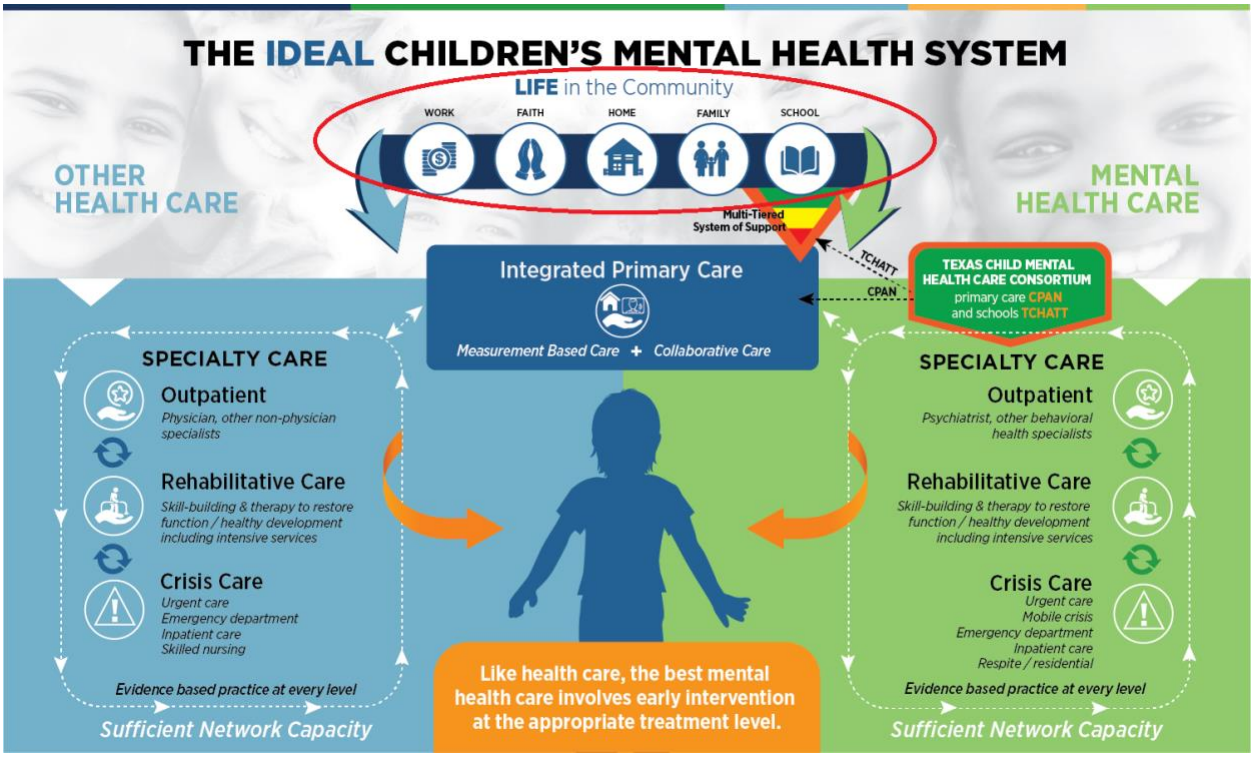
For health care providers and families across the nation, these systemic challenges create unnecessary frustration, a bottleneck to access, and inadequate case coordination — and they are not unique to Nueces County or Texas.

Fortunately, health care systems across Texas and the nation are in the early stages of improving how mental health treatment is organized and integrated into health care. We have grouped our discussion of these changes into distinct components, following our framework:

- Component 0: Life in the Community,
- Component 1: Integrated Primary Care,
- Component 2: Specialty Outpatient Care,
- Component 3: Specialty Rehabilitative Care, and
- Component 4: Crisis Care.

In the following subsections, we describe each of these components in greater detail.

Component 0: Life in the Community



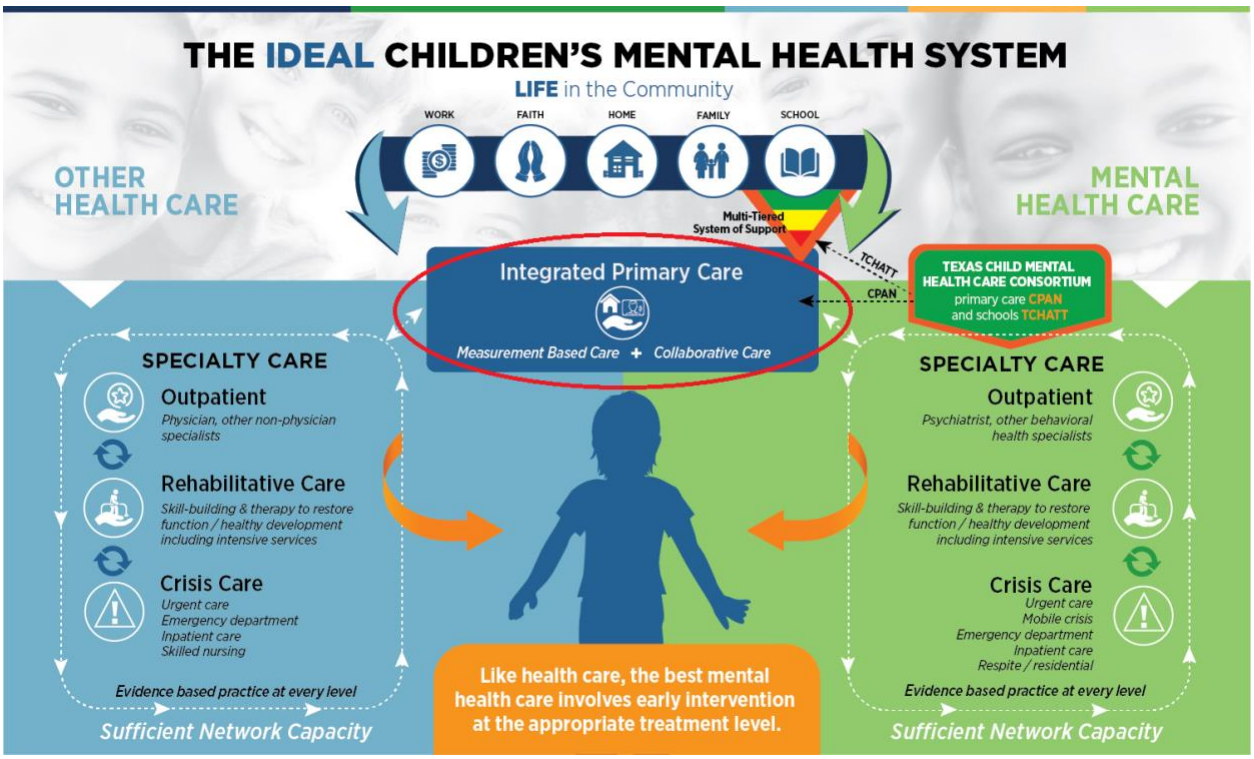
Component 0 refers to community settings that are potential points of connection to a broad range of child, youth, and family supports that help prevent behavioral health issues or lead to the early detection and minimization of behavioral health needs. Health needs — including diseases affecting the brain, such as mental health disorders, and physical health conditions — occur in the context of life: home, faith communities, childcare providers, schools, foster care, juvenile justice settings, and other places where children, youth, and families spend their time. These places can also be ideal settings for health promotion and disease prevention.

While the education, foster care, and juvenile justice systems are not health care providers, they are well-positioned to substantially mitigate mental health challenges by helping to support those in need with access to mental health services and key educational supports. For example, schools can help foster healthy development by implementing school-wide social and emotional wellness models that are intended to prevent some challenging behaviors while teaching the social and emotional skills that students need to succeed in school.[142] Partnerships between schools and mental health providers and other community resources can help ensure that students receive consistent and sustainable support, which is critical for overall care.

[142] Meadows Mental Health Policy Institute. (2018, November 1). Mental and behavioral health roadmap and toolkit for schools. https://www.texasstateofmind.org/uploads/RoadmapAndToolkitForSchools.pdf.

Likewise, providers within the foster care and juvenile justice systems play an important role in linking children and youth with mental health needs to care.

Component 1: Integrated Primary Care



Pediatric primary care is the front line for health care delivery and the place where families are most likely to obtain clinical care. These settings provide services that are generally affordable, accessible, and easy to identify and navigate. Specialty mental health providers do not have the capacity to screen and treat all children and youth with a mental health disorder, and connections to specialty mental health providers are not always made. Today, about 75% of children and youth with psychiatric disorders are seen in pediatric and other primary care settings.[143] Training and supporting these providers is an effective strategy for expanding access and connecting children and youth to appropriate services and mental health interventions.

Pediatricians and other primary care providers have traditionally had difficulty delivering mental health services because of limited time for each patient visit, minimal training and knowledge of behavioral health disorders, gaps in knowledge of local resources, and limited access to behavioral health specialists. However, a combination of recent policies and funding opportunities, technological advances, and a growing awareness of the connection between

[143] American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry into the pediatric health home.* https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

physical and mental health has led to numerous advances in the successful integration of mental health care into primary care practices. When pediatricians and other pediatric primary care providers are trained and positioned to help identify and respond to potential mental health concerns, children and youth receive improved mental health care through earlier detection and intervention. Furthermore, when primary care practitioners are trained and supported to respond to mild to moderate mental health needs, overtaxed mental health providers such as child and adolescent psychiatrists can focus on treating the needs of children and youth with more complex and urgent needs. Research shows that in states with fully-scaled statewide integrated care programs and properly trained pediatricians and other primary care providers, about two thirds of children and youth with behavioral health needs can be effectively served in integrated primary care settings.[144] New opportunities for using telehealth and telemedicine can further increase access to mental health care and the overall quality of care.

Drawing from research and national practice models on integrated behavioral health, we identified seven core components of integrated care, any of which could be adopted at the individual practice level to advance care in Nueces County. These core components include:[145]

1. **Integrated organizational culture**, where organizational leaders promote a culture that delivers effective and efficient integrated care in all areas of administrative and clinical practice;
2. **Population health management**, which requires knowing the physical, mental, and social needs of the patient population to deliver interventions across a continuum of care;
3. **Structured use of a team approach**, which includes shared workflows and a health care team that communicates and collaborates in the service of carrying out simultaneous, mutually reinforcing, and coordinated care;
4. **Integrated behavioral health staff competencies**, with each member of the multidisciplinary team having distinctive knowledge and skills to support coordinated care*;*
5. **Universal screening for physical and behavioral health conditions**, which occurs by regularly utilizing behavioral health screening tools to detect and monitor symptoms;
6. **Integrated and person-centered planning**, where each treatment plan incorporates all physical and behavioral health conditions, treatment/recovery goals, and intervention plans, and includes the values, lifestyles, and social contexts of the person obtaining health care; and

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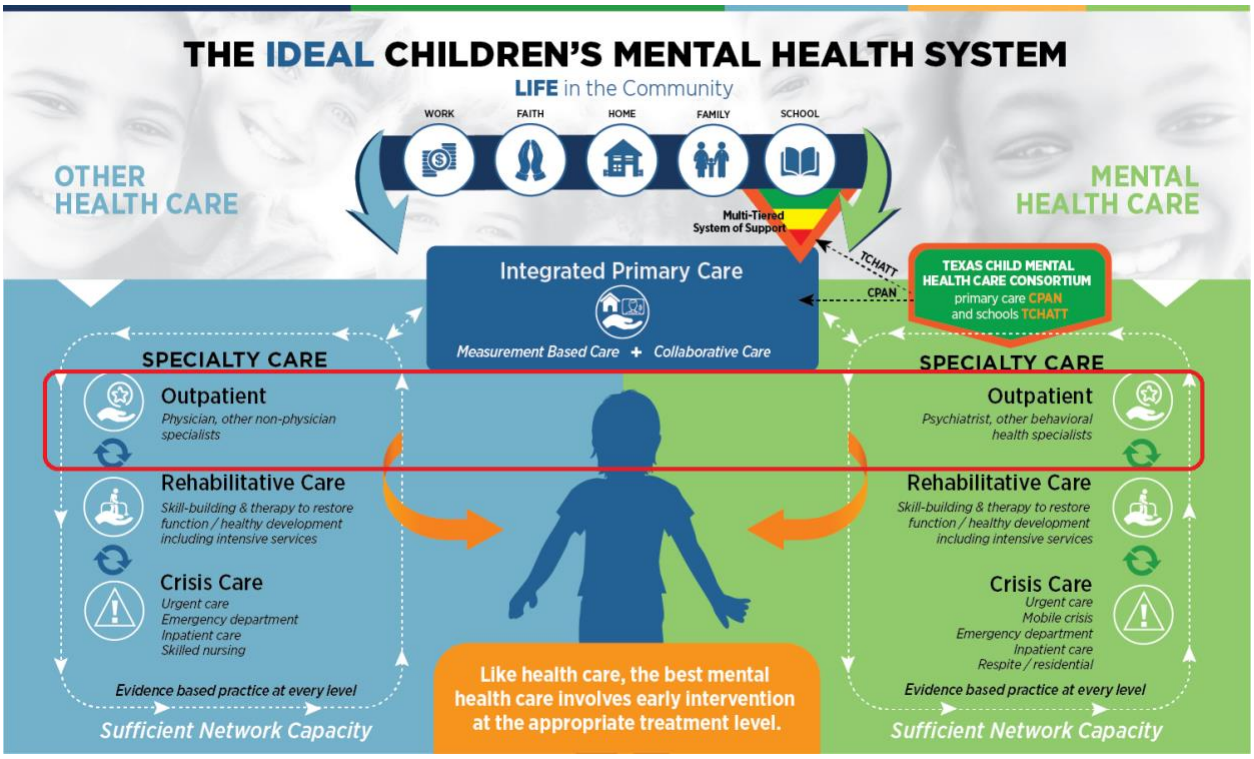
[144] Straus, J. H., & Sarvet, B. (2014). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*, *33*(12), 2153–2161.

[145] Meadows Mental Health Policy Institute. (2016, August). *Best practices in integrated behavioral health*. https://www.texasstateofmind.org/wp-content/uploads/2016/11/Meadows_IBHreport_FINAL_9.8.16.pdf

7. **Systematic use of evidence-based clinical models**, which includes applying a shared clinical protocol and guidelines that incorporate physical and behavioral health conditions to achieve better outcomes and more cost-effective care. For more information about the core IBH components, see: https://www.texasstateofmind.org/wp-content/uploads/2016/11/Meadows_IBHreport_FINAL_9.8.16.

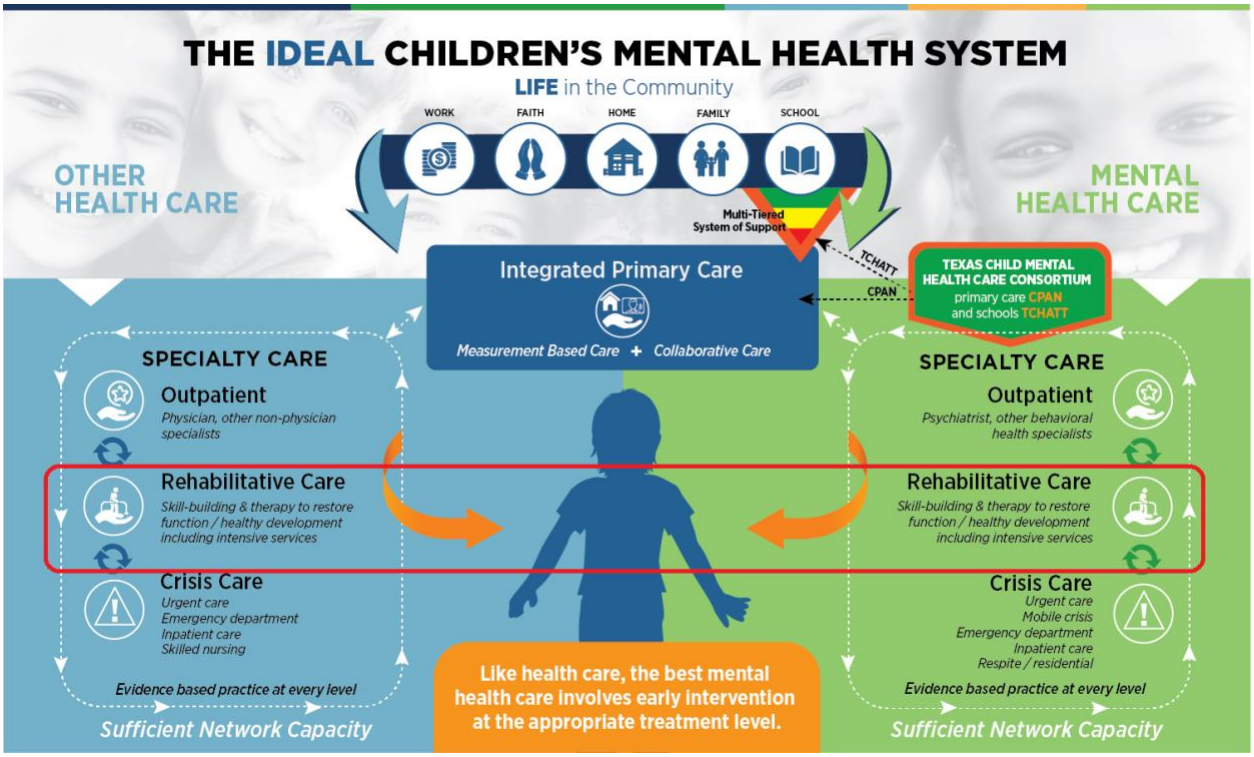
Component 2: Specialty Outpatient Care



Some conditions (including psychiatric and other illnesses) require tailored interventions provided by specialized providers in outpatient settings. If our framework was fully implemented, only about a quarter of children and youth with mental health conditions would need care in these types of setting, while the majority could be properly cared for through integrated primary care. Anxiety and routine depression can be readily treated in integrated primary care settings, but specialists are needed to treat more complex depression, bipolar disorder, post-traumatic stress disorder, and other conditions that require specialized interventions. Our framework would shift a large portion of the population (those with mild to moderate mental health conditions) from over-burdened specialty outpatient mental health care settings to integrated primary care settings, allowing specialists to focus on children and youth with more severe conditions, and re-allocating scarce resources to serve the children and youth with more intensive needs.

Providers of specialty outpatient mental health care include psychiatrists, psychologists, social workers, nurse practitioners, marriage and family therapists, professional counselors, and chemical dependency counselors in private practice, outpatient clinics, counseling centers, and school-based clinics that offer mental health services. This level of care typically offers individual, family, and group therapies and, ideally, a range of evidence-based treatments for specific childhood, adolescent, and familial conditions, such as cognitive therapies (e.g., cognitive behavioral therapy, Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, and Dialectical Behavior Therapy). Clinics may also provide some rehabilitation services (e.g., skill building – further described in the section on *Component 3: Specialty Rehabilitative Care*). Based on the best current prevalence estimates, about one quarter of the total number of children and youth with mental health needs, or about 6,000 children and youth in Nueces County, need specialty outpatient behavioral health care services each year.[146]

Component 3: Specialty Rehabilitative Care



Some mental health conditions are so complex that they impair functioning across multiple life domains and require evidence-based rehabilitation in addition to specialized treatment of the underlying condition. In the same way that a catastrophic orthopedic injury might require a

[146] We estimate that one out of four children and youth with mental health needs each year (about 6,000) requires specialty outpatient behavioral health care to adequately manage their conditions.

child to re-learn to walk or carry out other routine activities of life, a severe psychiatric condition that impedes functioning (e.g., a psychosis, untreated depression) may require specialty rehabilitative care to treat the underlying condition as well as restore healthy functioning at home, in school, and around the community. Children, youth, and their families with intensive needs require:

- A continuum of specialty rehabilitative care that includes skill-building and therapeutic interventions for the child or youth and their family, and coordination with the systems in which they function in order to help those systems accommodate the needs of the child; and
- A treatment team that engages, coordinates, and supports the school in developing intervention planning tailored to that student's unique mental health needs while in the educational setting, and a school liaison to help link children, youth, and families in need of intensive services to providers that offer specialty rehabilitative care.

A subset of these children, youth, and families with intensive needs will require even more support. We estimate that one in ten of these children and youth (1% of all children and youth with mental health needs) require time-limited, intensive mental health services:

- For older adolescents first experiencing psychosis, the best evidence-based intervention — Coordinated Specialty Care (CSC) — involves about two years of intensive outpatient treatment that combines effective medication, education, and skill-building for the youth and their family, encouraging them to maintain school enrollment and continue on (or regain) a healthy developmental track, as well as providing support to the youth's school or work setting in developing accommodations tailored to the youth's symptoms.
- For children and youth involved in the juvenile justice system who exhibit severe externalizing symptoms (e.g., classroom disruption, angry outbursts, defiance) related to untreated/inadequately treated depression or anxiety disorders (perhaps related to trauma), a three- to seven-month regimen of Functional Family Therapy (FFT) or Multisystemic Therapy (MST) would offer the most effective treatment and achieve the best outcomes.

  For children and youth who are receiving child welfare services, foster care models such as Treatment Foster Care Oregon have demonstrated effectiveness as a cost-effective alternative to group or residential treatment, incarceration, and hospitalization for youth who struggle with chronic antisocial behavior, emotional disturbances, and delinquency.

Sometimes a child or youth's needs are so complex that the treatment providers and child-serving agencies involved in their life (e.g., child welfare, special education, juvenile justice) are unable to identify the best treatment option for the child and family. In these cases, wraparound care coordination is necessary to help the family and involved parties pinpoint

critical needs and determine the best path forward.[147] Although wraparound is not a treatment modality, it is an essential care coordination support for the relatively small subset of children, youth, and families with particularly complex conditions and multi-agency involvement whose needs cannot be adequately met through discrete services.

The framework comprises a continuum of rehabilitation options to match services to the needs of each child, youth, and family, such as home and community-based skill-building and services. In general, these services are provided directly in the child or youth's home and community. The intent of these services is to provide the level, or dose, of clinical intervention and support necessary to successfully return each child or youth to a healthy developmental trajectory within their home and community. Specialty rehabilitative services are provided to children and youth at higher risk for out-of-home placement because of mental health issues, or who have returned or are being discharged home from residential treatment centers or psychiatric hospitals.

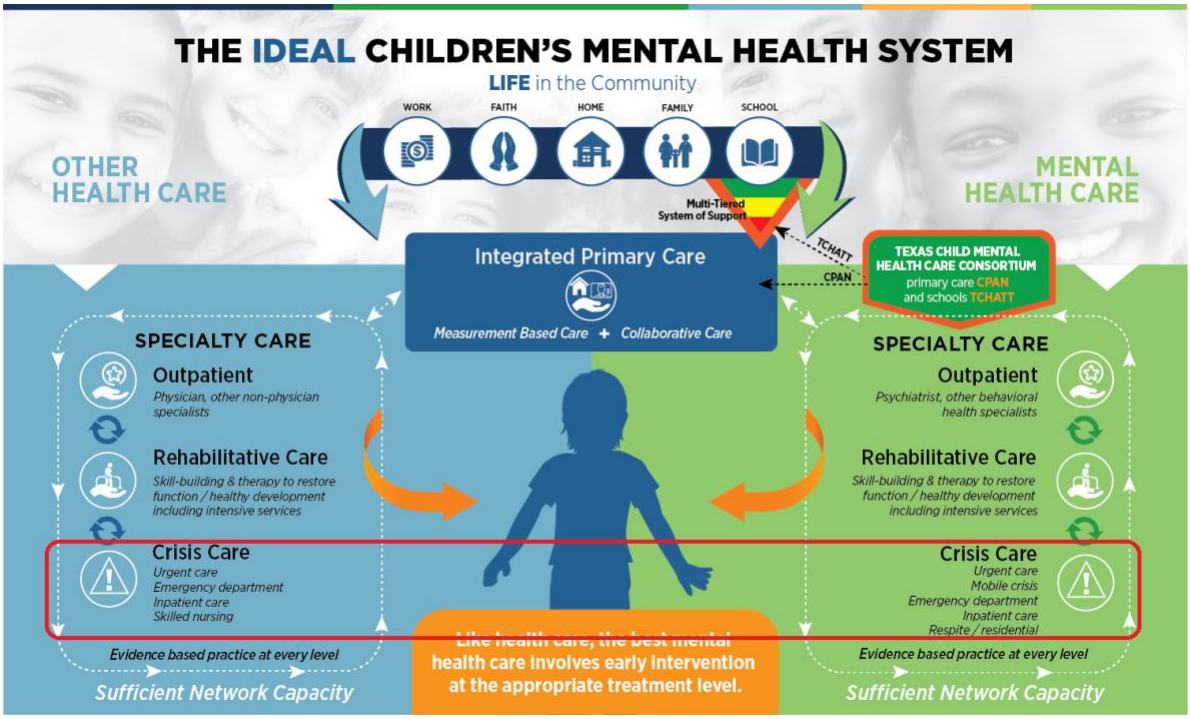
Screening is particularly essential during the onset of severe mental illness, especially when a youth or young adult initially displays psychotic symptoms such as hearing voices or experiencing other hallucinations or delusions. Referred to as "first episode psychosis" (or FEP) in medical terms, these symptoms most frequently occur during adolescence and in young adulthood. Many youth go untreated during these years. Services are most effective if they are initiated early in the development of mental health conditions. Treatment and early identification of mental illness for youth ages 15 and older has the potential to radically alter their developmental trajectory and their illnesses, promoting recovery without multiple hospitalizations and loss of education and skills development. Universal screening in integrated care settings, including schools, promotes early detection for children and youth who can then be connected to appropriate services. Those who are identified as having serious or complex conditions would receive the intensive services they need early on, rather than potentially deteriorating because of a lack of appropriate support and intervention in lower levels of care.

Currently, specialty rehabilitative care in Nueces County is limited to the public sector, just as it is throughout Texas and much of the rest of the nation. In Nueces County, these services are available only through the Nueces Center for Mental Health and Intellectual Disabilities (NCMHID). The current system has very limited evidence-based treatment options, particularly for specialty rehabilitation services like Coordinated Specialty Care (CSC), Multisystemic Therapy (MST), and Functional Family Therapy (FFT), which are effective alternatives to more

[147] Currently, the Texas Medicaid program requires wraparound service coordination for all children and youth receiving intensive home and community-based services. While the principles of wraparound should inform all intensive treatment, the evidence suggests that a wraparound facilitator and formal wraparound plan is only needed when the needs are so complex that a given type of care (e.g., CSC, FFT, or MST) is not sufficient.

restrictive settings such as hospitals, residential treatment centers, and juvenile justice facilities.

Component 4: Crisis Care



The framework's mental health crisis care continuum includes three distinct service types necessary for an ideal continuum of crisis services:

1. **A range of community-based crisis intervention services**, including mobile crisis outreach response teams that have the capacity to provide limited ongoing in-home supports, case management, and direct access to short-term, out-of-home crisis supports (e.g., crisis respite, emergency shelter);
2. **Acute inpatient care** for children and youth whose needs cannot be met in a community-based setting; and
3. **Residential treatment facilities** for children and youth with intensive needs who cannot be safely treated in any other setting. As noted earlier in this report, residential treatment should be reserved for children and youth with the most severe needs and only until they can be safely transitioned to community-based services.

Crisis Intervention Continuum:

- **Mobile crisis teams**
- **Screening, assessment, triage, ongoing consultation, and time-limited follow up**
- **Crisis telehealth and telephone supports**
- **Coordination with emergency medical services**
- **An array of crisis placements:**
  - **In-home respite**
  - **Crisis foster care**
  - **Crisis respite**
  - **Crisis stabilization**
- **Linkages to a full continuum of empirically-supported practices**
- **Linkages to transportation**

Although this entire array is difficult to achieve in many communities across Texas, some components exist within the

mental health, child welfare, and juvenile justice systems, though they are often not well coordinated or conceptualized as a single crisis system. This deficiency leads to redundancies that prevent children and youth from getting the right services at the right time.

Even when a full continuum of nonresidential crisis options is in place, some children and youth will still need inpatient care for acute and complex needs. As discussed earlier, although inpatient psychiatric care is not a substitute for ongoing, well-coordinated outpatient mental health care, it is an important piece of the crisis care continuum when there are immediate safety concerns. Inpatient psychiatric hospitalizations can be helpful for acute stabilization of children and youth with complex needs, such as high suicide risk or medication adjustments that require close medical monitoring. These hospitalizations should be available when needed, but generally should be brief and supported by the broader crisis array and system. For example, short-term placement in crisis foster or residential care can divert children and youth with less intense needs from inpatient settings as well as provide step-down support as they transition home from these settings. Intensive community-based services and supports can also help children, youth, and their caregivers make the transition back home after a hospitalization.

Residential treatment represents another component of the crisis care continuum for children and youth. It is designed for children and youth whose behavior cannot be managed safely in a less restrictive setting. Residential treatment is one of the most restrictive mental health service settings provided to children and youth. As such, it should be reserved for situations where less restrictive placements are not appropriate, including for children and youth with highly complex needs or dangerous behaviors (e.g., fire setting) who may not respond to intensive, nonresidential service approaches.[148] Across Texas and nationally, children and youth are too often placed in residential treatment because more appropriate, less restrictive community-based services are not available. When they are utilized, residential services should be brief, intensive, family-focused, and as close to home as possible.

[148] Stroul, B. (2007). Building bridges between residential and nonresidential services in systems of care: Summary of the special forum held at the 2006 Georgetown University Training Institutes. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

End Notes

[i] All Texas prevalence and population estimates were rounded to reflect uncertainty inherent in our application of national estimates to Texas counties. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts. Estimates between 1 and 5 were rounded to "<6"; values between 5 and 9 were rounded to "<10."

[ii] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region.

[iii] Kessler, R. C., et al. (2012)a. Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, *69*(4), 372–380, and Kessler, R. C., et al. (2012)b. Severity of 12-Month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 381–389.

[iv] Local SED prevalence was estimated from Holzer, C., Nguyen, H., & Holzer, J. (2018). *Texas county-level estimates of the prevalence of severe mental health need in 2017*. Meadows Mental Health Policy Institute.

[v] Holzer, C., Nguyen, H., & Holzer, J. (2018). *Texas county-level estimates of the prevalence of severe mental health need in 2018*. Meadows Mental Health Policy Institute. Poverty data were obtained from the U.S. Census Bureau, American Community Survey 2018 Five-Year Public Use Microdata Sample (PUMS): https://www.census.gov/programs-surveys/acs/data/pums.html

[vi] Based on our work in multiple states that have developed community-based service arrays in response to system assessments (WA, MA, CT, NE, and PA), the MMHPI team estimated that one in 10 children with SED would require time-limited, intensive home and community-based services to avoid or reduce risk of out-of-home or out-of-school placement.

[vii] Prevalence of mental health conditions among youth were estimated from the 12-month prevalence rates in Kessler, R. C., et al. (2012). Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 372–380.

[viii] Center for Behavioral Health Statistics and Quality. (2020). *2018 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/release/2018-national-survey-drug-use-and-health-nsduh-releases on March 19, 2020.

[ix] Kessler, D. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H-U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States: Anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, *21*(3): 169–184.

[x] Schizophrenia prevalence was estimated using the 12-month rates in Androutsos, C. (2012). Schizophrenia in children and adolescents: Relevance and differentiation from adult schizophrenia. *Psychiatriki, 23*(Supl), 82–93 (original article in Greek). Androutsos estimated that among youth ages 13–18, 0.23% meet criteria for the diagnosis of schizophrenia.

[xi] Local first episode psychosis prevalence rates were estimated from the 12-month rates in Kirkbride, J. B., et al. (2017). The epidemiology of first-episode psychosis in early intervention in psychosis services: Findings from the Social Epidemiology of Psychoses in East Anglia [SEPEA] study. *American Journal of Psychiatry, 174*, 143–153.

[xii] Local obsessive-compulsive disorder estimates were generated from the 12-month prevalence rates reported in Boileau, B. (2011). A review of obsessive-compulsive disorder in children and adolescents. *Dialogues in Clinical Neuroscience, 13*(4), 401–411; Peterson, B., et al. (2001). Prospective, longitudinal study of tic, obsessive-compulsive, and attention-deficit/hyperactivity disorders in an epidemiological sample. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(6), 685–695; and Douglas, H. M., et al. (1995). Obsessive-compulsive disorder in a birth cohort of 18-year-olds: Prevalence and predictors. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*(11), 1424–1431.

[xiii] Local eating disorder estimates were calculated from the 12-month prevalence rates reported in Swanson, S. A., et al. (2011). Prevalence and correlates of eating disorders in adolescents: Results from the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, *68*(7), 714–723. The prevalence estimate for eating disorders encompassed only anorexia nervosa and bulimia nervosa.

[xiv] Local self-harming and self-injury behavior was estimated from the 12-month prevalence rates reported in Muehlenkamp, J. J., et al. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*(11). https://doi.org/10.1186/1753-2000-6-10
[xv] Death by suicide data were obtained from the Centers for Disease Control and Prevention, Underlying Cause of Death 1999–2018, on the CDC WONDER Online Database.
[xvi] Kessler, D. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H-U. (2012).
[xvii] Adverse childhood experiences estimates were calculated using the state-level 12-month prevalence rates in Sacks, V., Murphey, D., & Moore, K. (2014). *Adverse childhood experiences: National and state-level prevalence (research brief No. 2014–28)*. Child Trends. https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf
[xviii] All Texas prevalence and population estimates were rounded to reflect uncertainty inherent in our application of national estimates to Texas counties. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts. Estimates between 1 and 5 were rounded to "<6," and values between 5 and 9 were rounded to "<10."
[xix] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region.
[xx] Behavioral health need according to severity level prevalence rates were estimated from 12-month rates reported in Kessler, R. C., et al. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617–627.
[xxi] Local serious mental illness prevalence was estimated using Holzer, C., Nguyen, H., & Holzer, J. (2017). *Texas county-level estimates of the prevalence of severe mental health need in 2017*. Meadows Mental Health Policy Institute.
[xxii] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region.
[xxiii] ACT need was estimated using the 12-month prevalence rates in Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many ACT teams do we need? *Psychiatric Services, 57*(12), 1803–1806.
[xxiv] FACT need was estimated using the 12-month prevalence rates in Cuddeback, G. S., Morrissey, J. P., & Cusack, K. J. (2008). How many forensic ACT teams do we need? *Psychiatric Services, 59*, 205–208.
[xxv] Major depression prevalence rates were estimated using the 12-month rates in Center for Behavioral Health Statistics and Quality. (2020). *2018 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/release/2018-national-survey-drug-use-and-health-nsduh-releases on March 19, 2020.
[xxvi] Bipolar disorder prevalence rates were estimated from 12-month rates in Holzer, C., Nguyen, H., & Holzer, J. (2016). *Texas county-level estimates of the prevalence of severe mental health need in 2016*. Meadows Mental Health Policy Institute.
[xxvii] Prevalence of post-traumatic stress disorder was estimated using the 12-month prevalence rates in Kessler, D. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H-U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States: Anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research, 21*(3): 169–184.
[xxviii] Schizophrenia prevalence estimates were generated using the 12-month prevalence rates in Simeone, J. C., Ward, A. J., Rotella, P., Collins, J., & Windisch, R. (2015). An evaluation of variation in published estimates of schizophrenia prevalence from 1990–2013: a systematic literature review. *BMC Psychiatry, 15*:193.
[xxix] Incidence of first episode psychosis were estimated from 12-month rates in Simon, G. E., Coleman, K. J., Yarborough, B. J. H., Operskalski, B., Stewart, C., Hunkeler, E. M., Lynch, F., Carrell, D., & Beck, A. (2017). First presentation with psychotic symptoms in a population-based sample. *Psychiatric Services, 68*(5): 456–461.
[xxx] Death by suicide data were obtained from the Centers for Disease Control and Prevention, Underlying Cause of Death 1999–2018, on the CDC WONDER Online Database. Suicide deaths were classified using underlying cause-of-death ICD-10 codes: X60–84 and Y87. To comply with the Public Health Service Act (42 U.S.C. 242m(d)), counts of deaths of fewer than 10 were suppressed using values of "<10."
[xxxi] Unless otherwise specified, estimated prevalence of substance use disorders were based on prevalence rates drawn from the 2017–2018 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.
[xxxii] All Texas prevalence and population estimates were rounded to reflect uncertainty in the underlying Texas Demographic Center population estimates. Because of this rounding process, row or column totals may not equal

the sum of their rounded counterparts. Estimated values between 1 and 5 were rounded to "<6," and estimated values between 5 and 9 were rounded to "<10."

[xxxiii] The prevalence of any substance use disorder among adults and youth living in poverty is based on ABODILAL (Illicit Drug or Alcohol Dependence in Past Year) x Poverty cross-tabulation, National Survey on Drug Use and Health, 2017-2018 restricted access file. The percentage was applied to the estimated number of adults and youth living in poverty in Texas. Poverty estimates were based on the American Community Survey 2018 poverty proportions, applied to the Texas Demographic Center's 2018 population estimates.

[xxxiv] The local prevalence of comorbid psychiatric and substance use disorders (SUD) among youth ages 12–17 was based on the intersection between the national prevalence rate of major depressive episodes and SUD, as reported in SAMHSA's 2019 report, *Behavioral Health Trends in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54), and the 2014–2016 National Survey on Drug Use and Health (NSDUH) sub-state rates of major depressive episodes for Texas.

[xxxv] Unless otherwise specified, estimated prevalence of substance use disorders were based on prevalence rates drawn from the 2017–2018 2017–2018 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[xxxvi] Death by drug overdose data were obtained from the Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death 1999–2018 on the CDC WONDER Online Database, accessed at http://wonder.cdc.gov/mcd-icd10.html. Overdose deaths were classified using underlying cause-of-death ICD-10 codes: X40–44, X60–64, X85, and Y10–Y14.

[xxxvii] The number of alcohol-induced deaths were obtained from the Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death 1999–2018 on the CDC WONDER Online Database, accessed at http://wonder.cdc.gov/mcd-icd10.html. Alcohol induced deaths were classified using any underlying cause of death and multiple causes of death category, "alcohol-induced causes." In order to meet the CDC's confidentiality restraints, counts of deaths of fewer than 10 were suppressed using values of "<10."

[xxxviii] Unless otherwise specified, estimated prevalence of substance use disorders were based on prevalence rates drawn from the 2017–2018 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[xxxix] All Texas prevalence and population estimates were rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimated values between 1 and 5 were rounded to "<6," and estimated values between 5 and 9 were rounded to "<10."

[xl] The prevalence of any substance use disorder among adults and youth living in poverty was based on ABODILAL (Illicit Drug or Alcohol Dependence in Past Year) x Poverty Cross-tabulation, National Survey on Drug Use and Health, 2017–2018 restricted access file. The percentage was applied to the estimated number of adults and youth living in poverty in Texas. Poverty estimates were based on the American Community Survey 2018 poverty proportions, applied to the Texas Demographic Center's 2018 population estimates.

[xli] The local prevalence of co-occurring psychiatric and substance abuse disorders (COPSD) among adults were based on the intersection between the national prevalence rate of any mental illness (AMI) and substance use disorder (SUD), as reported in SAMHSA's 2019 report, *Behavioral Health Trends in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54), and the 2016–2017 National Survey on Drug Use and Health (NSDUH) rates of AMI for Texas.

[xlii] Unless otherwise specified, estimated prevalence of substance use disorders were based on prevalence rates drawn from the 2017-2018 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[xliii] Death by drug overdose data were obtained from the Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death 1999–2018 on the CDC WONDER Online Database, accessed at http://wonder.cdc.gov/mcd-icd10.html. Overdose deaths were classified using underlying cause-of-death ICD-10 codes: X40–44, X60–64, X85, and Y10–Y14.

[xliv] Estimated 2020 population data were obtained from the 2019 American Community Survey population estimates. Projected population change was obtained from the Texas Demographic Center (2018). *Texas Population Projection Program – age, sex, and race/ethnicity (ASRE) population [Excel file].* demographics.texas.gov/Data/TPEPP/Projections/

[xlv] Estimated 2020 population data were obtained from the 2019 American Community Survey population estimates. Projected population change was obtained from the Texas Demographic Center (2018). *Texas*

Population Projection Program – age, sex, and race/ethnicity (ASRE) population [Excel file]. demographics.texas.gov/Data/TPEPP/Projections/

[xlvi] Emergency departments with fewer than 10 visits resulting in a psychiatric inpatient admission were included in the count of "all admissions," but were not included in emergency department-specific breakouts. These included Bayview Behavioral Hospital Emergency Department (seven visits) and Corpus Christi Medical Center – Heart Hospital Emergency Department (two visits).

[xlvii] Percentages in rows may not add up to 100% because a small number of admissions (fewer than 1%) did not have an identified payer. The table does not include hospitals with fewer than 10 admissions in the reported period. These include 30 total admissions across CHRISTUS Spohn Corpus Christi – Shoreline, Corpus Christi Medical Center – Bay Area, Corpus Christi Medical Center – Doctors Regional, and Corpus Christi Medical Center – Northwest.

[xlviii] Percentages in rows may not add up to 100% because a small number of admissions (fewer than 1%) did not have an identified payer. The table does not include hospitals with fewer than 10 admissions in the reported period. These include 30 total admissions across CHRISTUS Spohn Corpus Christi – Shoreline, Corpus Christi Medical Center – Bay Area, Corpus Christi Medical Center – Doctors Regional, and Corpus Christi Medical Center – Northwest.

[xlix] Hospitals with small counts of psychiatric bed utilization (hospitals that on average do not have at least one person in a bed on any given day) and hospitals without a reported psychiatric bed capacity were not included. These hospitals are CHRISTUS Spohn Corpus Christi – Shoreline, Corpus Christi Medical Center – Northwest, Corpus Christi Medical Center – Heart Hospital, Corpus Christi Medical Center – Bay Area, and Corpus Christi Medical Center – Doctors Regional Hospital.

[l] Of the 1,680 total admissions, only five people had lengths of stay of more than 24 days. These were not displayed on the graph.

[li] Of all admissions, only 23 people (3%) had lengths of stay longer than 24 days. These were not included on the graph.

[lii] All emergency department, inpatient and outpatient discharge information were obtained from the Texas Health Care Information Collection (THCIC) and represent calendar year (CY) 2018 (January 2018 – December 2018)

[liii] This column represents the number of bed days divided by 365 to estimate the number of beds needed for individuals over the course of the year.

[liv]All Texas prevalence and population estimates were rounded to reflect uncertainty inherent in our application of national estimates to Texas counties. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts. Estimates between 1 and 5 were rounded to "<6"; values between 5 and 9 were rounded to "<10."

[lv] MMHPI estimates that approximately two out of every three children (64%) with mental health needs have conditions that can be successfully managed in an integrated primary care setting.

[lvi] MMHPI estimates that one out of four children with mental health needs requires specialty behavioral health care to adequately manage their condition.

[lvii] This estimate was developed using the prevalence of children and youth with serious emotional disturbance who are also living in poverty. Local serious emotional disturbance prevalence was estimated from Holzer, C., Nguyen, H., & Holzer, J. (2018). *Texas county-level estimates of the prevalence of severe mental health need in 2018*. Meadows Mental Health Policy Institute. Poverty data were obtained from the U.S. Census Bureau, American Community Survey 2018 Five-Year Public Use Microdata Sample (PUMS). https://www.census.gov/programs-surveys/acs/data/pums.html

[lviii] MMHPI estimates that one in 10 children with mental health needs require mental health rehabilitation or intensive care to adequately manage their conditions.

[lix] Based on our work in multiple states that have developed community-based service arrays in response to system assessments (WA, MA, CT, NE, and PA), the MMHPI team estimated that one in 10 children with serious emotional disturbances would require time-limited, intensive home and community-based services to avoid or reduce risk of out-of-home or out-of-school placement.

[lx] All Texas prevalence and population estimates were rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column percentages or estimates may not equal the sum of their rounded counterparts. Estimated values between 1 and 5 were rounded to "<6," and estimated values between 5 and 9 were rounded to "<10."

[lxi] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the specified region.
[lxii] Local prevalence estimates of SED were drawn from Holzer, C., Nguyen, H., & Holzer, J. (2018). *Texas county-level estimates of the prevalence of severe mental health need in 2018*. Meadows Mental Health Policy Institute.
[lxiii] Data in the "Children and Youth Served in Ongoing Treatment" 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).
[lxiv] This percentage represents the proportion of children and youth served by the LMHA who were receiving Medicaid during FY 2018. Data provided by DSHS (personal communication, February 2019).
[lxv] Unduplicated utilization data across levels of care were obtained from Texas Health and Human Services Commission, February 2019, and reflect fiscal year 2018.
[lxvi] The percentage represents the proportion of the total unduplicated patients served in each level of care.
[lxvii] Poverty data obtained from the U.S. Census Bureau, American Community Survey 2018 Five-Year Estimates. Table S1701: Poverty Status in the Past 12 Months. Retrieved from https://data.census.gov/cedsci/
[lxviii] Locations of LMHA sites were obtained from the Nueces Center for Mental Health and Intellectual Disabilities (2020). Adult mental health. https://www.ncmhid.org/adult-mental-health-0
Locations of FQHC providers were obtained from the Texas Association of Community Health Centers (TACHC). Find a community health center. https://www.tachc.org/find-healthcare-center
[lxix] Data were obtained from Centers for Disease Control and Prevention, Underlying Cause of Death 1999–2018 on CDC WONDER Online Database. (Released December 2019). Data are from the Multiple Cause of Death Files, 1999–2018, as compiled from data provided by the 57 vital statistics jurisdictions through Vital Statistics Cooperative Program. Retrieved March 4, 2020, from http://wonder.cdc.gov/ucd-icd10.html
[lxx] Data obtained from the Texas Department of Family and Protective Services Data Book. Data retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/default.asp
[lxxi] All Texas prevalence and population estimates were rounded to reflect uncertainty inherent in our application of national estimates to Texas counties. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts. Estimates between 1 and 5 were rounded to "<6"; values between 5 and 9 were rounded to "<10."
[lxxii] Kessler, R. C., et al. (2012)a. Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 372–380, and Kessler, R. C., et al. (2012)b. Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 381–389.
[lxxiii] The percentage of adults with mental illness who can be served in integrated care was estimated using the rate of adults with mild and moderate need in Kessler, R. C., et al. (2012)b. Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 381–389.
[lxxiv] This category represents people with any mental health condition who need more intensive treatment than what can be provided in an integrated primary care setting.
[lxxv] This category represents the population of people with serious mental illnesses whoa are living in poverty, based on the 2018 American Community Survey. Local serious mental illness prevalence was estimated from Holzer, C., Nguyen, H., & Holzer, J. (2018). *Texas county-level estimates of the prevalence of severe mental health need in 2018*. Meadows Mental Health Policy Institute.
[lxxvi] ACT need was estimated using the 12-month prevalence rates in Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many ACT teams do we need? *Psychiatric Services, 57*(12), 1803–1806.
[lxxvii] FACT need was estimated using the 12-month prevalence rates in Cuddeback, G. S., Morrissey, J. P., & Cusack, K. J. (2008). How many forensic ACT teams do we need? *Psychiatric Services, 59*, 205–208.
[lxxviii] Substance use disorder prevalence rates were drawn from the 2017–2018 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas (Table 23).
[lxxix] The number of people with SUD who can be served in an integrated care setting was estimated using Madras, B. K., et al. (2008). Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later. *Drug & Alcohol Dependence, 99*(1), 280–295.
[lxxx] This category represents the remaining people with any SUD who need more intensive treatment than what can be provided in an integrated care setting (these people are categorized as needing specialty care).
[lxxxi] Utilization data were obtained from Texas Health and Human Services Commission, February 2019.

[lxxxii] Local prevalence estimates of SMI were drawn from Holzer, C., Nguyen, H., & Holzer, J. (2018). *Texas county-level estimates of the prevalence of severe mental health need in 2018*. Meadows Mental Health Policy Institute.
[lxxxiii] All Texas prevalence and population estimates were rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column percentages or estimates may not equal the sum of their rounded counterparts. Estimated values between 1 and 5 were rounded to "<6," and estimated values between 5 and 9 were rounded to "<10."
[lxxxiv] Unduplicated utilization data across levels of care were obtained from Texas Health and Human Services Commission, February 2019, and reflect fiscal year 2018.
[lxxxv] The percentage represents the proportion of the total unduplicated patients served in each level of care.
[lxxxvi] Local prevalence estimates of behavioral health conditions among veterans were drawn from national 12-month prevalence rates reported in Pemberton, M. R., Forman-Hoffman, V. L., Lipari, R. N., Ashley, O. S., Heller, D. C, & Williams, M. R. (2016). *Prevalence of past year substance use and mental illness by veteran status in a nationally representative sample*. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Nonmedical use of prescription psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs. Data were abstracted using data from the Substance Abuse and Mental Health Services Administration (SAMHSA)'s restricted online data analysis system (RDAS). National Survey on Drug Use and Health: 2-Year RDAS (2017 to 2018), //rdas.samhsa.gov/#/survey/NSDUH-2017-2018-RD02YR/crosstab/?weight=DASWT_1&run_chisq=false&results_received=true
[lxxxvii] Veteran prevalence and population estimates were rounded to reflect uncertainty in the underlying Veterans Affairs population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimated values between 1 and 5 were rounded to "<6", and estimated values between 5 and 9 were rounded to "<10."
[88] Texas Health and Human Services. (n.d.). RHP summary information: Total payments to date for DY2–8 (Excel) (1/31/20). https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/rhp-summary-information
[lxxxix] Texas Health and Human Services. (n.d.). *RHP summary information: Total payments to date for DY2–8 (Excel) (1/31/20).* https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/rhp-summary-information
[xc] Nueces County Hospital District. (2020). Medicaid 1115 waiver: Stakeholder opportunities & public notices – Nov. 20, 2019 demonstration year 9–10 RHP 4 plan update (final). https://www.nchdcc.org/public-notices.cfm

NUECES COUNTY HOSPITAL DISTRICT
87th (2021) Texas Legislative Session
Proposed Legislation List
As of: October 20, 2020

1. Texas Health and Safety Code, Chapter 281, Hospital Districts in Counties of at Least 190,000:
    a. Amend Subchapter E, District Finance, §281.094(a), Use of Certain Funds by the Nueces County Hospital District, to read as follows: "With the approval of the Nueces County Commissioners Court, the board of the Nueces County Hospital District may use funds made available to the district from sources other than a tax levy to fund health care services for residents of the district, including public health services, mental health and ~~mental retardation~~ intellectual disability services, emergency medical services, health services provided to persons confined in jail facilities, and for other health related purposes."

2. Texas Health and Safety Code, Chapter 285, Special Provisions Relating to Hospital Districts:
    a. Amend title of Subchapter F, Liability of Nonprofit Management Contractor, to read as follows: "SUBCHAPTER F. LIABILITY OF ~~NONPROFIT~~ MANAGEMENT CONTRACTOR";
    b. Amend §285.071, Definition, to read as follows: "In this chapter, "hospital district management contractor" means a ~~nonprofit~~ corporation, partnership, or sole proprietorship that manages or operates a hospital or provides services under contract with a hospital district that was created by general or special law."; and
    c. Amend §285.072, Liability of a Hospital District Management Contractor, to read as follows: "A hospital district management contractor in its management or operation of a hospital or provision of services under a contract with a hospital district is considered a governmental unit for purposes of Chapters 101, 102, and 108, Civil Practice and Remedies Code, and any employee of the contractor is, while performing services under the contract for the benefit of the hospital, an employee of the hospital district for the purposes of Chapters 101, 102, and 108, Civil Practice and Remedies Code."

3. Texas Health and Safety Code, Chapter 298C, Nueces County Hospital District Health Care Provider Participation Program:
    a. Amend Subchapter A, General Provisions, §298C.004(a), Expiration, to read as follows: "Subject to Section 298C.153(d), the authority of the district to administer and operate a program under this chapter expires December 31, ~~2021~~ 2023."
    b. Amend Subchapter A, General Provisions, §298C.004(b) to read as follows: "This chapter expires December 31, ~~2021~~ 2023."

# # #

NUECES COUNTY HOSPITAL DISTRICT
Board of Managers
Meeting Schedule
Calendar Year 2021

Meeting Dates & Times:

- Tuesday, January 19, 2021, 12:00 Noon
- Tuesday, February 16, 2021, 12:00 Noon
- Tuesday, March 16, 2021, 12:00 Noon
- Tuesday, April 20, 2021, 12:00 Noon
- Tuesday, May 18, 2021, 12:00 Noon
- Tuesday, June 15, 2021, 12:00 Noon
- Tuesday, July 20, 2021, 12:00 Noon
- Tuesday, August 17, 2021, 12:00 Noon – Adopt Annual Budget
- Tuesday, September 21, 2021, 12:00 Noon – Elect Officers & Appoint Committees
- Tuesday, October 19, 2021, 12:00 Noon
- Tuesday, November 16, 2021, 12:00 Noon
- Tuesday, December 14, 2021, 12:00 Noon

NUECES COUNTY HOSPITAL DISTRICT
Administrative Offices

555 N. Carancahua Street, Suite 950
Corpus Christi, Texas 78401-0835

Phone: (361) 808-3300
Fax: (361) 808-3274

BOARD OF MANAGERS ORDER
OCTOBER 20, 2020

AN ORDER GRANTING PROFESSIONAL SERVICES EXEMPTION FROM COMPETITIVE PURCHASING REQUIREMENTS RELATING TO THE ACQUISITION OF QUALITY ASSESSMENT, UTILIZATION REVIEW, AND CODING REVIEW SERVICES

WHEREAS, the Nueces County Hospital District (the "Hospital District") is a body politic and corporate and a political subdivision of the State of Texas, established and created pursuant to the Texas Constitution, Article IX, Section 4 and the Texas Health and Safety Code (the "Health Code" or "Code"), Chapter 281, and operated in accordance with the Health Code and other applicable laws of the State of Texas, including the Texas Local Government Code (the "Local Government Code"), Chapter 262;

WHEREAS, the Board of Managers of the Hospital District (the "Board") is the governing body of the Hospital District, pursuant to Health Code, §281.048, and pursuant to the collective authorities of the Health Code, §281.047 and §281.048, the Board has, and at the time of adoption of this Order had, full power and authority to manage, control, administer, and to adopt rules governing operation of the District;

WHEREAS, the term "purchase" means any kind of acquisition, including professional services, of an item as set forth at Local Government Code, §262.022(6) and the purchase of professional services may be exempted from the competitive purchasing requirements of Local Government Code, §262.023, as authorized by Local Government Code, §262.024(a)(4); and

WHEREAS, the Hospital District desires to acquire the professional services of the Texas Medical Foundation to provide continuing Quality Assessment, Utilization Review, and Coding Review Services relating to the medical aid and hospital care provided to Nueces Aid Program recipients during Calendar Year 2021, with renewal options for Calendar Years 2022 and 2023.

NOW, THEREFORE, BE IT ORDERED BY THE BOARD OF MANAGERS OF THE NUECES COUNTY HOSPITAL DISTRICT, THAT:

1. As authorized by Local Government Code, §262.024(a)(4), the Board hereby grants an exemption to the competitive purchasing requirements of Local Government Code, §262.023, for the Hospital District's acquisition of Quality Assessment, Utilization Review, and Coding Review Services from the Texas Medical Foundation for Calendar Years 2021, 2022, and 2023.

2. The Administrator shall be and is hereby expressly authorized and directed to do and perform all acts, and to execute all instruments, contracts, agreements, and any other related documents, whether or not herein cited, as required to carry out the intent, terms, and provisions of this Order, such execution to be conclusively evidenced by the performance of such acts.

3. The Administrator, in his capacity as the Secretary of the Hospital District Board, be and is hereby legally authorized and empowered to certify these orders and that the provisions hereof are in conformance with the laws of the State of Texas and the Governing Board Bylaws of the Hospital District.

4. This Order shall take effect and be in full force and effect upon and after its passage.

NUECES COUNTY HOSPITAL DISTRICT
BOARD OF MANAGERS

John B. Martinez, J.D.
Chairman

Sylvia Tryon Oliver
Vice Chairman

Belinda Flores, R.N.
Member

Vishnu V. Reddy, M.D.
Member

Daniel W. Dain
Member

John E. Valls
Member

Mariana Garza
Member

CERTIFICATE FOR ORDER
AN ORDER GRANTING PROFESSIONAL SERVICES EXEMPTION FROM COMPETITIVE PURCHASING REQUIREMENTS RELATING TO THE ACQUISITION OF QUALITY ASSESSMENT, UTILIZATION REVIEW, AND CODING REVIEW SERVICES

THE STATE OF TEXAS §
§
COUNTY OF NUECES §

I, the undersigned Secretary of the Board of Managers of the Nueces County Hospital District, hereby attest as follows:

1. The Board of Managers of said District convened in regular meeting on the 20th day of October, 2020, at the regular meeting place, and the roll was called of the duly constituted officers and members of said Board of Managers, to wit:

John B. Martinez, J.D., Chairman
Sylvia Tryon Oliver, Vice Chairman
Belinda Flores, R.N.
Vishnu V. Reddy, M.D.
Daniel W. Dain
John E. Valls
Mariana Garza

and all of said persons were present, except the following absentees: _____, _____, and _____ thus constituting a quorum. Whereupon, among other business, the following was transacted at said Meeting: A written

AN ORDER GRANTING PROFESSIONAL SERVICES EXEMPTION FROM COMPETITIVE PURCHASING REQUIREMENTS RELATING TO THE ACQUISITION OF QUALITY ASSESSMENT, UTILIZATION REVIEW, AND CODING REVIEW SERVICES

was introduced for the consideration of said District and read in full. It was then duly moved and seconded that said Order be passed, and, after due discussion, said motion, carrying with it the passage of said Order, prevailed and carried by the following vote:

YEAS: _____
NAYS: _____
PRESENT NOT VOTING: _____
ABSENT: _____

2. That a true, full and correct copy of the aforesaid Order passed at the meeting described in the above and forgoing paragraph is attached to and follows this Certificate; that said Order has been duly recorded in the minutes of said Meeting; that the above and forgoing paragraph is a true, full, and correct excerpt from the minutes of said Meeting pertaining to and passage of said Order; that the persons named in the above and forgoing paragraph are the duly appointed, qualified, and acting members of the Board of Managers of said District as indicated therein; that each of the members of the Board of Managers of said District was duly and sufficiently notified officially and personally, in advance, of the time, place, and purpose of aforesaid Meeting, and that said Order would be introduced and considered for passage at said Meeting, and that each of said members consented, in advance, to holding of said Meeting for such purpose; and that said Meeting was open to the public, and public notice of the date, time, place, and purpose of said Meeting was given all as required by Texas Government Code, §551.001 et.seq.

SIGNED AND SEALED THIS 20th day of October, 2020.

ATTEST:

_____

Jonny F. Hipp
Secretary, Board of Managers

{NCHD SEAL}

NUECES COUNTY HOSPITAL DISTRICT
Administrative Offices

555 N. Carancahua Street, Suite 950
Corpus Christi, Texas 78401-0835

Phone: (361) 808-3300
Fax: (361) 808-3274

BOARD OF MANAGERS ORDER
OCTOBER 20, 2020

AN ORDER GRANTING PROFESSIONAL SERVICES EXEMPTION FROM COMPETITIVE PURCHASING REQUIREMENTS RELATING TO THE ACQUISITION OF PROJECT MANAGEMENT, SUBJECT MATTER EXPERT, ENVIRONMENTAL AND POLICY SCAN, AND COMMUNITY STAKEHOLDER ENGAGEMENT SERVICES

WHEREAS, the Nueces County Hospital District (the "Hospital District") is a body politic and corporate and a political subdivision of the State of Texas, established and created pursuant to the Texas Constitution, Article IX, Section 4 and the Texas Health and Safety Code (the "Health Code" or "Code"), Chapter 281, and operated in accordance with the Health Code and other applicable laws of the State of Texas, including the Texas Local Government Code (the "Local Government Code"), Chapter 262;

WHEREAS, the Board of Managers of the Hospital District (the "Board") is the governing body of the Hospital District, pursuant to Health Code, §281.048, and pursuant to the collective authorities of the Health Code, §281.047 and §281.048, the Board has, and at the time of adoption of this Order had, full power and authority to manage, control, administer, and to adopt rules governing operation of the District;

WHEREAS, the term "purchase" means any kind of acquisition, including professional services, of an item as set forth at Local Government Code, §262.022(6) and the purchase of professional services may be exempted from the competitive purchasing requirements of Local Government Code, §262.023, as authorized by Local Government Code, §262.024(a)(4); and

WHEREAS, the Hospital District desires to acquire the professional services of the Texas Health Institute to provide project management, subject matter expert, environmental and policy scan, community stakeholder engagement services, and recommendations in connection with and to guide Accenture, LLP's social determinants of health dashboard framework and metrics during Calendar Years 2020 and 2021.

NOW, THEREFORE, BE IT ORDERED BY THE BOARD OF MANAGERS OF THE NUECES COUNTY HOSPITAL DISTRICT, THAT:

1. As authorized by Local Government Code, §262.024(a)(4), the Board hereby grants an exemption to the competitive purchasing requirements of Local Government Code, §262.023, for the Hospital District's acquisition, from Texas Health Institute, of project

management, subject matter expert, environmental and policy scan, community stakeholder engagement services, and recommendations in connection with and to guide Accenture, LLP's social determinants of health dashboard framework and metrics during Calendar Years 2020 and 2021.

2. The Administrator shall be and is hereby expressly authorized and directed to do and perform all acts, and to execute all instruments, contracts, agreements, and any other related documents, whether or not herein cited, as required to carry out the intent, terms, and provisions of this Order, such execution to be conclusively evidenced by the performance of such acts.

3. The Administrator, in his capacity as the Secretary of the Hospital District Board, be and is hereby legally authorized and empowered to certify these orders and that the provisions hereof are in conformance with the laws of the State of Texas and the Governing Board Bylaws of the Hospital District.

4. This Order shall take effect and be in full force and effect upon and after its passage.

NUECES COUNTY HOSPITAL DISTRICT
BOARD OF MANAGERS

_____
John B. Martinez, J.D.
Chairman

_____
Sylvia Tryon Oliver
Vice Chairman

_____
Belinda Flores, R.N.
Member

_____
Vishnu V. Reddy, M.D.
Member

_____
Daniel W. Dain
Member

_____
John E. Valls
Member

_____
Mariana Garza
Member

CERTIFICATE FOR ORDER
AN ORDER GRANTING PROFESSIONAL SERVICES EXEMPTION FROM COMPETITIVE PURCHASING REQUIREMENTS RELATING TO THE ACQUISITION OF PROJECT MANAGEMENT, SUBJECT MATTER EXPERT, ENVIRONMENTAL AND POLICY SCAN, AND COMMUNITY STAKEHOLDER ENGAGEMENT SERVICES

THE STATE OF TEXAS §
§
COUNTY OF NUECES §

I, the undersigned Secretary of the Board of Managers of the Nueces County Hospital District, hereby attest as follows:

1. The Board of Managers of said District convened in regular meeting on the 20th day of October, 2020, at the regular meeting place, and the roll was called of the duly constituted officers and members of said Board of Managers, to wit:

John B. Martinez, J.D., Chairman
Sylvia Tryon Oliver, Vice Chairman
Belinda Flores, R.N.
Vishnu V. Reddy, M.D.
Daniel W. Dain
John E. Valls
Mariana Garza

and all of said persons were present, except the following absentees: _____, _____, and _____ thus constituting a quorum. Whereupon, among other business, the following was transacted at said Meeting: A written

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was introduced for the consideration of said District and read in full. It was then duly moved and seconded that said Order be passed, and, after due discussion, said motion, carrying with it the passage of said Order, prevailed and carried by the following vote:

YEAS: _____
NAYS: _____
PRESENT NOT VOTING: _____
ABSENT: _____

2. That a true, full and correct copy of the aforesaid Order passed at the meeting described in the above and forgoing paragraph is attached to and follows this Certificate; that said Order has been duly recorded in the minutes of said Meeting; that the above and forgoing paragraph is a true, full, and correct excerpt from the minutes of said Meeting pertaining to and passage of said Order; that the persons named in the above and forgoing paragraph are the duly appointed, qualified, and acting members of the Board of Managers of said District as indicated therein; that each of the members of the Board of Managers of said District was duly and sufficiently notified officially and personally, in advance, of the time, place, and purpose of aforesaid Meeting, and that said Order would be introduced and considered for passage at said Meeting, and that each of said members consented, in advance, to holding of said Meeting for such purpose; and that said Meeting was open to the public, and public notice of the date, time, place, and purpose of said Meeting was given all as required by Texas Government Code, §551.001 et.seq.

SIGNED AND SEALED THIS 20th day of October, 2020.

ATTEST:

_____

Jonny F. Hipp
Secretary, Board of Managers

{NCHD SEAL}