Health and Human Services

Form O
Consolidated Local Service Plan (CLSP)

Local Mental Health Authorities and Local Behavioral Health Authorities

September 2017

Contents

Introduction

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

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

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

Section I: Local Services and Needs

I.A Mental Health Services and Sites

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

Operator (LMHA/LBHA or Contractor Name)	Street Address, City, and Zip	County	Services & Target Populations Served
Texoma Community Center	315 W. McLain Drive Sherman, TX 75092	Grayson	• Adults and Children • Screening, Assessment and Intake(both) • TRR Outpatient Services both children and adults • Services for co-occurring disorders • Substance use disorder prevention, intervention and treatment
Texoma Community Center	102 Memorial Drive Denison, TX 75020	Grayson	• Crisis Residential Services (Adults) • Transitional Living
Texoma Community Center	100 Memorial Drive Denison, TX 75020	Grayson	• HCBS Recovery Management for Adults • Psychosocial Rehabilitation for Adults

Operator (LMHA/LBHA or Contractor Name)	Street Address, City, and Zip	County	Services & Target Populations Served
Texoma Community Center	1228 E. Sixth Street Bonham, TX 75418 (Bonham, continued)	Fannin	• Adults and Children • Screening, Assessment and Intake(both) • TRR Outpatient Services both children and adults • Services for co-occurring disorders • Substance use disorder prevention, intervention and treatment
Texoma Community Center	301 N. Grand Avenue Gainesville, TX 76240	Cooke	• Adults and Children • Screening, Assessment and Intake(both) • TRR Outpatient Services both children and adults • Services for co-occurring disorders • Substance use disorder prevention, intervention and treatment
Texoma Medical Center-BHC	2601 Cornerstone Dr, Sherman, TX 75092	Grayson	• Inpatient Adult and Children
WNJ-Regional Medical Center-Behavioral Health	1111 Gallagher Drive Sherman, TX 75090	Grayson	• Inpatient Adult

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

- *Identify the Regional Health Partnership (RHP) Region(s) associated with each project.*
- *List the titles of all projects you proposed for implementation under the RHP plan. If the title does not provide a clear description of the project, include a descriptive sentence.*
- *Enter the number of years the program has been operating, including the current year (i.e., second year of operation = 2)*
- *Enter the static capacity—the number of individuals that can be served at a single point in time.*
- *Enter the number of individuals served in the most recent full year of operation. If the program has not had a full year of operation, enter the planned number to be served per year.*
- *If capacity/number served is not a metric applicable to the project, note project-specific metric with the project title.*

**MLIU=Medicaid/Low income/Uninsured*

	1115 Waiver Projects				
RHP Region(s)	Project Title (include brief description if needed)	Years of Operation	Capacity (target)	Population Served	Number Served/ Year
1, 18, 19	084434201.1.1 Implement Technology Assisted Services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate or deliver behavioral health services	6	747	*MLIU	2951 Individuals
1, 18, 19	084434201.1.2 Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (substance use disorder treatment)	6	226	*MLIU	1367 Individuals
1, 18, 19	084434201.1.3 Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (counseling for non-priority population)	6	308	*MLIU	1416 Individuals
1, 18, 19	084434201.1.4 Enhance performance Improvement and Reporting Capacity. **Metric**: Increase the number of reports generated through the quality improvement data systems by % over baseline	6	Reports, not people	*MLIU	16 reports
1, 18, 19	084434201.2.1 Develop Care Management Function that integrates primary and behavioral health needs of individuals.	6	173	*MLIU	1550 Individuals
1, 18, 19	084434201.2.2 Provide an Intervention for a targeted health population to prevent unnecessary use of services in a specified setting (i.e. criminal justice system, ER, Urgent Care, etc.)	6	1291	*MLIU	1639 Individuals

	1115 Waiver Projects				
RHP Region(s)	Project Title (include brief description if needed)	Years of Operation	Capacity (target)	Population Served	Number Served/ Year
18	084434201.2.3 Redesign Primary Care/Increase efficiency and redesign primary care program to be oriented around the patient so that primary care access and patient experience can be improved.	6	300	*MLIU	472 Individuals

I.C Community Participation in Planning Activities

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

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

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

• Behavioral Health Leadership Team
• Community Collaboration Meetings
• Jail Diversion Meetings
•
•
•

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

• Coordinating resources and maximizing the limited funds available within the community
•
•
•
•
•

Section II: Psychiatric Emergency Plan

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

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

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

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

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

II.A Development of the Plan

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

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

- Soliciting input

- TCC regularly meets with all the local hospitals in our service area with a focus on emergency room staff. Local psychiatric hospitals are also included. TCC sponsors jail diversion meetings/Mental Health Court in Cooke and Fannin counties and participates in Drug Court and Veteran's Court in Grayson County. TCC participates in Community Collaboration Meetings in Grayson County where issues related to jails and the legal system are discussed. We also provide training for law enforcement and judges in our area.

II.B Crisis Response Process and Role of MCOT

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

        - MCOT is available 24 hours/day

    b. After business hours

        - MCOT is available 24 hours/day

    c. Weekends/holidays

        - MCOT is available 24 hours/day

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

- Any request for a crisis assessment is responded to by the MCOT. After hours, Avail Solutions screens the initial crisis calls and determines when to contact the MCOT for an assessment.

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

- Every individual who calls needing a crisis assessment will receive a follow up within 24 hours after completion of the crisis assessment. All individuals who receive crisis services are referred to one of the programs offered by TCC through HHSC or 1115 Waiver.

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

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

    - Emergency rooms: Yes
    - Law enforcement: Yes

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

    - Emergency rooms: MCOT responds to any requests from emergency rooms or hospitals to provide options for treatment and referrals for individuals in crisis. TCC also provides training to ER staff on crisis procedures to reduce recidivism and expedite processing through the emergency department.
    - Law enforcement: TCC provides training to law enforcement and Judges on crisis procedures and appropriate crisis response. MCOT will respond to a crisis at any location requested by law enforcement if an officer is present. This often eliminates the need to admit the individual in crisis to the emergency department.

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

- MCOT will make the recommendation if the individual requires medical clearance from an emergency room or facilitate admission to the TCC Crisis Respite Facility. If local or state hospitalization is required, MCOT will arrange for the necessary admission paperwork and communicate with admissions staff.

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

- TCC maintains contracts with local psychiatric hospitals for individuals requiring hospitalization who don't have a funding source. MCOT responds and makes the determination and then activates the contract with the appropriate accepting hospital. If the client has funding, MCOT may help facilitate admission to a local psychiatric hospital upon request from the emergency department, or law enforcement. If the state hospital is deemed necessary, the MCOT makes all necessary arrangements to facilitate that admission.

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

- MCOT makes the determination with supervisor approval for any admission to CRU (Crisis Respite Unit). Length of stay and referral to other programs is determined by clinical staff after admission to the unit.

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

- For MCOT staff to go to a home, then law enforcement would be contacted to accompany them;
- For other locations, MCOT staff would deploy to the location they are called

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

- Contact TCC and request a crisis assessment.

b. After business hours

- Contact TCC and request a crisis assessment.

c. Weekends/holidays

- Contact TCC and request a crisis assessment.

7. If an inpatient bed is not available:

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

- Individual may be admitted to TCC CRU depending on clinical need, appropriateness and availability.

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

- TCC clinical staff (may include MCOT staff) provide follow-up and continuity of care crisis services.

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

- TCC clinical staff at CRU under the supervision of an LPHA will make a determination for a more restrictive environment is necessary.

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

- In some instances, MCOT staff may provide transportation. MCOT coordinates with local hospitals and other stakeholders to find appropriate transportation resources for the individual in crisis.

Crisis Stabilization

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

Name of Facility	TCC Crisis Respite Unit
Location (city and county)	102 Memorial, Denison Texas
Phone number	903-957-4818
Type of Facility (see Appendix A)	Crisis Respite
Key admission criteria (type of patient accepted)	Individuals who are not an imminent danger to self or others but need a more restrictive environment than being discharged to home, and a less restrictive environment than hospitalization.
Circumstances under which medical clearance is required before admission	CRU does not require medical clearance. Individual must be able to safely evacuate themselves from the facility and have medications necessary for life-threatening illness (e.g., diabetes, seizures).
Service area limitations, if any	CRU is available to any client served in crisis and is determined by LPHA supervisor based on availability.
Other relevant admission information for first responders	CRU is not a drop off facility. Admission must be approved by MCOT supervisor.
Accepts emergency detentions?	CRU is not a lock-down facility. Emergency detentions are not accepted.

Inpatient Care

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

Name of Facility	Texoma Medical Center Behavioral Health Center
Location (city and county)	Sherman, Grayson County Texas
Phone number	903-416-3000
Key admission criteria	Will accept indigent patients if TCC agrees to pay contract amount for stay.
Service area limitations, if any	Determined by facility
Other relevant admission information for first responders	TCC must approve admission and length of stay for any client who is to be considered for an inpatient stay under the current contract.
Name of Facility	Wilson N. Jones Regional Medical Center Behavioral Health Services
Location (city and county)	Sherman, Grayson County Texas
Phone number	903-870-7313
Key admission criteria	Will accept indigent patients if TCC agrees to pay contract amount for stay.
Service area limitations, if any	Determined by facility
Other relevant admission information for first responders	TCC must approve admission and length of stay for any client who is to be considered for an inpatient stay under the current contract.

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

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

- TCC does not currently have an OCR program, but would like to develop one if funding were available.

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

- Funding is the primary limitation to expanding access to individuals in crisis. TCC has largely funded our CRU and other crisis programs without additional funding.

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

- Yes. The jail liaison completes assessments in the jails (Cooke, Fannin and Grayson counties) and provides follow-up for individuals upon release. Liaison also works with local judges to divert from jail if possible, and coordinates with Mental Health Court and jail diversion meetings. Jail Liaison is engaged upon request from the jails or the magistrates in each county.

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

- N/A

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

- TCC would like to explore opportunities to develop an OCR program for Cooke, Fannin and Grayson counties.

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

- Our area would most benefit from an OCR operated by TCC.

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

- Local stakeholders are in favor of OCR program. The primary barrier to implementation is funding.

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

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

- TCC has implemented an integrated health care program and a substance use disorder program through the 1115 Waiver. Crisis services were also expanded using these funds. TCC has also been awarded some additional funding for local hospitalization which should be available soon. TCC works with the Grayson County Health Clinic, local non-profit substance use disorder services and local emergency rooms as requested. All the programs work together to meet the needs of the individuals in our area.

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

- TCC is involved in a continued effort to integrate our physical health care and psychiatric health care into one facility to lessen complications for individuals served and increase overall compliance with recovery plans.

II.E Communication Plans

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

- TCC maintains a website and provides printed information to stakeholders and the community regarding the services provided and how to access programs throughout the agency.

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

- TCC provides regular and comprehensive training to staff at all levels on procedures and protocols, as well as services offered by the center in all three counties.

II.F Gaps in the Local Crisis Response System

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

Counties	Service System Gaps
Grayson	• Jail Diversion Program (there is now a Community Collaboration Group which performs some functions of a jail diversion program), transitional housing, public transportation.
Cooke	• Transitional Housing and transportation
Fannin	• Transitional Housing and transportation

Section III: Plans and Priorities for System Development

III.A Jail Diversion

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

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

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

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
☐ Co-mobilization with Crisis Intervention Team (CIT)	
☐ Co-mobilization with Mental Health Deputies	
☐ Co-location with CIT and/or MH Deputies	
☐ Training dispatch and first responders	
☒ Training law enforcement staff	• Ongoing
☐ Training of court personnel	
☒ Training of probation personnel	
☒ Documenting police contacts with persons with mental illness	• Ongoing
☐ Police-friendly drop-off point	
☒ Service linkage and follow-up for individuals who are not hospitalized	• Ongoing

Intercept 1: Law Enforcement and Emergency Services	
Components	**Current Activities**
☐ Other: Click here to enter text.	
Plans for the upcoming two years: • Proposing addition of Licensed Chemical Dependency Counselor (LCDC) to the Mobile Crisis Outreach Team (MCOT)through HB 13 Mental Health Grant Program	

Intercept 2: Post-Arrest: Initial Detention and Initial Hearings	
Components	**Current Activities**
☒ Staff at court to review cases for post-booking diversion ☒ Routine screening for mental illness and diversion eligibility ☒ Staff assigned to help defendants comply with conditions of diversion ☒ Staff at court who can authorize alternative services to incarceration ☒ Link to comprehensive services ☐ Other: Click here to enter text.	• Weekly • Daily • Ongoing • Ongoing • Daily
Plans for the upcoming two years: • Develop and implement a jail diversion program in Grayson County, and expand jail diversion programs in Cooke and Fannin Counties. • Continue training of local law enforcement and judges • Proposing addition of LCDC to MCOT through HB 13 Mental Health Grant Program	

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
☒ Routine screening for mental illness and diversion eligibility	• Daily

Intercept 3. Post-Initial Hearing: Jail, Courts, Forensic Evaluations, and Forensic Commitments	
Components	**Current Activities**
☒ Mental Health Court	• Twice monthly
☒ Veterans' Court	• Monthly
☒ Drug Court	• Weekly
☐ Outpatient Competency Restoration	
☒ Services for persons Not Guilty by Reason of Insanity	• By court request
☐ Services for persons with other Forensic Assisted Outpatient Commitments	
☐ Providing services in jail for persons Incompetent to Stand Trial	
☐ Compelled medication in jail for persons Incompetent to Stand Trial	
☒ Providing services in jail (for persons without outpatient commitment)	• Medication services and follow-up post release
☒ Staff assigned to serve as liaison between specialty courts and services providers	• Daily
☒ Link to comprehensive services	• Daily
☐ Other:	
Plans for the upcoming two years:	
• Proposing addition of forensic psychologist through HB 13 Mental Health Grant Program to provide competency assessments	

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
☒ Providing transitional services in jails	• Daily

Intercept 4: Re-Entry from Jails, Prisons, and Forensic Hospitalization	
Components	**Current Activities**
☒ Staff designated to assess needs, develop plan for services, and coordinate transition to ensure continuity of care at release ☒ Structured process to coordinate discharge/transition plans and procedures ☐ Specialized case management teams to coordinate post-release services ☐ Other:	• Daily • Daily
Plans for the upcoming two years: • Proposed targeted Case Management for probationers and parolees	

Intercept 5: Community corrections and community support programs	
Components	**Current Activities**
☐ Routine screening for mental illness and substance use disorders ☒ Training for probation or parole staff ☒ TCOOMMI program ☐ Forensic ACT ☒ Staff assigned to facilitate access to comprehensive services; specialized caseloads ☒ Staff assigned to serve as liaison with community corrections ☒ Working with community corrections to ensure a range of options to reinforce positive behavior and effectively address noncompliance ☐ Other:	• TCOOMMI probation and parole programs • TCOOMMI and Jail Liaison • TCOOMMI and Jail Liaison • TCOOMMI and Jail Liaison • TCOOMMI and Jail Liaison
Plans for the upcoming two years:	

- N/A

III.B Other Behavioral Health Strategic Priorities

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

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

Related goals identified in the plan include:

- *Goal 1.1: Increase statewide service coordination for special populations*
- *Goal 2.1: Expand the use of best, promising, and evidence-based behavioral health practices*
- *Goal 2.3: Ensure prompt access to coordinated, quality behavioral healthcare*
- *Goal 2.5: Address current behavioral health service gaps*
- *Goal 3.2: Address behavioral health prevention and early intervention services gaps*
- *Goal 4.2: Reduce utilization of high cost alternatives*

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

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
Improving access to timely outpatient services	• Gap 6 • Goal 2	• Meeting with BHLT to increase information regarding access to services and continuity of care	• Enhance crisis services
Improving continuity of care between inpatient care and community services and reducing hospital readmissions	• Gap 1 • Goals 1,2,4	• Continuity of care liaison position created to provide follow-up on referrals from across multiple agency programs.	• Develop procedures that will allow for Person Centered Care approach that will walk individuals through the process of accessing services in multiple programs.
Transitioning long-term state hospital patients who no longer need an inpatient level of care to the community and reducing other state hospital utilization	• Gap 14 • Goals 1,4	• TCC has implemented an HCBS program to help integrate this population back into the community. • Continue providing intensive services for high utilizers	• Expand HCBS • Develop and implement an OCR program and expand transitional living facility.
Implementing and ensuring fidelity with evidence-based practices	• Gap 7 • Goal 2	• TCC has Fidelity Manager positions in its programs to work with QM staff to ensure adherence to multiple guidelines set forth	• Continue with monitoring and oversight of services provided and treatment regimens offered by TCC.

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
		by HHSC contract and 1115 Waiver.	
Transition to a recovery-oriented system of care, including use of peer support services	• Gap 8 • Goals 2,3	• TCC is currently working to develop peer involvement and support for individuals in both the SUD and Veteran's programs.	• TCC hopes to develop an employment program for individuals that will consist of a peer-led support system for individuals who wish to work.
Addressing the needs of consumers with co-occurring substance use disorders	• Gaps 1,14 • Goals 1,2	• All individuals have access to COPSD services and TCC has a Substance Use Disorder (SUD) program under 1115 Waiver; a separate SUD program specifically for women has also been implemented and the center is now providing OSAR services to Cooke, Fannin and Grayson counties.	• Expand SUD services to better meet the needs of our community.
Integrating behavioral health and primary care services and meeting physical healthcare needs of consumers.	• Gap 1 • Goals 1,2	• TCC provides Integrated Health Care Services for individuals from all three counties.	• TCC will move integrated services to a facility which will allow for both physical and psychiatric services in the same location and

Area of Focus	Related Gaps and Goals from Strategic Plan	Current Status	Plans
			expand the services offered to more individuals.
Consumer transportation and access to treatment in remote areas	• Gap 10 • Goal 2	• Currently, TCC provides some transportation services to individuals whom we serve	• Proposed additional funding for transportation through HB 13 Mental Health Grant Program
Addressing the behavioral health needs of consumers with Intellectual Disabilities	• Gap 14 • Goals 2,4	• Created an IDD Crisis Specialist position	• Proposed adding additional staff and a Board Certified Behavioral Analyst (BCBA) through HB 13 Mental Health Grant Program
Addressing the behavioral health needs of veterans	• Gap 4 • Goals 2,3	• Veteran's Court • Military Veteran's Peer Network (MVPN) Coordinator position	• Proposed funding for transportation and peer support funding through HB 13 Mental Health Grant Program

III.C Local Priorities and Plans

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

Local Priority	Current Status	Plans
Enhance Integrated Healthcare	• In process	• Obtain funding and develop a location for services
Outpatient Competency Restoration		• Obtain funding for program
Comprehensive Supported Employment Program	• Currently Operating	• Work with TWC to develop the program with input from local stakeholders and programs within the agency.
Enhance Transportation	• Seeking Additional Funds	• Continue to expand transportation resources for the community.

III.D System Development and Identification of New Priorities

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

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

a. Assign a priority level of 1, 2 or, 3 to each item, with 1 being the highest priority.
b. Identify the general need.

c. Describe how the resources would be used—what items/components would be funded, including estimated quantity when applicable.
d. Estimate the funding needed, listing the key components and costs. For recurring/ongoing costs (such as staffing), state the annual cost.

Priority	Need	Brief description of how resources would be used	Estimated Cost
1	*Transitional Living Beds*	• *Expand transitional living space to provide intensive residential services to high utilizers and those who need help maintaining a stable environment or transitioning to the community.*	• *$400,000/year*
2	*Expand integrated health care clinic*	• *Enhance integrated health care provision to allow access by all TCC individuals and operate both psychiatric and physical services from one location to increase compliance and success.*	• *$250,000/year*
3	*Outpatient Competency Restoration Program*	• *Develop and implement an OCR program for all three counties to further reduce state hospital stays due to forensic commitments.*	• *$300,000/year*

Appendix A: Levels of Crisis Care

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

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

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

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

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

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

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

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

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

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

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

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