Austin State Hospital Brain Health Redesign Subcommittee, Work Group & Engagement Group Members

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Subcommittees

Campus Master Plan			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
Chair	Steve Strakowski, MD	Associate VP Regional Mental Health	Department of Psychiatry, Dell Medical School
Member	Jim Baker, MD	Associate Chair of Clinical Integration & Services	Department of Psychiatry, Dell Medical School
Member	Scott Briner	Chief Executive Officer	Sweeny Community Hospital
Member	Lauv Bruner	Project Manager, Mental Health Care Redesign	Department of Psychiatry, Dell Medical School
Member	David Evans	Chief Executive Officer	Integral Care
Member	Mike Geeslin	Chief Executive Officer	Central Health
Member	Sara Gonzalez	Vice President of Advocacy and Public Policy	Texas Hospital Association
Member	Greg Hansch	Public Policy Director	NAMI Texas
Member	August W. Harris, III	Realtor; President,	Moreland Properties; Covenant Financial Solutions
Member	Sydney Harris	Director Mental Health Care Redesign	Department of Psychiatry, Dell Medical School
Member	Sandy Hentges Guzman	Legislative Director	Sen. Kirk Watson's Office
Member	Katherine Jones	Director, Strategy & Missions	Design Institute for Health, Dell Medical School
Member	David Lakey, MD	Vice Chancellor for Health Affairs & Chief Medical Officer	University of Texas Systems
Member	Beto Lopez	Director, System Design	Design Institute for Health, Dell Medical School
Member	Lisa Owens	Chief Financial Officer	Central Health
Member	Karen Ranus	Executive Director	NAMI Austin
Member	Steve Steffensen, MD	Chief of Learning Health System, Clinical Affairs	Department of Neurology, Dell Medical School
Member	Dennis Wilson	Sheriff	Limestone County

Integrated Service Design			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
Chair	Beto Lopez	Director, System Design	Design Institute for Health, Dell Medical School
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Member	Sydney Harris	Director Mental Health Care Redesign	Department of Psychiatry, Dell Medical School
Member	Katherine Jones	Director, Strategy & Missions	Design Institute for Health, Dell Medical School
Member	Steve Strakowski, MD	Associate VP Regional Mental Health	Department of Psychiatry, Dell Medical School
Care Advisory Panel	Tim Bray	Associate Commissioner	State Hospital System, HHSC
Care & Service Area Advisory Panel	David Evans	Chief Executive Officer	Integral Care
Care Advisory Panel	Mike Geeslin	Chief Executive Officer	Central Health
Care Advisory Panel	Sara Gonzalez	Vice President of Advocacy and Public Policy	Texas Hospital Association
Care Advisory Panel	Dawn Handley	Chief Operations Officer	Integral Care
Care Advisory Panel	Sandy Hentges Guzman	Legislative Director	Sen. Kirk Watson's Office
Care Advisory Panel	Octavio Martinez, MD	Executive Director	Hogg Foundation
Care & Service Area Advisory Panel	Lisa Owens	Chief Financial Officer	Central Health
Care & Service Area Advisory Panel	Andrea Richardson	Executive Director	Bluebonnet Trails Community Services
Care Advisory Panel	Sheriff Dennis Wilson	Sheriff	Limestone County

Facilities Planning			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
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Member	Sydney Harris	Director Mental Health Care Redesign	Department of Psychiatry, Dell Medical School
Member	Sandy Hentges Guzman	Legislative Director	Sen. Kirk Watson's Office
Member	Katherine Jones	Director of Strategy & Missions	Design Institute for Health, Dell Medical School
Member	Beto Lopez	Director, Systems Design	Design Institute for Health, Dell Medical School
Member	Ryan Losch	Project Manager	Page Southerland Page, Inc.
Member	Renu Razdan	Construction Specialist	Facility Maintenance and Construction, HHSC
Member	David Rea	Associate VP Campus Planning & Project Management	University of Texas at Austin
Member	Brock Rindahl	Project Manager, Office of Planning & Construction	University of Texas at Austin
Member	John Robert	Director Maintenance and Construction Department	HHSC
Member	Jim Shackleford	Director, Capital Planning and Construction	University of Texas at Austin
Member	Steve Sonnenberg, MD	Professor of Psychiatry, Population Health, and Medical Education	Department of Psychiatry, Dell Medical School

Policy & Legislation Coordination			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
Chair	Sandy Hentges Guzman	Legislative Director	Sen. Kirk Watson's Office
Member	Amanda Flores	System Planning Specialist	State Hospital System, HHSC
Member	Brady Franks	Government Relations	University of Texas at Austin
Member	Sara Gonzalez	Vice President of Advocacy and Public Policy	Texas Hospital Association
Member	Greg Hansch	Public Policy Director	NAMI Texas
Member	Colleen Horton	Advocate for Dual IDD/MH	Hogg Foundation
Member	Nelson Jarrin	Sr. Director of Government Affairs	MMHPI
Member	David Lakey, MD	Vice Chancellor for Health Affairs & Chief Medical Officer	University of Texas Systems
Member	Eric Woomer	Governmental Affairs Consultant & Lobbyist	Eric Woomer Policy Solutions

Communications			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
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Member	Lauv Bruner	Project Manager, Mental Health Care Redesign	Department of Psychiatry, Dell Medical School
Member	Sydney Harris	Director Mental Health Care Redesign	Department of Psychiatry, Dell Medical School
Member	Beto Lopez	Director, System Design	Design Institute for Health, Dell Medical School
Member	Steve Strakowski, MD	Associate VP Regional Mental Health	Department of Psychiatry, Dell Medical School
Advisor & Trusted Council	Kate Alexander	Policy Director	Sen. Kirk Watson's Office
Advisor & Trusted Council	Tracy Asamoah, MD	Pediatric & Adolescent Mental Health Provider	Private practice
Advisor & Trusted Council	Bryan Black	Director of Communications	HHSC
Advisor & Trusted Council	Ariell Gills	Mental Health Lead Liaison, Inpatient Services	Gulf Coast Center
Advisor & Trusted Council	Amanda Groller	Program Manager, Crisis Counseling Program Disaster Response	Gulf Coast Center
Advisor & Trusted Council	Melissa Loe	Chief Communications Officer	HHSC
Advisor & Trusted Council	Valerie Milburn	Mental Health Advocate & Board Chair	Communities in Recovery
Advisor & Trusted Council	Lisa Owens	Chief Financial Officer	Central Health
Advisor & Trusted Council	Karen Ranus	Executive Director	NAMI Austin
Advisor & Trusted Council	Ellen Richards	Chief Strategy Officer	Integral Care

Finance			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
Chair	David Evans	Chief Executive Officer	Integral Care
Ex Officio Member	Bob Blount	Founder & Chief Executive Officer	Town Square Health
Member	Tim Bray	Associate Commissioner	State Hospital System, HHSC
Member	Shannon Hangered	Private Consultant	
Member	Martin Harris, MD	Chief Business Officer	Department of Internal Medicine, Dell Medical School
Ex Officio Member	Sandy Hentges Guzman	Legislative Director	Sen. Kirk Watson's Office
Member	Roger Jefferies	Director of Criminal Justice Planning	Travis County
Member	Lisa Kirsch	Senior Policy Director	Dell Medical School
Member	Lisa Owens	Chief Financial Officer	Central Health
Member	John Petrila	Vice President of Adult Policy	MMHPI
Ex Officio Member	David Weden	Chief Financial Officer	Integral Care

Academic Integration			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
Chair	Jim Baker, MD	Associate Chair of Clinical Integration & Services	Department of Psychiatry, Dell Medical School
Member	Kathleen Casey, Ph.D.	Director of Clinical Innovation & Development	Integral Care
Member	Lynn Crimson, Ph.D.	Dean, College of Pharmacy	University of Texas at Austin
Member	Amanda Flores	System Planning Specialist	State Hospital System, HHSC
Member	Victor Garza, MD	Psychiatry Clerkship Director	Texas A&M University
Member	Donna Rolin, Ph.D.	Assistant Professor, Director of Psychiatry MH Nurse Practitioner	University of Texas at Austin
Member	Amy Shaw Thomas	Vice Chancellor for Academic & Health Affairs	University of Texas System
Member	Cathy Stacey, Ph.D.	Executive Director of Psychiatry	Department of Psychiatry, Dell Medical School
Member	Steve Strakowski, MD	Associate VP Regional Mental Health	Department of Psychiatry, Dell Medical School
Member	Kathy Ybanez-Llorente, Ph.D.	Associate Professor of Professional Counseling	Texas State University
Member	Luis Zayas, Ph.D.	Dean, Steve Hicks School of Social Work	University of Texas at Austin

Work Groups

Local Mental Health Authorities			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
Co-Chair	David Evans	Chief Executive Officer	Integral Care
Co-Chair	Andrea Richardson	Executive Director	Bluebonnet Trails Community Services
Member	Charlie Boone	Chief Executive Officer	Tejas Health Management Association
Member	Holly Borel	Chief Executive Officer	Spindletop Center
Member	Ray Helmcamp	Executive Director	Central County Centers
Member	Lee Johnson	Deputy Director	Texas Council of Community Centers
Member	Bill Kelly	Executive Director	MHMR Authority of Brazos Valley
Member	Allison Million	Family Partner	Gulf Coast Center
Member	George Patterson	Chief Executive Officer	Texana Center
Member	Evan Roberson	Executive Director	Tri-County Behavioral Healthcare
Member	Ross Robinson	Executive Director	Hill Country MH & DD Centers
Member	Susan Rushing	Chief Executive Director	Burke
Member	Barbara Tate	Executive Director	Heart of Texas Region MHMR Center
Member	Melissa Tucker	Chief Executive Officer	Gulf Coast Center
Member	David Weden	Chief Administrative Officer/Chief Financial Officer	Integral Care
Member	Dion White	Chief Executive Officer	Center for Life Resources

Community General Hospital Work Group			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
Co-Chair	Scott Briner	Chief Executive Officer	Sweeny Community Hospital
Co-Chair	Sara Gonzalez	Vice President & Public Policy	Texas Hospital Association
Member	Aisha Ainsworth	Advocacy Communications	Texas Hospital Association
Member	Sharon Beasley	Legal Manager	Texas Hospital Association
Member	Kristine Christian, MSN, RN	Director, Emergency Services	CHI St. Joseph Bryan
Member	Marisa Finley	Vice President Healthcare Policy	Baylor Scott & White Health
Member	Ed Prettyman, Psy.D.	Chief Executive Officer	Texas NeuroRehab Center
Member	Lisa Salter	Chief Executive Officer	Georgetown Behavioral Healthcare
Member	Meghan Weller	Director, Government Relations	HCA

Health Districts, FQHCs, & Population Health			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
Chair	Lisa Owens	VP, Financial Officer	Central Health
Member	Sarah Cook	Senior Director of Strategy, Communications & Population Health	Community Care Collaborative
Member	Eva Cruz-Hamby	Director of Health Services	McClennan County
Member	Mike Dotson	Chief Executive Officer	AccessHealth
Member	Mike Geeslin	President & Chief Executive Officer	Central Health
Member	Virginia L. Headley, PhD	Interim Executive Director	Williamson County & Cities Health District
Member	Liz Jacobs, MD	Chair of Primary Care & Value Based Health	Dell Medical School
Member	Michael Lawson, MD	Chief Medical Officer	AccessHealth
Member	Lilly Moncivais	Indigent Health Care Program Director	Brazos Valley Council of Governments
Member	Rhonda Mundhenk, JD, MPH	Chief Executive Officer	Lone Star Circle of Care
Member	Paul Nguyen	Chief Executive Officer	CommuniCare
Member	Alan Schalscha, DO	Chief Medical Officer	CommUnity Care
Member	Rachel Toronjo	Research & Planning Coordinator	Central Health
Member	Melissa Renee Valdez, MD	Director of Psychiatry & Behavioral Health	Lone Star Circle of Care

Peer & Family Work Group			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
Co-Chair	Greg Hansch	Public Policy Director	NAMI Texas
Co-Chair	Karen Ranus	Executive Director	NAMI Austin
Member	Noah Abdenour	Peer Specialist	Bluebonnet Trails Community Services
Member	Jeffrey Brooke	Peer Specialist	Center for Life Resources
Member	Cynthia Cunningham	Executive Director, Family Member	NAMI Waco
Member	Rachel Dunlap	Family Partner	Center for Life Resources
Member	Lynne Friese	Family Partner	Hill Country MHDD Centers
Member	Colleen Horton	Program Officer, Family Member	Hogg Foundation
Member	Jason Johnson	Peer Specialist	Hill Country MHDD Centers
Member	Valerie Milburn	Peer	Communities for Recovery
Member	Allison Million	Family Partner	Gulf Coast Center
Member	Doris Osei	Family Member	NAMI Fort Bend
Member	Paula Pollei	Education/Outreach, Family Member	NAMI Temple
Member	Jessica Saner	Peer Specialist	Austin State Hospital
Member	Jody Schulz	Executive Director, Family Member	NAMI Brazos Valley
Member	Pat Sumner	Family Member	NAMI Fort Bend
Member	Kate Youman	Peer	Communities for Recovery

Law Enforcement Work Group

STATUS	NAME	TITLE	ORGANIZATION
Chair	Dennis Wilson	Sheriff	Limestone County
Member	Calvin Boyd	Sheriff	Burnet County
Member	Sally Hernandez	Sheriff	Travis County
Member	Jason Johnson	Peer Specialist	Hill Country MHDD Centers
Member	Jesus Ramos	Sheriff	Lampasas County
Member	Jeremy Shipley	Sheriff	Freestone County
Member	Jody Shultz	Peer	NAMI
Member	Glenn Smith	Sheriff	Waller County
Member	Rodney Watson	Sheriff	Hill County
Member	Gerald Yezak	Sheriff	Robertson County

Subspecialty Work Group

STATUS	NAME	TITLE	ORGANIZATION
Chair	Jim Baker, MD	Associate Chair of Clinical Integration & Services	Department of Psychiatry, Dell Medical School
Member	Kurt Cousins, MD	Child/Adolescent Psychiatrist	Integral Care
Member	Amanda Flores	System Planning Specialist	State Hospital System, HHSC
Member	Colleen Horton	Program Officer, Family Member	Hogg Foundation
Member	Becky Morales, LCSM	Manager of Collaborative Care	Dell Medical School & Integral Care
Member	John Nguyen, MD	Addictionologist	Integral Care
Member	Jessica Saner	Peer Specialist	Austin State Hospital
Member	Kate Youman	Peer	Communities for Recovery

IT Integration Work Group			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
Chair	Steve Steffensen, MD	Chief of Learning Health System, Clinical Affairs	Department of Neurology, Dell Medical School
Member	Nora Belcher	Executive Director	TeHA
Member	Robert Dominguez	Practice Administrator – Clinical Operations	Integral Care
Member	Hal Katz	Partner	Hurch Blackwell
Member	Scott Trapp	Director IT Operations	Tejas Health Management Association
Member	Alex Vo	Chief Executive Officer	Medical Branch Innovations, UTMB

Engagement Groups

Legal Engagement Group			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
Member	John Hathaway	Associate Court Judge	Travis County Juvenile Court
Member	Guy Herman	Judge	Probate Travis County
Member	Nancy Hohengarten	Judge	Travis County Court #5
Member	Polly Jackson Spencer	Retired Judge	Probate Court Bexar County
Member	Dan Prashner	Associate Judge	Probate Travis County
Member	Mike Shirley	ADA Diversion Courts	Montgomery County
Member	David Slayton	Administrative Director	Office of Court Administration
Member	Steve Strakowski, MD	Associate VP Regional Mental Health	Dell Medical School

Historic Preservation Engagement Group			
STATUS	**NAME**	**TITLE**	**ORGANIZATION**
Chair	August W. Harris, III	Realtor; President	Moreland Properties; Covenant Financial Solutions
Member	Brian Bolinger	Former Executive Director	Texas State Historical Association
Member	Sandy Hentges Guzman	Legislative Director	Sen. Kirk Watson
Member	Anne Hebert	Community	Hyde Park Neighborhood
Member	Michael Holleran	Director, Graduate Program in Historic Preservation	School of Architecture, University of Texas at Austin
Ex Officio Member	Evan Thompson	Executive Director	Preservation Texas

Campus Master Plan Subcommittee
Executive Summary

The Campus Master Plan Subcommittee was tasked with composing the final recommendation, including the Master Plan document as reflected by the work of the Steering Committee, to submit to Health and Human Services (HHSC). The subcommittee has two deliverables:

- Legislator-Level Master Plan due no later than December 31, 2108 to propose high-level cost estimates for the 86th legislative session.

- Schematic Design due no later than November 30, 2020

Based on the Austin State Hospital (ASH) Brain Health System Redesign (ASH Redesign) this subcommittee presented drafts and final proposal documents to the Steering Committee for an editorial review and approval prior to submission to HHSC. These documents were derivatives of benchmarks the Campus Planning Subcommittee set to include in the recommendation and Master plan that included:

- Gantt deliverables from all other subcommittees.

- Data analytics – population estimates, needs estimates, epidemiological data

- Clinical model details

- Preliminary and final financial modeling.

The integration and support of all subcommittees and workgroups, positioned the Campus Plan Subcommittee with proficiency in developing the final recommendation that included four caveats for the ASH Redesign. The subcommittee envisions the ASH Redesign continuum of care as a new person-centered Austin State Hospital building on the historic campus that is surrounded by residential care facilities and private community partners to ensure best practices in crisis management, primary care, and competency restoration.

This system redesign is intended to influence a standard in brain health in the ASH service area and possible the State of Texas and beyond.

Integrated Service Design (ISD) Subcommittee Executive Summary

The ISD subcommittee was created to take a person-centered approach to understanding the needs of the ASH service area and the supporting continuum of mental health services. In addition to researching existing published work on previous state hospital evaluations of ASH and regional and national advancements in mental health delivery, the ISD sponsored two qualitative information gathering efforts, one focused on adult care and the other on child and adolescent care, to surface the varying individual needs, organizational capabilities and stakeholder perspectives of those serving and being served by ASH. Those efforts engaged representative counties and the people in their communities across the ASH service area, including urban, suburban, coastal and rural regions.

Integrated Service Design, through this information gathering and in collaboration with other ASH Redesign Subcommittees and Work Groups, developed a recommendation for the ASH Steering Committee for how to consider the continuum of care, anchored around the needs of the people served, providers, and the community of people who support them.

The ISD Subcommittee produced three substantive reports outlining findings and recommendations:

1. Qualitative Field Work and Stakeholder Findings: A study and report of qualitative insights and needs around how ASH might better serve the needs of the adults (inclusive of geriatric special needs), children and adolescents, and patients with neurodevelopmental challenges across the service area of 38 counties for adults, 57 for adolescents, and 75 for children.

2. Child and Adolescent Psychiatric Services (CAPS) Study: A specific study and report on CAPS considerations that uses both qualitative and quantitative approaches to understand the needs, current providers, and gaps for serving the brain health needs of children and adolescents in the ASH service area. ASH CAPS reports no waitlist, in contrast with the adult hospital, so there was a desire to know where/how youth are receiving care and what that means for this redesign.

3. Integrated Service Design Blueprint: A framework and blueprint that illustrates a person-centered continuum of care for people, spanning: awareness and prevention, detection and identification, treatment, crisis care, and recovery. The framework details the different service needs people have as they traverse the different stages of the continuum. The framework also points to key stakeholders, including community organizations as well as formal and informal provider groups, who can play a vital role to ensure that care is person centered and needs are being met before, during and after crisis to offset the growing demand on ASH.

Through these three bodies of work, the ISD identified several opportunities for potential development within the HHSC's current model of care within ASH. Furthermore, the work identifies opportunities to improve care and outcomes, and to use evidence-based models to support people with the right care at the right time in the right place and where cost reflects the appropriate level of care.

Facilities Planning Subcommittee
Executive Summary

The Facilities Planning Subcommittee was tasked with integrating other committees to select and guide the Architect and Engineering team (A/E) to create the ASH Brain Health System Master Plan for a new integrated approach to brain health for Texas into a physical design. The subcommittee provided guidance for the A/E team throughout pre-planning phase, which included programming and framing, identifying the optimal building design to respond to the vision identified by the Campus Master Plan Subcommittee, as well as each of the other subcommittees and workgroups.

Benchmarks the Facilities Planning Subcommittee set and accomplished included:

- Contract a consultant to create the Master plan.
    - Accomplished: July 2018
- Determine the specific process to be followed for the preliminary schematic design collaboratively with HHSC to ensure both UT and HHSC requirements are met.
    - Accomplished: June 2018
- Submit RFQ for A/E to develop the Schematic Design.
    - Accomplished: November 2018
- Provide a preliminary Architectural plan
    - Accomplished: December 2018
- Contract an A/E firm for to develop the Schematic Design.
    - Tentative: February 2019 – Planning Phase

The Facilities Planning Subcommittee engaged closely with the Finance Subcommittee on cost discovery for a modern hospital facility and additional campus enhancements to improve the continuum of care in the ASH service area. This subcommittee worked closely with the Policy, Integrated Service Design, and Campus Master Plan Subcommittees to achieve the highest level of accuracy and best practices in the creation of a Master Plan that proposes a foundation for redesigning the ASH Brain Health System.

In consideration of outcomes sought by the Facilities Planning Subcommittee, the continuum of care was a primary focus alongside the Master Plan. This subcommittee discussed potential community partners to include on the ASH campus for the continuum of care that extends beyond hospital discharge. These potential community partners would provide services that include but are not limited to:

- Peer Services
- Substance Use/Rehabilitation Services

- Mobile Crisis
- Specialty Care Services
- Housing Services
- Ambulatory Care
- Workforce Training
- Skilled Nursing
- Resource Center for School Safety
- Veteran Services

The initial goals set forth in the Gantt for the Facilities Planning Subcommittee have been met and the subcommittee will continue to meet throughout the Planning Phase.

Policy & Legislature Coordination Subcommittee Executive Summary

Overview:

The subcommittee will work to move identified policy changes into the legislative process in support of the master plan. Specifically, it will provide input on suggested policy changes to subcommittees and the steering committee, strategize and coordinate information sharing and updates to state and legislative leadership and interested policy focused organizations in 2018.

Executive Summary:

The Policy and State Legislature Subcommittee was created to ensure recommendations in the master plan reflect the interest of policy makers and challenge of legislating change across a system of care while working to ensure the greatest likelihood of the recommendations being acceptable to/adopted by the legislature.

Members of the subcommittee represented key stakeholder groups including persons with lived experience, advocates and providers, many of whom served on other subcommittees and work groups. This ensured quick feedback as ideas were considered in other meetings as well as a depth of knowledge as this group considered policy recommendations. Members were also active in statewide coalitions with similarly aligned goals for improving the continuum of care opening the potential for broadening support of the master plan and associated recommendations.

The subcommittee strategy was to encourage a pragmatic approach to developing recommendations in the master plan - highly prioritized and limited in number. Also, ensuring regular updates to key officials in anticipation of the 86th legislature was a high priority.

Recommendations include:

- brief key legislators and staff to brief during 2018
- host a briefing in January 2019
- align messaging with the San Antonio State Hospital Redesign for consistency in legislative discussions and funding requests
- keep unique policy change recommendations to a minimum while referencing recommendations from various stakeholder groups that align with the ASH Redesign master plan

Communications Strategy Subcommittee Executive Summary

The Austin State Hospital (ASH) Brain Health System Redesign reaches beyond building a new hospital into the development of a robust continuum of care to be viewed as an example for communities across Texas. The communications strategy subcommittee is tasked with developing a plan to guide implementation of communications to reach stakeholders, constituencies, and other relevant parties regarding the Austin State Hospital Brain Health System Redesign effort.

The subcommittee was formed of a multi-disciplinary group of individuals representing various organizations and communications expertise, referenced in Appendix 5. The group prepared a plan identifing seven communication objectives and two core audience segments: internal and external. The internal audience focuses on project leadership and their networks. The external audience segment prioritizes five groups for these early phases: public officials, law enforcement, professional organizations and associations, mental health justice system, and media. Three core communications strategies are idenitifed to reach the audiences and meet the objectives using modern methodologies. A digital toolbox will serve to align the internal audience. For the external audience, a set of outreach opportunities coupled with a final report are designed to inform the five key audiences across the large service area. Next steps are to build and launch the components in November and December 2018. The plan includes the current version (4.0) of approved initial messages and FAQ's which will continue to be updated.

Principles

ASH Brain Health System Redesign communications will:

1. Continue to emphasize the importance of putting people first – the right care at the right place at the right time.

2. Establish a voice, shared language, and messages that use plain and empowering language.

3. Align project leadership around a consistent message.

4. Engage stakeholders in a conversation that elevates mental health for everyone.

5. Reframe the opportunity from a facility redesign to a system redesign.

6. Share the vision and project status with stakeholders in a manner that is transparent and timely.

7. Make visible the whole continuum of mental health needs and services.

Proposed Strategies

Core Strategy: Align and equip project leadership (primarily designated spokespeople and steering committee, but also subcommittees, work groups, engagement groups) to be the primary mechanisms of consistent communication to their networks about information regarding the ASH Brain Health System Redesign Planning Phase. Dell Med will develop a set of core messages/talking points/FAQ about the project to be pre-approved by HHSC, which will then be provided to project leadership.

Strategy 1: Digital Toolbox: Create and deliver communication resources, assets, tools, content, for project leadership to communicate consistently.

Strategy 2: Outreach Opportunities: Identify and coordinate opportunities (conferences, briefings, media interviews, etc.) for project leadership and designated spokespeople to inform and educate key audiences about ASH Brain Health System Redesign.

Strategy 3: Online Final Report: Present the final report delivered to HHSC an accessible PDF.

Finance Subcommittee Executive Summary

The Finance Subcommittee was tasked with providing financial background on the current state of the Austin State Hospital (ASH) service area, potential financial support of the campus and service area, and review potential funding methods.

The team worked closely with Meadows Mental Health Policy Institute to gather data on current spend through the Local Mental Health Authorities (LMHA). Through a survey, the team gathered pertinent information on the amount of contracted funding LMHAs receive and what services the funding supports. The survey also pulled details of other funding that LMHAs have received to support their mental health services. These details provided insight on the current spend to the Steering Committee demonstrating where funding is currently being allocated towards.

The team also worked closely with the Integrated Service Design Subcommittee to establish potential funding sources to support the recommended continuum of care and Blueprint. Philanthropic organizations were categorized as potential sources for unmet needs of the ASH campus and service area. Within the next phase, the team will continue to build upon this list to support the needs of the campus.

Financial models examined included CCBHC and elements of 1115 Waiver. Understanding these two models as they currently are and the potential changes each will encounter in the future was important to share with the team as we enter into the next phase of the project. The team will continue to evaluate funding opportunities and how they can support the ASH Brain Health System Redesign.

Academic Integration Subcommittee
Executive Summary

The Austin State Hospital (ASH) Brain Health Redesign reaches beyond building a new hospital into the development of a robust continuum of care to be viewed as an example for communities across Texas. Based on **Riders 147 and 86** the Academic Integration Subcommittee, as referenced in Appendix 5, proposes the inclusion of academia into the continuum by developing principles and strategies for the integration of research and education into the new brain-health's programs, focusing on University of Texas at Austin collaborators, and other academic institutions in the ASH service area.

Principles

Academic partnerships will:

1. Strongly articulate what public/academic partnerships have to offer patients
2. Foster academia as partner, not authority
3. Engage community providers, not just ASH
4. Foster fidelity to evidence-based models of care
5. Foster integrated care: physical/mental and interdisciplinary
6. Foster patient-focused translational research
7. Foster public sector workforce development
8. Strive for sustainability
9. Measure their success

Proposed Strategies

Strategy 1: Finance and develop a Public Mental Health Leadership Institute to coordinate multiple regional education and workforce development programs in public mental health to educate and grow the state's mental health workforce and improve behavioral health service delivery.

Strategy 2: Include in the institute's mandate leveraging of new and established telemedicine networks and asynchronous learning hubs to allow more efficient provider education, consultation and care.

Strategy 3: Include in the institute's mandate performing community and academic focus groups and surveys to determine best, and promising, practices in mental health training at Austin State Hospital and regional community center, and the dissemination of those best practices.

Strategy 4: Include in the institute's mandate the development of mental healthcare training standards for regional colleges, universities and medical schools - including specific training in the mental healthcare of specialty populations such as children, adolescents, people with substance use disorders, dual IDD/MH, traumatic brain injury and the elderly, and people in need of competency restoration.

Strategy 5: Develop legislative initiatives that finance expanded community/academic partnerships through joint hiring of medical and other clinical leadership in state hospitals, community centers, and integrated FQHC's.

Strategy 6: Engage community colleges and universities in the development of new associate and undergraduate degree programs that represent innovative ways to increase workforce.

Strategy 7: Develop HHSC polices that provide direct-service clinicians the necessary resources to mentor and supervise mental health learner experiences in state hospitals and community mental health centers to assure the success of community/academic training programs.

Strategy 8: Develop and revise HHSC policies so that they foster improved access of state hospital and community center patients to translational research offerings intended to improve the outcomes that matter to patients.

Local Mental Health Authority Workgroup Executive Summary

The Local Mental Health Authority (LMHA) Work Group was tasked with providing transparent and timely communication on the Austin State Hospital (ASH) Brain Health System Redesign amongst the LMHAs within the ASH Service Area. Along with timely communication as information was shared throughout the preplanning phase, the LMHA team coordinated meetings to present updates on the project and allow for members of the Texas Council and ASH Regional LMHA leadership to provide feedback. The feedback was provided to the Steering Committee to review and address changes needed to the continuum of care.

The LMHAs admitting persons to ASH value the state hospital as the unique partner providing the most intensive level of inpatient care meeting the acute needs of persons experiencing a psychiatric crisis. The LMHAs recognize the partnership requires active participation from the LMHA in order to successfully transition a person to less intensive levels of care as the person progresses through their recovery plan. Through state and local investments, the continuum of local care has been enhanced allowing persons to transition from the intensive care received through ASH to their chosen home community where they may realize their goals by participating in ongoing supports including continued care, housing and employment.

Meadows Mental Health Policy Institute (MMHPI) drafted a survey to capture information from the LMHAs on the services provided within the communities of the ASH Service Area. The survey captured best practices encounters, numbers of persons served, and outcomes of services showcasing the current support within the continuum of care. The LMHA team worked collaboratively with MMHPI to finalize the survey. The survey was then shared with the 11 LMHAs of the ASH service area, responses were captured, and results were shared with the team. MMHPI presented the compiled data to the LMHA Work Group to validate the results highlighting the strengths of the current continuum of care and emphasizing gaps in care. The decisions informed through the data will benefit persons through a strengthened continuum of care available at the right time and place.

Survey results are represented within Appendix 12.

Community General Hospital Workgroup Executive Summary

The subcommittee on hospitals is co-chaired by Texas Hospital Association (THA) and Texas Organization of Rural and Community Hospital (TORCH) representatives. Hospitals are an integral piece of the mental health continuum of care. Acute care hospitals are often the first place patients present when they experience a mental health emergency and connect patients to appropriate mental health services. Additionally, the associations represent inpatient psychiatric hospitals, who are part of the Austin State Hospital (ASH) service territory and contract with the state to provide state hospital beds in the community.

The purpose of the workgroup is to ensure the hospital perspective is represented on the steering committee and to have a network of hospital representatives who can provide feedback to the steering committee during the redesign process.

The workgroup has engaged representatives from different hospitals in the catchment area and has solicited initial feedback from the hospitals through a survey. The goal of the initial outreach was to gain perspective on the hospital experience working with ASH, whether or not the hospital was able to provide inpatient psychiatric beds, what barriers exist to expanding that capacity, how often hospitals board patients while waiting for bed placement, and the number of mental health professionals currently working in the facility.

Community General Hospital Workgroup Survey Summary

The Community General Hospital Work Group for the Austin State Hospital (ASH) Redesign conducted a survey of local hospitals within that ASH service area. The work group sent the survey to approximately 100 hospitals and received 53 responds. The focus of the survey included questions on mental health services, work force availability and support, length of stay for people receiving mental health services, and satisfaction of ASH interaction.

OVERVIEW

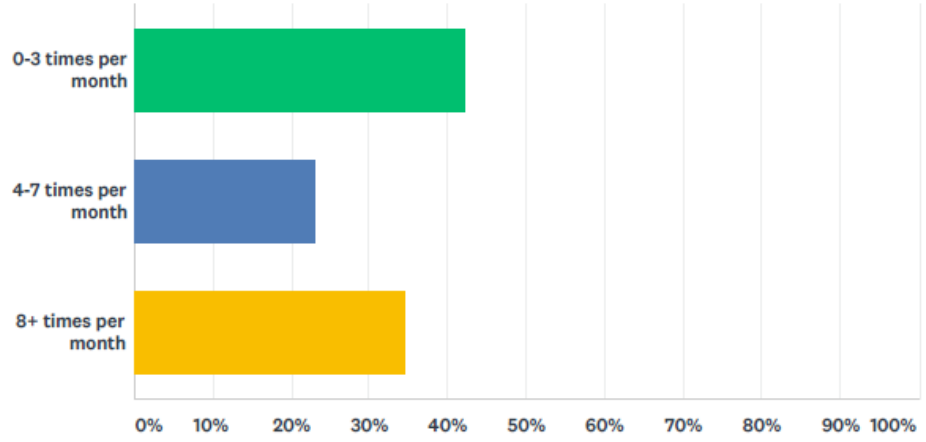
The Community General Hospital Work Group, led by Co-Chairs Sara Gonzalez, VP & Public Policy of Texas Hospital Association and Scott Briner, CEO of Sweeny Community Hospital, was tasked with serving as liaisons within the ASH service area to incorporate information from general hospitals on the need of brain health care and gather information to support the need of a continuum of care. In the pre-planning phase of the ASH Redesign, the team focused efforts on a survey to populate this information and also begin the discussion of potential hospital partners to help build the continuum of care.

FINDINGS

Of the 53 hospitals to respond to the survey, majority of hospitals do not have psychiatric beds to provide care for individuals requiring subacute mental health treatment. There are only 117 beds dedicated to psychiatric care within the general hospitals of the ASH service area for nearly 4 million people. Of these 117 beds reported, 97% of them are operational. Survey results indicate the barrier to hospitals operating at full capacity is due to lack of staffing to support all of their beds.

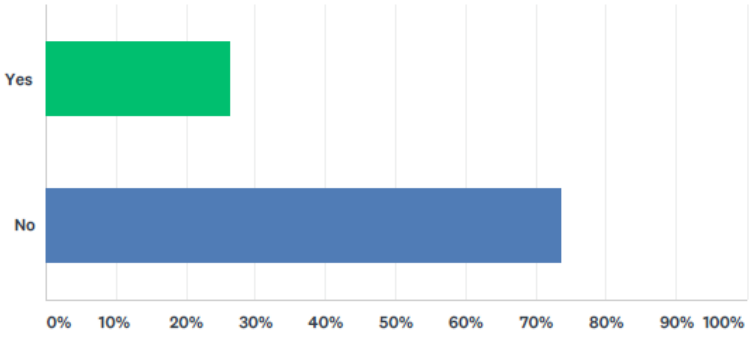
Additional barriers include for psychiatric care included staff shortages for operating supplementary beds, operating costs for patients with moderate to low acuity, lack of funding as well as staffing. These indicators make it increasingly difficult for emergency departments to operate efficiently as many facilities board patients in their emergency departments due to a lack of psychiatric facilities in the ASH service area to accommodate those needing care longer than 7 - 10 days.

Fig 1. Community Hospitals that care for patients on ER due to lack of psychiatric resources



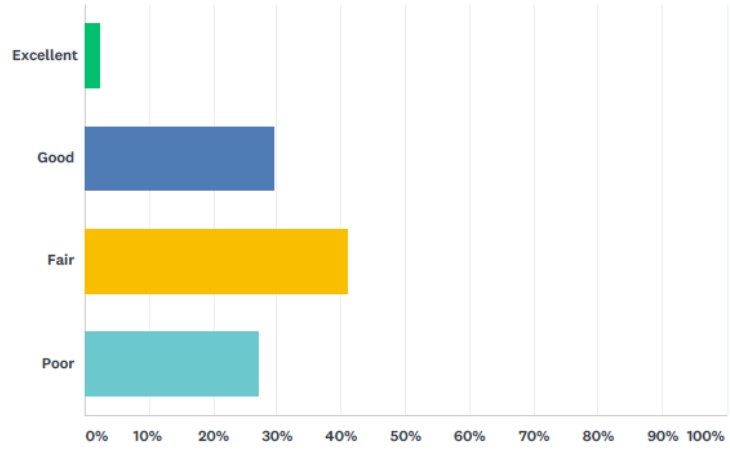
At 74%, the majority of the respondents report not having a psychiatric consultant in their facility creating a gap of integration of brain health and primary care services worth exploring.

Fig 2. 74% of facilities in the ASH service area do not have psychiatric staff on non-psychiatric units.



Respondents indicated admission into ASH is difficult primarily due to the lengthy wait times and therefore have to either keep the person in their emergency department or find another psychiatric bed that may not be easily accessible. This type of issue spills over several operation such as the sheriff departments, emergency departments and caregivers. Additional indicators include lack of funding to cover costs of indigent adults who need care and require treatment at a state hospital facility.

Fig 2. 74% of facilities in the ASH service area do not have psychiatric staff on non-psychiatric units.



RECOMMENDATIONS

Respondent suggestions include of additional accommodations for both inpatient and outpatient services. General recommendations include:

- Staff recruitment to better integrate primary care and psychiatric care
- Capital funding to accommodate lack of costs for the indigent
- Education on academic requirements or staff to allow cross training
- Community based resources to reduce subacute care in emergency departments
- Access to a bed registry to alleviate the often times lengthy search for a psychiatric bed

Many counties are without any community-based services to serve those experiencing a brain health crisis due to their remote locations. Collaboration across counties and LMHA service regions will help fulfil the need to accommodate people who live in the community to assist them in continuing to have the best quality of life possible.

Health District and FQHC/CHC Workgroup Executive Summary

The Health District (HD) and Federally Qualified Health Center (FQHC)/Community Health Center (CHC) workgroup created a forum for input from key health providers and county executives charged with the provision of community-based health care services for uninsured and underinsured in the Austin State Hospital (ASH) service area. The workgroup included a multi-disciplinary group of leaders that spoke to both the provisioning and design of those services from a government, business, technology, medical, and experience basis. The key roles or deliverables of this workgroup were and will continue to be:

1. To share innovative ideas for delivering care in the service area, and

2. To review and provide feedback on the care continuum redesign for persons served by ASH.

The workgroup provided input or feedback to the other steering committees as needed.

As the continuum of care is redesigned for the persons served by the state hospital system and the ASH, it will be critical to ensure that there are sufficient and appropriate community-based services in the service area. Moving forward, the work group will assist with identifying key health issues, including social determinants of health, that impact the delivery of care to specific populations served by ASH for prioritization and consideration in the planning process. The initial strategy of the workgroup will be to identify and engage a broad group of advisors working in the HD, county health and FQHC/CHC's in order to have an advisory role in the development of the long term planning for a full continuum of services offered on campuses as well as community based care. At this time, there are no recommendations from this workgroup as it is in the formation and planning stage.

Peer & Family Workgroup
Executive Summary | November 2018

• Introduction

The Peer and Family Work Group, in alignment with the first Core Principle of the planning process in which "persons receiving care come first", consists of individuals with lived experience and family members who have a track record of navigating public and private systems and who have a broad network of engagement with members and representatives of family and peer support organizations throughout the catchment area.

• Purpose

The Peer and Family Work Group is tasked with providing feedback and input into all elements of the ASH Brain Health System Redesign to ensure that persons receiving care and those who support them in their recovery help guide the development of this plan in collaboration with other stakeholders.

• Opportunity

As the state of Texas begins a long-term investment to transform the current system of mental health care—which is disproportionately reliant on the criminal justice system, crisis care and a medical model approach—peers and family members recognize the unique opportunity to help guide the transformation. We are committed to changing the language, shifting perceptions and moving toward a person-centered recovery model.

• Strategy

In its commitment to ensuring a cascading of peer and family voices into the larger system redesign, nine of the work group members have been integrated into other subcommittees and work groups. In addition, the work group has been engaged in providing feedback on the plan, the blueprint and communication strategy.

• Recommendations

The Peer and Family Work Group recommends the following:

- **The use of person-first, respectful language should be integrated into all aspects of the redesign.** Word choice has a powerful impact on how people view mental health and people living with mental health conditions and the people who love and care for them. While the first phase of this redesign is focused on building a hospital, we request a movement toward consistently referring to persons, rather than patients.

- **The principle, philosophy, and concept of *recovery* should be integrated into all ASH Brain Health System Redesign documents, statements, and work products.** The adoption of recovery by many behavioral health systems in recent years has signaled a dramatic shift in the expectation for positive outcomes for individuals who experience mental and/or substance use conditions. Today, when individuals with mental and/or substance use disorders seek help, they are commonly met with the knowledge and belief that anyone can recover and/or manage their conditions successfully. It is critical that ASH Brain Health System Redesign incorporate this in all public-facing and internal materials and procedures.

- **The importance of engaging *families and other natural supports* should be considered a fundamental principle of the ASH Brain Health System Redesign.** The process of recovery is supported through relationships and social networks. This often involves family members and other natural supports, who become the champions of their loved one's recovery. They provide essential support to their loved one's journey of recovery and similarly experience the moments of positive healing as well as the difficult challenges.

- **The concept of *person-centered care* should be fully integrated into all ASH Brain Health System Redesign documents, statements, and work products.** Person-centered care means that persons receiving care have an influence over their services, including the amount, duration, and scope of services, as well as choice of providers. Person-centered care also is respectful and responsive to the cultural, linguistic, and other social and environmental needs of the individual.

- **The ASH Brain Health System Redesign should embrace *trauma-informed care and practice* as a core tenet.** This means that the system 1.) *Realizes* the widespread impact of trauma and understands potential paths for recovery; 2.) *Recognizes* the signs and symptoms of trauma in persons receiving care, families, staff, and others involved with the system; 3.) *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and, 4.) Seeks to actively resist *re-traumatization*.

- **The ASH Brain Health System Redesign should acknowledge that the use of involuntary mechanical or human restraints or involuntary seclusion is only justified as an emergency safety measure in response to imminent danger to one's self or others.** These extreme measures can be justified only so long as, and to the extent that, the individual cannot commit to the safety of themselves and others. Additionally, the principles and design should reflect that restraint and seclusion have no therapeutic value. They should never be used to "educate persons receiving care about socially acceptable behavior;" for purposes of punishment, discipline, retaliation, coercion, and convenience; or to prevent the disruption of the therapeutic milieu.

Law Enforcement Workgroup
Executive Summary

The Law Enforcement Work Group was tasked with providing education to the Austin State Hospital (ASH) Redesign project on the current involvement of law enforcement within the mental health system to assist in discovering and subsequently providing insight to areas that need improvement. An additional goal of the group was to provide educational options in locating available resources for County Sheriff's. Through this education, the goal is to address other available options when there is no psychiatric bed immediately available in the local area. With education and support through ASH Brain Health Redesign, the team will strengthen the use of the continuum of care.

The Law Enforcement Work Group for the ASH Redesign conducted a survey of the 75 counties in the ASH service area with a focus on the effects of mental health services in law enforcement. The survey requested specific information around transportation, length of stays in jails, funding and wait times for psychiatric beds.

The Law Enforcement Work Group engaged closely with the ASH Redesign *Peer and Family Planning Workgroup* to gain knowledge on person-centered expectations from the perspective of a patient and/or caregiver.

Findings

The majority of the service area is rural at 80% with only 12 urban counties. Urban is defined as at least 250 people per square mile. Of the 75 Sheriff offices requested to complete the survey, 30 responded. Of those 30, the consensus was three primary concerns:

- need for continuity of care across the service area and with a focus on regional and local service areas
- the effect of substance use on brain health and resources to either provide intervention services via outlets such as a Mobile Crisis Outreach Team (MCOT) or Crisis Respite
- additional community resources to provide Substance Use Disorder (SUD) treatment
- extensive travel across counties and regions to obtain access to psychiatric bed

The commonality of the findings is considered significantly reliable because 69% of the participants have 25 years or more of professional law enforcement experience.

Recommendations

Participant suggestion of additional community services are based on a lack of psychiatric bed availability locally and regionally. General recommendations include:

- Training for deputies that include Mental Health 1st Aid and CIT
- Community based resources
- Access to a bed registry to alleviate the often times lengthy search and travel for a psychiatric bed

Many counties are without any community based services to serve those experiencing a brain health crisis due to their remote locations. Collaboration across counties and LMHA service regions will help fulfil the need to accommodate people who live in the community to assist them in continuing to have the best quality of life possible.

Reference

Retrieved from https://afsp.donordrive.com/index.cfm?fuseaction=cms.page&id=1226&eventID=5545 on September 25, 2018.

Law Enforcement Workgroup Survey Summary

The Law Enforcement Work Group for the Austin State Hospital (ASH) Redesign conducted a survey of the 75 counties in the ASH service area with a focus on the effects of mental health services in law enforcement. The survey requested specific information around transportation, length of stays in jails, funding and wait times for psychiatric beds.

Overview

The Law Enforcement Work Group, led by Limestone County Sheriff Dennis Wilson, was tasked with providing education to the ASH Redesign project on the current involvement of law enforcement within the mental health system to assist in discovering and subsequently providing insight to areas that need improvement. An additional goal of the group was to provide educational options in locating available resources for County Sheriff's. Through this education, the goal is to address other available options when there is no psychiatric bed immediately available in the local area. With education and support through ASH Brain Health Redesign, the team will strengthen the use of the continuum of care.

The Law Enforcement Work Group engaged closely with the ASH Redesign Peer and Family Planning to gain knowledge on person-centered expectations from the perspective of a patient and/or caregiver.

Findings

The majority of the service area is rural at 80% with only 12 urban counties. Urban is defined as at least 250 people per square mile. Of the 75 Sheriff offices requested to complete the survey, 30 responded. Of those 30, the consensus was three primary concerns:

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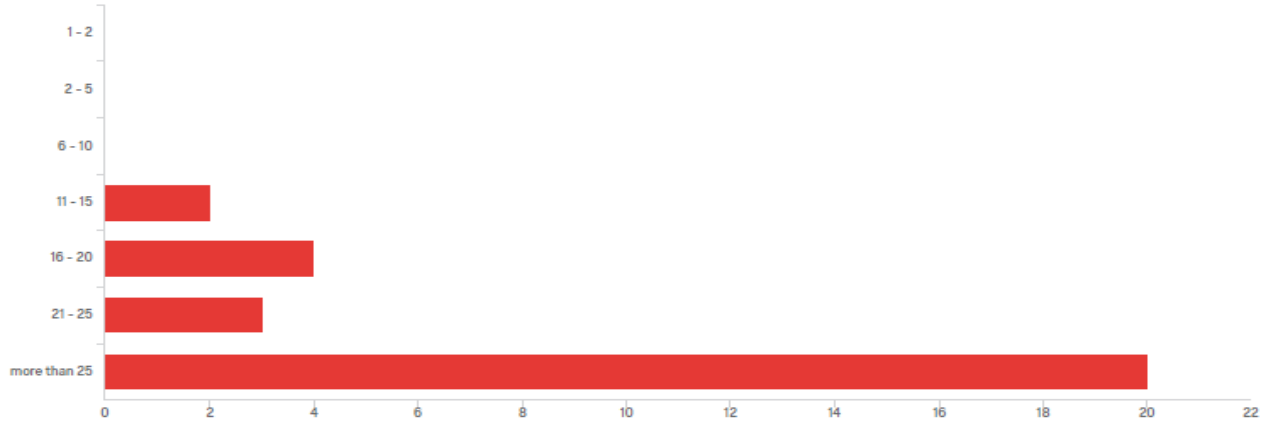
- other community resources to include Substance Use Disorder (SUD) treatment

The commonality of the findings is considered significantly reliable because 69% of the participants have 25 years or more of professional law enforcement experience.

Fig 1. Distinction between veteran sheriffs with 25 or more year and other participants with less.



Nearly half, 37% of the people arrested that have a brain health diagnosis spend over a month in jail with no services. The areas where this is most prevalent are the rural counties of the service area. Exactly 50% of the participants reported people are in their jail facilities 72 hours or less.

The length of time in jail as it relates to Crisis Intervention Training (CIT) may be directly correlated to one another as deputies that have not received the minimally required CIT training all participants is 37% as well. However, this survey did not delve further into this observation.

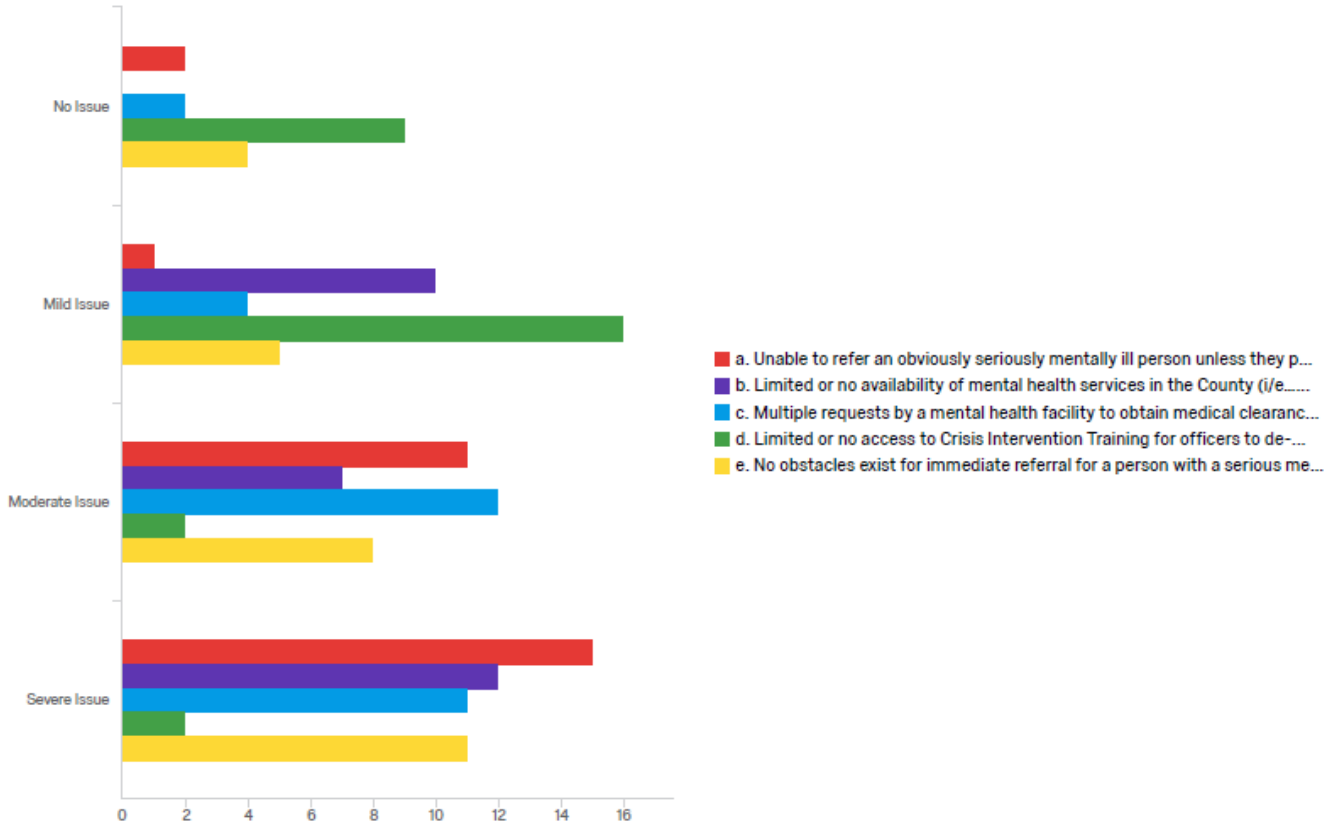
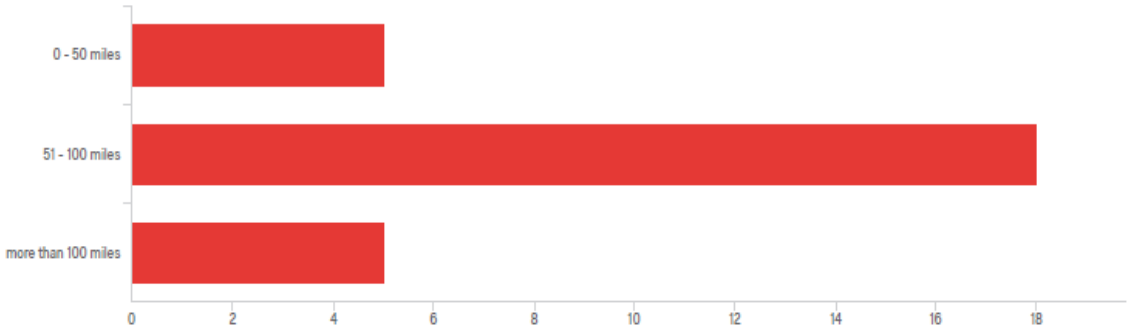


Fig 2. Q. What obstacles affect the ability of law enforcement to make referrals for persons with mental illness? Select one for each category.

Transportation was considered a primary issue for the rural counties as 62% of the counties report traveling 51 – 100 miles to transport a patient to a brain health facility.



According to the American Foundation for Suicide Prevention, suicide claims more lives that war, murder and natural disasters combined. Suicide has increased in the last five years according to 66% of participants.

Recommendations

Participant suggestion of additional community services are based on a lack of psychiatric bed availability locally and regionally. General recommendations include:

- Training for deputies that include Mental Health 1st Aid and CIT
- Community based resources
- Access to a bed registry to alleviate the often times lengthy search for a psychiatric bed

Many counties are without any community-based services to serve those experiencing a brain health crisis due to their remote locations. Collaboration across counties and LMHA service regions will help fulfil the need to accommodate people who live in the community to assist them in continuing to have the best quality of life possible.

Subspecialty Workgroup
Executive Summary

The Austin State Hospital (ASH) Brain Health Redesign reaches beyond building a new hospital into the development of a robust continuum of care to be viewed as an example for communities across Texas. The ASH Redesign Subspecialty Work Group proposes to advise the redesign process with the intention of assuring the needs of children and adolescents, people with dual intellectual/developmental and mental health challenges, and people who need treatment for substance use disorders are addressed in the transformation design.

The work group was formed of a multi-disciplinary group of individuals representing various organizations, referenced at the beginning of this appendix, recommend principles and strategies for a design of services based on best-practices from the clinical perspective, the perspective of patients and their families and person-centered planning for services in the specialty population groups.

Principles

Programs that care for children, for the aging, and those with dual substance use and/or dual neurodevelopmental or post-brain-injury disorders in acute, residential and community settings will:

1. Assure local access to subspecialty services
2. Foster early detection and treatment in mental health and non-mental health service settings
3. Reflect cultural humility, that is, broadly encompassing race, ethnicity, culture, and language, as well as social, gender, sexual, and disability identities.
4. Emphasize the use of comprehensive, integrated, evidence-based and emerging best practices: motivational interviewing, psychotherapy, case management, peer services, trauma-informed care, and person-centered treatment planning
5. Be mindful of the need for supported education, employment and housing as keys to clinical outcomes
6. Foster caregiver and family support as key to clinical outcomes
7. Provide local, developmentally-appropriate services to emerging adults, including youth with IDD and/or substance use challenges
8. Emphasize opportunities for trainees to develop skills in caring for subspecialty populations
9. Measure their success in caring for these populations

Proposed Strategies

Strategy 1: Promote a standard of care that embraces universal screening in primary care to detect anxiety, depression, trauma history, and substance use disorders. Create a paradigm of care that ahead of behavior considers mental health and wellness management and control.

Strategy 2: Develop regional standards of care for access to all levels of mental healthcare – acute, stepdown, etc. – that assure inclusiveness irrespective of age and regardless of the presences of dual substance use and/or dual neurodevelopmental or post-brain-injury disorders; and, that also address geographical access and wait-times.

Strategy 3: Promote financing of prompt access to care in county jails and juvenile detention centers, including access to aggressive and early substance use treatment (including medication assisted treatment), developmentally-appropriate care, trauma-informed care, and peer support services.

Strategy 4: Develop training standards for regional colleges, universities and medical schools that include specific training in the mental healthcare of specialty populations.

Strategy 5: Seek public/philanthropic funding of an institute, rooted in community organizations and representative of regional academia, families, peer organizations and providers, intended to coordinate regional education and workforce development programs focused on the mental health needs of children, adolescents, the aging, those with substance use disorders, and/or neurodevelopmental or post-brain-injury disorders.

Strategy 6: Include in the institute's mandate a collaboration with HHSC in the implementation of evidence-based practices by regional practitioners, and in implementation of a coherent approach to measuring quality and outcome in specialty populations.

Strategy 7: Include in the institute's mandate efforts to educate communities and their policymakers about contemporary understanding of substance use disorders and their effect upon the brain.

Strategy 8: Include in the institute's mandate efforts to create a regional paradigm of care that considers mental health and wellness for people with neurodevelopmental disorders or traumatic brain injury, instead of fociusing on behavior management and control.

Strategy 9: Work with HHSC to systematically eliminate the historic regulatory and financial models that silo substance use disorder services and inhibit access to contemporary and integrated care.

Strategy 10: Finance, in Medicaid and indigent care programs, non-traditional services that increase access to care for specialty populations, for example transportation and childcare, and contemporary telehealth models inclusive of peer support and local provider support.

Information Technology Workgroup
Executive Summary

The Information Technology (IT) Work Group was tasked with reviewing the current IT infrastructure within the ASH service area and provide suggestions and best practices for improvements of information sharing and technologically relevant inclusions. The group examined and researched established telehealth systems and processes to help define the most suitable needs to redesign the ASH brain health system.

The Information Technology Work Group for the ASH Redesign conducted a survey of the Local Mental Health Authority (LMHA) with a focus on Telemedicine. Questions targeted the platform on which Telemedicine program is hosted, community partners and services for which it is utilized.

Additionally, the IT workgroup engaged with other ASH Redesign subcommittees and work groups such as the *Facilities Planning Subcommittee* on IT infrastructure for current facility infrastructure to begin to gage the potential inclusions and exclusions for the new system, the *Finance Subcommittee* to review sustainability possibilities, *LMHA Workgroup* to determine current community practices.

Findings

Of the 12 LMHAs in the ASH service area requested to complete the survey, four responded. Of the four, each utilized a different platform to host its telehealth system. However, there were many overlaps in the types of services each LMHA provides. Also notable from the survey is that telehealth is utilized by local jails and sheriffs to connect with peer groups, schools, medical professional and LMHAs. Of the four respondents, one half acknowledged using telehealth in local ERs. Finally, one respondent indicated having used a hardware solution initially and switching to a cloud-based system due to the increased amount of support provided.

Recommendations

Based on the findings from the survey and communications with the various workgroups and subcommittees, recommendations include the incorporation of a cloud-based IT system that will accommodate telehealth, a state-wide Bed Registry and state-wide common electronic health record. The system should be flexible enough to cross legal, law enforcement, medical, psychiatric, LMHAs and other relevant agencies.

Information Technology Workgroup
Survey Results Report

The Information Technology Work Group for the ASH Redesign conducted a survey of the Local Mental Health Authority (LMHA) with a focus on Telemedicine. Questions targeted the platform on which Telemedicine program is hosted, community partners and services for which it is utilized.

Overview

The IT Work Group led by Stephen Steffensen, M.D. was tasked with reviewing the current IT infrastructure within the ASH service area and to provide suggestions and best practices for improvements of information sharing and connecting technologically. The group examined and researched established telehealth systems and processes to help define the most suitable needs to redesign the ASH brain health system.

The IT Work Group engaged with other ASH Redesign subcommittees and work groups as needed – such as with the Facilities Planning for IT infrastructure for current facility infrastructure to begin to gage the potential inclusions for the new system, Finance in terms of sustainability, LMHA to determine current telehealth practices, and others as determined.

Findings

Of the 12 LMHAs requested to complete the survey, four responded. Of the four, each utilized a different platform to host its telehealth system. However, there were many overlaps in the types of services.

Figure 1 show 100% of the respondents use telehealth for Initial Assessment and Office/Outpatient Visit and 25%, one respondent uses it for Individual Psychotherapy. One respondent stated their telehealth system provides 46% of their physical services.

Q2 - What service(s) does your organization provide with the Telemedicine system? Select all that apply.

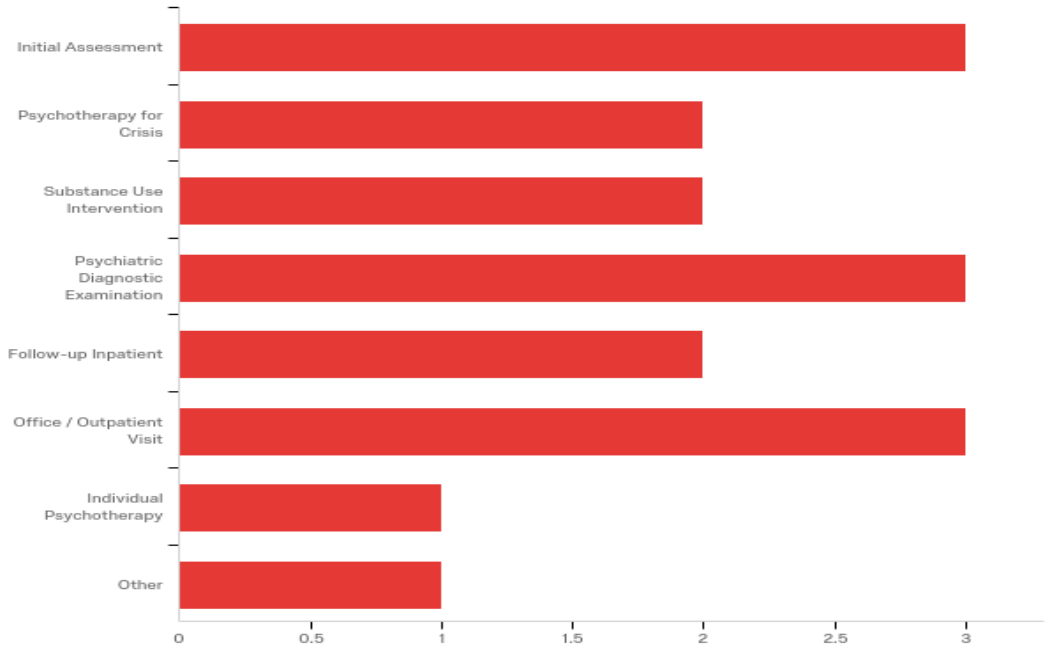


Fig.1

Figure 2 shows usage in local jails, peer groups and schools by each of the respondents.

Q3. Please select all external community partners your organization provided telemedicine services to.

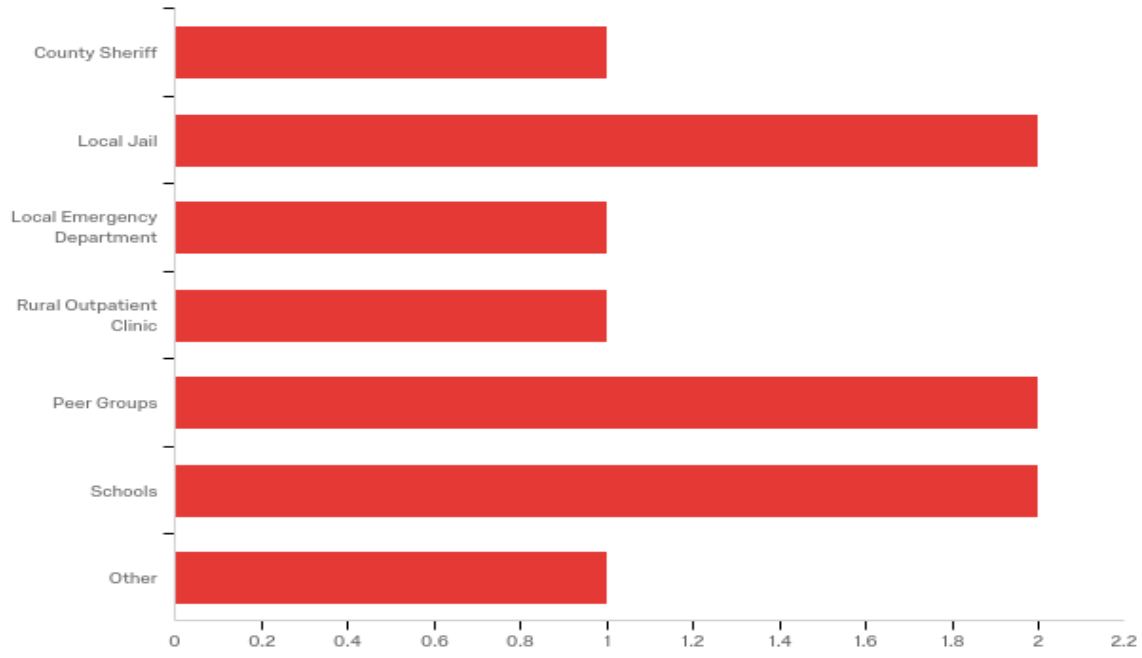


Fig.2

There appears to be a distinctive difference in how telehealth is utilized local jails and sheriffs. Of the four respondents, 50% acknowledged using telehealth in local ERs.

One respondent indicated having used a hardware solution initially and switching to a cloud-based system due to the increased amount of support provided.

Recommendations

Develop or purchase cloud-based IT system that will accommodate Telehealth, a state-wide Bed Registry and state-wide common Electronic Health Record. The system should be flexible enough to cross legal, law enforcement, medical, psychiatric and LMHAs.

Legal Engagement Group
Executive Summary

The Legal Engagement Workgroup was tasked with providing education to the Austin State Hospital (ASH) Redesign project on the current involvement of the judicial members within the mental health service system and judicial influences on matters of mental health. The workgroup suggested areas of administrative improvement to the ASH Redesign Steering Committee for people with mental health challenges who have interactions within judicial, legal and criminal justice departments.

The Legal Engagement Workgroup was comprised of:

STATUS	NAME	TITLE	ORGANIZATION
Member	John Hathaway	Associate Court Judge	Travis County Juvenile Court
Member	Guy Herman	Judge	Probate Travis County
Member	Nancy Hohengarten	Judge	Travis County Court #5
Member	Polly Jackson-Spencer	Retired Judge	Probate Court Bexar County
Member	Dan Prashner	Associate Judge	Probate Travis County
Member	Mike Shirley	ADA Diversion Courts	Montgomery County
Member	David Slayton	Administrative Director	Office of Court Administration
Member	Steve Strakowski, MD	Associate VP Regional Mental Health	Dell Medical School

Intentional considerations of this workgroup included

- ASH waitlist
- Inpatient competency restoration
- Outpatient competency restoration
- Utilization of private psychiatric hospitals and/or private partners
- Clinical authority and legal authority coordination

The workgroup communicated with other ASH Redesign subcommittees and workgroups such as the Academic Integration Subcommittee for insight into best practices for competency restoration and the Policy Subcommittee regarding legislative policy around mandated procedures and standard operating procedures for writs and the Code of Criminal Procedure in

an effort to review system processing wait times as it relates to a person with mental challenges.

The goal of these collaborations was to provide insight to judicial process as it pertains to solution-focused outcomes for the system redesign.

This workgroup will continue to work collaboratively with the ASH Redesign team as the project progresses.

ASH Historic Preservation Engagement Group Executive Summary

The Historic Preservation Engagement Group was tasked with engaging both community stakeholders and issue specific stakeholders regarding both the facilities on the ASH campus as well as historic records that may exist on site and elsewhere. Concurrently, the Group provided ongoing guidance to the ASH Brain Health Center Committee and the Master Plan Subcommittee.

The Group explored the surface of a very rich and complex history of the ASH campus and its role in brain health delivery since 1857. With the assistance of the Texas Historical Commission (THC) and Preservation Texas, the Group identified those buildings that might be considered historic when applying the Secretary of the Interior's standards for historic preservation. Currently only Building 501 is a landmark and is listed on the National Register of Historic Places. The Group considered THC's 2016 Feasibility Study that identified the opportunity to create the Austin State Hospital National Register Historic District (NRD). With the evolution of the campus master plan that would eliminate a number of very significant and eligible industrial buildings (524, 538, and 551), modifications to THC's recommended NRD boundaries were considered.

Within the framework of this discussion was the recognition of the need to repurpose the historic or eligible buildings through adaptive reuse to support ASH's mission well into the future. Depending upon the intended use, repurposing can be a cost-effective alternative to new construction for institutional buildings like this that were meant to be durable. With the creation of an NRD, funding through both State and Federal historic tax credits might be available to offset a significant portion of the restoration costs for these historic or eligible buildings.

Recommendations

- Establish an NRHD with the assistance of THC.
- Conduct an assessment of each eligible building within the NRHD.
- Identify archeological features on campus including the use of ground penetrating radar.
- Partner with the UT School of Architecture to create design charrettes for each prospective building within the proposed NRHD demonstrating adaptive reuse.
- Identify and engage partners in either service delivery or in the continuum of care that are so critical to the success of the effort to redesign brain healthcare delivery who might be ideal tenants and are right sized for historic or eligible buildings.
- Identify support and auxiliary services that should be collocated on campus to support the Brain Health Center that might be ideal tenants and are right sized for historic or eligible buildings.
- Work to foster community support for a Facilities Master Plan that repurposes historic/eligible buildings as a best-case model for adaptive reuse through public/private partnerships.
- Create the opportunity to engage and educate the broader public regarding the history of mental health and its future via a museum and education center on campus.
    - Identify and secure artifacts and objects that will provide an understanding of the material culture of ASH and that would be essential for future interpretation of the site.
    - Secure those patient records and other physical plant records that are or may be of historic value:
        - Identify methods for their proper storage and care on site; and
        - Provide access for future research to further knowledge about brain health as well as the history of the ASH campus and of those who both received treatment and worked there.