ASH Redesign Phase III
Housing Work Group Process, Aims and Recommendations

The ASH Redesign Housing Workgroup gathered stakeholders during an 11-month period to generate solutions for the unmet therapeutic and other housing needs within the ASH service area. The group (Appendix A) was data-driven in developing specific recommendations toward goals set forth by Phase II of the ASH project. The group was tasked with three primary goals, which are noted below.

The ASH Redesign Housing Workgroup Goals

- To determine different types and amounts of housing needed to move people from ASH to more appropriate care and residential settings, within the ASH service area
- To develop a viable funding list for this housing for the service area
- To identify funding opportunities for a plan to build housing on and off the ASH campus

To provide informed recommendations, the group requested and reviewed point-in-time ASH service area data for two primary ASH populations – 1) Individuals whose stay at ASH exceeded 365 days (referenced below as the 365 list), and 2) Individuals who were frequently readmitted to ASH over a specific period of time (images 1 and 2 below).

Image 1: All Catchment LMHA 365 General Characteristics

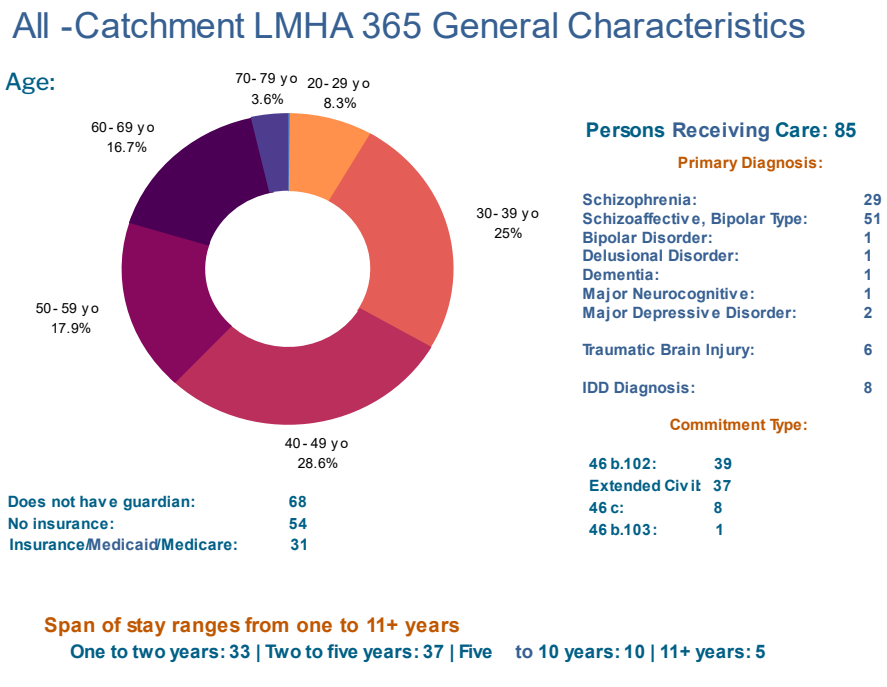
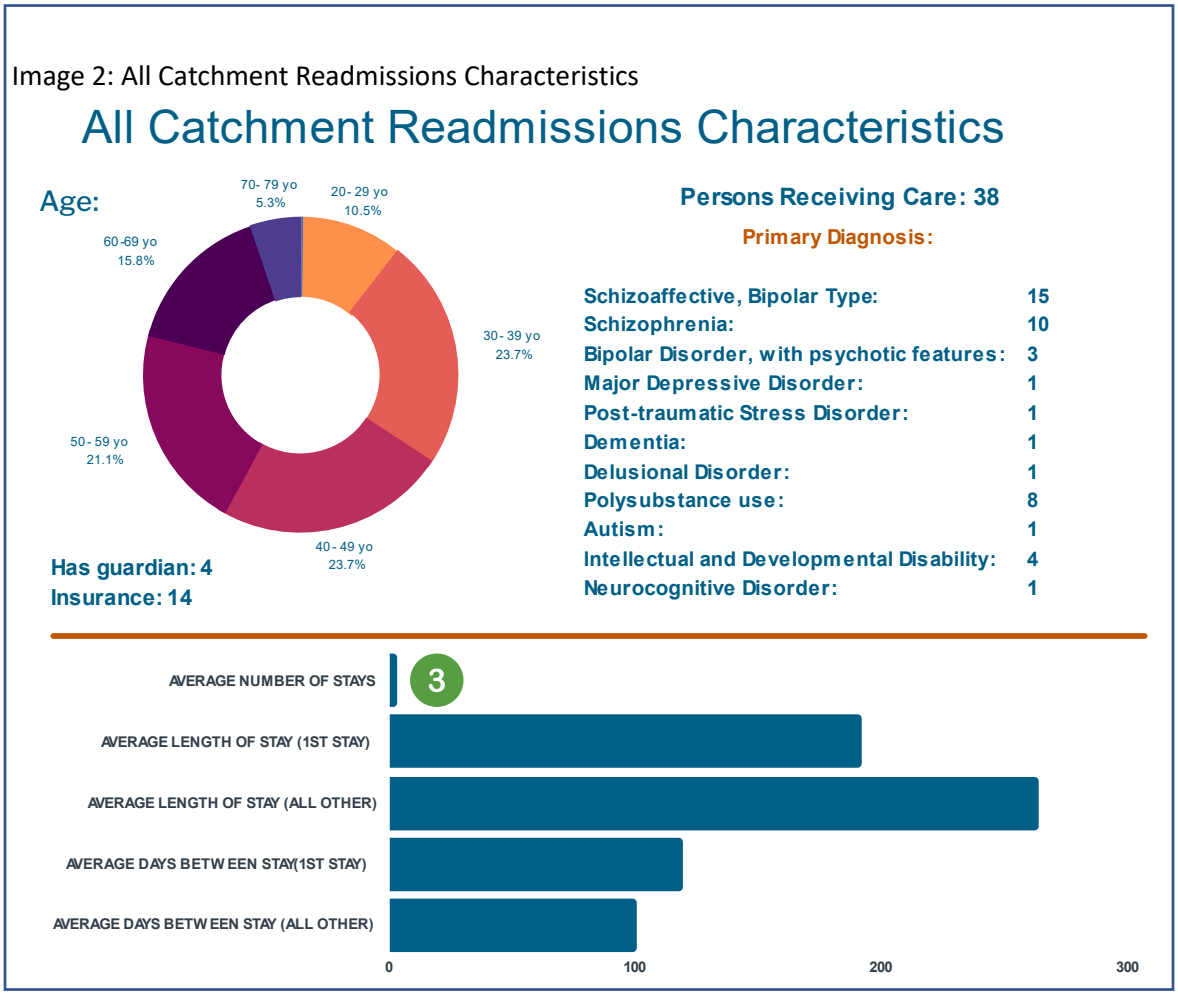


Image 2: All Catchment Readmissions Characteristics



The data were differentiated by Local Mental Health Authority (LMHA) service areas to facilitate geographic review. Along with a detailed data approach to developing recommendations, the group also focused on a person-centered strategy to have a better understanding how specific individuals interact within a complex overburdened system. Details in both data sets were extensive, with de-identified provider notes listing barriers to discharge, barriers to community resources, and services and supports needed in community mental health care. Both data sets covered all counties in the service area for adults from both groups, as well as “other” counties that had person experiences in ASH but were outside the defined ASH service area (note, that all state hospitals take admissions from anywhere in Texas, although are concentrated within specific regions).

Significant and complex discharge barriers were identified linked particularly to a lack of the full range and capacity of therapeutic housing needed to safely and effectively discharge or maintain individuals in the community. These barriers appeared equally pressing in both urban and rural counties. Notably, throughout the service area, individuals were routinely prevented from discharge because there was no alternative housing, given their often complex needs. Broad access to a fluid continuum of housing options, including near-hospital level step-down, permanent supportive housing, group and independent homes, and community-based services waiver supports was a repeated themes preventing ASH discharge.

A scan of available housing options in the ASH service area highlighted the following significant gaps:

- Less than 10 permanent supportive housing (PSH) units with mental health support are available across the ASH service area;
- There is one residential step-down pilot: 2 sites with 6 beds each;
- Boarding and group homes are not regulated, resulting in inadequate data to assess quality, quantity, safety, and sanitation;
- Housing assistance and voucher programs, while critical to the housing continuum, present unique challenges for those who experience SMI in navigating eligibility, advocacy, and access;
- Waiver supports are often blocked from providing access and lack intensive structure, supervision, safety, and support;
- Nursing home facilities routinely deny access to people with mental illness due to a lack of comfort and training required to serve individuals with psychiatric needs.

Based on this information, in order to most effectively use the new ASH and increase functional bed capacity, we must prioritize and optimize alternative (to ASH) resources - namely housing, and residential care - for two specific cohorts of people. The first group is those individuals who experience stays longer than 365 days, and the second group is people who have experienced frequent readmissions. Individuals within these groups have complex needs that create unique barriers at each end of the care continuum. The barriers result in persons rapidly destabilizing once discharged, or these barriers leave individuals stagnating in the hospital indefinitely. In order to offer humane, peaceful, and intensively supported living spaces we need to develop an intentional, scalable, housing, and residential community continuum model. The housing continuum currently lacks adequate temporary and long-term housing and residential options that can facilitate the appropriate level of care needed to address a majority of the complex needs of these vulnerable individuals, and so the following recommendations are made.

Recommendations

I. Academic Hub for the New Hospital

The new Austin State Hospital provides a timely opportunity to use academic and community partnerships to develop an academic hub for the new hospital. The academic hub's focus would be on moving people out of long-term hospital levels of care into more home-like or residential environments either on campus or in their home communities. The hub would allow interdisciplinary teams to convene to address social determinants of health that create complex barriers to long term successful hospital discharge. Undergraduate students, graduate students, and faculty from an array of academic areas, which include but are not limited to medicine (e.g. psychiatry, neurology), nursing, social work, psychology, law, pharmacy, and public affairs could comprise these teams and support the operations of the new ASH in two ways. First, this pipeline of learners could potentially maintain a workforce that innovatively and effectively addresses unique barriers preventing successful discharge, while working alongside ASH's current staff, whose primary focus is on acute symptoms and immediate risk. This dyad could enhance hospital function, by increasing volume of staff available for people receiving care. Second, this academic hub would encourage collaboration with educational, peer, family, and other community advocates. These interdisciplinary teams could develop a community wrap-around approach

with a compassionate service infrastructure for people who need long-term intensive, supported housing and residential care.

Another aim of the hub would be to work collaboratively with the service area. By creating effective discharge solutions with community providers and stakeholders inside and outside Travis County. An example of such a partnership could be between the All Texas Access program (HHSC) and academic institutions to expand ASH's continuum of care to reach rural communities. These and other collaborations will expose the gaps, barriers, and critical assets present in each community to create more effective care continuum. This function of the Hub would expand valuable stakeholder collaborations, as well as maintain those already gained through ASH Redesign workgroup processes. This recommendation supports the original master plan from Phase I to develop a campus continuum to develop solutions through partnerships and share the expertise throughout the service area of ASH to improve care across the region. It is also consistent with the legislative intent behind the new hospitals being built in Texas to establish working partnerships between HHSC and Texas's institutions of higher learning, especially the medical schools.

To implement a successful academic hub, a steering committee, comprised of academic, community, clinical, and HHSC stakeholders is recommended. The primary aim would be to develop a financial, strategic, and staffing plan for the hub. Given the potential for cross-education and stakeholder collaboration, there may be funding and partnership opportunities within ASH or throughout the state hospital system that the committee utilizes. The investment in this workgroup could yield solutions that enhance workforce pipeline and professional development in community psychiatry, evidence-based treatments, and partnership development throughout the catchment.

Collaboration between HHSC and academia continues to be positively viewed by stakeholders throughout all phases of the ASH Redesign Project. As work continues, this partnership can prioritize serving ASH's most vulnerable individuals, with coordination beyond hospital care through the care continuum. This effort will support a range of disciplines and serve as a community convener to continue developing actionable, evidence-driven results in partnership with hospital, community, academic, and HHSC stakeholders. This recommendation resonates with Phase III's Competency Restoration and Academic and Area Experts Work Groups, all supporting a partnership between academia and HHSC using the ASH Campus as a platform for innovative care development through an interdisciplinary approach.

II. Intentional Supportive Community or Unit – Housing Model on Campus

Building a housing/residential model on the ASH campus provides a unique opportunity to understand and scale housing efforts throughout the ASH service area. ASH Redesign Phase III Housing Workgroup data consistently pointed to the need for a paradigm shift in understanding the complex housing and residential needs for people served by ASH, especially for those who experience stays longer than 365+ days. The data suggest that one of the most common barriers to discharge is the lack of settings equipped to manage the intensity of these individuals' persistent, residual psychiatric symptoms. In addition, these individuals often experience cognitive and medical comorbidities along with legal and/or other barriers making it difficult for them to meet eligibility criteria for services and/or housing currently

available in the community. These barriers leave people stranded in state hospitals, while also blocking new admissions due to lack of functional bed capacity.

To address this problem, the ASH Housing Workgroup recommends building an intentional community residential care unit, facility, and/or a small set of group homes on the ASH campus. This residential model defines a "home" as providing wraparound intensive, supportive, person-centered, services in a structured and secure setting, such as with private assisted living or nursing facility models. This approach could be achieved as a residential small unit, small group homes, or ideally as a separate residential facility. An example of a cost model are group homes supported through Supportive Housing Rental Assistance, in which LMHAs can use 10% of the rental assistant funds to house those who discharge from the state hospitals or an HHSC funded psychiatric bed. The use of rental assistance could potentially also support a larger facility to capture both small and larger housing options in the continuum.

A residential unit, group homes, or facility would shift from hospital-like to home-like care and provide flexibility in serving as a transitional or long-term support. Moreover, an intentional, supportive, on-campus housing community could offer better, more appropriate care at less cost. Resourcing a residential community on the campus in combination with an academic hub creates opportunities for a scalable residential model, one that is secure, safe, and most importantly, person-centered, and replicable throughout the service area. As the ASH Campus completes the new hospital construction and builds more academic partners, the combination would create an opportunity for a campus housing pilot at the ASH Campus. The campus housing pilot could use one of the old existing hospital wings to demonstrate the model and determine if campus housing assists in increasing the functional bed-capacity of ASH. The campus housing pilot could use clinical staff from the academic hub and partnership, peer services, and existing ASH Redesign efforts to develop a plan, pilot, demonstration period throughout a two-year period, and report back at the 89th legislative session of the feasibility and opportunities to expand.

Image 3: Cost Breakdown for 365+ day stays

In an effort to maintain an intentional, supportive residential community on the ASH campus, we recommend separating the hospital and the residential facility. The separation of the two will ensure the residential facility operates in an appropriate step-down level of care at the lower cost than a hospital. The 365+ days list has individuals whose stay ranges from 1 to 15 years. Growing discharge barriers correlate with longer lengths of stay and greater expense. For the current 365+ days list of roughly 85 people the state spends about $88M based on a $752 bed day rate and an average stay of 2-5 years (ASH Report 1, ASH Costs). With a residential facility on campus for a step-down level of care, funding could be better allocated in order to optimize the impact per dollar invested

while supporting an individual's transition out of the hospital to an appropriate level of care, while also increasing the functional capacity of ASH for people needing inpatient services.

The Phase I ASH Redesign report provided an option B for the hospital plan, which included a residential care facility, at an estimated $15 to $45M to construct a 48-72 bed facility with an estimated operating budget of $10M annually. Calculating today's costs for inflation and the impact of the COVID pandemic, a 48-72 bed facility would cost an estimate of $30M to $90M for construction near the 88th Legislative Session, with a similar operating budget, adjusted for inflation, at approximately $12M. The facility estimated cost is an estimated cost and can vary depending on location on the ASH campus and need of site preparation. Such a facility would immediately open up to 72 beds in the ASH.

Option B: 216 or 240 bed adult hospital + 48 or 72 bed residential facility	
Component	**Cost**
Hospital	$234-246M
Site Preparation	$39M
Residential facility	$15-45M
Long-stay placement team	$0.3M
Total	**$288-330M**

Type of Facility	Description	Estimated Cost
Residential Facility on ASH campus (48 to 72 beds)	A transitional or long-term residential unit, • Secure • Safe • Less acute than hospital • Intense wrap around services (See academic Hub description) • home like environment and sense of community especially for people experiencing stays well beyond 365 days • IOP/PHP • Substance use disorder interventions Strong community bridging teams	Estimated $30 to $90M for construction; $12 million in yearly operating costs

With the right housing supports, the hurdles faced in hospital discharge and recovery in the community can be supported more consistently. Increased housing support opportunities would immediately increase the bed capacity of ASH. With the 72-bed facility model, this would increase open beds for ASH. Applying an average of 120-day length stay, the ASH has the potential to increase the annual number served by 200 people. This work group recommends a implementing a range of housing solutions, although initially focusing on longer-term residential care. Short-term residential options are also

needed for people discharging from ASH. This model would also align and compliment efforts around competency restoration recommendations for a hospital step-down, restoration, and court coordination for people experiencing frequent readmissions or who have a *not-likely-to-restore competency* status.

III. Bridging hospital to community

As discussed in the Peer and Family Workgroup Recommendations, bridging provides individuals transitioning out of the hospital with a point of contact in the community meant to connect them to needed services. In Massachusetts, bridging is peer-run and managed by the Kiva Centers, which allows flexibility in assisting individuals both within the hospital and the community. Currently HHSC does not have a similar program. Bridging is especially important for people who experience frequent readmissions. Provider, peer, and housing supports are critical for linking a person at discharge to the array of community supports needed for recovery.

Repeatedly in the review of person-centered stories, cross-service area gaps were noted for people needing same-day service handoffs, particularly in the ability to maintain medications and critical social services, such as housing and legal advocacy. Lack of adequate bridging from hospital to community-based supports often results in repetitive hospital readmissions and reliance on emergency and criminal legal systems. Such crisis cycling in turn results in an expensive crisis response. Housing and residential case management, robust coordinated specialty care (such as ACT and First Episode Psychosis teams), and strong community peer and family supports could be strengthened and supported by state-funded infrastructure, technical assistance, and grant funded pilots. Strengthening these areas would help to build housing and peer bridges to make navigation of supports more effective. Ensuring access to and maintaining supportive housing could relieve the strain placed on community crisis response resources.

IV. Data & Collaboration

Data management, service area environmental scans, and service area collaborative efforts are required to provide humanistic and evidence-based care. This information can contribute to building the ASH Continuum of Care, in which housing is prioritized as a way to reduce, and eventually eliminate, crisis cycling. The Academic Hub, as a collaborative effort, might serve as a data warehouse or 'honest broker' to support partners throughout the service area. Data sharing is critical to understanding and addressing gaps in the ASH-region's care continuum. The Housing Workgroup recommends continuing to gather essential service area data to create new and strengthened existing data capabilities, which could be managed by the Academic Hub.

HHSC Initiatives that align with ASH Redesign Workgroup Recommendations

There are a number of initiatives currently within HHSC that are striving to understand and determine housing and residential needs, particularly for people currently residing at state hospitals. The efforts of HHSC and local city and county groups are intrinsically linked to effective functioning of the state hospital and its role in the community mental health care continuum. Also critical are the efforts to understand more integrated health care and substance use treatment supports, as all can typically intersect in the complex experiences of patients and are direly needed to expand a more effective mental health continuum of care overall for Texans. This workgroup discussed many of the ongoing state and local efforts around housing, many of which can be found on HHSC's website. More information on such programs are listed in Appendix 10 of the ASH Phase III report.

A Note of Urgency

The stakeholders of the workgroup reinforce their recommendations to develop planning teams to establish a housing continuum that will create varying levels of care for Texan's vulnerable populations living with mental illness. However, we cannot ignore the immediate need for housing and residential care as a treatment intervention for ASH's most vulnerable patients. This report supports efforts at local and state levels that are more immediately expanding access to housing resources, as residential care and housing stability is at a crisis point for this population. Members of the workgroup emphasize the urgency of housing and residential solutions. As an example, the ongoing Rider 100 study efforts to target potential operational plans for resourcing SSLCs and State Hospital campus residential care efforts could provide a relatively immediate option for expanding long-term residential care. Collectively, these efforts, if implemented could start supporting individuals ready to discharge from ASH to a more appropriate levels of care. Regardless of which solutions are adopted, the need is immediate for alternative residential placements for people with severe mental illness, suggesting both short- and long-term planning efforts must be initiated.

Appendix A: Work Group Members

Name	Organization/Role	Role
Cory Morris, MSW	Project Manager, Policy and Partnerships Center for Youth Mental Health Dell Medical School	Co-Chair
Ashley Trust, MD	Psychiatrist Associate Program Director, General Adult Psychiatry Assistant Professor of Psychiatry Psychiatry Department Dell Medical School	Co-Chair
Lauv Bruner	State Hospital Construction Project Coordinator, Health & Specialty Care, HHSC	Member
Sonja Burns	Mental Health Advocate	Member
Helen Eisert	Senior Housing Policy Advisor, Office of Mental Health Coordination, HHSC	Member
Marilyn Hartman	Member, Advocate, and Housing Specialist – NAMI Central Texas	Member
Dawn Handley	COO, Integral Care	Member
Michelle Hallee	Assistant District Attorney, Special Prosecutions Travis County	Member
Shaun Lee	Program Manager, Heart of Texas	Member
Melissa Shearer	Director, Travis County Mental Health Public Defender	Member
Christa Signor, MSRLS CTRS	Healthcare System Liaison, Ending Community Homelessness Coalition - ECHO	Member
Nicole Wiscombe	YHDP Project Director, Heart of Texas MHMR	Member