Feasibility Study of Regional Advisory Council Diversion Evaluation

As Required by

2020-21 General Appropriations Act,

House Bill 1, 86th Legislature,

Regular Session, 2019

(Article II, HHSC, Rider 41)

Health and Human Services

Commission

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TEXAS
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Executive Summary

This *Feasibility Study of Regional Advisory Council Diversion Evaluation* is submitted pursuant to Rider 41 of the 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission, Rider 41).

Rider 41 requires the Texas Health and Human Services Commission (HHSC) to submit an evaluation report on the feasibility of requiring trauma service area regional advisory councils to implement a program to allow emergency medical services providers to navigate medically stable psychiatric emergency detention patients to the most appropriate setting. As part of the evaluation, HHSC is required to consider the potential for Medicaid cost savings and options for reimbursement to the regional advisory councils or emergency medical services providers with those savings. The report will be submitted to the Governor and the Legislative Budget Board.

This report uses national guidelines published by the Substance Abuse and Mental Health Services Administration as standards of care to evaluate the capacity of psychiatric crisis services in Texas Trauma Service Areas (TSAs). Due to the limited financial and service capacity of multiple TSAs, the implementation of psychiatric crisis services in many TSAs is not feasible without significant investment to motivate stakeholders to form coalitions required for the delivery of these services.

1. Introduction

This report presents an evaluation regarding the feasibility of implementing an emergency psychiatric diversion program like the program implemented by the Southwest Texas Regional Advisory Council (STRAC) for other Texas Trauma Service Areas (TSA). The *National Guidelines for Behavioral Health Crisis Care* published by the Substance Abuse and Mental Health Services Administration (SAMHSA), are standards of care used determine the feasibility of implementing a Psychiatric Emergency Service (PES) based on three core functions:

- Regional Crisis Call Center
- Crisis Mobile Team Response
- Crisis Receiving and Stabilization Facilities

Although the implementation of these core functions will be unique to each Trauma Service Area (TSA), all 22 Regional Advisory Councils would need to form coalitions with providers and local agencies in their region for this model to be implemented in other regions of the state.

1.1 Trauma Service Area

In 1989, the 71st Texas Legislature passed The Omnibus Rural Health Care Rescue Act. In response, the Bureau of Emergency Management was directed to develop trauma care systems, implement Emergency Medical Services (EMS), designate trauma facilities, and develop a registry to monitor financial and clinical outcomes (Bolenbaucher, 2008). The Texas trauma system is divided into 22 TSAs to delineate geographical boundaries for patient referral (Kitchen, 2017). The Bureau of Emergency Management developed and implemented a regional trauma system plan in each TSA, leading to the formation of 22 Regional Advisory Councils (RACs) as the established organizational bodies for each TSA. Designations and names for each RAC can be found in Appendix B.

1.2 Regional Advisory Council

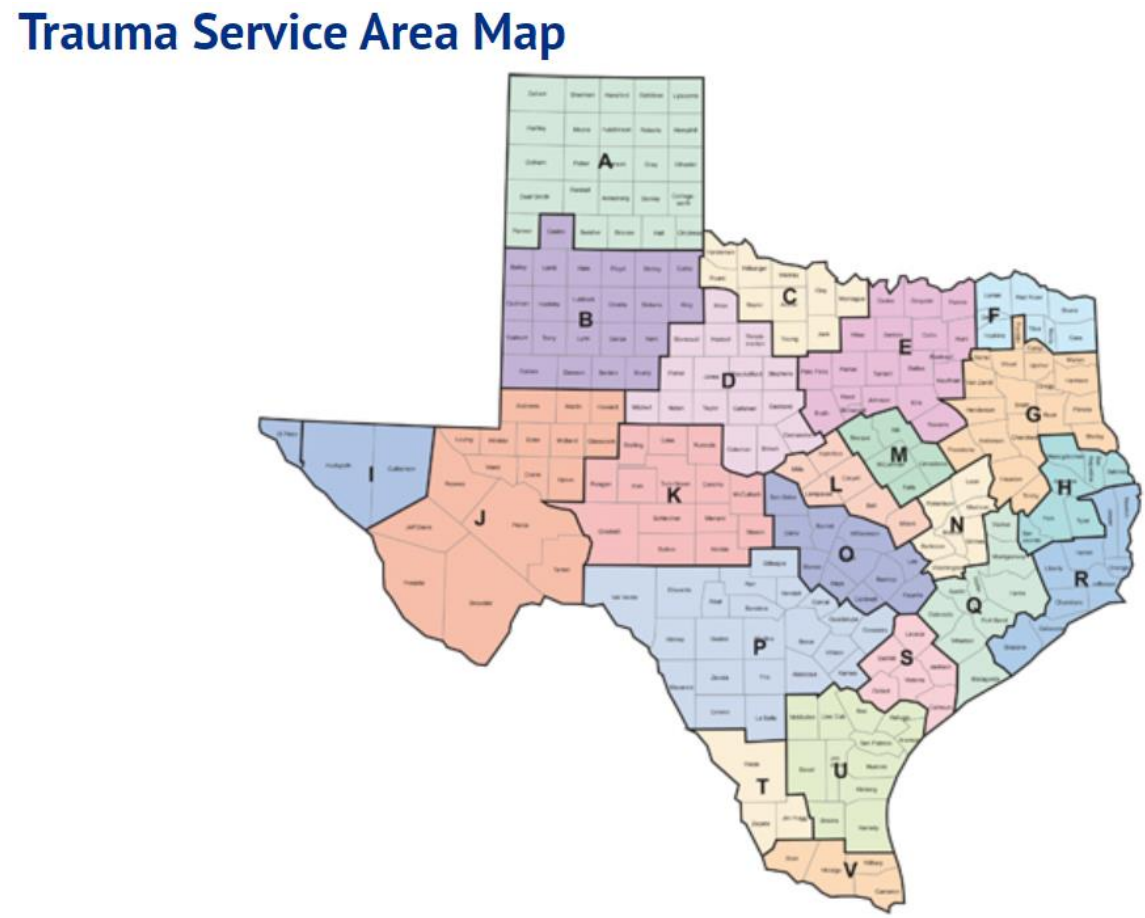
RACs are organizations consisting of healthcare entities and concerned citizens responsible for the oversight and administration of emergency trauma systems for a given TSA in Texas (Friedrich, 2020). RAC funding is distributed through the EMS and Trauma Care System Fund established by the 75th Legislature (1997). The 76th Legislature (1999) empowered the Texas Department of Health now the

Department of State Health Services to distribute funding directly to RACs if the council is a non-profit organization.

1.3 RAC Services

Figure 1 shows the area covered by each of the RACs across the state (Bolenbaucher, 2008). RAC services include the development, implementation, and monitoring of a regional emergency service trauma system plan. Not all RACs have the same organizational structure, but each council is tasked with the objectives of reducing trauma incidence through performance improvement, data collection & analysis, and education. The most common services provided by RACs are provider education programs and performance improvement guidance.

Figure 1



Bexar County is unique among Texas RACs, STRAC pays for clinicians in PES facilities and in STRAC's 9-1-1 call center facility MEDCOM to provide coordination to the most appropriate level of care. Three facilities in Texas currently provide in-house PES:

- Methodist Specialty and Transplant Hospital
- Southwest General Hospital
- San Antonio Behavioral Healthcare Hospital

2. Background

The psychiatric programs delivered by the Southwest Texas Regional Advisory Council (STRAC) and the Southwest Texas Crisis Collaborative (STCC) are examples of regional emergency services with all three core functions of a PES as highlighted by SAMHSA guidelines. These programs include psychiatric care for mental health patients in a hospital ED and direction for law enforcement for patients detained due to a mental health crisis.

2.1 The Center for Health Care Services, the Local Mental Health Authority for Bexar Southwest Texas Regional Advisory Council

The Southwest Texas Regional Advisory Council (STRAC) is the RAC recognized by the Texas Department of State Health Services in charge of Trauma Service Area P (Southwest Texas Regional Advisory Council [STRAC], 2014). STRAC is a tax-exempt non-profit organization that represents all licensed health care entities within Trauma Service Area P, "including 74 general and specialty hospitals, with 2 Level I Trauma Centers, 16 Percutaneous Coronary Intervention (PCI) Centers, 12 Stroke centers, air medical providers, and over 70 EMS agencies" (STRAC, Southwest Texas Crisis Collaborative section, 2012-2020). STRAC memberships include organizations across the trauma care continuum, but only hospital and EMS members have regulatory requirements to maintain active participation which include mandatory committee meetings and annual dues (Southwest Texas Regional Advisory Council, 2016).

2.2 Southwest Texas Crisis Collaborative

Since 1993, STRAC has provided a foundation for standardization and process improvement across the trauma care continuum. The coalitions formed by stakeholders to address gaps in the behavioral health system continue to work together as part of the Southwest Texas Crisis Collaborative (STCC). The goal of these coalitions is to "end ineffective utilization of services for the safety net population" by developing a comprehensive and integrated trauma care system.

2.3 STCC Projects

2.3.1 MEDCOM Law Enforcement Navigation of Emergency Detention Patients (LENav)

In 2015, the STCC collected data from Bexar County EDs showing that almost half of all psychiatric crisis patients have no physical health conditions that need to be treated in an emergency setting (Roser, Law Enforcement Navigation Section, 2019). However, these patients spent an average of 9 hours in hospital beds that could be needed for patients presenting to the ED with traumatic injuries. In 2018, STRAC implemented the LENav program, allowing law enforcement officers to coordinate with STRAC's MEDCOM communications facility to divert medically stable patients to psychiatric emergency facilities in San Antonio.

2.3.2 Program for Intensive Care Coordination (PICC)

The STCC implemented an additional layer of care in the outpatient setting to better address the unique needs of individuals detained six or more times per year. Teams consisting of a Qualified Mental Health Professional, a specialized Mental Health Officer, and a Mobile Integrated Healthcare Medic can engage with patients, provide case management, medication management, psychosocial rehabilitation, transportation, and connections to community resources.

2.3.3 Haven 4 Hope (H4H) and San Antonio Fire Department

Haven for Hope (H4H) is an acute care station located approximately 2 miles from downtown San Antonio and staffed seven days a week by an overnight paramedic. This paramedic responds to 9-1-1 calls on campus and navigates patients to appropriate levels of care (Garza, 2018). STRAC and the STCC developed a collaborative model in coordination with San Antonio Fire Department's Mobile Integrated Healthcare team to address high emergency service utilization on the H4H campus.

2.3.4 Psychiatric Boarding and Psychiatric Emergency Service (PES)

When a psychiatric patient visits an Emergency Department (ED) that does not have onsite mental health services, ED staff must place patients in a holding period known as "boarding" while searching for an available inpatient psychiatric bed (Zeller et al.; 2014). Studies of boarding times in EDs for psychiatric patients describe wait times ranging from 4 to 24 hours (American College of Emergency Physicians, 2008). These long wait times often exacerbate psychiatric symptoms and can increase the cost of care (Korn et al., 2000). To combat the psychiatric boarding problem, some trauma systems implement Psychiatric Emergency

Services as patient triage, sending each to the most appropriate treatment setting (Breslow et al., 1996).

PES provides clinical assessments, psychiatric evaluations, and linkage to services for adult mental health patients presenting to emergency departments. Psychiatric Emergency Services (PES) emerged as a subspecialty of psychiatric practice due to the rising number of ED patients suffering from mental health crises (Zeller, 2010). National guidelines published by the Substance Abuse and Mental Health Services Administration (SAMHSA) define three core functions of a behavioral health crisis system:

- Regional Crisis Call Center
- Crisis Mobile Team Response
- Crisis Receiving and Stabilization Facilities

3. Feasibility

3.1 PES Core Functions

Using SAMHSA's core functions as standards of care, the following sections explore the feasibility of implementing PES in all 22 TSAs in Texas (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

1) Regional Crisis Call Center

Services offered by a Regional Crisis Call Center include 24/7/365 availability for mental health crisis calls and clinicians are staffed to oversee assessment, triage, and diversion of patients in behavioral health crises. For example, STRAC's MEDCOM facility is housed inside the trauma system's 9-1-1 call center, enabling coordination of psychiatric emergencies (STRAC, 2012-2020). STRAC also houses licensed clinicians within MEDCOM 24/7 to facilitate interfacility transfer requests to PES facilities.

(a) *Implementing a Central Hub*

Texas TSAs do not all have regional communications centers run by their RACs. 9-1-1 call systems use Public Safety Answering Points (PSAPs). PSAPs are call centers run by sheriffs' offices, police departments, and other local government entities (Federal Communications Division - Data.Gov. 2017). Some county or city departments designated as 'Primary PSAPs' receive calls for specific areas and facilitate transfers to 'Secondary PSAPs,' such as Fire Departments or EMS offices. RAC personnel in these TSAs may not be directly involved with the response to a medical crisis. Those PSAPs must consolidate to function under a regional communications center (with similar capabilities to STRAC's MEDCOM facility) before a PES is implemented in those TSAs.

(b) *Embedding Licensed Clinicians/Implementing Dispatch Triage*

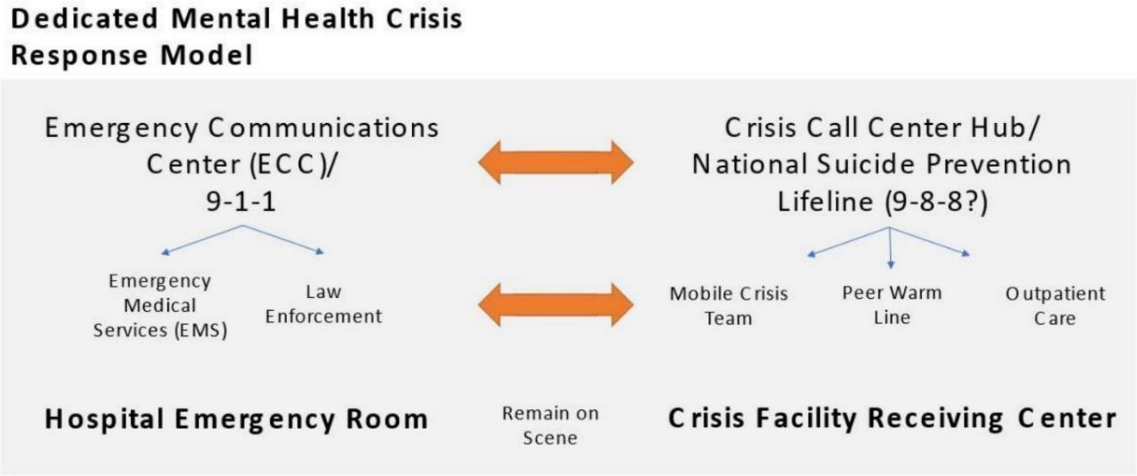
STRAC clinicians use tele-screening during interfacility transfers to evaluate the widest range of treatment options (STRAC, 2012-2020). Smaller RACs may not have the financial capacity to hire licensed professionals. For example, the North Texas RAC's budget for fiscal year 2020-21 allows a total of $21,600 for staff salaries (North Texas Regional Advisory Council, 2020). According to the Bureau of Labor

Statistics, the average Texas physician's salary was more than $150,000 a year in 2019 (U.S. Bureau of Labor Statistics, 2020). Triage of psychiatric emergency patients without a licensed clinician relies on risk assessments delivered by emergency dispatch staff at each PSAP, requiring standardized training across all PSAPs (Crisis Intervention Team, 2019). SAMHSA Guidelines recommend the Dedicated Mental Health Crisis Response Model (Figure 2) to limit the involvement of hospitals and law enforcement to medical stabilization or public safety for mental health crises (SAMHSA, 2019).

(c) *Next Generation 9-1-1 (NG911) Implementation*

NG911 is a collaborative effort between 911 stakeholders and the National 911 program to upgrade the technological capacity of current emergency communication services (Commission on State Emergency Communications - Texas, & 911.gov, 2019). The Commission on State Emergency Communications currently supports an endeavor by the 22 Regional Planning Commissions (RPC, not RAC) to implement Emergency Services IP-Enabled Networks (ESInets), to provide regional IP connectivity between PSAPs (Commission on State Emergency Communications - Texas, & 911.gov, 2019). Implementation of a Psychiatric Emergency Service that uses real-time data to track patients (like STRAC's MEDCOM facility) requires integration with previously implemented ESInets, or implementation paralleling NG911 initiatives across the state.

Figure 2



2) Mobile Crisis Teams

STRAC employs mental health professionals and paramedics for the PICC and H4H programs and coordinates with law enforcement for emergency detention patients (STRAC, 2020; Miramontes & Winckler 2018). National guidelines do not cite law enforcement detentions as the best practice due to statistics citing a 25-50% fatality rate for law enforcement encounters with mentally ill individuals (DeGue et al., 2016). Instead, SAMHSA recommends the implementation of Mobile Crisis Teams in each region. Mobile Crisis Teams are clinicians and other healthcare professionals who respond with face-to-face help for harm reduction and assessment of mental health crises while connecting patients to facility-based care. Table 1 details the minimum expectations and best practices for Mobile Crisis Team Services.

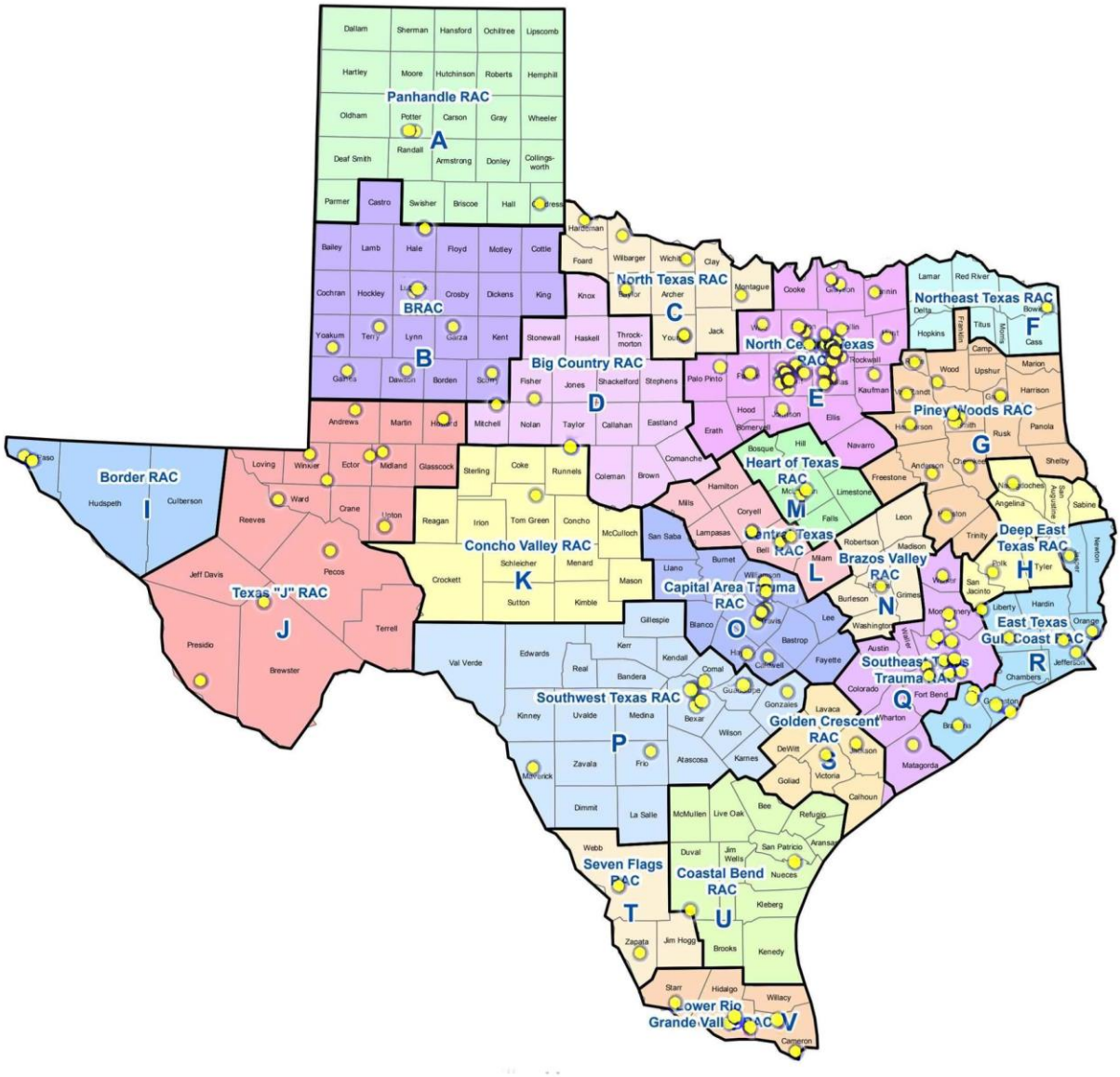
Table 1 – Mobile Crisis Team Services

Minimum Expectations	Best Practices
1. Include a licensed or credentialed clinician able to assess the individual needs within the region of operation. **2. Respond to the individual's location (i.e. home, work, park, etc.) without restricting services to select locations within the region or particular days or times.** **3. Connect individuals to facility-based care as needed through warm hand-offs and appropriate transportation if situations warrant transition to other locations.**	1. Incorporate peers within the mobile crisis team. 2. Respond without law enforcement accompaniment unless special circumstances warrant inclusion to support true justice system diversion. 3. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement. 4. Schedule outpatient follow-up appointments in a manner synonymous with a warm hand-off to support connection to ongoing care.

3) Crisis Receiving and Stabilization Facilities

STRAC uses value-based contracts with behavioral health providers in Bexar County to divert patients to Crisis Receiving and Stabilization Facilities. The feasibility of a similar PES in other TSAs across Texas depends heavily on the capacity of psychiatric facilities in each region. The following survey uses treatment data from SAMHSA to break down the capacity of each TSA based on facilities with walk-in PES services in the region. Figure 3 is a map of 22 TSAs marked to indicate mental health facilities with walk-in PES (U.S. Department of Health & Human Services [HHS] & SAMHSA, 2020). Table 2 sorts TSAs by the number of Mental Health (MH) facilities with walk-in PES.

Figure 3 – Map of Texas TSAs and MH facilities with walk-in PES



Walk-in PES data retrieved from SAMHSA Behavioral Health Treatment Locator, (HHS, & SAMHSA, 2020).

Table 2 – TSAs Sorted by Number of MH facilities with Walk-in PES

MH capacity	TSA Designation	Counties in TSAs with Metropolitan status (>50,000 people)
TSAs with highest number of PES facilities (>10)	E (Dallas), Q (Houston), J (Midland-Odessa), R (Beaumont/Galveston), B (Lubbock), G (Tyler/Longview), P (San Antonio)	46 out of 117 counties are metropolitan (39%)
TSAs with average number of PES facilities (3-9)	C, O, V, A, I, L, M, T, U	25 out of 79 counties are metropolitan (32%)
TSAs with lowest number of PES facilities (<3)	D, H, K, S, F, N	11 out of 58 counties are metropolitan (19%)

3.2 Mental Health Crisis Capacity Varies Between TSAs

As of April 2020, 246 out of 254 counties in Texas are federally designated mental health professional shortage areas, and only 86 counties have facilities with walk-in PES (Health Resources and Services Administration [HRSA], & HHS, 2002-2020). El Paso, Bexar, Wharton, Harris, Galveston, Dallas, and Lubbock are the only counties considered 'partial shortage areas,' and Williamson is the only county in Texas (out of 254) that is not a designated shortage area.

3.3 Coalition Building

In the 2016 Bexar County Mental Health Systems Assessment (published by the Meadows Mental Health Policy Institute), the primary barrier for psychiatric emergency services is "lack of consensus regarding consistent county-wide policies, procedures, and metrics for adults who present in psychiatric crisis." If implemented, a PES will require cooperation with multiple local agencies and providers to integrate a call center with PSAPs and divert medically stable psychiatric patients to PES facilities. In order to a set strategic vision, develop shared metrics and policies, and mobilize resources and investments as part of an

integrated system of care, STRAC formed the STCC Steering Committee with providers in TSA-P (STRAC, 2012-2020). The implementation of a successful PES hinges on the formation of similar committees. SAMHSA Guidelines recommend the formation of this committee as part of a Behavioral Health Leadership Team (BHLT) (SAMHSA, 2020). By including members from organizations across the entire psychiatric crisis care spectrum (i.e. emergency dispatch, EMS, and psychiatric facilities), these teams will address barriers unique to psychiatric crisis services in each TSA. The BHLT can consider the varying population demographics and provider capacities in each TSA, as well as the limited financial capacity of some RACs.

4. Potential for Medicaid Cost Savings

4.1 PES Cost Savings

In a 2019 systematic review by Evans et al. published in the Journal of Psychosomatic Research, several PES models show reductions in psychiatric boarding and a couple provide cost-saving outcomes (Evans et al., 2019). The Rapid Assessment Interface and Discharge (RAID) model implemented by England's National Health Service had a benefit-cost ratio of 4:1. These cost savings came from a reduction in acute inpatient bed days (Confederation, 2011). Other studies have shown different sources of PES cost savings. A 2016 study of an integrated mental health emergency department found cost savings from reductions in waiting times, restraints, and criminal justice resources (Okafor et al., 2016). STRAC published 2008-2018 aggregate cost-effectiveness data for the H4H program and estimated that $96 million was saved in cost avoidance over 100,000 diversions from ED or jail in San Antonio and Bexar County (McClatchy, 2018; Price et al., 2016). A 2014 study evaluating the Alameda Model in California includes a cost comparison of psychiatric crisis services and psychiatric boarding costs, noting that a max utilizer psychiatric emergency patient is still cheaper than a psychiatric boarded patient (Zeller et al., 2014). The following cost comparison uses the same crisis stabilization rate paid by Medi-Cal, as well as other psychiatric crisis rates paid by other states and compares them to the cost of psychiatric boarding (Department of Health Care Services, 2020).

4.2 Cost Comparison

The cost of psychiatric boarding extends beyond each ED patient in a mental health crisis. Excessive boarding contributes to overcrowding and leads to medical errors and increased patient mortality (Fordyce et al, 2003; Richardson, 2006). A 2012 study analyzed more than 68,000 adult ED admissions and found that psychiatric patients waiting for inpatient placement prevented 2.2 bed turnovers and remained in the ED 3.2 times longer than non-psychiatric patients. The same study calculated a direct financial loss of $1,198 per patient and an opportunity cost of $2,264 (Nicks & Manthey, 2012). Table 3 compares this opportunity cost to rates for emergency psychotherapy services published in Medicare and state fee schedules (Centers for Medicare & Medicaid Services, 2020; The Meadows Mental Health Policy Institute for Texas, 2018).

Table 3 – Psychiatric Crisis Rates Compared to Psychiatric Boarding Cost

Payer	Code	Description	Unit	Fee
Cost of Psychiatric Boarding			**Per patient**	$2,264
Medicare [(*payable by Texas Medicaid*); Texas Medicaid and Healthcare Partnership]	A0428 + A0425	Ambulance service, basic life support, non-emergency transport + ground mileage, per statute mile.	Service + ground mileage	$186 + $4.71 per mile
Medicare (*not payable by Texas Medicaid*)	90839	Psychotherapy for crisis; first 60 minutes	First 60 minutes	$147.61
	90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)	Each additional 30 minutes	$70.74
California (DHCS, 2020)	90839	PSYTX Crisis Initial 60 min	First 60 minutes	$38.01
	90840	PSYTX Crisis Ea Addl 30 min	Each additional 30 minutes	$18.98
Delaware	S9485	Crisis intervention mental health services – site-based	Per diem	$766.52

Payer	Code	Description	Unit	Fee
Cost of Psychiatric Boarding			**Per patient**	$2,264
Louisiana	S9485	Crisis intervention mental health services – site-based	Per diem	$353.65
	90839	Psychotherapy for crisis	1st 60 min	$123.60 (MD) $98.88 (APRN/Psych) $85.52 – (LCSW/LPC)
	90840	Psychotherapy for crisis	Each additional 60 min	$61.50 (MD) $49.20 (APRN/Psych) $43.05 (LCSW/LPC)
New Jersey	H2011	Psychiatric Emergency Rehabilitation Services (PERS)	Per diem (1–24 hrs.)	$820.80
		Follow-up PERS	Hour unit	$92.82 (limit 2)
		Follow-up PERS	Additional per diem beyond 24 hrs.	$653.40
		Outreach	Per episode	$862.19
		Crisis Intervention	15 min unit	$11.26

HHSC was directed to consider the potential for Medicaid cost savings through providing reimbursement to the RACS or EMS providers with those savings. All PES rates surveyed in Table 3 generate cost savings compared to the cost of psychiatric boarding. If implemented, these rates would reimburse providers across the continuum of care and provide the RACs with funding for coordination and diversion of psychiatric patients.

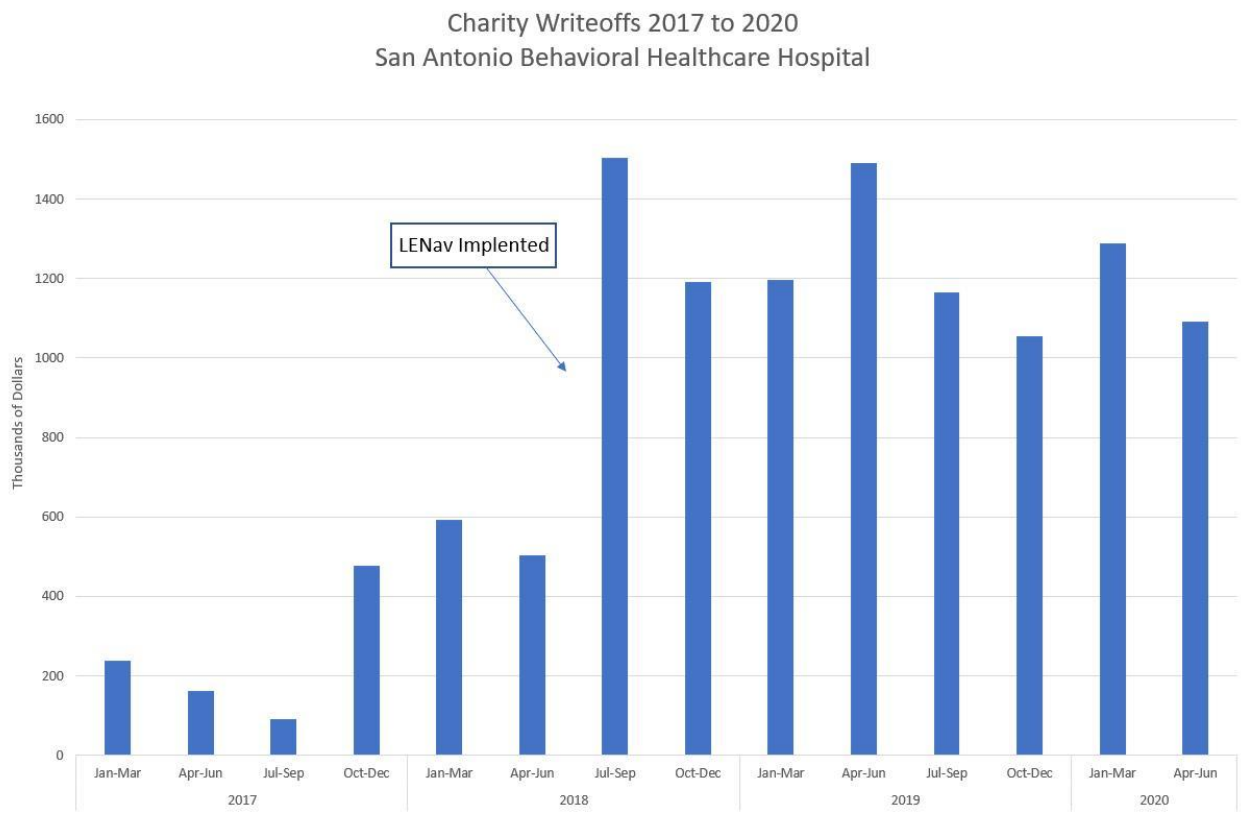
4.3 Payer Sources for RACs/PES

STRAC funds MEDCOM and PES programs through gifts, grants, and contributions received each year. STRAC received more than $32 million dollars in public support between 2013 and 2017 (STRAC & IRS, 2019). RAC funding from Department of State Health Services is substantially less; all 22 RACs split $2.4 million in fiscal years 2018 and 2019 (Texas EMS Trauma & Acute Care Foundation, 2020). The widely varying financial capacities of each RAC make the implementation of PES more feasible in some RACs than others. Additionally, a lack of reimbursement for PES will be a barrier for RACs looking to form the collaborative partnerships required to implement the core functions of PES (Meadows Mental Health Policy Institute, & Methodist Healthcare Ministries of South Texas, 2016). Implementing a psychiatric crisis rate (like the rates listed in Table 2) may prompt PES providers to join coalitions required for PES implementation.

In a 2018 letter to State Medicaid Directors, the Centers for Medicare and Medicaid Services (CMS) gave states guidance on how to receive FFP for "services provided to individuals residing in psychiatric hospitals and residential treatment settings that are not ordinarily [matched] because these facilities qualify as IMDs" (Mayhew, 2018, p. 13). Federal funds used for IMD services must be under a 1915(c) waiver according to this letter. Texas does not have a 1915(c) waiver to provide a dedicated funding stream for PES services, so PES facilities are currently providing charity care for uninsured patients.

After implementation, some PES facilities in the STRAC LevNav program reported an increase in charity care (Graph 1); however, published data and STRAC indicate high cost-effectiveness for PES. At the 2019 Texas Hospital Association (THA) Behavioral Health Conference, the Vice President of Behavioral Health at Nix Health Care System (a participant in STRAC's LevNav program) reported the financial impact of the unfunded patient burden on Nix facilities from MEDCOM Law Enforcement diversions. All Nix facilities closed in 2019 (Sabawi, 2019). No published report links psychiatric diversion patients to an increase in charity care, but data provided to HHSC by San Antonio Behavioral Healthcare Hospital shows 35-37 percent of MEDCOM navigations are for uninsured patients (Appendix C).

Graph 1



4.4 Options for Reimbursement

SAMHSA Guidelines publish recommended coding options for each PES core function. The codes for each core service and payor status for federal and state Medicaid dollars are listed in Table 4.

4.5 Financial Barriers

The lack of payor sources at the state and federal level for PES is a barrier for coalition building and program planning. The feasibility of a PES in every TSA in Texas may depend on a funding source for the codes in Tables 3 and 4. Without reimbursement, some stakeholders may resist the coalition-building efforts required to plan and implement psychiatric crisis services.

Table 4 – SAMHSA Recommended Psychiatric Crisis Codes

Service	Recommended Coding Option	CMS payor status (CMS, 2020)	Texas Medicaid payor status (TMHP, 2020)	SAMHSA Recommendations
Crisis Line	**H0030** – Behavioral Health Hotline Service	Listed in Physician's Fee Schedule, RVUs are 0.00 (not a benefit)	Not a benefit	Contract with local agencies as a safety net resource
Mobile Crisis Response	**H2011** – Crisis intervention service, per 15 minutes	Listed in Physician's Fee Schedule, RVUs are 0.00	$36.89	The rate reflects actual provider costs within that region by limiting use of this code to only mobile crisis teams as part of the PES system. But, different regions will have different costs.
Crisis Stabilization Facility	**S9484** – Crisis Intervention Mental Health Services per Hour **S9485** – Crisis Intervention Mental Health Services per Diem	Listed in Physician's Fee Schedule, RVUs are 0.00 (not a benefit)	Not a benefit	This rate needs to fund a multidisciplinary team 24/7/365. Policy for facilities in the PES should also allow additional services as needed (Medications, radiology, labs, etc.)

5. Conclusion

Pursuant to the direction of Rider 41 of the 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019, this report evaluated the feasibility of implementing psychiatric crisis services in the 22 Texas Trauma Service Areas by the 22 Regional Advisory Councils in Texas. This report also assessed the potential Medicaid cost-savings from these services and reimbursement options for RACs and EMS providers.

According to this evaluation, STRAC (the RAC in Texas with a PES that includes all three core functions described in SAMHSA Guidelines) works cooperatively with local agencies and psychiatric providers to implement their PES, while forming broad coalitions across Bexar County between multiple workgroups and a leadership committee. After evaluation, this model does not seem feasible in other parts of Texas for a number of reasons. First, due to the scarcity of PES walk-in services based on the large size and scope of coverage that would be required across the state. Second, the cost and challenges associated to add the required elements, a regional crisis call center, crisis mobile team response and crisis receiving and stabilization facilities to successfully implement the PES model. Third, the coordination between multiple entities in each RAC to implement the model in a sustainable fashion is very different for each region, so the existing model in Bexar County may not be feasible in other Trauma Service Areas.

List of Acronyms

Acronym	Full Name
BHLT	Behavioral Health Leadership Team
BVRAC	Brazos Valley Regional Advisory Council
CATRAC	Capitol Area of Texas Regional Advisory Council
CTRAC	Central Texas Regional Advisory Council
CVRAC	Concho Valley Regional Advisory Council
DETRAC	Deep East Texas Regional Advisory Council
ED	Emergency Department
EMS	Emergency Medical Services
ESInet	Emergency Services IP-Enabled Networks
H4H	Haven for Hope
HHSC	Health and Human Services Commission
HOTRAC	Heart of Texas Regional Advisory Council
LENav	Law Enforcement Navigation of Emergency Detention Patients
MH	Mental Health
NCTTRAC	North Central Texas Trauma RAC
NETRAC	Northeast Texas Regional Advisory Council

Appendix A. RAC Designations and Names

RAC Designation	RAC Name	TSA Designation
RAC A	Amarillo Panhandle RAC	TSA-A
RAC B	Lubbock TSA-B RAC (BRAC)	TSA-B
RAC C	Wichita Falls NTRAC	TSA-C
RAC D	Abilene Big Country RAC	TSA-D
RAC E	Dallas/Ft Worth North Central Texas Trauma RAC (NCTTRAC)	TSA-E
RAC F	Northeast Texas Regional Advisory Council (NETRAC)	TSA-F
RAC G	Piney Woods Regional Advisory Council	TSA-G
RAC H	Deep East Texas Regional Advisory Council (DETRAC)	TSA-H
RAC I	BorderRAC	TSA-I
RAC J	Texas J Regional Advisory Council	TSA-J
RAC K	Concho Valley Regional Advisory Council (CVRAC)	TSA-K
RAC L	Central Texas Regional Advisory Council (CTRAC)	TSA-L
RAC M	Heart of Texas Regional Advisory Council (HOTRAC)	TSA-M
RAC N	Brazos Valley Regional Advisory Council (BVRAC)	TSA-N
RAC O	Capitol Area of Texas Regional Advisory Council (CATRAC)	TSA-O
RAC P	Southwest Texas Regional Advisory Council (STRAC)	TSA-P
RAC Q	SouthEast Texas Regional Advisory Council (SETRAC)	TSA-Q
RAC R	East Texas Gulf Coast Regional Trauma Advisory Council	TSA-R
RAC T	Seven Flags Regional Advisory Council	TSA-T
RAC U	Coastal Bend Regional Advisory Council	TSA-U
RAC V	Lower Rio Grande Valley Regional Advisory Council	TSA-V

Appendix B. MEDCOM LE Navigations

		Uninsured	% Uninsured
Total 2019 MedCom LE Navigations	**1211**	**430**	**35.51%**
MEDCOM/Bexar County Sheriff Office (BCSO)	11	2	18.18%
MEDCOM/Castle Hills PD	2	1	50.00%
MEDCOM/Castroville PD	1	1	100.00%
MEDCOM/Edgewood ISD PD	23	0	0.00%
MEDCOM/Kirby Police Dept	2	0	0.00%
MEDCOM/Leon Valley Police Department	30	18	60.00%
MEDCOM/Live Oak Police Department	1	0	0.00%
MEDCOM/Medina County Sheriff	4	2	50.00%
MEDCOM/New Braunfels Police Dept	12	2	16.67%
MEDCOM/NISD Police	25	2	8.00%
MEDCOM/SAISD PD	36	3	8.33%
MEDCOM/San Antonio Police Dept (SAPD)	1052	393	37.36%
MEDCOM/Universal City Police Department	3	0	0.00%
MEDCOM/VIA Transit Police	9	6	66.67%

		Uninsured	% Uninsured
Total YTD 2020 MedCom LE Navigations	**659**	**246**	**37.33%**
MEDCOM/Bexar County Sheriff Office (BCSO)	45	12	26.67%
MEDCOM/Castle Hills PD	3	3	100.00%
MEDCOM/Converse Police Dept	1	1	100.00%
MEDCOM/Edgewood ISD PD	5	1	20.00%
MEDCOM/Kirby Police Dept	1	0	0.00%
MEDCOM/Leon Valley Police Department	15	7	46.67%
MEDCOM/Live Oak Police Department	3	1	33.33%
MEDCOM/Medina County Sheriff	1	0	0.00%
MEDCOM/New Braunfels Police Dept	6	2	33.33%
MEDCOM/NISD Police	10	0	0.00%
MEDCOM/SAISD PD	8	2	25.00%
MEDCOM/San Antonio Police Dept (SAPD)	551	212	38.48%
MEDCOM/UTSA PD	1	1	100.00%
MEDCOM/VIA Transit Police	8	3	37.50%
MEDCOM/Windcrest Police Dept	1	1	100.00%

Appendix C. References

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