Addendum: A Comprehensive Plan for State-Funded Inpatient Mental Health Services

In Response to S.B. 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, Rider 147)

Health and Human Services Commission

January 2019
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Executive Summary

As a result of the 2018-19 General Appropriations Act, Senate Bill (S.B.) 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission [HHSC], Rider 147), HHSC is implementing Phase I of a three-phased approach to expand, renovate, and transform the state hospital system. HHSC leveraged this opportunity to improve the efficiency and effectiveness of state hospital administrative and clinical operations, as well as strengthen the continuum of care.¹

Phase I includes $300 million in construction and renovation projects:

- Pre-planning and planning for replacement of the Austin and San Antonio state hospitals;
- Planning and construction of a new hospital in Houston, adjacent to the existing Harris County Psychiatric Center;
- Planning and construction of a 100-bed maximum security unit (MSU) and planning for a 100-bed non-MSU at Rusk State Hospital (RSH) to partially replace current capacity²;
- Renovation of four existing buildings at Kerrville State Hospital (KSH) to add an MSU and renovation of an existing building at San Antonio State Hospital (SASH) to add non-MSU capacity; and
- A pending proposal for pre-planning for new hospitals in the Dallas/Fort Worth Metroplex and Panhandle to expand capacity.³

The agency makes the following specific recommendations to improve behavioral health service delivery and allow for the efficient use of state resources, as outlined in Rider 147. These recommendations were developed in conjunction with university partners and other stakeholders, and may require additional resources or legislative involvement to implement.

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¹ The spectrum of integrated, complementary services for people with severe mental illness.
² Construction funds for the MSU are included in Phase I. Additional appropriations will be necessary to support the construction of the non-MSU in Phase II.
³ These projects are contingent on approval from the Legislative Budget Board and Governor.
● Develop or optimize tiered residential transition options.
● Revise state hospital admissions statutes to determine the most appropriate facility for competency restoration for persons charged with certain crimes.
● Provide consultation to initiate psychiatric medication in jail.
● Create an interdisciplinary team to support persons with complex needs.
● Construct new state hospital facilities to expand capacity and replace existing capacity that is beyond the point of maintenance or renovation. Critical funding includes the additional resources needed to continue projects initiated during Phase I, as summarized in Table 1.

### Table 1. Request to Continue Projects Initiated in Phase I

<table>
<thead>
<tr>
<th>Project</th>
<th>Phase II Cost Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin State Hospital Replacement (Construction)</td>
<td>$282,680,000</td>
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<td>$323,264,360</td>
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<tr>
<td>San Antonio State Hospital Non-MSU Renovation (Operations)</td>
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<td><strong>Total Request to Continue Initiated Projects</strong></td>
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This report is an addendum to *A Comprehensive Plan for State-Funded Inpatient Mental Health Services* (Comprehensive Plan). It details the work done between December 2017, when HHSC received approval for the projects, and the addendum’s publication in January 2019, as well as summarizes recommendations that have come out of that work.
1. Introduction

Rider 147 outlines the Legislature’s intent to implement a three-phased approach to expand, renovate, and transform the state hospital system. HHSC was appropriated $300 million for Phase I projects during the 2018-19 biennium.

These projects and other changes are designed to:

- Enhance safety, quality of care, and access to treatment;
- Expand capacity and reduce waiting lists for inpatient psychiatric treatment, particularly MSUs; and
- Increase collaboration with potential partners, specifically higher education and health-related institutions.

The strategy for the replacement or significant repair of state hospitals or other state-funded inpatient mental health facilities was outlined in the Comprehensive Plan submitted to the Governor and the Legislature on August 23, 2017.

The Comprehensive Plan also outlined initiatives for HHSC to undertake to transform state-funded inpatient mental health care, such as standardizing best practices at the state hospitals, working with the judiciary to review commitment processes and make recommendations that will alleviate pressure on the system, and coordinating with stakeholder to develop a “smarter” continuum of care, among others.

The information contained in this addendum to the Comprehensive Plan provides an update on the implementation of Phase I and summarizes many of the recommendations that came out of the work completed during Phase I.
2. Background

Current State Hospital System

As part of the continuum of care for Texans with mental illness, HHSC operates a network of state-funded inpatient psychiatric hospitals, which includes nine state psychiatric hospitals and a youth residential treatment center. Each state hospital serves adults, and five provide child or adolescent services, or both. Adult admissions are divided into two main groups based on commitment type: forensic\(^4\) or civil\(^5\).

Patient Populations Served

Over the past several biennia, the Legislature has added more than 600 inpatient psychiatric beds at the community level. This network complements the state hospital system; however, as noted in Figure 1, it means state hospitals are increasingly filled with patients on forensic commitments. Just ten years ago, the state hospital population was only 30 percent forensic. By fiscal year 2018, 60 percent of patients were on forensic commitments.

The increase in forensic commitments is due, in part, to a steady increase in the number of people determined incompetent to stand trial. This is significant because the average patient on a forensic commitment has a longer length of stay of 187

\(^4\) Admission authorized by the Code of Criminal Procedure, Chapters 46B and C.
\(^5\) Voluntary admission or admission ordered under Health and Safety Code, Chapter 574.
days, compared to the average 75 days for an individual discharged from a civil commitment.\textsuperscript{6}

Compounding the issue, approximately 34 percent of state hospital beds, or 762 beds, are occupied by long-term patients (those with lengths of stay longer than 365 days).\textsuperscript{7} This longer length of stay impacts hospitals’ annual admissions (Figure 2), as the number of beds occupied by long-term patients reduces the number of beds available for new patient admission.

**State Hospital Infrastructure**

As noted in the Comprehensive Plan, while the state hospital system provides state-of-the-art psychiatric services, the facilities’ aging infrastructure creates operational challenges. The Austin State Hospital (ASH) Pre-Planning Report, described in detail later, notes that, “After decades of deferred maintenance, the outmoded ASH has aged beyond repair ... It does not meet many of today’s recommended design features that optimize care delivery and decrease the risk of violence and other negative outcomes.”\textsuperscript{8} All projects supported with Rider 147 funds are intended to create facilities that will enhance patient care by incorporating architectural best practices for psychiatric hospitals into the design.

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\textsuperscript{6} As of August 2018
\textsuperscript{7} As of May 2018
\textsuperscript{8} Department of Psychiatry at The University of Texas at Austin Dell Medical School, *Austin State Hospital Brain Health System Redesign*, 2018.
3. Stakeholder Engagement Efforts

To take full advantage of the unique opportunity to rebuild the state hospital system and to facilitate information sharing and collaboration, HHSC has engaged a diverse array of stakeholders throughout the process.\(^9\)

**Steering Committees**

HHSC partnered with universities, The Dell Medical School at The University of Texas at Austin (UT Dell) and The University of Texas Health Science Center San Antonio (UT Health SA), who formed steering committees to drive pre-planning efforts for state hospital replacement projects at ASH and SASH. Steering committee members include representatives from urban and non-urban local mental health authorities (LMHAs), law enforcement, hospital districts, medical schools, mental health stakeholder organizations, local legislators, hospital or facility architectural and design experts, HHSC representatives, or other key leaders as appropriate.

Steering committees have met at least monthly since early 2018 to ensure steady progress. They formed various subcommittees and work groups, and engaged individuals impacted by the state hospitals from across their service areas.

**Stakeholder Engagement Workshop**

On November 7, 2018, the ASH and SASH steering committees came together with individuals leading the planning effort in Houston for an engagement workshop at HHSC. The event provided HHSC and partners working on the projects in Austin, Houston, Kerrville, Rusk, and San Antonio an opportunity to exchange information and share ideas. While many topics were discussed at the event, the steering committees focused much of the conversation on several themes.

- Efforts to improve the continuum of care and address gaps are critical.
- State hospital patients need housing or residential options at discharge.

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\(^9\) Appendix A lists instances where HHSC has shared information and collected feedback in various settings throughout implementation of Phase I.
Changes to the forensic commitment and competency restoration process should be considered to streamline the system and improve access. These themes are directly addressed by the initiatives and recommendations described in following sections.
4. Improvement Efforts

Over the last three biennia, enhancing the mental health continuum of care has been a considerable focus for HHSC and the Texas Legislature. The Legislature has appropriated significant resources to develop and implement an array of programs and supports for persons with mental illness. Some of these initiatives focus on alternatives to inpatient treatment, while others focus on community-based services like prevention and early identification.

Rider 147 created an opportunity for HHSC to build on previous efforts and improve the overall system of care. Some changes can be implemented by the agency independently, while several require collaboration with other agencies or entities, statutory changes, or additional resources. The sections below summarize ongoing efforts and recommendations for future improvements.

Ongoing Initiatives

Strengthening the Continuum of Care

While Texas has significantly invested in the continuum of care for individuals with mental illness over the last several biennia, there are still areas that need strengthening to optimize the system. According to the ASH Pre-Planning Report, “Various components of the continuum exist within the public sector and function reasonably well ... however there are still gaps with the system that can be addressed in the community.”

Concurrent with efforts to improve state hospital infrastructure, HHSC is working to eliminate gaps in the continuum of care. The agency is collaborating with partners to link programs and initiatives and identify opportunities to support care coordination in the state. Systems involved include, community-based behavioral health, criminal justice, housing, public health, family, peers, and other services.

Immediate and short-term opportunities have been identified, including:

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10 Department of Psychiatry at The University of Texas at Austin Dell Medical School, Austin State Hospital Brain Health System Redesign, 2018.
● Streamline the transition process for people with an intellectual or development disability (IDD) from a state hospital into Home and Community-Based Services programs;
● Review rules and contracts with outpatient providers to strengthen the connections between hospitals and the community;
● Enhance peer support in the inpatient-to-community transition process; and
● Assemble a collaborative review team to examine and employ best practices for long-term, complex patients who no longer need inpatient treatment.

See Appendix B for a full table outlining identified initiatives and opportunities.

**Workforce Retention and Recruitment**

State hospitals have excellent staff. However, it is extremely difficult to recruit and retain a sufficient number of qualified staff to operate at target levels. Over recent years, the state hospitals’ daily census has been reduced due to shortages in critical positions. Beds made unavailable due to workforce shortages have contributed to increased waiting lists and wait times for admission.

HHSC’s workforce efforts include a major communications campaign, with a new recruiting webpage and videos highlighting the state-of-the-art care state hospitals provide. HHSC has conducted a pilot, with initial success, to reduce turnover and contract expenditures through localized pay rate increases for critical positions. HHSC’s 2020-21 Legislative

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11 HHSC recently published a report, State Hospital Workforce, which includes an evaluation of state hospital compensation levels, data on turnover and vacancy rates, details on ongoing recruiting efforts, and recommendations. The report can be found at: [https://hhs.texas.gov/file/102486/download?token=AfA21Xs_](https://hhs.texas.gov/file/102486/download?token=AfA21Xs_)


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*Stakeholders and the public at large are keenly aware of the precarious workforce situation at SASH. Periodic unit closures and suspension of new admissions over the years because of staff shortages is widely known in the community.*

- SASH Pre-Planning Report
Appropriations Request includes an exceptional item for additional targeted pay increases at facilities with the greatest challenges recruiting and retaining staff.

**Develop and Implement Competency Restoration Guidelines**

Both the ASH and SASH pre-planning reports emphasize decreased hospital admissions due to long lengths of stays, particularly longer stays for individuals on forensic commitments.

To address this, a centralized screening and standardized assessment protocol could ensure uniform application of assessment criteria. Additionally, standardized competency restoration curriculum will promote consistency in restoration services across the state, regardless of setting (e.g., state hospital, out-patient, or jail-based programs), and assure judges that an individual could be adequately treated in any setting deemed clinically appropriate.

As noted previously, approximately one-third of the individuals at state hospitals have been hospitalized for more than a year, some on forensic commitments for competency restoration. For individuals who have been in treatment for more than a year, and for whom competency is not likely to be restored, less restrictive treatment options might be appropriate.

**Standardization of Policies and Procedures**

Internally, the State Hospital System has been working to standardize policies and procedures across hospitals through the centralized System Governing Body.\(^{13}\) Administrative and clinical operations at the hospitals are being reviewed, with best practices adopted for a consistent, quality standard of care across the system. HHSC’s primary goal is to increase consistency in clinical and programmatic operations, (e.g., intensive observations, pharmacy, physical medicine, etc.), which will result in more efficient, effective, and predictable outcomes; additionally,

\(^{13}\) Required by The Joint Commission and Centers for Medicare & Medicaid Services.
business processes, such as contracting, accounting, and budgeting, will be improved.

**University Partnerships**

In addition to the formal agreements with universities related to Rider 147 construction projects, HHSC has established partnerships with academic institutions related to workforce development and clinical care. HHSC:

- Partnered with Midwestern State University to create a forensic nursing certification program in which state hospital staff serve as adjunct faculty;
- Contracts with The University of Texas Health Science Center Houston (UT Health Houston) to operate Harris County Psychiatric Center, and for ten full-time doctors to provide telemedicine services to state hospitals and state supported living centers (SSLCs);\(^{14}\)
- Established an agreement with UT Dell to recruit the ASH medical director, who is responsible for leading the hospital’s clinical operations; and
- Contracts with The University of Texas Health Science Center Tyler (UT Health East Texas) to operate a 14-bed crisis stabilization unit and 30-bed inpatient unit. UT Health East Texas and HHSC are also examining additional areas for enhanced collaboration, including expanded workforce programs, provider recruitment and retention, and contracted medical services.

As seen in the examples above, the uniqueness of each community creates an opportunity to develop partnerships that meet the specific needs of each state hospital and academic institution. HHSC recommends the agency and academic institutions build on the success of current agreements and explore additional opportunities for partnerships related to state hospital operations.

**Recommendations for Further Enhancements**

HHSC and its partners have been working diligently to enhance the continuum of care for individuals with mental illness in Texas. A major focus of this work has been to address issues impacting patients’ length of stay. Below are specific recommendations for additional enhancements to the system, which HHSC has

\(^{14}\) For the operations of the Harris County Psychiatric Center, HHSC contracts with the Harris Center (an LMHA), which subcontracts with UT Health Houston.
developed by working closely with the ASH and SASH steering committees\textsuperscript{15} and other stakeholders.

**Develop or Optimize Tiered Residential Transition Options**

The ASH and SASH pre-planning reports emphasize the need for additional residential options for individuals transitioning out of a state hospital. While programs have been developed, there are still many state hospital patients for whom an appropriate residential placement is a barrier to discharge. The SASH Pre-Planning Report recommends additional “housing options for patients who have severe mental illnesses, especially those with chronic, difficult to remit psychotic symptoms and need secure facilities.”\textsuperscript{16} Similarly, the ASH Pre-Planning Report endorses, “… a comprehensive plan for expanding residential care, supported housing, and home health capacity.”\textsuperscript{17}

Therefore, HHSC recommends a system of tiered residential transition options to meet the varied needs of each individual. Options should include:

- Structured residential settings that foster readiness for community residence;
- Veterans Administration housing options for qualified patients; and
- Available funding that follow patients out of the hospital and pays for options such as assisted living, supported housing, or group homes.

\textsuperscript{15} As part of the pre-planning process for hospital replacement projects at ASH and SASH, the steering committees were asked to summarize their work and recommendations into pre-planning reports. The pre-planning report executive summaries, including recommendations made by the steering committees, are included as Appendices C and D.


\textsuperscript{17} Department of Psychiatry at The University of Texas at Austin Dell Medical School, *Austin State Hospital Brain Health System Redesign*, 2018.
**Revise Statutes Related to the Admissions Process**

Statutory changes to the admissions and dangerousness review processes can provide greater efficiency of state hospital bed use. Current law requires treatment in an MSU maximum security facility for people deemed incompetent to stand trial for charges listed in Code of Criminal Procedure, Article 17.032(a). As a result, neither the state hospitals nor the courts have discretion to send a patient to a more clinically appropriate setting for admission.

The lack of clinical discretion limits HHSC’s ability to manage its resources and apply thoughtful and professionally appropriate determinations to maximum security admissions. This impacts wait lists, as the longest wait times are for persons statutorily required to be admitted to a maximum security facility.

HHSC recommends statutory changes to capitalize on the State Hospital System’s clinical and forensic expertise and ability to examine the specific circumstances related to each individual’s situation and determine the most appropriate facility for admission (i.e., MSU, non-MSU, SSLC, or outpatient). This revised process would ensure a person receives services in the most appropriate treatment setting on a case-by-case basis, taking into account factors not currently considered in the admissions process, such as treatment history, current mental health condition, and IDD diagnosis.

HHSC also recommends changing the mandatory 30-day evaluation period at an MSU for individuals found not guilty by reason of insanity to allow earlier review within the initial 30-day period, or while the individual is still in jail.

These changes would allow individuals to be treated in the least restrictive setting determined appropriate and would decrease MSU demand.

**Provide Consultation to Initiate Psychiatric Medication in Jail**

Clinical consultation services performed by state hospital psychiatrists, LMHAs, or jail mental health providers, for individuals who are incarcerated could improve their mental health. Expert psychiatric resources would equip jails to start and
guide appropriate treatment as early as possible once a need is identified, thus helping to decrease lengths of stay for individuals admitted to the hospital for competency restoration or eliminate the need for hospitalization.

Many individuals wait for admission to the hospital in jails, where the initiation of medications can occur. Some LMHAs have formal relationships with jails for the provision of mental health care to people who are incarcerated, but this is not always the case. Mental health care in jails differs significantly across the state due to variations in resources. Some jails have financial resources and the clinical staff and expertise necessary to start psychiatric medications, some of which have complex monitoring protocols; however, others do not.

LMHAs, state hospitals, or other entities possess the clinical and forensic services expertise necessary and could consult with jails on medication protocols. With resources to support clinical staff and medications, consultation could allow more jails to initiate psychiatric medications to individuals before admission to a state hospital. For the individuals waiting, access to earlier treatment improves well-being and long-term recovery. At the same time, individuals who have already initiated medications may be more stable, and have a shorter length of treatment necessary, allowing state hospitals to serve more individuals.

**Establish an Interdisciplinary Team**

As discussed previously in this report, and in the ASH and SASH pre-planning reports, over 750 state hospital beds are occupied by long-term patients, meaning that over 30 percent of beds within the system are essentially inaccessible for new patients. Many long-term patients do not require acute inpatient psychiatric hospitalization, but do not have an appropriate alternative placement.

As a first step, creating an interdisciplinary team, with state hospital staff, community providers, academia, and other experts to review these cases could improve outcomes for patients and increase access to care for those waiting by moving individuals to less-restrictive, more home-like settings. The team should have the resources to conduct an analysis of each patient’s specific needs, work to eliminate barriers to discharge, and develop an appropriate discharge plan.

**Construct New State Hospital Facilities**

As highlighted in the ASH and SASH pre-planning reports, state hospitals play an integral role within the continuum of care. They provide care for the most complex
mental health patients who require longer lengths of stay and the majority of patients on forensic commitments. However, the current conditions of some hospital buildings are adversely impacting the ability to operate. To maintain the current level of service, it is necessary to construct new state hospital facilities to replace those that cannot be efficiently maintained or renovated. Details about specific projects are outlined in the “Phase I Project Summary” and “Phase II Project Summary” sections.
5. Phase I Project Summary

The following section provides a detailed summary of each project implemented during Phase I of the state hospital redesign initiative. See Appendix D for details.

Construction Project Process

Construction projects are divided into three primary stages:

- Pre-planning: exploratory stage where community need, resources, and specialty facility design elements are developed with stakeholders;
- Planning: architectural and engineering plan design and development; and
- Construction: final stage of the building or renovation project.

State Hospital Replacements

As previously described, HHSC partnered with universities to engage in the pre-planning and planning for the complete replacement of two state hospitals that have “-aged beyond repair,” Austin and San Antonio. The work done during pre-planning and planning will prepare these sites for construction during Phase II.

HHSC partnered with UT Dell to replace ASH with a new, minimum 240-bed facility and with UT Health SA to replace SASH with a new, minimum 300-bed facility.

Interagency cooperation contracts for pre-planning were executed in February 2018. As described previously, this work focused on establishing steering committees with diverse mental health experts and other stakeholders represented from the hospitals’ respective service areas.

HHSC amended contracts with the universities to include architectural planning activities. UT Dell and UT Health SA subcontracted with architectural and

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18 Department of Psychiatry at The University of Texas at Austin Dell Medical School, Austin State Hospital Brain Health System Redesign, 2018. Austin State Hospital Pre-Planning Report.
engineering firms, which began designing the replacement hospitals in the fall of 2018. Both universities also engaged a construction manager at risk (CMR).\(^{19}\)

Construction requires additional appropriations. If funded by the 86th Legislature, construction could begin in late 2019 and be complete by mid-2023.

**Continuum of Care Campus in Harris County**

HHSC partnered with UTHealth Houston to build a new psychiatric hospital with at least 240 beds. The new hospital will be adjacent to Harris County Psychiatric Center in the Texas Medical Center. Once complete, HHSC will own the building and plans to contract with UTHealth Houston for facility operation.

HHSC executed an interagency cooperation contract with UTHealth Houston for the planning and construction of the new hospital in June 2018. HHSC then finalized a long-term lease for the property with the Texas Medical Center in August 2018.

UTHealth Houston executed a subcontract with an architectural firm, which began planning work immediately after the lease was finalized. UTHealth Houston also executed a contract with a CMR in December 2018. Construction should begin in mid-2019 and be complete by the end of 2021.

**Rusk State Hospital Units**

At RSH, HHSC is using the CMR model to construct a new 100-bed MSU and, if construction is funded by the 86th Legislature, a new 100-bed non-MSU. The overall capacity of RSH is expected to remain the same after construction is complete; however, MSU capacity will increase by converting 60 non-MSU beds to MSU beds, expanding the MSU at RSH from 40 to 100 beds.

To improve efficiency, HHSC will complete architectural planning for both units simultaneously. However, Phase I funds only support the construction of the MSU. Additional appropriations are necessary for construction of the non-MSU building.

\(^{19}\) The CMR provides assistance to the owner and the architectural firm during the design process. The CMR provides the guaranteed maximum price after the completion of an interim design phase (decided by all the parties) and assures that the project can be built within that price and with the specified timeline without compromising the performance and quality of the project.
HHSC expects to execute contracts with an architectural and engineering firm and a CMR in early 2019. Construction of the MSU is expected to begin late 2019 and be complete by early 2022. If appropriations for the non-MSU building are received in Phase II, construction is anticipated to begin in late 2021 and be complete in early 2024.

**State Hospital Renovations**

To improve access and address the wait list as quickly as possible, HHSC initiated two renovation projects to increase capacity in the near term. Units at KSH and SASH will be completed in time for the agency to begin admitting patients in fiscal year 2021; however, without additional operations funding, the State Hospital System will not have the budget to support the additional 110 beds. Funding requests are outlined in Table 2.

**Kerrville State Hospital**

HHSC is renovating four buildings on the KSH campus to add 70 MSU beds. HHSC began architectural planning after finalizing a contract with an architectural and engineering firm in February 2018. The construction documents were finalized in January 2019. Construction is scheduled to begin in June 2019, and HHSC anticipates admitting patients to the MSU in early 2021. To support operations once construction is complete, HHSC has requested $7.9 million for the 2020-21 biennium.

**San Antonio State Hospital**

HHSC began renovating a building at SASH to add 40 non-MSU beds. Planning for the project began in February 2018 after finalizing a contract with an architectural firm. Construction documents were finalized in November 2018, with construction expected to begin in May 2019, and patients moving in by fall 2020. Operation of the new 40-bed unit will require $7.6 million for the 2020-21 biennium.

**Table 2. Operations – Completed Phase I Projects**

<table>
<thead>
<tr>
<th>Project</th>
<th>Cost Estimate</th>
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<tbody>
<tr>
<td>Kerrville State Hospital MSU Renovation</td>
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<td>$7,580,300</td>
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<tr>
<td>Project</td>
<td>Cost Estimate</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Operations Total</td>
<td>$15,514,375</td>
</tr>
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**Potential Projects**

On July 16, 2018, HHSC submitted a funding request to the Legislative Budget Board (LBB) and Office of the Governor to begin pre-planning for the construction of new psychiatric hospitals in areas of the state that do not have a state hospital and have been identified as potential areas for capacity expansion. If approved, the funding would allow HHSC to partner with two additional academic institutions, The University of Texas Southwestern and Texas Tech University Health Science Center, to explore opportunities to build a state hospital in the Dallas-Fort Worth Metroplex and the Panhandle, respectively.

**Projects Not Approved**

In the Comprehensive Plan, HHSC outlined its intent to request approval from the LBB and Office of the Governor to purchase the vacant Hillcrest Hospital in Waco and begin initial pre-planning efforts. This funding was not approved; therefore, HHSC did not move forward with the project.
HHSC’s Legislative Appropriations Request includes items to support state hospital redesign by funding operations for complete projects, moving planned projects into construction, and initiating pre-planning and planning for new projects. Requests are outlined in the following sections and detailed in appendices E, F, and G.

## Phase II Projects – Construction

In Phase I, HHSC used Rider 147 funds to support pre-planning and planning efforts at two state hospital campuses in need of complete replacement, ASH and SASH. These efforts, along with planning efforts at RSH, provided detailed cost estimates. During Phase II, HHSC is requesting construction funds to complete these projects.

- Austin State Hospital: The anticipated cost to replace the current hospital infrastructure with a new 240-bed facility is **$283 million**.
- San Antonio State Hospital: The anticipated cost to replace the current hospital with a new 300-bed facility is **$323 million**.
- Rusk State Hospital Non-MSU: Construction of the 100-bed non-MSU is estimated to cost **$90 million**.

### Table 3. Phase II: Construction – Current Projects

<table>
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<th>Project</th>
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<tr>
<td>Austin State Hospital Replacement(^{20})</td>
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<td>$90,054,363</td>
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<tr>
<td><strong>Construction Total</strong></td>
<td><strong>$695,998,723</strong></td>
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</tbody>
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\(^{20}\) Detailed cost estimates are in Appendix E.
\(^{21}\) Detailed cost estimates are in Appendix F.
\(^{22}\) Detailed cost estimates are in Appendix G.
The Comprehensive Plan also calls for planning and construction of new state-funded psychiatric hospitals in Dallas-Fort Worth and the Panhandle in Phase II. These areas have been identified because of their current distance from a state hospital. While the original plan assumed construction for these projects could start in the 2020-21 biennium, because pre-planning has not been approved, construction would be delayed until the 2022-23 biennium.23

**Phase II Projects – Pre-Planning and Planning**

*Analysis for the Ten-Year Plan for the Provision of Services to Persons Served by State Psychiatric Hospitals* noted that the condition of five state hospitals made it more cost effective to replace than to maintain the facilities.24 HHSC began to address three of these campuses in Phase I: ASH, SASH, and RSH. During Phase II, HHSC is requesting funds to begin pre-planning and planning activities at the other campuses identified for replacement, Terrell State Hospital and North Texas State Hospital - Wichita Falls ($17.5 million each), as outlined in Table 4.

**Table 4. Phase II: New Projects**

<table>
<thead>
<tr>
<th>Project</th>
<th>Cost Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terrell State Hospital (Pre-Planning and Planning)</td>
<td>$17,500,000</td>
</tr>
<tr>
<td>North Texas State Hospital – Wichita Falls (Pre-Planning and Planning)</td>
<td>$17,500,000</td>
</tr>
<tr>
<td>Dallas-Fort Worth Metroplex New Facility (Planning)</td>
<td>$16,500,000</td>
</tr>
<tr>
<td>Panhandle New Facility (Planning)</td>
<td>$16,500,000</td>
</tr>
<tr>
<td><strong>New Projects Total</strong></td>
<td><strong>$68,000,000</strong></td>
</tr>
</tbody>
</table>

23 This assumes pre-planning funds allocated in Phase I will be approved and are not needed in Phase II funding.

In summary, the following is the total updated request for the Comprehensive Plan for State-Funded Inpatient Mental Health Services.

**Table 5. Total 2020-21 Funding Needs**

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Subtotal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction – Current Projects (Table 3)</td>
<td>$695,998,723</td>
</tr>
<tr>
<td>Operations – Completed Projects (Table 2)</td>
<td>$15,514,375</td>
</tr>
<tr>
<td>New Projects (Table 4)</td>
<td>$68,000,000</td>
</tr>
<tr>
<td>HHSC Project Oversight and Coordination</td>
<td>$5,157,372</td>
</tr>
<tr>
<td><strong>Total Phase II Request</strong></td>
<td><strong>$784,670,470</strong></td>
</tr>
</tbody>
</table>
Since HHSC submitted the Comprehensive Plan in August 2017, in-depth analyses by HHSC, along with its partners, has led to the development of recommendations for improving the system of care for individuals in need of inpatient psychiatric care in Texas. HHSC has also taken significant steps to begin implementing Phase I of the state hospital redesign initiative to rebuild state hospital infrastructure. The agency has begun pre-planning and planning for construction projects in Austin, Houston, Kerrville, Rusk, and San Antonio. Completion of these projects will help increase access to the state hospitals; however, other changes as outlined above are needed to ensure sustainable improvements to the system.

The new hospital facilities, coupled with the recommended improvements to state hospital operations and the continuum of care, will significantly impact the lives of Texans in need of state-funded inpatient mental health services. While work on Phase I continues at its brisk pace, HHSC is also looking ahead to Phases II and III, 2020-21 and 2022-23 biennia, respectively, and will continue to work with legislative and community partners to achieve the best outcomes for Texans.
# List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASH</td>
<td>Austin State Hospital</td>
</tr>
<tr>
<td>BGSF</td>
<td>Building Gross Square Footage</td>
</tr>
<tr>
<td>CMR</td>
<td>Construction Manager at Risk</td>
</tr>
<tr>
<td>HHSC</td>
<td>Health and Human Services Commission</td>
</tr>
<tr>
<td>IDD</td>
<td>Intellectual or Developmental Disability</td>
</tr>
<tr>
<td>KSH</td>
<td>Kerrville State Hospital</td>
</tr>
<tr>
<td>LBB</td>
<td>Legislative Budget Board</td>
</tr>
<tr>
<td>LMHA</td>
<td>Local Mental Health Authority</td>
</tr>
<tr>
<td>MSU</td>
<td>Maximum Security Unit</td>
</tr>
<tr>
<td>RSH</td>
<td>Rusk State Hospital</td>
</tr>
<tr>
<td>SASH</td>
<td>San Antonio State Hospital</td>
</tr>
<tr>
<td>SSLC</td>
<td>State Supported Living Center</td>
</tr>
<tr>
<td>UT Dell</td>
<td>The Dell Medical School at The University of Texas at Austin</td>
</tr>
<tr>
<td>UTH Health Houston</td>
<td>The University of Texas Health Science Center at Houston</td>
</tr>
<tr>
<td>UT Health East Texas</td>
<td>The University of Texas Health Science Center Tyler</td>
</tr>
<tr>
<td>UT Health SA</td>
<td>The University of Texas Health Science Center at San Antonio</td>
</tr>
</tbody>
</table>
## Appendix A. Opportunities for Stakeholder Engagement

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHSC Public Hearing</td>
<td>August 10, 2017</td>
</tr>
<tr>
<td>Texas State of Mind Conference</td>
<td>September 2017</td>
</tr>
<tr>
<td>Behavioral Health Advisory Committee</td>
<td>October 2017; January 2018; May 2018</td>
</tr>
<tr>
<td>Joint Committee on Access and Forensic Services</td>
<td>October 2017; January 2018; April 2018</td>
</tr>
<tr>
<td>Texas Indigent Defense Council</td>
<td>November 2017</td>
</tr>
<tr>
<td>Behavioral Health Coordinating Council</td>
<td>January 2018</td>
</tr>
<tr>
<td>SASH Town Hall</td>
<td>February 7, 2018</td>
</tr>
<tr>
<td>ASH Town Hall</td>
<td>February 9, 2018</td>
</tr>
<tr>
<td>KSH Town Hall</td>
<td>February 21, 2018</td>
</tr>
<tr>
<td>RSH Town Hall</td>
<td>February 14, 2018</td>
</tr>
<tr>
<td>Terrell State Hospital Town Hall</td>
<td>April 4, 2018</td>
</tr>
<tr>
<td>North Texas State Hospital Town Hall</td>
<td>May 9, 2018</td>
</tr>
</tbody>
</table>
## Appendix B. Continuum of Care Initiatives and Opportunities

<table>
<thead>
<tr>
<th>Categories:</th>
<th>Initiatives and Opportunities:</th>
</tr>
</thead>
</table>
| Issues Being Actively Addressed | - Establish a review team for complex patients with lengths of stay greater than 365 days who no longer need inpatient care.  
- Streamline transition for individuals with IDD from institutions, including state hospitals, to home and community-based services.  
- Enhance peer support services in the inpatient-to-community transition process.  
- Review rules and contracts with outpatient providers to strengthen connections between hospitals and the community in discharge planning for state hospital patients.  
- Coordinate with the Veterans Administration and Veterans Mental Health Eligibility and Service Coordination |
| Issues Requiring Additional Funds | - Dedicate LMHA continuity of care staff at each state hospital.  
- Develop transitional housing options.  
- Enhance community outpatient intensive treatment programs.  
- Develop or optimize tiered residential transition options.  
- Provide consultation for psychiatric medications to jails. |
| Issues Requiring Additional Support | - Review and revise the Home and Community Based Services-Adult Mental Health program.  
- Change statute to determine the most appropriate facility for competency restoration for persons committing certain crimes.  
- Change mandatory 30-day evaluation period at an MSU for individuals found not guilty by reason of insanity. Statutory changes could allow earlier review within the initial 30-day period, or while the individual is still in jail. |
Appendix C. Executive Summary of the Austin State Hospital Pre-Planning Report as Prepared by the ASH Steering Committee

Submitted to HHSC in December 2018
AUSTIN STATE HOSPITAL

ASH Brain Health System Redesign

Report

As Requested by
Senate Bill No. 1, Riders 145, 147
Eighty-fifth Texas Legislature

The University of Texas at Austin Dell Medical School
December 2018
Executive Summary
EXECUTIVE SUMMARY

Texans deserve the best mental (brain) health care available. In response to this goal, the 85th Legislature invested $300 million to initiate and plan several public hospital expansions and replacements to advance the mental health care of its citizens. The Legislature expressed its intent to complete expansion and replacement of the hospitals over a three biennia period. Additionally, the Legislature encouraged academic/public partnerships in these plans. After decades of deferred maintenance, the outmoded Austin State Hospital (ASH) must be replaced. Austin State Hospital was specifically referenced in the Cannon Report as needing replacement with planning funds toward this end allocated in the 85th Session. Consequently, the Health and Human Services Commission (HHSC) approached Dell Medical School (DMS) of the University of Texas at Austin to lead the redesign of ASH and the delivery of mental health services in the ASH Service Area. Dell Medical School organized a regional Steering Committee and planning cascade, engaging stakeholders from throughout the ASH Service Area to complete this task. The core principle leading planning was “People first.”

ASH serves 38 counties for adults and 75 counties for youth. In FY18, ASH operated 252 beds, including a 30-bed child and adolescent unit (CAPS). At times, capacity at ASH has been reduced due to workforce shortages, a problem that affects the entire Service Area and state. ASH is always full. The structure and workflow of the hospital are better designed for longer-term subacute care rather than either short-term acute stabilization or residential care. Nonetheless, approximately 70 individuals essentially live at ASH. Consequently, these 70 beds are ‘off-line’ for new admissions, resulting in 95 individuals each day waiting to be accepted into ASH, usually from jails. Increasingly, ASH is occupied by individuals mandated to the hospital by courts for competency restoration, waiting to stand trial. Competency restoration procedures are overly complex and conflate clinical need for treatment with inability to participate in legal decision-making. Waitlists in jails delay initiation of treatment and timely resolution of legal charges. A typical inpatient competency restoration at ASH costs more than $75,000 and lasts longer than ideally recommended. Less expensive, more effective, alternatives

The core principle leading planning was “People first.”
are available, if gaps and processes in care can be addressed. Indeed, underfunded gaps in mental health care in the ASH Service Area cost Texas over $150 million annually, with much of this cost in the legal system. Better allocation of these dollars would gain efficiencies and make care more effective.

Within the ASH Service Area, more than 20 community hospitals treat over 12,000 people annually. These hospitals typically have up to 150 beds available daily to provide acute stabilization in lieu of an admission to ASH. These facilities are better designed than ASH for short-term admissions. The 12 regional Local Mental Health Authorities (LMHAs) buy private beds in these facilities to manage people needing care. These LMHAs also serve over 80,000 adults and 50,000 youth annually in outpatient and crisis programs. Despite providing these services, the existing systems cannot address the epidemiological need. Currently, nearly 600,000 residents in the Service Area will experience a need for mental health services. Additionally, the Service Area population is rapidly growing and mental disorders directly scale with the population. Simply building a few more hospital beds will not manage this growth.

With this information in mind, we developed a care continuum (the ASH Brain Health System Redesign). This continuum served as a substrate to frame recommendations for the 86th Legislative session and beyond. These recommendations are:

**Transform the Austin State Hospital (ASH) Campus**

1. Replace the existing outmoded adult hospital with a new state-of-the-art facility.
   a. Appropriate at least $285M to replace the hospital during the 86th Legislative session.
   b. Identify funding to update and maintain the ASH Child and Adolescent units.
   c. Have HHSC fund a team to relocate long-stay individuals to better placements.
2. Improve ASH operations.
   c. Develop a plan to transfer management of ASH operations to an academic partner.
   d. Increase ASH operating budget to offer locally competitive employee salaries.
3. Change the ASH reporting structure.
   e. Move ASH governance and fiduciary oversight to an independent hospital board.
4. Initiate a brain health platform on the ASH campus and beyond.
   f. Have HHSC release an RFI to identify partners to build a mental health care continuum.
   g. Have HHSC fund a campus oversight team to lead campus development.
Optimize the Use of Community Psychiatric Beds in the Region

1. **Expand the community psychiatric bed-purchasing program (CPB).**
   a. Increase CPB funding to LMHAs by at least 10% (~$1.7 million for 200-250 annual admissions).

2. **Expand CPB to provide short-term competency restorations.**
   b. Fund a pilot program to expand CPB programs for short-term competency restorations.

Redesign Competency Restoration Programs and Processes

1. **Establish consistent competency standards and assessments across all courts.**
   a. Ask the Judicial Commission on Mental Health (JCMH) to convene a workgroup to develop statewide competency standards, assessments and workflows.

2. **Establish a formal 60-day inpatient competency restoration limit.**
   b. Change 46B statutes to set time expectations and a formal 60-day cap on competency restoration processes to disentangle clinical care and legal decision-making.

3. **Create a regional competency restoration team to work across venues.**
   c. Fund a regional competency restoration team to work across venues.

Increase Residential Care and Supported Housing Capacity

1. **Foster better use of the HCBS-AMH 1915(i) State Plan Amendment program.**
   a. Have HHSC fund a regional work group to eliminate perceived and real barriers to better use of HCBS-AMH 1915(i) funding to expand supported housing.

2. **Finance expansion of evidence-based residential care and supported housing.**
   b. Have HHSC develop a comprehensive plan for expanding residential care, supported housing, and home health capacity in the state (including ASH Service Area).

One perpetual belief about paying for mental health care is that it is ‘too expensive’; inherent in this notion is the myth that if we do not pay for mental health care, there are no costs. However, mental health expenses occur regardless of the systems we do or do not provide to address them;
with well-designed care systems, these costs can be quantified and designated to improve care as efficiently and effectively as possible. More importantly, an established continuum of care is specifically designed to decrease the human suffering associated with these illnesses. We believe that investment in new public psychiatric hospitals is a great step in the evolution of how we care for Texans. Doing so can lead Texas to the forefront of public mental health as a national leader in how best to advance brain health.
Appendix D. Executive Summary of the San Antonio State Hospital Pre-Planning Report as Prepared by the SASH Steering Committee

Submitted to HHSC in December 2018
Planning Report for the Redesign of San Antonio State Hospital and Reinvigoration of Behavioral Health Care in South Texas

THE EXECUTIVE COMMITTEE FOR THE REDESIGN OF SAN ANTONIO STATE HOSPITAL
Submitted to Texas Health and Human Services
December 2018
Redesign of San Antonio State Hospital and Reinvigoration of Behavioral Health Care in South Texas

Prepared by the University of Texas Health Science Center at San Antonio for Texas Health and Human Services under contract HHS000099200001, authorized by S.B. Bill 1, Riders 145 and 147 of the 85th Texas Legislature.

Developed in collaboration with:
- Methodist Health Ministries of South Texas
- Bexar County, Sheriff’s Office and Department of Behavioral & Mental Health
- Center for Health Care Services
- City of San Antonio, Department of Human Services & Fire Department’s Emergency Medical Services
- Clarity Child Guidance Center
- Gulf Bend Center
- Haven for Hope
- Hill Country MHDD Centers
- Meadows Mental Health Policy Institute
- National Alliance for Mental Illness, San Antonio
- Southwest Texas Regional Advisory Council for Trauma
- Texas Health and Human Services, Behavioral Health
- University Health System
- University of Texas at San Antonio School of Architecture

Citation Information:
Buildings themselves do not cure behavioral health disorders. However, their design and upkeep do affect the successful implementation of direct treatments. They can make the difference between life and death for many patients who rely on their environment to provide safety and to instill hope that they might overcome crushing despair. The impact of facility design on staff morale and safety also has a growing evidence base (1-3).

Just as importantly, a facility's characteristics broadcast how a community values, disdains, or merely tolerates those whom it serves. Bleak and austere surroundings convey expectations for deprivation, sacrifice, or repentance. Bright and enriched settings suggest optimism and affirms that the community holds those residing there in high regard. Whatever its original design and intended ambience, poor maintenance signals that residents and staff are a low priority for the community's resources and concern. Bearing in mind that state behavioral health inpatient facilities are often one's home for extended periods, the physical environment exerts a profound impact on how patients regard themselves and can either aggravate families' worst fears about their loves ones' plight or nourish hope that even severe disorders can be surmounted.

The purpose of behavioral health care is to help people become well. Hospital services are an important element of that. However, the vast majority of those obtaining treatment at San Antonio State Hospital (SASH) have longer-term care needs that no single inpatient stay, no matter how magnificent the building, can fully alleviate. Many people may not have needed SASH's services if less restrictive community-based treatments and services had been either better available or more effectively delivered. Therefore, this report addresses pressing issues around behavioral health care in our communities because of their profound implications for both the individuals who are the users of inpatient services and for the efficient use of hospital resources to yield the greatest benefit.

To fulfill the requests that Texas Health and Human Services specified in our contract's Statement of Work, this report's organization progresses from assessment of current and future needs to recommendations for the planned replacement of SASH. Accordingly, Section I establishes context by summarizing the development of hospital care for those with behavioral health disorders and discusses recent trends nationwide that shape the role of state hospitals and the challenges they face today. Section II contains an assessment of needs that reflects extensive consultation with
community stakeholders. Section III presents recommendations concerning the new facility and covers both clinical care models and building characteristics. Their goals are to be responsive to community and staff concerns, issues raised in prior assessments of the facility, and grounded in contemporary best-practices. Section IV likewise contains recommendations for the broader public mental health system in our region. Section V presents a vision for a better integrated and effective system of behavioral health care that overcomes its current shortcomings.

The table below summarizes our recommendations. In the electronic version of this document, each recommendation contains a link to its more detailed presentation and to the other parts of this report that contain additional relevant background.

At a Glance: Key Recommendations of the Executive Committee for the Redesign of San Antonio State Hospital

<table>
<thead>
<tr>
<th>I. Clinical Practice Models and Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Refocus SASH’s Service and Admission Patterns to Serve as a Tertiary Treatment Center</td>
</tr>
<tr>
<td>We strongly endorse the recommendations from numerous prior reports that Texas’ state-operated psychiatric hospitals become almost exclusively “tertiary care facilities for the most complex mental health patients and a significant portion of the forensic population.”</td>
</tr>
<tr>
<td>2. Improve Regional Collaboration</td>
</tr>
<tr>
<td>Form a Regional Council involving SASH, LHMA’s, and local law enforcement to improve transparency and consistency for admission criteria, waitlists, and other processes.</td>
</tr>
<tr>
<td>3. Promote Recovery and Readiness for Community Life</td>
</tr>
<tr>
<td>a. Implement a robust rehabilitation program.</td>
</tr>
<tr>
<td>b. Incorporate principles of trauma-informed care.</td>
</tr>
</tbody>
</table>
c. Maintain and expand peer support collaboration.
d. Make physical fitness and health a priority, reduce established risk of early mortality

4. Improve Discharge Planning & Transitional Programming
   a. Upgrade technology and available personnel to insure access to benefits.
   b. Improve coordination with external agencies before discharge.
   c. Create transitional housing programs to evaluate and foster readiness for community residence.
   d. LMHAs that pursue Certified Community Behavioral Health Clinic status are expected to enhance their range of services, accessibility, and care coordination capacities. State hospitals may benefit from these developments, and the state should support LMHAs in these efforts.

5. Insure Timeliness and Continuity of Pharmacotherapy
   a. Improve communication on current and regimens and response between inpatient and outpatient providers.
   b. Anticipate potential problems with postdischarge implementation of treatment.
   c. Visit with prescriber should occur within 7 days of discharge.
   See additional recommendations for system-wide continuity of care, p. 81ff.

6. Develop ECT Program and TMS Capability
   In addition to inpatient program, also consider possible role of facility for outpatient treatment and maintenance when private local providers are not available to the patient.
7. Upgrade Communication and Information Technology Capabilities
   a. Adequate supply and quality of computer and related facilities for patient training and personal use, with appropriate controls for content and security.
   b. Install a dedicated wi-fi network for visitors.
   c. Replace current card-stamp system to record patient program engagement with wristband scan system, use data for treatment monitoring and regulatory purposes.
   d. Adopt silent personal alarm system, staff have alert button on their person that notifies team of location when assistance is needed and is less inflammatory for agitated patients.
   e. Video/telephonic capabilities to enable, among other things:
      - Contact with family members in therapy sessions and ‘virtual visitation’
      - Telemedicine with outside specialists
   f. Integrate technology systems between campuses and within state hospital system and its partners.

8. Facilitate Family Participation in Treatment and Provide Support
   a. Leverage technology to overcome limitations of significance distance.
   b. Maintain and enhance overnight lodging capacities for families with long travel times.
   c. Establish convenient Family Resource Center staffed by peer support and benefit specialists.
   d. Enable communication between direct care/nursing staff and caregivers for education, modelling of beneficial approaches to help patient, and support.

9. Capacity for On-Site Medical Care
   a. A suitably equipped examination room should be on each unit.
   b. Maintain and enhance general ambulatory medical care on site, as well as dental and ophthalmic/optometric services.
c. HHS should study the issue of pregnant women who need admission to state hospitals.
d. Take care in the design of living units at SASH that they are accessible to persons with physical limitations or in need of “in-home” medical procedures such as portable oxygen and GI tubes.

10. Develop Clinical Program and Aftercare for those with Early Phase Psychosis

a. Consider dedicated unit or subcluster within unit for early-episode young adults.
b. Develop facilities on-campus and in aftercare locations that are inviting and appealing to non-chronically ill patients.

11. Adolescents

a. Restrict SASH resources for those with demonstrable need for extended-stay inpatient care and fill need for acute-care hospitalization services closer to home communities.
b. Maintain and enhance school-based educational services. Create charter school or similar entity if the campus' local school district opts to scale back resources.
c. Recognize special training required for direct care staff.
d. Insure adequate rehabilitation staff to maintain activity and structure.
e. Facilitate family partnerships and peer support services.
f. Make overnight lodging available for families travelling significant distances so that travel burden does not detract from optimal visit time and interaction.

12. Develop Alternatives to Hospitalization for Long-Stay Elderly Individuals

Locate or devise care settings more appropriate for lifelong placement than state psychiatric hospitals.
13. Base Admission for those with Developmental Disorder on Functional Criteria and Improve Range of Services

a. Diagnoses of intellectual disability, autism spectrum disorder, and other developmental conditions should not automatically preclude admission to SASH. Suitability determinations should instead be based on functional capacities and needs. When these can be accommodated within the hospital’s resources, such supports should be available. Consultation from the adjacent state living center may be helpful.
b. Solutions for those with longer-term behavioral-support needs should be developed in collaboration with other agencies.

14. Reduce Suicide Risk with Programmatic Solutions

a. Patient routine must include activities which are gratifying and where one experiences making a positive contribution that is useful and appreciated.
b. Constant observation for patients at high self-harm risk cannot be passive but need to include engagement and encouragement to engage in activities as appropriate.

15. Substance Use and Addiction Treatments

a. Enhance substance abuse treatments tailored to needs of those with behavioral health disorders and perhaps age group.
b. Recognizing the contextual nature of many addictions, early and vigorous liaison with aftercare providers is important to relapse prevention.

16. Forensic Commitments: Reduce Reliance on SASH for Competency Restoration

a. Heed prior state reports emphasizing the drain on clinical capacity that arises when state hospitals are overused to treat individuals who lack adjudicative competence due to psychiatric illness.
b. Improve resources for outpatient treatment of those posing no imminent danger.
c. Strengthen treatment capacity for those held in jails pending transfer to state hospital on incompetent-to-stand-trial commitments.
d. Disallow extensions of inpatient commitments for those with conditions unlikely to improve to attain adjudicative competence.

17. Forensic Commitments: Develop Benchmarks for Adequate Pharmacotherapy Trials

18. Ensure Adequate Staffing and Address the Chronic Problems of Workforce Recruitment and Retention
   a. Create realistic staffing ratios for the patient group served that comport with best practices. Factor in periodic needs to address behavioral crises, 1:1 assignments, adequate break times, etc. without detriment to the care of other patients (see also Safety, p. 75)
   b. Improve the career appeal of state hospital employment through competitive compensation, professional development opportunities, and the positive experience of longer-term engagement with patients than other settings.

II. The Built Environment: New Facility Characteristics

1. Design and Construction Incorporates Current Best-Practices and Guidelines for the Environment of Care
   a. Optimize social density.
   b. Create homelike, noninstitutional environment.
2. Unit Size
   a. Limit maximum adult census to 24 per unit.
   b. Limit maximum adolescent census to 16 per unit.
   c. Design and program for smaller groupings based on age, functional status, or treatment needs.

3. Design Layout to Optimize Social Density
   a. Prevent sense of crowding and social compression.
   b. Respect patient privacy to the extent compatible with individual safety and therapeutic needs.
   c. Provide variety of smaller, distinct social and seating arrangement for patients to self-calibrate degree of social engagement they find manageable.

4. Design Admission and Facility Entryways to Convey Therapeutic Atmosphere

5. Create Unit Entry & Reception Areas that are Inviting and Secure
   a. Situate observation area within view of entry to promote security and visitor orientation and welcome.
   b. Create “coves” or circular arrangement of seating; avoid linear seating arrangements that evoke “bus station” ambience.
   c. Incorporate mixture of social areas rather than a single overwhelming and compressed single traditional dayroom.

6. Insure Easy Access to Fresh Air and Outdoor Spaces
   a. Design for open feeling, rather than confining/courtyard-like outdoor areas.
   b. Landscaping and hardscaping suitable for strolling and safe use with wheelchairs, walkers, etc. minimizing risk from falls.
c. To the extent practicable, design barrier enclosure to blend with environment and avoid prison-like visual cues.
d. Provide adequate shaded spots for relaxation. Provide drinking water outdoors.

7. Patient Rooms and Bathrooms
   a. Use predominantly single-patient bedrooms.
   b. Include some bedrooms meeting double-room requirements to flexibly accommodate handicap needs, other alternate bedding, patient preference or clinical desirability for roommate, room for staff member doing 1:1, and to temporarily go above desired unit census.
   c. Bathrooms adjacent to bathroom, mostly all with direct access from bedroom; hall access considered for certain settings.
   d. If bathing and showering facilities are not in the bedroom-adjoint bathroom, provide easy access that maintains privacy to extent possible.

8. Create Open Setting that Encourages Interaction
   a. Reduce “fortress” like intersection of patient and staff areas consistent with safety and privacy needs.
   b. Social areas with mixture of seating arrangements and densities; lets patients self-calibrate range of exposures to social stimulation.

9. Maximize Exposure to Natural Lighting and Use Appropriate Artificial Light Sources
   a. Allow greatest exposure to natural light consistent with interior climate control needs.
   b. Minimize use of fluorescent fixtures in patient living areas.
   c. Allow patient control of bedroom lighting, especially at nighttime, consistent with supervision needs.
10. Use Layouts and Materials that Prevent Unfavorable Acoustics
   a. Avoid long, straight corridors.
   b. Use noise-dampening flooring.
   c. If preponderance of hard furnishings adversely affects sound absorption, consider other methods to dampen reverberant sound (e.g., wall and ceiling design or texture).

11. Create Adequate Spaces for Treatment on or Close to Unit
   a. Insure enough separate spaces to enable several activities simultaneously.
   b. Provide adequate number of offices for clinicians to meet with patients comfortably.
   c. Create staff meeting spaces near patient areas to maximize direct care staff involvement.
   d. Strive to make medication administration an interactive and positive experience.
   e. Provide calming comfort room as resource for patients to regain composure and defuse escalating behavioral situations.
   f. Medical examination areas.

12. Staff Support
   a. Include break, rest and dining areas with access to comfortable, shaded outdoor areas.
   b. Spaces for training and conferences, both without and outside the secure patient-care perimeter.
   c. Design for staff washroom facilities close to worksite.
   d. Staff exits to include security stations to provide nighttime escort to vehicles.

13. Create Accessible, Centralized Off-Unit Facilities and Amenities
   a. Locate off-unit areas to facilitate unescorted access by patients who can do so.
   b. Consider off-unit dining areas to develop patient autonomy and decision-making, as indicated.
14. Incorporate Dedicated Space for Positive Visiting Experiences Close to Patient Living Areas
   a. Visiting areas to include comfortable homelike surroundings and consideration of child-friendly materials. Provide informational materials.
   b. Establish Family Resource Center
   c. Include infrastructure for ‘virtual visiting’ through private yet supervisable audiovisual facilities.

15. Safety Factors
   a. Ligature resistant fixtures and hinges, modern locking devices and so on are required are costly. Prices may rise as new requirements are enforced while there are few vendors. These costs must not be borne at the expense of other clinically important factors and recommendations.
   b. Furnishings must avoid an institutional character while being appropriate to the security needs of the setting.
   c. Appropriate staffing patterns must be adopted that are suited to the patient populations served. Staffing calculations to meet patient care and therapeutic needs should be based on realistic scenarios that allow for periodic behavioral crises, 1:1s, escorts, etc., not just ideal ones in which staff are not occupied with these responsibilities.
   d. Evaluate adoption of newer staff personal alert devices that lead to efficient dispatch of assistance and avoids escalation associated with raised voices for help.
   e. Clear, distance-legible, reflective, and pictographic signage.

16. Educational Facilities for Patients
   a. School-Age: Collaborate with school authorities to establish classrooms and furnishings to provide an educational setting most similar to age-appropriate school surroundings in the community. Include areas
for special services that minimize disruption to the school day of students who receive them.
b. Adults: Include space and facilities for adult educational opportunities such as GED completion.

17. Training, Continuing Education and Staff Development

a. Include space and facilities for training and staff development.
b. Provide education, conference space and facilities outside of secure patient areas so SASH can serve as a regional resource for continuing education programs for community providers.

18. Patient Resource ‘Mall’

Provide a designated patient-accessible area for benefits counseling and to obtain other supportive services such as housing, transportation, vocational and other community resources in preparation for discharge.

19. Medical Capabilities and Flexible-Use during Crises or Disasters

Incorporate building elements that can support an emergent need for isolation areas, care for evacuees, moving patients to nondamaged locations within facility, staff accommodation, etc.

III. Enhancements to the Regional Systems of Care and Prevention in South Texas

1. Improve Continuity of Care

a. Establish a standard of care that psychiatric prescribers may accept a discharge summary from a psychiatric hospital as the basis for renewing medication prior to a full evaluation they conduct themselves.
b. Improve tracking of the clinical course of patients as they move through the mental health care system, identifying high utilizers and prioritizing for intensive case management.
c. Shared medical records between pharmacies, state hospitals, LMHA's and private hospitals, accessible to front line clinicians.

2. Assisted Community Treatment & Adherence
   a. Expanded capacity for AOT programs at LMHA’s
   b. Increased ability to provide extensive case management, particularly for homeless or marginally housed individuals.
   c. Supports to enhance adherence with medication and other outpatient treatments
   d. Allow for return to hospital if outpatient treatment non-adherence results in significant worsening of function.
   e. Encourage programs to adopt best-practices for determining individual contributors to nonadherence, collaborative goal-setting, incentives, and advance directives.

3. Expand Substance Abuse Treatment Services
   a. Enhance treatment programs for pregnant women with substance abuse disorders.
   b. Increase number of fellowships in Addiction Psychiatry and Medicine through state funding to medical schools.
   c. Acknowledge resurgence of methamphetamines as a Texas crisis; in some areas it is more prevalent than opioid abuse.
   d. Increase availability of and access to opioid antagonists. Incorporate availability of medication assisted treatment for opioid addiction (MAT; buprenorphine) behavioral health treatment in sites providing these services.
   e. Review funding rates to substance abuse service facilities as capacity to provide treatment is impacted by rates and the current rates do not support growth.
g. Commercial insurance plans should provide adequate coverage for substance abuse services.

h. There is a gap in substance abuse treatments for those with developmental handicaps that needs to be addressed systemically.

4. Increased Support for Guardianship Arrangements
   a. Identify patients who lack capacity for making financial and medication decisions.
   b. Assign qualified guardians when families are unable or unwilling to carry out this role.
   c. Manage patient funds (especially disability payments) such they are appropriately spent on food, housing, and medical care.

5. Forensic Patients and Competency Restoration Outside the State Hospital: Outpatient and Jail-Based Services
   Improve alternatives to hospital-based commitments for competency restoration and broaden options for conditional discharges that fulfill public safety goals.

6. Develop Facilities for Intensive Acute Care in Rural Areas
   a. Create state-funded, but locally-operated psychiatric hospitals that serve as regional “hub” facilities.
   b. Each serves several LMHAs.
   Combine local community funding for construction with state appropriations for operation.

7. Children and Adolescents: Behavioral Health Care
   a. Improve access to timely and high-quality outpatient care for youth.
   b. Integrated behavioral health and pediatric services improved access but have proved unsustainable when reliant on fee-for-service revenues. HHS will need to be proactive in supporting these endeavors.
c. School-based mental health services can improve access, and Texas has some strong models for doing so.

d. Collaboration with local educational authorities to develop an appropriate spectrum of day programs is essential to improve long-term outcomes of the most at-risk youngsters.

e. Expansion of the number and quality of residential treatment centers is desirable to offset demand for hospital-based care and as a more positive alternative for youngsters with unsuccessful foster care placements.

f. Substance use services for adolescents must be robust.

8. Children and Adolescents: Prevention

a. We encourage further support to prevent and intervene early for the abuse and neglect of children whose contribution to mental health problems is now well established.

b. Improve supports to foster parents caring for children with behavioral health disorders.

c. Actively address the needs for youth aging out of foster care.

9. Recommended Statutory and Process Changes

a. Limit lengths of stay for individuals committed by criminal court for competency restoration.

b. Expedite action when court orders to compel treatment are necessary.

c. Allow Crisis Stabilization Units to obtain compel-medication orders when needed to preserve safety.

d. Allow judicial orders for compulsory pharmacotherapy in assisted outpatient treatment when needed to avert deterioration in illness.

e. Allow electronic applications for Emergency Detention by LMHA and MH Officers in the jails, as well as physicians.
On behalf of our communities throughout South Texas we want to acknowledge the strong collaboration and support that HHS and the Legislature have extended our group. We value this unique opportunity to have participated in the development of these proposals as we prepare for what we anticipate will be a new golden era in public health.
## Appendix E. Detailed Project Summary

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Project Description</th>
<th>Budget and Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin State Hospital</td>
<td>Construction of 240-bed replacement hospital</td>
<td>• Pre-planning: 02/18 – 12/18 ($2.5 M)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Planning: 12/18 – 11/20 ($13 M)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Construction: 10/19 – 02/23 ($283 M)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Move in: 03/23</td>
</tr>
<tr>
<td>Dallas Fort Worth Metroplex Project</td>
<td>Initiate pre-planning activities for the construction of a new hospital in the Dallas Fort Worth Metroplex</td>
<td>• Pre-planning: TBD – TBD (TBD)</td>
</tr>
<tr>
<td>Continuum of Care Campus</td>
<td>Construction of new 240-bed hospital adjacent to the existing Harris County Psychiatric Center</td>
<td>• Finalize Lease with Texas Medical Center: 08/18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Planning: 08/18 – 08/19 ($8.5M)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Construction: 06/19 – 11/21 ($116.5 M)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Move in: 12/21</td>
</tr>
<tr>
<td>Kerrville State Hospital</td>
<td>Renovation of four existing buildings to add 70-bed MSU</td>
<td>• Planning: 03/18 – 02/19 ($1.5 M)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Construction: 06/19 – 04/21 ($29 M)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Move in: 06/21</td>
</tr>
<tr>
<td>Panhandle Project</td>
<td>Initiate pre-planning activities for the construction of a new hospital in the Panhandle</td>
<td>• Pre-planning: TBD – TBD (TBD)</td>
</tr>
</tbody>
</table>

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25 The timeline and budget are dependent upon additional legislative appropriations.
26 The date the hospital can begin admitting patients.
27 The timeline and budget are dependent upon approval from the LBB and Governor.
28 Cost estimates and timelines for planning and construction will be developed during the pre-planning process.
29 The date the hospital can begin admitting patients.
30 The gap between planning and construction accounts for bidding and negotiations.
31 The date the hospital can begin admitting patients.
32 The timeline and budget are dependent upon approval from the LBB and Governor.
33 Cost estimates and timelines for planning and construction will be developed during the pre-planning process.
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Project Description</th>
<th>Budget and Timeline</th>
</tr>
</thead>
</table>
| Rusk State Hospital           | Construction of 100-bed MSU to partially replace current capacity<sup>34</sup> | • Pre-planning: Completed prior to 85th Legislature<sup>35</sup>  
• Planning: 03/19 – 02/20 ($4.5 M)  
• Construction: 10/19 – 01/22 ($87M)<sup>36</sup>  
• Move in: 02/22<sup>37</sup> |
| Rusk State Hospital           | 100-bed non-MSU to partially replace current capacity     | • Pre-planning: Completed prior to 85th Legislature<sup>38</sup>  
• Planning: 03/19 – 02/20 ($4.5 M)  
• Construction: 12/21 – 02/24 ($90.1 M)  
• Move in: 03/24<sup>39</sup> |
| San Antonio State Hospital    | Renovation of an existing building to add 40 non-MSU beds  | • Planning: 02/18 – 12/18 ($0.5M)  
• Construction: 05/19 – 12/20 ($11M)  
• Move in: 01/21<sup>40</sup> |
| San Antonio State Hospital    | Construction of a 300-bed replacement hospital            | • Pre-planning: 02/18 – 12/18 ($1 M)  
• Planning: 12/18 – 11/20 ($13.5 M)  
• Construction: 10/19 – 11/22 ($323 M)<sup>41</sup>  
• Move in: 12/22<sup>42</sup> |

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<sup>34</sup> RSH has an MSU capacity of 40 beds. When the new unit opens, 60 current non-MSU beds will be converted to MSU beds for a total MSU capacity at RSH of 100 beds.

<sup>35</sup> Center for Sustainable Development at The University of Texas at Austin, Planning Modern Psychiatric Care Facilities: Rusk State Hospital + Beyond, 2017.  

<sup>36</sup> Planning and construction will overlap. The construction phase will start while design documents are begin completed with details.

<sup>37</sup> Date hospital can begin admitting patients.

<sup>38</sup> Center for Sustainable Development at The University of Texas at Austin, Planning Modern Psychiatric Care Facilities: Rusk State Hospital + Beyond, 2017.  

<sup>39</sup> The construction timeline and budget are dependent upon additional appropriations.

<sup>40</sup> The date the hospital can begin admitting patients.

<sup>41</sup> The timeline and budget are dependent upon additional legislative appropriations.

<sup>42</sup> The date the hospital can begin admitting patients.
## Appendix F. Austin State Hospital Detailed Cost Estimate

<table>
<thead>
<tr>
<th>Project Component</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>240-Bed Hospital Building – 373,900 building gross square footage (BGSF)</td>
<td>$173,923,000</td>
</tr>
<tr>
<td>Hospital Site Development – 15 acres</td>
<td>$12,173,000</td>
</tr>
<tr>
<td>Existing Motor Pool Relocation</td>
<td>$750,000</td>
</tr>
<tr>
<td>Modular/Interim Kitchen and Dishwashing Facility</td>
<td>$4,202,000</td>
</tr>
<tr>
<td>Interim Maintenance, Warehouse, and Linen Facility</td>
<td>$3,000,000</td>
</tr>
<tr>
<td>Rerouting of Electrical and Infrastructure</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Abatement and Demolition to Prepare Building Site</td>
<td>$1,922,000</td>
</tr>
<tr>
<td>Limited Campus Driveways</td>
<td>$3,030,000</td>
</tr>
<tr>
<td><strong>Construction Subtotal(^{43})</strong></td>
<td><strong>$200,000,000</strong></td>
</tr>
<tr>
<td>Escalation(^{44},^{45})</td>
<td>$24,000,000</td>
</tr>
<tr>
<td>Build Out Costs(^{46},^{47})</td>
<td>$58,680,000</td>
</tr>
<tr>
<td><strong>Total Project Cost(^{48})</strong></td>
<td><strong>$282,680,000</strong></td>
</tr>
</tbody>
</table>

\(^{43}\) The total cost incurred by a contractor to perform the complete scope of work. This includes labor, material, equipment, insurance, contractor’s general conditions, and fees, plus overhead.

\(^{44}\) Escalation was calculated at 4 percent a year for 3 years.

\(^{45}\) An anticipated increase of the cost or pricing of goods and services (labor, material, and equipment) in a given economy over a defined period. This escalation cost can include the potential cost increase due to tariffs on steel and aluminum, cost of inflation in general, availability of labor and material, and the current market forces.

\(^{46}\) Build out costs were calculated at 32 percent of the construction total with escalation.

\(^{47}\) Cost for the project not included in the contractor’s contract that include project contingency, design fees, management fees, testing, and inspections.

\(^{48}\) The cost per square foot is $790.87.
In addition to the cost estimate for a replacement facility, the ASH pre-planning report also includes an estimate for the construction of a 48-bed residential care unit, which could be built on the ASH campus. This unit could be used to care for certain long-term patients in need of residential care, but no longer requiring an inpatient level of care. While there would be an initial investment for construction, operating residential beds are significantly less expensive than inpatient hospital operating costs.

**Austin State Hospital Construction Cost Estimate – 48-Bed Residential Unit**

<table>
<thead>
<tr>
<th>Expense</th>
<th>Cost Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction Cost</td>
<td>$25,875,750</td>
</tr>
<tr>
<td>Escalation</td>
<td>$3,105,000</td>
</tr>
<tr>
<td>Build Out Cost</td>
<td>$9,245,000</td>
</tr>
<tr>
<td><strong>Total Project Cost</strong></td>
<td><strong>$38,136,000</strong></td>
</tr>
</tbody>
</table>
## Appendix G. Rusk State Hospital Non-MSU Detailed Cost Estimate

<table>
<thead>
<tr>
<th>Project Component</th>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost per square foot&lt;sup&gt;49&lt;/sup&gt;</td>
<td>$500</td>
</tr>
<tr>
<td>Total square feet</td>
<td>121,300 sq ft</td>
</tr>
<tr>
<td><strong>Construction Subtotal&lt;sup&gt;50&lt;/sup&gt;</strong></td>
<td><strong>$60,650,000</strong></td>
</tr>
<tr>
<td>Escalation&lt;sup&gt;51, 52&lt;/sup&gt;</td>
<td>$7,573,002</td>
</tr>
<tr>
<td>Build Out Costs&lt;sup&gt;53, 54&lt;/sup&gt;</td>
<td>$21,831,361</td>
</tr>
<tr>
<td><strong>Total Project Cost</strong></td>
<td><strong>$90,054,363</strong></td>
</tr>
</tbody>
</table>

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<sup>49</sup> Cost per square foot is calculated using the average cost per square foot for the ASH and SASH projects developed during the pre-planning process.

<sup>50</sup> The total cost incurred by a contractor to perform the complete scope of work that includes labor, material, equipment, insurance, contractor’s general conditions, and fees, plus overhead.

<sup>51</sup> Escalation was calculated at 4 percent a year for 3 years.

<sup>52</sup> An anticipated increase of the cost or pricing of goods and services (labor, material, and equipment) in a given economy over a defined period. The escalation cost can include the potential cost increase due to tariffs on steel and aluminum, cost of inflation in general, availability of labor and material, and the current market forces.

<sup>53</sup> Build out costs were calculated at 32 percent of the construction total with escalation.

<sup>54</sup> Cost for the project not included in the contractor’s contract that include project contingency, design fees, management fees, testing, and inspections.
# Appendix H. San Antonio State Hospital Detailed Cost Estimate

<table>
<thead>
<tr>
<th>Project Component</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>296-Bed Hospital Building (462,261 BGSF) and Support Functions for 340 Beds (24,761 BGSF), total of 487,029 BGSF&lt;sup&gt;55&lt;/sup&gt;</td>
<td>$192,027,688</td>
</tr>
<tr>
<td>Hospital Site Development – 30 acres</td>
<td>$22,665,655</td>
</tr>
<tr>
<td>Additional Support Services Space for the SSLC and Texas Center for Infectious Disease&lt;sup&gt;56&lt;/sup&gt;</td>
<td>$11,383,698</td>
</tr>
<tr>
<td><strong>Construction Subtotal</strong>&lt;sup&gt;57&lt;/sup&gt;</td>
<td><strong>$226,077,041</strong></td>
</tr>
<tr>
<td>Escalation&lt;sup&gt;58&lt;/sup&gt;,&lt;sup&gt;59&lt;/sup&gt;</td>
<td>$27,129,245</td>
</tr>
<tr>
<td>Build Out Costs&lt;sup&gt;60&lt;/sup&gt;,&lt;sup&gt;61&lt;/sup&gt;</td>
<td>$70,058,074</td>
</tr>
<tr>
<td><strong>Total Project Cost</strong>&lt;sup&gt;62&lt;/sup&gt;</td>
<td><strong>$323,264,360</strong></td>
</tr>
</tbody>
</table>

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<sup>55</sup> The replacement hospital is being designed for 296 beds. There is also a renovation at SASH of existing buildings to add 40 beds for a total of 336 beds. Support spaces will need to be sufficient to support the total number of beds.

<sup>56</sup> Currently, SASH provides support services to other facilities on the campus (San Antonio SSLC and Texas Center for Infectious Disease). These shared support services spaces are in poor condition and in need of replacement when SASH is replaced.

<sup>57</sup> The total cost incurred by a contractor to perform the complete scope of work that includes labor, material, equipment, insurance, contractor’s general conditions, and fees, plus overhead.

<sup>58</sup> Escalation was calculated at 4 percent a year for 3 years.

<sup>59</sup> An anticipated increase of the cost or pricing of goods and services (labor, material, and equipment) in a given economy over a defined period. The escalation cost can include the potential cost increase due to tariffs on steel and aluminum, cost of inflation in general, availability of labor and material, and the current market forces.

<sup>60</sup> Build out costs were calculated at 33 percent of the construction total with escalation.

<sup>61</sup> Cost for the project not included in the contractor’s contract that include project contingency, design fees, management fees, testing, and inspections.

<sup>62</sup> The cost per square foot is $691.47.