Austin

MEMORANDUM

To: Mayor and City Council

Through: Jon Fortune, Deputy City Manager
Stephanie Hayden-Howard, Assistant City Manager

From: Carrie Rogers, Government Relations Officer

Date: August 3, 2026

Subject: **No Wrong Door: Coordinated Crisis Response Program**

The purpose of this memorandum is to provide information relating to a new initiative to support individuals at the intersection of homelessness, public safety, and mental health.

Overview

As part of Austin's commitment to supporting our community's most vulnerable residents, the City Manager's Office established *No Wrong Door* (NWD), a coordinated crisis response program to reduce the cycle of arrests, emergency room visits, and homelessness among people with the most complex social and behavioral health needs. NWD's mission is to collaboratively identify permanent supportive solutions for high utilizers via community services such as housing, social support, health care, behavioral health, and substance use treatment, aiming for positive client progress across the ecosystem. The phrase "no wrong door" is frequently used in health and human services to indicate that there is no required, specific point of entry for treatment or services.

High utilizers, in the context of NWD, are currently defined as people who generate disproportionate demand and are indexed in the top 1% of number of arrests, behavioral health call-outs, substance use-related incidents, or Criminal Trespass Notices. This clearly defined population is causing excessive system costs and resource use across multiple response systems, while also risking their health and safety by living in perpetual crisis without dedicated care. Across the entire emergency response system, the street is the most expensive setting, compared with shelter, jail, and health care. Leaving this population without structured, sustained intervention costs more in public safety, emergency medical, and community impact than the coordinated response provided by the NWD framework.

According to the Meadows Mental Health Policy Institute (MMHPI), there are at least 950 people in Travis County who are at this intersection of the local emergency response system. This high-utilizer

population has a significant financial impact across the local criminal justice, homelessness, and health care capacity. The cost is estimated to be $144,000 per person, or a total cost of $137 million annually.

Without adequate or consistent alignment, it has been challenging for each individual agency or organization *alone* to capture and quantify the needs of high utilizers, make informed decisions, and further improve response to this population. Collaborating through a common effort supports transparency, builds trust, aids in analysis for improved services, and streamlines workflows. This coordination will also reduce operational demands in public safety departments while ensuring specialized services for this unique population.

Program Partners

Connecting high-utilizing individuals with coordinated community services and appropriate medical care involves many partners. To address these issues, participating agencies entered a Memorandum of Understanding (MOU) to share resources and information with the mission of reducing the impact of high utilizers on community resources in Austin-Travis County. The MOU approach involves data-driven inquiry, personalized care plans, and advocating for innovative policy and program responses. Each client must authorize a release of information via form before data is shared between organizations.

NWD consists of 17 local and regional agencies and organizations, each serving their community by engaging individuals who are statistically identified as high utilizers of the Austin-Travis County criminal justice, health care, and homelessness systems. Within the City of Austin, Austin Homeless Strategies & Operations (HSO), Austin Police (APD), Austin-Travis County Emergency Medical Services (EMS), Austin Fire (AF), and Austin Community Court (CC), along with external emergency response partners, including Ending Community Homelessness Coalition (ECHO), Travis County District Attorney, Travis County Attorney, Central Health, Downtown Austin Alliance, Integral Care, Ascension Texas, Baylor Scott & White, CapMetro, and The Sobering Center.

NWD partners meet monthly for executive leadership discussions involving all participating departments, agencies, and organizations. These executive conversations have focused on strategic progress and updates, with leadership from NWD partners addressing interlocal coordination efforts, shared legislative priorities, and client referral pathways. Operationally, designated staff from NWD partners will meet biweekly for multi-agency meetings throughout 2026 to discuss the service needs of NWD high utilizers – in compliance with applicable laws – and follow up with individualized care coordination and case management. This collective planning, along with the resulting data, ongoing client outcomes, and systemic impacts, will present opportunities to better influence broader structural and procedural functions.

In addition, Austin Mayor Kirk Watson convened leadership at the City, Travis County, Integral Care, and Central Health to examine behavioral health contract requirements, available resources, and how services could be provided more effectively. For example, the City has had nearly a dozen behavioral health-related programs performing similar or adjacent work and serving multiple departments. The lack of coordination has led to confusion and poor triage at the time of crisis.

Legislative Efforts
Ahead of the 90th Texas Legislature, Austin Government Relations (AGR) has been working with the Office of the Governor, Senator Tan Parker, Representative Donna Howard, and additional legislative leaders and stakeholders across the State to discuss and craft legislation aimed at addressing the gaps identified during the development of NWD – among them the lack of appropriate beds and gaps between service points.

On June 24, 2026, APD Chief Lisa Davis and HSO Director David Gray testified before the House Committee on Intergovernmental Affairs for the interim charge hearing on *Mental Health Impacts, Homelessness, and System Recidivism*. Chief Davis spoke on the structural problem of custody transfer and the insufficient local capacity impacting law enforcement's response to people in crisis. Director Gray shared that while local housing capacity is scaling, the need is growing faster for medically acute high utilizers who lack suitable housing options.

Austin provided written testimony from Mayor Watson, Chief Davis, and Director Gray for the July 7th Senate Health and Human Services Committee interim charge hearing on *Strengthening Crisis-Related Mental Health and Homelessness Services*. Their testimony called for ongoing funding to expand regional mental health beds, emphasizing the creation of a crisis care facility for Central Texas and nearby areas. They also supported statutory amendments to improve the efficiency and appropriateness of medical and judicial procedures under state psychiatric law. Local governments statewide echoed similar concerns and issues in their communities.

Mayor Watson submitted a letter to the Sunset Advisory Commission, outlining procedural challenges and proposing legislation to resolve these problems, as part of the current review of the Texas Health and Human Services Commission.

Funding
NWD is currently supported through existing program resources within APD, EMS, HSO, AGR, and CC. A realignment of current behavioral health and homelessness programs across the City's public safety departments as well as HSO and CC is underway. There are four pending grants from the Department of Justice (DOJ) and Texas Office of the Governor (OOG) to further support this work and a planned, joint appropriations request with Travis County and Central Health for the Texas Legislature to fund a Central Texas Mental Health Crisis Care Center.

Reporting
Routine reporting will be provided to the City Council. While new initiatives take time to grow roots, there are significant milestones achieved through this ongoing collaboration.

- Austin and Travis County have committed to pursue and construct a mental health crisis center together.
- Integral Care and Central Health have committed to participate in daily bed availability reporting via the Capital Area Trauma Regional Advisor Council (CATRAC) dashboard. Daily access to open mental health beds for Austin-Travis County first responders will be a critical tool.
- Executed Memorandum of Understanding with 17 partners, including the District Attorney and County Attorney.

- Realigning duplicative behavioral health program dollars to fund a more streamlined, coordinated triage of mental health calls for service.
- Developing a universal inventory of resources across partners that is available to first responders and additional responsive care such as HSO.

Next Steps

A briefing to the City Council is planned for September 2026. City staff continue to collaborate with local and regional stakeholders for administrative, legislative, funding, data exchange, and service coordination priorities. Should you have any questions, please contact Carrie Rogers, Government Relations Officer, at carrie.rogers@austintexas.gov or Maris Herold, Austin Police Chief of Strategic Initiatives, at maris.herold@austintexas.gov.

cc: T.C. Broadnax, City Manager
Erika Brady, City Clerk
Jason Hadavi, City Auditor
Mary Jane Grubb, Municipal Court Clerk
Judge Sherry Statman, Municipal Court
CMO Executive Team
Department Directors

Attachment: Attachment A – *No Wrong Door* one-pager / As of July 22, 2026
Attachment B – Mayor Watson Letter to the Sunset Advisory Commission regarding the Health and Human Services Commission Review

No Wrong Door

Coordinated Crisis Response Across Public Safety, Mental Health, & Homelessness

Unprecedented local need

Many people with complex social and behavioral health needs cycle through a fragmented emergency response system, across law enforcement, emergency medical care, the criminal justice system, emergency health systems, and community service providers.

High system utilizers (APD data 2021-'25)

2% of total unduplicated individuals arrested

17% accounted for all arrests

85% experienced homlessness

55% behavioral health issues

Justice-involved clients (2023)

50% re-arrested within 10 weeks

21% of Integral Care clients

15% at least 1 psych. inpatient hospitalization

8% in crisis residential programs

43% at least 1 psych. inpatient hospitalization in 12 months

- **High system utilizers without sustained care** cost taxpayers $137 million annually for at least 950 people across Travis County hospitals, emergency rooms, police services, and jail.
- **Integral Care's** psychiatric crisis stabilization beds cost $776 per day on average, and the Extended Observation Unit up to $2,283 per day.
- **Austin State Hospital's** daily average fee is $917 for adult inpatient services.

Ongoing efforts & service gaps

Austin-Travis County is advancing its regional response through specialized interlocal initiatives, including deflection efforts addressing public safety, mental health, and homelessness. Although services are available across the community, **demand continues to increase** due to the number and complexity of cases, while minimal bed availability creates additional pressure.

Immediate crisis care for complex co-occurring cases remains one of the most acute gaps in the Austin-Travis County continuum of care. Long-term treatment options for significant and chronic substance use and mental health conditions are scarce, often leading to discharge to the street with only a short-term fix and no sustained care plan. Intermediate, step-down residential capacity is just as important for ongoing care.

Central Health, Travis County's hospital district, and Integral Care, the Local Mental Health Authority, are adding beds and expanding capacity, but **state support is crucial.**

No Wrong Door

Coordinated Crisis Response Across Public Safety, Mental Health, & Homelessness

System-wide needs

Available resources have not kept pace with accelerating demand for appropriate service capacity that is both accessible and available. People who most frequently use emergency response systems require **more personalized, ongoing behavioral health care** than the general population in need of mental health services. Meeting that need **requires specialized capacity** beyond conventional housing and homelessness services, and it is also where the crisis-care gap is most apparent.

This means **additional inpatient beds** for psychiatric, substance use disorder treatment, and extended observation as well as a **24/7 dedicated, single-point, no-refusal receiving option** for law enforcement, first responders, and walk-in referrals.

Legislative considerations

01

Fund a mental health crisis care center for complex co-occurring cases

Invest in a mental health care continuum that builds out a holistic crisis response through alternatives to incarceration including intensive outpatient services, additional residential capacity to bridge the gap between acute crisis, and independent living, and step-down services for all.

02

Expand warrantless emergency detention authority beyond peace officers

Authorize trained mental health professionals, such as physicians, nurses, and clinicians, to initiate warrantless detention for local law enforcement to defer medically acute cases to health professionals and focus on public safety responsibilities.

03

IMD Medicaid Waiver to allow expansion of step-down residential treatment

A Section 1115 Waiver allows treatment for patients with co-occurring conditions in a step-down residential facility, alleviates the bottleneck in the mental health system of care, and is significantly more affordable than patients cycling through expensive, uncompensated ER visits and county jails.

04

Remove exclusionary criteria for hospitals

Remove policies that deny or restrict care to people due to specific disabilities or a related condition.

05

Track regional inpatient psychiatric & behavioral health bed availability

Amend Texas Health and Safety Code (Sections 773.112 & 773.114) to leverage existing RAC reporting infrastructure to include inpatient psychiatric and behavioral health bed capacity.

Austin | Office of Mayor Kirk Watson
301 West Second Street, Austin, TX 78701

July 24, 2026

The Honorable Lois Kolkhorst
Chair, Sunset Advisory Commission
P.O. Box 12068
Austin, Texas 78711

Dear Chair Kolkhorst:

I want to first thank you again for the years of service you have invested not only in the State of Texas but specifically your tireless efforts to improve public health in Texas. Your leadership in the areas of maternal health, nutrition, and behavioral health have demonstrated your deep commitment to improving the health of all Texans. I also thank you for our years of service and working together in the Texas Senate. I have great memories.

After listening to the testimony at your July 7th Senate Health and Human Services hearing on the mental health and homelessness interim charge, I am both encouraged and frustrated. Following millions of dollars in investment, we know far more than we did when you first started, and we have made significant progress under your leadership. Yet in many ways, we are still far from achieving a comprehensive solution for these complex and elusive challenges that impact every corner of this state – welding the rotors as they whirl.

The wisdom and serendipity of your dual role as Chair of the Sunset Advisory Commission and Chair of the Senate Health and Human Services Committee is not lost on us. At this opportune moment in our respective leadership roles, I wanted to share some thoughts and recommendations on the intersection of local government and the important work of the Texas Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS).

Austin has long been a partner with HHSC, DSHS, Department of Family Protective Services (DFPS) and many other state agencies. With this in mind, we offer the following comments on Austin priorities, potential statutory changes, and funding recommendations related to or adjacent to HHSC's work.

General Comments
Austin supports a strong state-local partnership that prioritizes prevention, community stability, and efficient delivery of essential health and human services. Continued investment in core public health infrastructure and community–based services will help Texas communities respond to growing behavioral health services, housing, and public health challenges while easing the increasing strain on local healthcare organizations and the emergency healthcare system.

Austin encourages policies that streamline service delivery, reduce administrative burden, and strengthen coordination between state agencies, healthcare providers, and local and regional community partners. Austin also encourages the strengthening of DSHS by transitioning it to an independent department within the State government, with mental health and nursing homes moving from HHSC to DSHS as part of the emergency healthcare system. Texas needs to have a clear and coordinated healthcare service that is better positioned to lead public health strategy, modernize the public health infrastructure, and support Texans' healthcare needs. This level of leadership is critical as local public health departments face significant budget challenges due to substantial cuts in federal funding and ongoing uncertainty related to likely additional cuts in core public health grants.

July 7th Senate Hearing – The "Worried Well," Super Utilizers and Anosognosia

You and I both know that in most industries, it's easier to focus on the "worried well' — the low-hanging fruit. Our mental health care system faces similar challenges, such as limited funding, bed capacity transparency, and a shortage of qualified clinicians. As a result, many facilities struggle to serve the complex behavioral health and social needs of this highly visible population effectively. In Austin and across Texas, there's often nowhere for them to go. The default disposition for these individuals is either jail or a hospital emergency department, both of which are very expensive options and not the appropriate level of care for the patient. The impact on our healthcare systems is significant and contributes to ER overcrowding, meaning care for others is delayed while the ER bed is occupied sometimes for days before the patient can be dispositioned. More often than not, these patients are seen, stabilized, provided an outpatient referral, and return to the streets to repeat the cycle. Our local healthcare executives, mental health experts, and public safety experts all continuously report negative impact of underinvestment in mental health services, which leads to more costly and less efficacious short-term fixes.

I want to be very clear – the challenge with many of these folks is not that they do not want care – they do not *realize* they need it. This lack of insight into their own debilitation, called anosognosia, is the reason mandated treatment is a critical tool. The state, under the doctrine of *parens patriae*, is compelled to protect individuals who are unable to protect themselves. By protecting these members of our community through mandated treatments, we are better able to protect Texas.

***No Wrong Door* – System Coordination**

Since April 2026, the Austin Police Department is leading a multi-agency coordination effort focused on connecting the top 100 of the estimated 950 highest utilizers in Travis County to services called *No Wrong Door* (attached). A memorandum of understanding (MOU) was developed to ensure appropriate protection of data sharing across agencies, as well as a Release of Information (ROI) form for clients. This effort has confirmed what practitioners have long known and what you heard at your July 7th hearing. There is an absence of enough high-acuity beds and lack of compelled system coordination.

Austin State Hospital

According to Austin State Hospital (ASH), less than half of its patients are from Travis County. ASH patients committed through the county court, even if they hail from another county, would be recorded as a Travis County/Integral Care patient, based on their county of commitment, not their county of residence.

- Patients considered Not Guilty by Reason of Insanity averaged approximately three years' stay before community reintegration.
- Beds are no longer turning over at previous rates of 7-10 days; patients are staying significantly longer, reducing overall availability.

People remain at ASH not due to ongoing clinical need, but because no appropriate community housing options exist for them to transition to. Intermediate step-down supply would have to expand significantly in Travis County or the patient's home county to truly relieve the bottleneck.

Criminal Justice Diversion Programs
In March of this year, Austin Police Chief Lisa Davis attended a community meeting at our downtown central library. While there, on another floor, a man stood up from his computer and proceeded to beat to death the man sitting next to him. Chief Davis was summoned to the incident, where she personally arrested the suspect.

This violent offender had approximately a dozen felony offenses, with half of them being dismissed due to prosecutorial discretion following an incompetency finding. He then participated in a diversion program where he spent six months in inpatient care before the incident. Without question, diversion must be handled within a post-adjudication structure, in which a sentence is deferred pending successful completion of an extended mental health program.

Systematically, diversion can help, but it's not foolproof, and success depends largely on a local justice system's ideologies and capacity to strengthen any favorable outcomes, especially among people experiencing homelessness who lack the basic needs to remain stabilized after leaving the structure of diversion.

Transparency, Reporting and Data
Under 26 Texas Administrative Code 306.153, Texas funds community-based private psychiatric beds using state general revenue allocated to Local Mental Health Authorities (LMHAs). If a private psychiatric hospital signs a vendor contract with an LMHA to accept these state-funded patients, they must report bed utilization and capacity directly to that specific LMHA. A universal real-time reporting platform for bed availability exists, but is not operationally being used between hospitals, LMHAs and psychiatric hospitals. Regional Advisory Councils (RACs) already use a statewide, real-time bed availability reporting platform, called *EMResource* for hospitals and could serve as the platform to expand reporting on in-patient psychiatric facilities. EMResource already has in-patient psychiatric reporting capability used by acute care hospitals. By amending Texas Health and Safety Code Sections 773.112 and 773.114 of the Texas Health and Safety Code to leverage existing RAC reporting infrastructure to include inpatient psychiatric and behavioral health bed availability, Texas can better address the primary stopgaps that stall healthcare legislation: cost to taxpayers and administrative burden on staff. DSHS' *EMResource* can update emergency department status, facility statuses, including diversion, and physical bed counts, and can bypass the need to develop a new system. This same system was used during the pandemic for daily COVID bed reporting and is optimal for local psychiatric bed reporting needs.

We understand that the Hospital Preparedness Program (HPP) grant largely funds the RAC is one of the grants that is at risk of being decreased or eliminated at the Federal level. We recommend appropriating these funds to DSHS and task the RACs to develop a mental health system of care,

like they have successfully done for trauma, stroke, and are concurrently developing for perinatal care systems. DSHS also identified in their self-evaluation the need for a disaster fund similar to Texas Department of Emergency Management (TDEM) for disaster response given the often years delay in FEMS reimbursement.

Substance Use Disorders

More than 30 years ago, there was a shift in thinking within the substance abuse field that promoted the idea that only voluntary treatment was effective. This prompted many psychiatric facilities and psychiatrists to abandon involuntary options despite the existing legal framework at the time. Drug courts emerged as a response to the gaps in purely voluntary approaches and turned out to be effective through judicial authority compelling someone toward sobriety.

San Antonio has successfully piloted chemical dependency commitments, producing strong outcomes in programs starting with medical detox, moving to inpatient rehab, and leading to sober living. Structured treatment through Assisted Outpatient Treatment (AOT) was also very successful when paired as *court-ordered* treatment. The pilots began by approaching people who were repeatedly entering and leaving rehab voluntarily, asking whether they would be open to a program they could not leave early from. People responded positively, and the initial cohort comprised people who were voluntarily willing to be committed.

The legal bar for a chemical dependency commitment in San Antonio-Bexar County is lower than for a standard Peace Officer Emergency Detention (POED), as it only requires a finding that the person's substance use makes it foreseeable (not necessarily imminent) that harm will occur to themselves. For people using methamphetamine, opiates, or large quantities of alcohol, meeting this criterion was relatively straightforward clinically. Inpatient commitment can last up to 90 days, can be converted to outpatient status for up to one year, and modification between inpatient and outpatient status is permitted; this function would be transformative in Austin-Travis County.

Pilot participants would be near the end of their 90-day inpatient commitment in excellent condition, presenting themselves as sober, engaged, and voluntarily wanting to continue treatment. Attorneys, however, found it difficult to justify keeping them on involuntary commitment when they appeared mentally competent and were willingly participating. In nearly every case, once taken off commitment, clients relapsed within approximately two weeks.

Funding has been identified as the single largest barrier to ongoing success, as the local LMHA has cited policy that only covers chemical dependency treatment when it is part of treating a crisis resulting from a mental illness. This means that law enforcement must wait for someone to medically deteriorate to the extent of being a danger to self or others before they can intervene again, as chemical dependency treatment is not funded as a standalone service once a mental health crisis is stabilized. Even then, intervention on AOT requires that a motion be filed first, followed by a court hearing to convince a judge that someone meets a high legal threshold.

Using chemical dependency warrants in metropolitan areas like Austin-Travis County promotes continuity of care through a preplanned process where officers leverage relationships with clients to pre-fill the warrant and complete acute portions after a live assessment confirmed the individual meets the criteria. The chemical dependency warrant could then be converted to a full chemical

dependency commitment, whereas starting with a POED doesn't sufficiently specify the chemical dependency component as the primary purpose for care continuity.

Travis County has not used any type of mental health warrant since 1989, when the then-probate court judge first decided to discontinue them. However, APD and the County Attorney's office are encouraged by the concept of involuntary chemical dependency commitment (in tandem with Assisted Outpatient Treatment) to sustain involuntary clinical treatment as a specialized alternative for substance use disorders.

Peace Officer Emergency Detention (POED)
Chapter 573 of the Health and Safety Code only authorizes peace officers to detain an individual for psychiatric evaluation. Published medical evidence has identified that this approach leads to a high percentage of individuals being detained inappropriately as evidenced by the discontinuation of the order following psychiatric evaluation. The evidence also identifies that clinicians are more qualified at identifying individuals who are in need of a "hold" for psychiatric evaluation.

A Meadows Institute evaluation in Austin identified the top locations for a POED response by the Austin Police Department as either a hospital emergency department or a psychiatric facility, largely to issue these orders on individuals who have already been evaluated by a physician who has determined the need. This approach wastes valuable law enforcement resources that are better utilized responding to emergencies in the community. The utilization of peace officers as the sole professional who can make the determination of the need to hold an individual, also means that it is likely a large percentage of the individuals detained are done so inappropriately. These issues are particularly impactful in rural communities who have limited law enforcement and EMS resources and often long transport times to move the individual to a location for appropriate assessment.

Recommended Statutory Changes
The combination of challenges outlined above – nowhere to go and no warm hand-offs between service points – informs the following:

- Amend Texas Health and Safety Code Chapter 241 to address exclusionary criteria for hospitals by removing policies that deny or restrict care to people due to specific disabilities or a related condition.
- Amend Texas Health and Safety Code Chapter 573 code and create a subsection to allow physicians and their delegates the ability to issue a hold order for psychiatric evaluation to defer medically acute cases to health professionals.
- Amend Texas Health and Safety Code Sections 773.112 and 773.114 to leverage the existing RAC reporting platform to include inpatient psychiatric and behavioral health bed capacity with required reporting every four hours of all facilities with in-patient psychiatric beds.
- Amend Texas Health and Safety Code Chapter 574 to reduce State legal threshold for involuntary psychiatric intervention for participants under Assisted Outpatient Treatment demonstrating clear evidence of clinical deterioration/substantial likelihood of treatment nonadherence.
- Amend Texas Health and Safe Code Chapter 573 to require coordinated discharge between local entities for transportation, follow-up medication and care, including contingencies for nonadherence.
- Amend Texas Government Code Chapter 531 and Texas Occupations Code § 1701.404 to implement and fund Crisis Worker Certification as required training for staff on Mobile Crisis

Outreach Teams (MCOT) and Receiving Centers in Texas to work in the state's crisis continuum for MCOT field deployment and warrantless emergency detention triage, and establish standardized statewide requirements.

- Amend Texas Health and Safety Code Chapter 462 to require mandatory participation by residential substance use rehabilitative facilities to sustain involuntary clinical treatment for substance use disorders through chemical dependency commitments.
- Amend Texas Health and Safety Code Chapter 614 to authorize data sharing for efficient service coordination by authorizing reasonable information exchange between public agencies for people in recidivism to enable coordinated resource navigation for Individualized Service Plans.

Recommended Administrative Changes

- Amend Chapter 25 Texas Administrative Code 133 to address exclusionary criteria for hospitals by removing policies that deny or restrict care to people due to specific disabilities or a related condition.
- Amend Chapter 25 Texas Administrative Code 157.123 to require Texas RACs to include inpatient psychiatric and behavioral health bed capacity and funds RACs to develop a mental health system of care, as a component of the emergency healthcare system
- Amend Chapter 26 Texas Administrative Code 306.201 to require transportation, follow-up medication and care, including contingencies for nonadherence.
- Review disability determinations and claims, which currently take a minimum of 275 days for an initial decision. Appeals and reconsideration requests can take two years or longer to resolve. While federal funding constraints may limit the agency's capacity, the review could evaluate potential efficiencies, including streamlined intake requirements, improved case triage, process and staff support, quality review, and the use of AI-enabled tools.

Funding Considerations

- Fund statute changes recommended in Texas Health and Safety Code Chapter 573 and Chapter 574.
- Fund a Central Texas mental health crisis center for complex co-occurring cases. Specifically, invest in a mental health care continuum that builds out a holistic crisis response through alternatives to incarceration, additional residential capacity to bridge the gap between acute crisis and independent living, and step-down services for all: *no wrong door*.
- Fund intensive outpatient services that are community-based to preserve jail capacity and reduce pressure on local emergency response systems.
- Provide additional funding to DSHS to solidify funding for the RACs to support the enhancement of the *EMResource* platform, create regional tele-psychiatry resources for consultation services, and create regional navigation for patient care and placement support for first responders and critical access hospitals.
- Seek a federal IMD Medicaid Exclusion Waiver to increase access to inpatient treatment for adults with severe mental illness and allow for expansion of step-down residential treatment.
- Create a Disaster Contingency Account similar to Account 453 that may be utilized by DSHS who has responsibility for the medical care and public health component of disaster response. This will strengthen the ability of DSHS to deploy Emergency Medical Task Force

(EMTF), through the lead RACs, resources during emergencies. These teams have been critical in the responses to rural communities who have been impacted by natural and manmade disasters.

Closing

Appended to this memorandum are additional suggestions relating to the work of HHSC.

Again, I appreciate your leadership and I am grateful to have you in this role at this moment in time. We also value our HHSC partnership approach with local governments and community providers. We stand ready to support collaborative solutions that improve health outcomes, strengthen prevention efforts, reduce recidivism, and expand access to essential services for Texans. Call on me. You may also visit with Carrie Rogers, Austin Government Relations Officer, at carrie.rogers@austintexas.gov.

Sincerely,

Kirk Watson
Mayor

Cc: Members of the Texas Sunset Advisory Commission
Sadie Smeck, Policy Analyst, Sunset Advisory Commission
Lyle Blanco, Policy Analyst, Sunset Advisory Commission
T.C. Broadnax, Austin City Manager
Lisa Davis, Austin Police Chief
Maris Herold, Austin Police Department, Chief of Strategic Initiatives
Dr. Mark Escott, Austin Chief Medical Officer
David Gray, Austin Homeless Strategies and Operations Director
Robert Luckritz, Austin-Travis County Emergency Medical Services Chief
Carrie Rogers, Austin Government Relations Officer
Adrienne Sturrup, Austin Public Health Director

Encl: Attachment A – Additional HHSC Sunset Recommendations
Attachment B – Austin-Travis County *No Wrong Door* Program Overview

Attachment A – Additional HHSC Sunset Recommendations

Program	Recommendations
Public Health Provider Charity Care Program	Oppose Charity Care pool reductions that support uncompensated care delivery. Support long-term sustainability planning prior to 2030.
Aging Adults	Expand availability and accessibility of services for aging adults and caregiver support. Ensure facility regulation oversight and QA mechanisms.
Community Health Workers	Expand Community Health Workers reimbursements for Centers for Medicare and Medicaid Services. If not reimbursable, consider prioritizing preventive and community-based care models. Implement statewide workforce development strategies.
Infectious Disease Prevention	Support local public health preparedness and rapid outbreak response capacity. Maintain needed disease surveillance for identification and response to public health threats.
Data	Strengthen interoperability between state and local systems. Continue investment in public health data modernization initiatives.
Funding and Grants	Continue efforts to reduce administrative burden for local health departments. Maintain flexible grant structures for community specific needs. Ensure continuity of funding for proven public health and human service programs. Fund chemical dependency treatment, as it is not funded as a standalone service.
Local Mental Health Authorities	Strengthen coordination between LMHAs and local public health systems. Fund and support crisis response services and behavioral health continuity of care. Expand access to integrated behavioral health and substance use services.
Public health infrastructure and effective health and safety policies	Support sustainable DSHS public health data systems and disease surveillance. Support sustainable State laboratory capacity and public health emergency preparedness infrastructure. Support sustainable local disease prevention infrastructure, outbreak, preparedness, and access to preventive public health services. Support sustainable food safety policies and inspection frameworks that protect public health, support consumer confidence, and promote efficient coordination with local business.
Continuum of care, prevention services and access to basic needs for at-risk Texans	Strengthen behavioral health, intellectual and developmental disability (IDD), crisis response, and substance use services, including Sobering Center operations and crisis care. Support FYI Vouchers and housing stability supports. Support public health infrastructure, HIV/STI prevention services, disease surveillance and public health emergency preparedness. Expand food access (WIC/SNAP), maternal and child health services, early childhood supports and affordable childcare access. Support senior, disability, and vulnerable population services.
Disability determinations and claims	Review the disability determination and claims process to identify potential efficiencies, including streamlined intake requirements, improved case triage, process and staff support, quality review, and the use of AI-enabled tools.