



# **State Hospital System Long-Term Plan**

**As Required By  
The 2014-15 General Appropriations Act, S.B. 1,  
83<sup>rd</sup> Legislature, Regular Session, 2013 (Article II,  
Department of State Health Services, Rider 83)**



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## Table of Contents

<b>Executive Summary</b> .....	<b>1</b>
<b>Introduction</b> .....	<b>3</b>
<b>Background</b> .....	<b>3</b>
<b>Estimating Bed Need – Today and Tomorrow</b> .....	<b>4</b>
<b>Clarify and Transform Roles</b> .....	<b>6</b>
<b>Expanding Access through Contracts</b> .....	<b>7</b>
<b>Academic Affiliation</b> .....	<b>9</b>
<b>University or Private Hospital Operators</b> .....	<b>9</b>
<b>Repair and Replace Aging State Hospitals</b> .....	<b>10</b>
Current Trends and Best Practices .....	11
Client Benefits .....	11
Administrative/Operational Benefits.....	11
<b>Investing in the Future</b> .....	<b>12</b>
Addressing Workforce Issues .....	12
Expanding Community Alternatives and the Continuum of Care .....	14
Enhancing Information Technology to Support Care .....	14
<b>For Further Evaluation and Analysis</b> .....	<b>14</b>
Disproportionate Share Hospital (DSH) Payments.....	14
Third Party Revenue .....	15
<b>Financial Overview/Implications</b> .....	<b>15</b>
<b>Conclusion</b> .....	<b>16</b>
<b>Appendix A: Additional Tables</b> .....	<b>17</b>

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## **Executive Summary**

The state hospital system has faced mounting challenges in recent years. A rapidly growing population, increasing numbers of forensic patients, workforce shortages, and aging facilities have made it increasingly difficult for the state hospitals to meet the demand for inpatient care. A robust system of community-based services can reduce the need for inpatient care, but communities across Texas have struggled to provide the comprehensive array of services necessary to address the needs of their residents.

To address these needs, the Texas Legislature has made significant investments in the state's mental health system over the last three biennia. Legislators recognized that while these investments could alleviate some of the pressure on the state hospital system, a long-term plan was needed to address the underlying issues and position the state to meet the need for inpatient services in future years. Guidance related to the development of the plan was provided in the 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, Department of State Health Services, Rider 83).

The State Hospital Long-Term Plan lays out the need for inpatient psychiatric care in Texas and recommendations for how state and local hospitals can make fundamental changes to address this need. Details regarding methodology, assumptions, and information gathered to inform this report can be found in a supplemental study, The CannonDesign Analysis for the Department of State Health Services (DSHS) Ten Year Plan. The following are the key recommendations from the DSHS State Hospital System Long-Term Plan.

### **Transform and Clarify the Role of State and Local Hospitals**

- Transition the primary role of the state mental health hospitals into tertiary referral centers providing recovery care for the most complicated mental health patients and those individuals on forensic (criminal code) commitments.
- Transition local hospitals to providers of initial assessment, crisis management and short-term inpatient recovery care of voluntary and involuntary mental health patients.

### **Expand Access through Local Contracting**

- Expand access to inpatient care by contracting with local public, community not-for-profit, private and university hospitals.
- Ensure that any new inpatient resources are targeted to areas with unmet need and allocated through a statewide needs-based system that is informed by a collaborative local planning process.

### **Replace and Renovate State Hospitals**

- Replace five state mental health hospitals with new facilities that more easily support contemporary mental healthcare.
  - Austin State Hospital, North Texas State Hospital-Wichita Falls, Rusk State Hospital, San Antonio State Hospital, and Terrell State Hospital (procurement in process with a private entity).

- Repair and improve six state mental health hospital buildings and facilities that are in fair to good condition.
  - Big Spring State Hospital, Kerrville State Hospital, North Texas State Hospital-Vernon, Rio Grande State Center, El Paso Psychiatric Center, and Waco Center for Youth.
- Demolish all state mental health hospital structures that can no longer be safely occupied, or for which no cost benefit can be determined for re-use.
- Reduce the overall size of state mental health hospital campuses to a target size of 1 acre per 8-12 beds.

#### **Pursue Academic Affiliation**

- Establish centers of excellence at each of the hospitals that will continue to be DSHS-operated facilities (i.e. Kerrville State Hospital's specialty forensic focus) and continue to pursue academic affiliations in support of this goal.

#### **University or Private Hospital Operation**

- Actively pursue academic/university operators of the new/replacement hospitals to promote workforce development and integrated care.
- Explore benefits and opportunities for private operation of new/replacement hospitals.

#### **Address Other Critical Issues**

- Ensure that existing technology systems/infrastructure is maintained and data exchange capability is pursued to ensure that care is integrated with other providers.
- Continue to work to address workforce issues including examination of compensation packages, educational packages, and loan forgiveness for direct care providers (social work, nursing and medical staff) to mitigate impact of market competition on fulfilling the mission of the state mental health hospitals.
- Continue efforts to decrease demand for psychiatric beds through enhancement of the continuum of care including increasing prompt access to substance abuse treatment, supported housing and crisis services that provide alternatives to hospitalization, and innovative approaches to engagement and continuity of care such as the use of peers as navigators.

## **Introduction**

The 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, Department of State Health Services, Rider 83) directed DSHS to develop a long-term plan to address the needs of the state hospital system.

The rider specifies that the plan will consider state hospital system operational needs, including infrastructure needs of the existing facilities, future infrastructure needs, capacity needs across various regions of the state, and associated costs. The plan must consider current state funded hospital capacity for individuals requiring hospitalization, timely access to patient care in the least restrictive setting as clinically appropriate, best practices in psychiatric inpatient care, opportunities for patients to receive care closer to their homes, and efficient use of state resources. DSHS is required to seek public input during development of the plan, and is authorized to contract for necessary technical expertise to assist in the development of the plan. DSHS shall coordinate with the Department of Aging and Disability Services (DADS) in the development and implementation of the plan, in order to ensure consideration of cross agency issues impacting State Hospitals and State Supported Living Centers. DSHS shall submit the plan to the Office of the Governor and the Legislative Budget Board.

## **Background**

Over the last three biennia, the Texas Legislature has made significant investments to strengthen the state's mental health system. In 2009 and 2011, the Texas Legislature provided funding to enhance crisis response systems, develop local crisis stabilization facilities as alternatives to hospitalization, and provide transitional services to individuals after crisis stabilization. This was followed in 2013 by a significant level of investments in behavioral health services, including expansion of outpatient mental health and substance abuse service capacity, supportive and recovery housing, and more crisis services. In addition, the 83<sup>rd</sup> Texas Legislature established an array of programs to address the needs of special populations, including veterans, children at risk for parental relinquishment of custody, homeless and incarcerated individuals with mental illness, and individuals who are high utilizers of the state hospital system.

While these investments have helped to address critical needs, several key trends directly impact care delivery today and are expected to continue to put pressure on an already challenged system. The rapid growth and projected steady increase of the population, the availability of mental health professional staff, and increase in the forensic (criminal code commitment) population will all influence the demand for inpatient and outpatient psychiatric services over the next ten years in Texas.

According to the Office of the State Demographer, the Texas population is projected to grow 24 percent: from 26.6 million in 2013 to over 33 million in 2024. The percentage of individuals over the age of 60 is also expected to rise, resulting in increasing numbers of patients with complex co-morbidities. This population is proven to consume health care resources at a higher rate, given the corresponding rise in chronic diseases and age-related mental illnesses.

In addition to overall population changes, there have been changes in the state hospital system's patient population. Over the past few years, an increase in the number of patients with forensic

commitments presenting at state hospitals has put pressure on the availability of civil beds. This population, on average, has a longer length of stay than civil consumers, and is expected to grow, further challenging the ability of the existing state hospital system to care for patients involved with the criminal justice system and to locate placement for these individuals in the community. At the same time, patients with medical complexities and co-occurring conditions are on the rise, many of whom are part of the forensically- and civilly-committed population. Patients with medical complexities and co-occurring conditions require additional care and support. This trend is expected to continue through the next decade, putting additional stress on the state hospital system as these patients will require an additional layer of support.

As these issues began to take shape, DSHS had begun to take steps to increase access and engage new partners in meeting these challenges. For example, new partnerships have been established with local hospitals to expand access to inpatient services, outpatient competency restoration programs have been developed in 12 communities, local crisis and jail diversion efforts have been strengthened, and systems have been redesigned to identify and provide community services for nursing home residents with mental illness.

However, although community partners can provide services for many acute patients, they are not equipped to handle patients with more complex conditions. Consequently, a growing proportion of the population served by the state hospitals is comprised of patients who are more acutely ill, both psychiatrically and physically. Treatment of this population requires more intense staffing and services.

The DSHS Long-Term Plan lays out a schedule for expediting change across the system, describes the financial implications, and notes the benefits to the system and the people served if a course is set for the future that includes reducing ongoing deferred maintenance and replacing or renovating outdated facilities, ensuring availability of a skilled workforce equipped to provide services to complex patients, and addressing the needs of a growing population.

### **Estimating Bed Need – Today and Tomorrow**

Texas is a large state with unique strengths and needs related to geography, workforce, and local economies. In light of the state's changing demographics, understanding the current need for inpatient psychiatric care and anticipating the future demand is critical. Recognizing this, the 83<sup>rd</sup> Texas Legislature directed DADS and DSHS to develop long term plans and authorized the agencies to contract for necessary technical expertise to inform the planning process. DSHS and DADS collaborated with the Health and Human Services Commission (HHSC) to issue a Request for Proposals, and CannonDesign was selected to perform these services.

A key portion of CannonDesign's analysis for DSHS relates to current and future needs for psychiatric bed capacity in Texas. CannonDesign's best estimate of total need for privately and publicly funded inpatient beds is 5,425 beds in 2014 and 6,032 by 2024. In order to facilitate discussion and decision making, this document lays out the broad context for these figures.

## **Met Need (4,855 beds)**

Both the state and local communities are making substantial contributions toward meeting the need for inpatient hospitalization for persons with mental illness. It should be noted that some beds in this category may not have been immediately accessible requiring waits over 24 hours for care or travel more than 2 hours. Due to the costs associated with this level of care, the current financial burden for both the state and local communities is significant.

- **State Operated Beds (2,463 beds)**  
DSHS operated 2,463 total inpatient psychiatric beds in fiscal year 2014 in its 11 facilities.
- **State Contracted Beds (456 beds)**  
The state also contracts for inpatient care through contracts with local inpatient facilities or with Local Mental Health Authorities (LMHAs). In fiscal year 2014, DSHS funded 456 beds in private facilities.
- **Locally Supported Beds (1,936 beds)**  
Local communities have assumed a significant portion of the responsibility for inpatient care. Approximately 50 percent of these beds are funded by third party insurance including Medicaid and Medicare. Fifty percent is indigent care funded by local communities. The best estimate for the number of locally supported beds in fiscal year 2014 is 1,936 beds.

## **Unmet Need (570 beds)**

Despite efforts to meet the needs of this population, communities have expressed concern that some individuals remain in emergency rooms and jails for long periods of time because they are unable to obtain access to this level of care. Based on national prevalence and need data, the following is an estimate of unmet need/latent demand in Texas.

- **Criminal Justice System (169 beds)**  
Persons with serious mental illness (SMI) represent about ten percent of the criminal justice population, a much higher proportion than in the general population. Because some of these individuals will require hospitalization, this figure assumes an average of 55 days of inpatient care for six percent of those with SMI who are entering or exiting the criminal justice system. While the criminal justice system is responsible for providing care during incarceration, these individuals will require services in the community when they are released. Strengthened community-based services and jail diversion efforts could also result in many such individuals avoiding incarceration in the future, increasing the need for community-based services.
- **People with Serious Mental Illness Unconnected with Care (401 beds)**  
There are a significant number of individuals who are not connected with ongoing care. These individuals frequently come into contact with the mental health system during a crisis. Based on national prevalence and need data, the estimated unmet need/latent demand in Texas is 401 beds.

## **Population Growth (607 beds)**

With the state’s population growing at 1.8 percent each year, an additional 607 beds will be needed to accommodate the increasing demand for hospital beds over the next ten years.

Quantifying the demand for inpatient care in Texas today and the potential impact of a growing population with a shifting demographic base is a necessary step in the re-examination of inpatient psychiatric care in Texas. However, these estimates should be considered “directional,” offering guidance to inform planning efforts. Continued investments in community based crisis alternatives and a full array of ongoing care have the potential to “bend the curve” and decrease these estimates of need for inpatient psychiatric care.

## **Clarify and Transform Roles**

Across the nation, discussions are underway regarding ensuring “the right place” for services. The concept of “the right place” challenges all providers in the behavioral health care continuum to rethink their roles and scope of services to ensure that consumers receive the least restrictive care as close to their homes as possible. Planning for inpatient capacity must consider not only the expanding Texas general population, national and state forensic commitment trends, and increases in persons presenting with comorbidities (i.e. substance use disorders, chronic disease, and medical complexities). Planning must also include the significant latent demand that is currently not being met among those who are unserved in dispersed communities across Texas and persons with mental illness incarcerated in Texas prisons and jails who will need services when they are released.

Because local inpatient facilities are spread across the wide geography of Texas, they are well-positioned to expand capacity into high need areas. Acknowledging the capacity of local providers to care for many more persons in need of inpatient care, these same providers and a number of other stakeholders have indicated to DSHS that over the near to medium term, many individuals (particularly those with the most complex needs) are anticipated to be best served by a state hospital system.

DSHS proposes:

- Transitioning state hospitals into tertiary care facilities for the most complex mental health patients and a significant portion of the forensic population.
- Moving initial assessment, crisis management, and short-term inpatient recovery care of voluntary and involuntary inpatients to local hospitals in coordination with LMHAs and using a strong collaborative planning process.

In order to incorporate this vision into DSHS planning and projections, the re-defined roles have been translated into market share assumptions by CannonDesign, illustrated in Figure 1. Understanding that a period of transition would be required if Texas moves toward this vision, the chart below shows the anticipated balance of individuals in the state that state psychiatric

hospitals would serve. These estimates provide a starting point for planning, and may be adjusted as needed.

**Figure 1: DSHS Proposed Market Capture by Group**

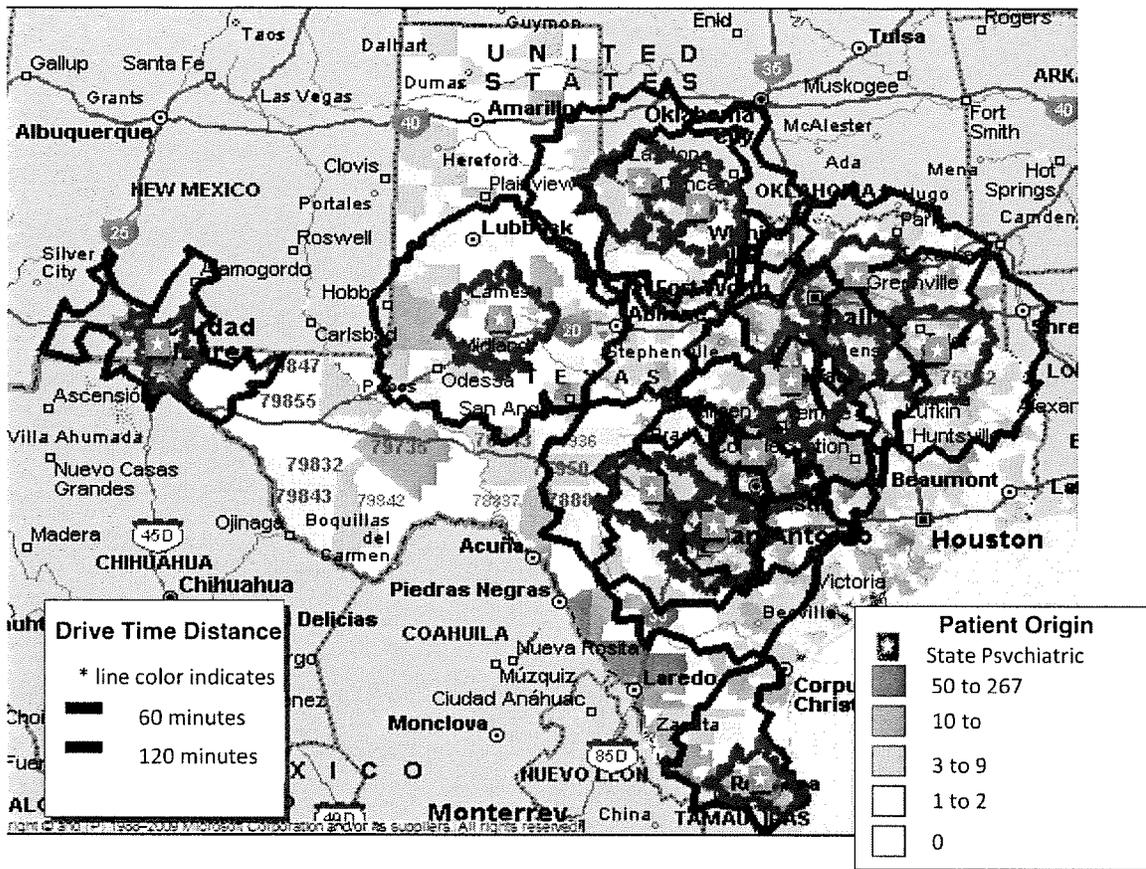
Legal Status	Age Group	Admission Type / Comorbidities	Length of Stay (Days)		
			<7	7 - 14	14+
Forensic	Child/Adolescent	All	3%	7%	90%
	Adult	All	3%	7%	90%
	Geriatric	All	3%	7%	90%
Civil	Child/Adolescent	Involuntary Admission	5%	20%	75%
		Voluntary Admission	5%	10%	75%
		Medically Complex	0%	0%	0%
		Substance Abuse	0%	10%	80%
		Eating Disorder	0%	25%	90%
Civil	Adult	Involuntary Admission	10%	20%	95%
		Voluntary Admission	5%	20%	90%
		Medically Complex	0%	20%	90%
		Substance Abuse	0%	10%	70%
Civil	Geriatric	Involuntary Admission	10%	10%	10%
		Voluntary Admission	5%	10%	10%
		Medically Complex	10%	10%	10%
		Substance Abuse	5%	10%	10%

**Expanding Access through Contracts**

A significant “latent need” for inpatient care in Texas has been identified. DSHS could expand access to hospital services through contracts to address this need in a manner that allows individuals to be served close to home, respects the needs of family/support systems, and reduces the burden on law enforcement.

The needs analysis suggests that many patients are admitted to facilities over 100 miles from their homes, and some areas of the state are more than two hours away from the nearest state mental health hospital. The bed analysis and demand forecast indicate that all state hospitals are appropriately located in relation to need, having significant demand within a two-hour drive time perimeter or a specialized focus that draws patients from across the state. However, three potentially underserved areas were identified: the Panhandle, Harris/Montgomery County area, and the Waco/Dallas/Arlington corridor. Furthermore, it is anticipated that additional capacity in the border region and west Texas would benefit these communities. This can be seen in the map shown in Figure 2, which shows portions of the state that fall outside of the two-hour drive time perimeter (identified with blue lines). Green shading shows the rate of hospital admissions per capita for each county, with darker shading indicating higher rates of admissions.

**Figure 2: State Psychiatric Hospital Origin and Drive Time Distance, FY13**



DSHS proposes meeting the “latent demand” using contracts with local public, community not-for-profit, private and university hospitals (either directly or through LMHAs) as opposed to expansion of the state hospital system. The DSHS Legislative Appropriations Request (LAR) proposes to add 150 beds in the fiscal year 2016-2017 biennium to address this unmet need. An additional 50 beds per year beyond the current LAR would address the estimated population growth. The combined expansion in contracted beds is shown in Table 1. DSHS is collecting additional data regarding available inpatient capacity in order to better assess the ability of local hospitals to expand beyond these initial figures.

**Table 1. Proposed Schedule of Costs: Expand Contracts (in millions)**

	Biennium 2016-17	Biennium 2018-19	Biennium 2020-21	Biennium 2022-23	Biennium 2024-25	Biennium 2026-27
Current Beds	362 (\$130)	612 (\$230)	862 (\$330)	1,112 (\$430)	1,332 (\$518)	1,432 (\$558)
Additional Beds	250 (\$70)	250 (\$70)	250 (\$70)	220 (\$64)	100 (\$30)	100 (\$30m)

*The cost to fund 50 beds for one year is \$10 million. When new beds are added, the first year is a ramp-up period, with only a portion of the beds becoming operational (e.g., 100 of 250 new beds). Therefore, additional dollars are needed to maintain the total number of new beds in subsequent biennia.*

## **Academic Affiliation**

There could be substantial benefits to be gained by university affiliations and partnerships. These partnerships could help to address the critical workforce issues faced by the state hospital system. Research shows that recruitment can be enhanced by more robust relationships with academic institutions that allow young trainees to be exposed to the mission of the state hospital system during their training. State hospitals also offer a unique opportunity for trainees to gain expertise in treatment for people with complex conditions, which contributes to the development of a future workforce with the competencies needed to treat the population served in the state's mental health system.

Universities also bring unique expertise to enhance the system of care in our public facilities. Academia is in the forefront of research and development of best practices, including evolving models of care. As healthcare moves toward a more integrated system that relies on collaborative practice models, university partnerships can facilitate the continuing evolution of best practices within the state hospital system and foster more holistic healthcare for patients.

DSHS proposes the establishment of centers of excellence at each of the hospitals that will continue to be DSHS operated facilities and will continue to pursue academic affiliations in support of this goal. Each of these facilities has a specialized focus that presents a unique set of challenges (i.e., Kerrville State Hospital's specialty forensic focus). Special attention will be given to Waco Center for Youth, as this facility's specialty focus on high-needs youth may help address needs in the Department of Family and Protective Services system. Working with the most challenging sets of conditions sets state mental health hospitals apart as experts that serve as a resource to the entire health care system. In association with regional academic centers, DSHS seeks to foster a role for these hospitals as teaching hospitals, patient care hospitals, and research hospitals in the same tradition as the university hospital system.

## **University or Private Hospital Operators**

In addition to partnering with universities in the areas of workforce development and patient care, DSHS will actively pursue agreements with universities to assume operation of the new/replacement hospitals, except for the North Texas State Hospital Vernon location. This facility, with its specific forensic responsibilities to serve maximum security level patients, is anticipated to continue to be operated by DSHS directly. Additional planning will be needed in relation to the Rio Grande State Center campus and its role ensuring access in south Texas to inpatient mental health services, as well as its roles as a state supported living center and public health outpatient clinic.

The initial focus for seeking university operators will be on state facilities in close proximity to potential academic partners. Additional opportunities for transition to operation by universities will be considered over the ten year period.

There may also be benefits to private operation of new facilities. Private entities may have advantages to state run facilities through greater flexibility to respond to changing needs and

market conditions, particularly workforce challenges. They may also make capital investments that reduce ongoing operational costs.

Procurement is currently in process to secure a private operator for Terrell State Hospital. If negotiations are successful, the options for operation and replacement will be fully assessed. If not, consideration will be given to transferring Terrell State Hospital to a university operator. As planning for replacement facilities moves forward, DSHS will continue to explore all available options to identify the most advantageous operating models for each hospital.

**Repair and Replace Aging State Hospitals**

One of the themes presented by the outside consultants highlights that the physical facilities of the mental health hospitals are aging, functionally outdated, and not conducive to contemporary mental health care. Abandoned and underutilized buildings were noted as diverting resources away from operational buildings, and the historic self-contained nature of state hospital life meant that large portions of campuses were now unused. The consultants also noted that changes in the type of patients served – an aging population and more forensic patients, for example – left existing facilities unconducive to appropriate patient care. Multi-bed rooms, for example, were not reflective of current best practice. They recommended down-sizing of campuses and gradual replacement of these facilities and infrastructure.

The consultants provided models of care from other states that would help state hospitals address the increased acuity of their patient population and achieve shorter lengths-of-stay through:

- Reducing the number of people in a room,
- Increasing the amount of shared space, and
- Arranging their layout so that staff can be deployed more efficiently.

These approaches seem to improve both safety and clinical care. They also recommended special facilities for medically fragile and other special patient groups.

The consultants stopped short of recommending replacement of all facilities as the most cost effective approach to care. Instead, they recommended replacement of those facilities with patient care areas that are in the poorest condition, based upon a facility condition index. For the remainder, they recommend funding needs related to interior and exterior environment. They also recommend demolition of unused and unsafe structures, and downsizing campuses through sale or lease. Costs associated with these activities are shown in Table 2.

**Table 2. Schedule of Costs: Replacement of State Facilities (in millions)\***

Facility	Preparation		Replacement	
	Costs	Biennium	Costs	Biennium
North Texas-Wichita Falls	\$10.0	2016-17	\$133.3	2018-19
Terrell State Hospital	\$13.5	2016-17	\$180.3	2018-19
Austin State Hospital	\$14.1	2018-19	\$188.7	2020-21

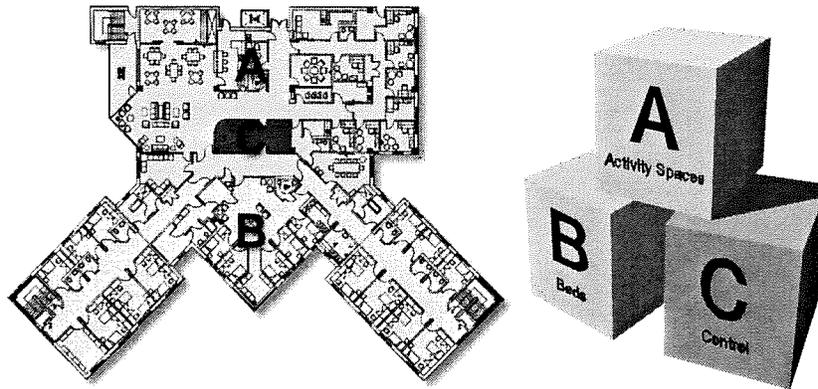
Facility	Preparation Costs	Biennium	Replacement Costs	Biennium
Rusk State Hospital	\$13.4	2020-21	\$179.6	2022-23
San Antonio State Hospital	\$14.1	2022-23	\$188.4	2024-25

*NOTE: Preparation costs include planning, design, bid proposal and other costs prior to actual construction. Replacement costs include demolition of unused and unsafe buildings.  
\* Cost may be reduced through replacement projects funded through private sector collaborations, including current plans for transfer of Terrell State Hospital to private operator.*

### Current Trends and Best Practices

CannonDesign researched national trends and best practices related to inpatient facilities and highlighted the key components of modern psychiatric unit design, as shown in Figure 3.

**Figure 3: Establishing unit zoning that supports an active treatment model of care**



As buildings are replaced, DSHS will have the opportunity to build facilities with floorplans that reflect best practices in building design and support emerging models of care. This will result in a number of benefits for the people served and for hospital staff.

#### *Client Benefits*

- Single resident bedrooms afford greater privacy and dignity for patients and facilitate accommodation of individual treatment needs.
- Greater variety of activity and social spaces afford a greater level of choice and control for patients.
- Active daytime treatment offered in “therapy malls” offer amenities that patients are likely to utilize in their communities, which enhances patient satisfaction and facilitates successful transition back to the community, particularly for long-term patients.

#### *Administrative/Operational Benefits*

- Appropriate zoning of resident units provides optimized care and treatment opportunities, focusing on activity, bedroom, and controlled staff/support areas as distinct areas within the unit, organized around a central “awareness point.”

- Unit design incorporating distinction between “on-stage” and “off-stage” areas minimizes disruption of treatment activities on the unit (i.e., food delivery and waste removal occur in an “off-stage” area).
- Unit design becoming more standardized and modular allows the flexibility needed to more readily adapt to near and long-term shifts in consumer profiles and populations.

### *Renovate Facilities*

In addition to construction of new facilities, DSHS proposes:

- Capital improvement plans over the next six biennia to renovate facilities and address deferred maintenance needs of six facilities: Big Spring, El Paso Psychiatric Center, Kerrville, the Vernon Campus of North Texas State Hospital, Rio Grande State Center and Waco Center for Youth
- Demolishing all structures that can no longer be safely occupied, or for which no cost benefit for re-use can be realized.
- Reducing the overall size of state mental health hospitals to a target size of 1 acre per 8-12 beds.

The projected costs for renovation and deferred maintenance are shown in Table 5.

**Table 5. Schedule of Costs: Renovate and Maintain State Facilities (in millions)**

Facility	Preparation	Biennium	Renovation	Biennium
	Costs		Costs	
Rio Grande State Center	\$0.8	2016-17	\$8.2	2018-19
North Texas-Vernon	\$4.4	2018-19	\$45.7	2020-21
Big Springs State Hospital	\$4.0	2018-19	\$40.9	2020-21
Kerrville State Hospital	\$4.9	2020-21	\$50.0	2022-23
El Paso Psychiatric Center	\$1.1	2024-25	\$14.7	2026-27
Waco Center for Youth	N/A	N/A	N/A	N/A

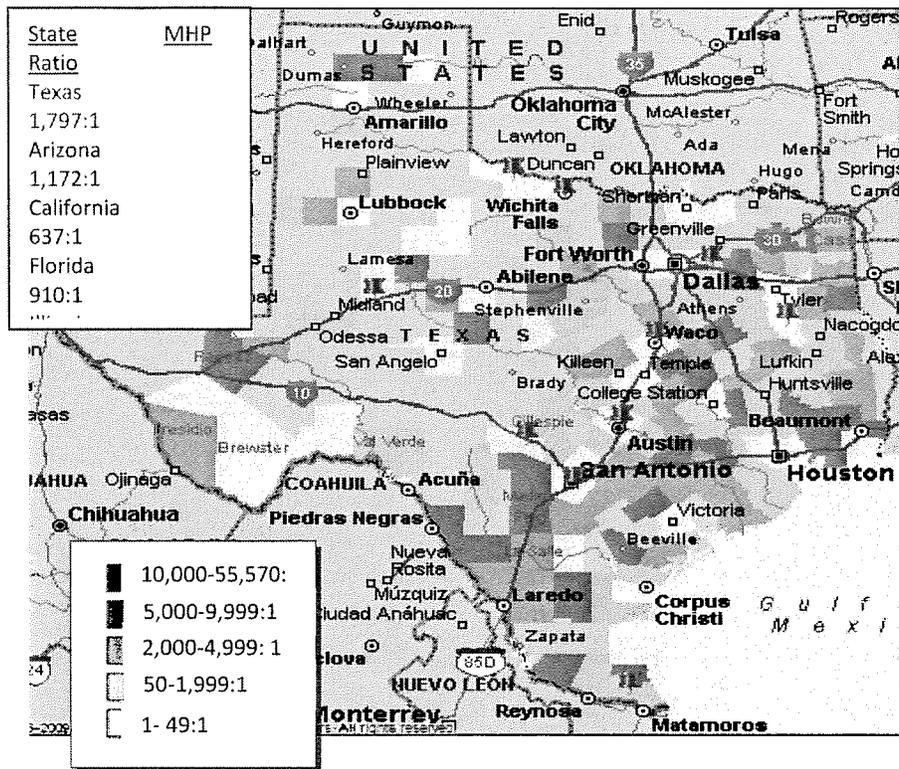
*NOTE: Preparation costs include planning, design, bid proposal, and other costs prior to actual construction. Renovation costs include demolition of unused and unsafe buildings.*

## **Investing in the Future**

### **Addressing Workforce Issues**

Texas is experiencing a critical shortage of psychiatrists, licensed professionals counselors, social workers, and staff such as Psychiatric Nursing Assistants (PNAs) providing direct care. Two hundred (79 percent) of Texas counties and parts of five other counties are federally designated as Health Profession Shortage Areas for mental health, and 69 percent of counties have no psychiatrists. As shown in Figure 4, these needs are particularly acute in rural areas, where the behavioral health provider to patient ratio is as high as 1 to 55,570.

**Figure 4. Population to Mental Health Provider Ratio in Texas**



Workforce challenges are particularly acute in the state hospital system, where vacancy rates and turnover rates strain the ability of facilities to maintain a consistent bed capacity and provide continuity of care for patients. While pay increases for psychiatrists and PNAs have been helpful, the challenges are ongoing. For example, at the end of fiscal year 2014, the vacancy rate for non-psychiatric physicians was 23 percent, and turnover rates for other direct care staff ranged from 26 to 35 percent.

DSHS proposes:

- In consultation with HHSC, a deeper examination of compensation packages (and related costs), educational packages, and loan forgiveness for direct care providers (social work, nursing, and medical staff).

As noted earlier in this report, there are workforce benefits to university affiliations. Work experience in state hospitals exposes trainees to the mission of the state hospital system and benefits recruitment efforts. These relationships also offer trainees experience in working with complex conditions, which helps to develop a skilled workforce for the future. Establishing centers of excellence could also make state hospital employment more attractive in a competitive employment market.

## **Expanding Community Alternatives and the Continuum of Care**

There are a number of community based services that would be anticipated to decrease demand for inpatient care over time:

- Supported Housing including models such as the Home and Community Based Services (1915i) program being implemented to provide more intensive supports to those with a history of high inpatient use
- Substance use treatment
- Enhanced continuity of care including the use of peers to engage hard to reach consumers and help connect individuals with care
- Expansion and enhancement of crisis alternatives to divert individuals from unnecessary inpatient hospitalizations

CannonDesign's analysis shows a high readmission rate to the state mental health hospitals for patients who have co-occurring substance use disorders, and so increasing the availability of less expensive substance abuse treatment beds in the community would significantly reduce the need for extended acute recovery care beds.

## **Enhancing Information Technology to Support Care**

In their report, CannonDesign encouraged expansion of the technological infrastructure necessary to transition acute assessment services to community settings and community hospital emergency departments, and modernization of state hospital technological infrastructure. DSHS acknowledges that the mental health system of the future has two major requirements in terms of information management. First, they require a contemporary and robust electronic medical record system. Second, they should be seen as part of the whole health system and their health data and medication data should be shared and accepted by and from other health providers. State mental health hospitals need to be part of Health Information Exchanges to ensure coordinated care when patients transition to new providers.

The DSHS 2016-2017 LAR includes funding to support technology infrastructure in the state hospital system.

## **For Further Evaluation and Analysis**

Changes proposed in this plan, particularly changes in the population served by the state hospitals, will have an effect on the financial management of the state hospitals. Additional analysis is needed to determine the extent of the impact and the overall impact on the revenues and expenditures.

## **Disproportionate Share Hospital (DSH) Payments**

State hospitals currently receive revenue through the Disproportionate Share Hospital Program (DSH). In fiscal year 2011, these payments averaged approximately \$29 million per state hospital. To be eligible for DSH, each hospital must meet the Medicaid Utilization Rate, which

requires that eligible hospitals bill Medicaid for a number of bed days equal to or greater than one percent of total bed days. Payments are based on the number of Medicaid billable days.

As the state hospitals in Texas move toward new models of care, there are several issues that could impact DSH.

- As the system moves in the direction of extended acute and long-term civil and forensic patients, it is likely that the Medicaid billable days will be reduced due to benefit limitations.
- As more long-term geriatric patients are placed outside the state hospitals, it is likely that the percent of patients in the Institution of Mental Disease (IMD) exclusion range (ages 21 to 64) will increase. State hospitals are classified as IMDs, and Medicaid reimbursement is prohibited for patients in IMDs who fall between the ages of 21 and 64. These patients are not eligible to be counted as uncompensated care.
- It is currently unclear how potential academic or private partnerships might impact DSH revenue, and this issue will need further research and analysis.

These factors could potentially reduce Medicaid billable days and DSH payments for those hospitals that are eligible for DSH. In addition, there may be a risk that multiple hospitals could drop below the one percent threshold, making those hospitals ineligible for DSH payments.

### **Third Party Revenue**

Transitioning state hospitals to primarily long-term forensic and extended care acute patients could result in a significant drop in third party revenue collections, which includes reimbursement from Medicare, Medicaid, private third-party payers, and self-pay patients. Currently, third party revenue comprises approximately 16 percent of the budget for state hospitals. The majority of revenue is earned during the first 30-60 days of a patient's stay, and most commercial insurance companies and managed care organizations do not pay beyond the first 15 to 30 days. Medicare and Medicaid generally pay for additional time based on how many episode days and/or lifetime benefit days the patient has. Although Medicare will reimburse for forensic patients, Medicaid and most commercial payers will not. As the state hospitals shift to a larger proportion of forensic and longer-term patients who have exhausted available benefits, there will be a commensurate decrease in revenue collection.

### **Financial Overview/Implications**

To implement all of these changes, a significant amount of funding would be required. In order to support decision making, DSHS staged potential expenditures over six biennia. For each potential renovation or replacement project, the prior biennia is used for architectural plans and other preparatory activities to actual construction. Table 6 summarizes the anticipated investments that will be needed over the next 12 years, including projected inflation for project costs and the current baseline state hospital budget. A more detailed version of this table is found in Appendix A, Table 7.

**Table 6. Proposed Schedule of Additional Costs (in millions)\*\*\***

Biennium	New Contract				Project Total**
	Beds*	Preparation	Renovation	Replacement	
2016-17	\$70.0	\$24.3	-	-	<b>\$94.3</b>
2018-19	\$170.0	\$22.5	\$8.2	\$313.6	<b>\$514.3</b>
2020-22	\$270.0	\$18.3	\$86.6	\$188.7	<b>\$563.6</b>
2022-23	\$364.0	\$14.1	\$50.0	\$179.6	<b>\$607.7</b>
2024-25	\$418.0	\$1.1	-	\$188.4	<b>\$607.5</b>
2026-27	\$458.0	-	\$14.7	-	<b>\$472.7</b>
	<b>\$1,750.0</b>	<b>\$80.3</b>	<b>\$159.5</b>	<b>\$870.3</b>	<b>\$2,860.1</b>

*\*These costs include dollars to add and maintain the new contract beds.*

*\*\* Costs may be reduced through replacement projects funded through private sector collaborations*

*\*\*\* Does not include projected inflationary costs*

### **Conclusion**

The Texas state hospital system is facing significant challenges, which will continue to grow in the coming years. In addition to aging and outdated facilities, there is a growing demand for inpatient capacity across the state. Addressing these needs will require a significant investment, but will also provide a unique opportunity to transform the existing system. By redefining the role of state facilities to focus on forensic and civil patients with the most complex needs, purchasing additional capacity in local hospitals so individuals can be served in their own communities, establishing academic partnerships, and modernizing state facilities to align with current best practices, the state will be better prepared to meet the needs of a growing population in a dynamic environment.

**Appendix A: Additional Tables**

**Table 7: Detailed Schedule of Costs (in Millions)\*\*\*\***

Biennium	Increased Contract Beds*		Preparation	Renovation	Replacement	Project Total****		
2016-2017	250 new	\$70.0	Replace Wichita Falls	\$10.0	\$0.0	NA	\$0.0	
			Terrell	\$13.5				
			Renovate Rio Grande	\$0.8				
<b>Total 16-17</b>		<b>\$70.0</b>	<b>\$24.3</b>	<b>\$0.0</b>		<b>\$0.0</b>	<b>\$94.3</b>	
2018-2019	250 new	\$70.0	Replace Austin	\$14.1	Rio Grande	\$8.2	Wichita Falls	133.3
			Terrell				180.3	
	250 beds continued	\$100.0	Renovate Big Springs	\$4.0				
			Vernon	\$4.4				
<b>Total 18-19</b>		<b>\$170.0</b>	<b>\$22.5</b>	<b>\$8.2</b>		<b>\$313.6</b>	<b>\$514.3</b>	
2020-2021	250 new	\$70.0	Replace Rusk	\$13.4	Big Springs	\$40.9	Austin	\$188.7
			Vernon	\$45.7				
	500 beds continued	\$200.0	Renovate Kerrville	\$4.9				
<b>Total 20-21</b>		<b>\$270.0</b>	<b>\$18.3</b>	<b>\$86.6</b>		<b>\$188.7</b>	<b>\$563.6</b>	
2022-2023	220 new	\$64.0	Replace San Antonio	\$14.1	Kerrville	\$50.0	Rusk	\$179.6
			Renovate NA					
	750 beds continued	\$300.0						
<b>Total 22-23</b>		<b>\$364.0</b>	<b>\$14.1</b>	<b>\$50.0</b>		<b>\$179.6</b>	<b>\$607.7</b>	
2024-2025	100 new**	\$30.0	Replace NA	\$0.0		San Antonio	\$188.4	
	970 beds continued	\$388.0	Renovate El Paso	\$1.1				
	<b>Total 24-25</b>		<b>\$418.0</b>	<b>\$1.1</b>	<b>\$0.0</b>		<b>\$188.4</b>	<b>\$607.5</b>
2026-2027	100 new **	\$30.0	Replace NA		El Paso	\$14.7		
	1070 beds continued	\$428.0	Renovate NA					
	<b>Total 26-27</b>		<b>\$458.0</b>	<b>\$0.0</b>	<b>\$14.7</b>		<b>\$0.0</b>	<b>\$472.7</b>
<b>TOTAL</b>		<b>\$1,750.0</b>	<b>\$80.3</b>	<b>\$159.5</b>		<b>\$870.3</b>	<b>\$2,860.1</b>	

\*Includes ramp-up in year one.

\*\* Population growth only

\*\*\*Costs may be reduced through replacement projects funded through private sector collaborations

\*\*\*\*Does not include projected inflationary costs.