HB 3793: Standards and Methodologies

HB 3793 (83rd Legislature, Regular Session, 2013) directs the Department of State Health Services (DSHS) to develop a plan to ensure the appropriate and timely provision of mental health services and to allocate mental health outpatient and hospital resources for the forensic and civil/voluntary populations. It also requires DSHS to establish an Advisory Panel to assist with the development of the plan and to identify standards and methodologies for implementing the plan.

The HB 3793 Advisory Panel convened in September 2014, and the Initial Plan was adopted in December 2014. Over the next nine months, DSHS worked with the Advisory Panel to develop the standards and methodologies necessary to operationalize the framework set out in the Initial Plan. One of the key tasks remaining after the Initial Plan was adopted was completion of a community-based assessment of existing capacity and needs.

The 2014-2015 General Appropriations Act, S.B. 1, 83rd Legislature, 2013 (Article II, DSHS Rider 83) requires DSHS to develop a Ten Year Plan for the provision of psychiatric inpatient hospitalization. In April 2014, DSHS contracted with CannonDesign to assist in developing the Ten Year Plan. The scope of work included an assessment of the current system, with a focus on capacity and demand needs considered in the context of the full continuum of care. DSHS leveraged the resources and expertise provided by CannonDesign to inform the work of the HB 3793 Advisory Panel. Members of the Panel provided input during the assessment phase and the visioning process.

The Standards and Methodologies below were developed collaboratively and approved by the HB 3793 Advisory Panel, with one exception. DSHS has separate comments regarding capacity needs, which are found at the end of the document.

Capacity

Statutory Charge (Health and Safety Code 533.051(b)(1) and 533.051(b)(2))

- *A determination of the needs for outpatient mental health services of the two groups of patients [forensic and civil/voluntary]*
- *A determination of the minimum number of beds that the state hospital system must maintain to adequately serve the two groups of patients*

Standards

1. DSHS will have a sufficient number of state-funded inpatient beds of the correct type to admit all forensic, civil, and voluntary patients requiring inpatient services without delay or diversion.
2. As part of the continuum of care, DSHS will have sufficient outpatient capacity to provide the appropriate level of care to all forensic, civil, and voluntary individuals referred to or seeking services without delay or diversion.
3. Fund and maximize utilization of hospitalization prevention programs at the local level that are person centered, recovery based, and utilize peer services.

Methods

Inpatient

To capture unmet or current need, DSHS consultants assisting with the Ten Year Plan developed a methodology tailored to the care model described in this Standards and Methodologies document. The forecast methodology incorporates factors that include incidence and prevalence rates, the steady growth in population, changing demographics, trends such as an increase in the forensic population, the future role of the state hospitals, and changes in the continuum of care. Using this model, the DSHS consultants suggest a current need of about 4,400 state-funded beds[1], and an additional 50 new beds per year to address anticipated changes in demand. This document will lay out HB3793 Advisory Panel recommendations as well as the DSHS efforts to provide information to the Texas Legislature related to provider capacity, ramp-up, and workforce.

HB3793 Advisory Panel Consensus on Inpatient Capacity Needs

The HB 3793 Advisory Panel reached consensus that the best available estimate of current need in Texas is about 4,400 beds. Currently there are about 2,900 DSHS-funded psychiatric beds in Texas, if state hospital beds and purchased community beds are included. So currently, about 1,500 new beds[2] are necessary to meet the Advisory Panel's consensus recommendation. In addition, the HB 3793 Advisory Panel consensus is that an additional 60 beds would need to be brought online each year to maintain the recommended ratio of beds to population given projected population growth.

The Advisory Panel recognized that if DSHS purchased 1,500 beds at the current average cost for state hospital beds, it may cost over $300 million annually. However, the Panel recognized that the current demand need not be for state operated hospital beds alone and that DSHS may be able to contract for additional acute psychiatric capacity. The panel acknowledged that after the immediate need for substantially greater access to psychiatric beds is addressed, that some use of alternative bed-types (such as detox beds or crisis stabilization unit beds) may prove to be a cost-effective option that reduces the longer-term need for state hospital beds. The Panel also recognized that the cost to purchase care in some rural and border communities with high demand and few current resources may be higher than the cost of a state hospital bed.

Given the challenges in developing capacity, the Advisory Panel consensus was that the most prudent approach would be a significant initial increase in state-funded psychiatric beds followed by a gradual increase in beds that attempts to meet both the current and future demand. The Panel recommended adding 720 beds in the next biennium, and then 1,260 beds over the subsequent six years in order to meet current and future demands by the end of eight years. The Panel agreed that over the long term, a mix of bed types, based upon regional needs and prompt access to an appropriate level of care, may allow achievement of access and availability goals at the most efficient cost. This approach would also allow an ongoing reassessment of need versus capacity after the first two years of implementation.

[1] 4,400 was a preliminary estimate from CannonDesign. The estimate in the consultant's final report is that the total current need is approximately 4,300 beds.
[2] Based on the consultant's final estimate, this number would be 1,400.

The consensus estimates of current and future bed needs are intended to provide sufficient capacity for both civil and forensic needs, with flexibility built in to address variations in need and local choice/resources.

Outpatient

If current demographic trends continue, consultants to the department project that capacity will need to increase by approximately 1.8% per year. Currently, approximately 57,000 medically indigent adults and 4,200 medically indigent children receive ongoing mental health services funded through DSHS each month. In 2024, the system would need to be serving an additional 11,000 adults and 800 children to keep up with population growth.

Using available demographic data and results from the 2012 National Survey on Drug Use and Health, DSHS estimates that roughly 58,000 medically indigent adults with serious mental illness and 19,000 medically indigent children with serious emotional disturbance may have unmet needs for mental health services. Need does not, however, equate to demand. Individuals who need services may not seek admission for a variety of reasons. Furthermore, demand is influenced by many factors. DSHS uses historical waiting list data to help project future demand. Over the last biennium, an average of approximately 9,900 adults and 680 children were placed on the waiting list for some period of time each year. The 83rd Legislature provided funding to expand outpatient capacity to serve an additional 6,533 adults and 853 children. If historical trends continue, it is possible that without increased funding to address population growth, some individuals may present for services and find capacity is not immediately available. Differences in per capita funding across the state (including state and local contributions), the variable mental health disorder prevalence and Medicaid eligibility rates across the state, and the impact of variable size in local mental health authority catchment areas might also impact the ability to address the projected demand within available resources.

It should be noted that substantial improvement in areas such as jail diversion, engagement, retention, and continuity of care could significantly impact demand. For example, looking only at the jail bookings with all data elements required to match with the DSHS system (about half of all bookings), approximately 10% of them meet the DSHS service criteria and have had at least one service contact in the three years prior to booking. Only 2% were in service at the time of their booking. If jail diversion efforts successfully diverted 10% of the identified prior clients into comprehensive community-based mental health and substance abuse treatment, an additional 5,300 individuals would need mental health and substance abuse services (an estimated 3,400 medically indigent adults).

Allocation

Statutory Charge (Health and Safety Code 533.051(b)(3))

- *A statewide plan for and the allocation of sufficient funds for meeting the outpatient mental health service needs of and for the maintenance of beds by the state hospitals for the two groups of patients*

Standard

Sufficient resources are allocated and managed efficiently, effectively, and collaboratively.

Methods

1. Allocation of Inpatient Beds

a. Eliminate forensic commitments from the State Hospital Allocation Methodology (SHAM). Forensic beds will not be directly allocated to the LMHAs. Although LMHAs will retain a number of responsibilities related to forensic commitments, forensic capacity will be managed by the state.

b. Replace the State Hospital Allocation Methodology (SHAM) committee with a diverse, statewide stakeholder group to foster strategies that promote efficient and effective use of inpatient beds.

   i. The Department of State Health Services (DSHS) State Hospital Allocation Methodology committee would be replaced with an MHSA Access-to-Care Workgroup. The initial workgroup meeting would include the current HB3793 Advisory Panel membership. At its initial meeting the workgroup would consider future membership to include, but not be limited to, representatives appointed by MHSA stakeholder organizations involved in criminal justice, law enforcement, county management, city management, providers of mental health and/or substance use services, providers of physical healthcare services, and consumer and/or family advocacy. The workgroup will: 1) advise MHSA on the evaluation and improvement of standards and methods that ensure that appropriate and cost-effective behavioral healthcare – inpatient, outpatient, and substance use services – is available and accessible; 2) advise MHSA regarding allocation of current and future appropriated funds. The workgroup will meet once per quarter. MHSA will prepare an agenda, coordinate and facilitate meetings, and provide data necessary for the workgroup to do its work.

c. Until an alternative methodology is determined by the proposed MHSA Access-to-Care Workgroup, DSHS will allocate civil/voluntary beds on a per capita basis using the existing methodology.

d. Provide LMHAs/NorthSTAR and the stakeholder group with monthly reports on utilization.

2. Allocation of Outpatient Capacity

a. Maintain current allocation methodology for existing funds for outpatient and other community-based services.

b. To the extent permitted by legislative direction, use new funding to achieve a more equitable distribution of resources. DSHS will work with stakeholders to develop a specific methodology consistent with legislative intent and guidance for any new funds appropriated for community-based services.

c. Expand the scope of the stakeholder group addressing use of inpatient beds to include issues relating to allocation and utilization of community-based services.

   i. See c-i under number 1, above

Maintaining Access and Availability

Statutory Charge (Health and Safety Code 533.051(b)(4))

- *A process to address and develop, without adverse impact to local service areas, the accessibility and availability of sufficient outpatient mental health services provided to and beds provided by the state hospitals to the two groups of patients based on the success of contractual outcomes with mental health service providers and facilities under Sections 533.034 and 533.052*

Standard

The needed level of care—inpatient, transitional and long-term residential, crisis, or outpatient—is available without delay or diversion to every eligible individual, including individuals seeking services voluntarily and those on civil and forensic commitments.

Fiscal Year 2015 Methods

1. Optimize utilization of capacity.
    a. Develop a state-level report for stakeholders to see daily availability of state-funded contract and state hospital beds.
    b. Expand state-level clearinghouse waitlist for matching available beds for forensic patients and develop daily bed availability report to address civil and voluntary patients in need of a bed.
    c. Develop and manage alternatives and incentives for optimizing average length-of-stay in state-funded hospital beds in order to minimize diversion and waitlists while also minimizing potentially preventable readmissions to any public or private psychiatric facility in the state.
    d. Develop and manage alternatives and incentives for optimizing intensity of community-based services by DSHS-funded providers (mental health and chemical dependency) in order to minimize service waitlists while also minimizing acute care admissions and achieving positive outcomes.
    e. Develop a process to monitor optimal use of community alternatives to state-funded contract and state hospital beds.
2. Enhance stakeholder education.
    a. Simplify the nomenclature for current community alternatives (e.g., NowCare, UrgentCare, EmergentCare) and provide information to stakeholders about appropriate referrals to each level of care.
    b. Compile and disseminate a list of available resources for information, training, and technical assistance.
    c. Pursue opportunities to provide training and information to judges, attorneys, and other audiences (offering continuing education credits when possible).
    d. Provide technical assistance to state hospital and Local Mental Health Authority staff on effective engagement with courts and attorneys.
    e. Develop system-wide procedures related to transition from forensic to civil commitments to maximize resources in the criminal justice system, and address any statutory barriers identified.

Fiscal Year 2016-2017 Methods

1. Continue to optimize use of capacity.
    a. Expand state-level reporting to show daily capacity for all state-funded crisis beds.
2. Continue to enhance stakeholder education.
    a. Develop and maintain an easily accessible online guide to alternatives to inpatient treatment and other community services, with sections tailored to specific audiences.
    b. Expand the online guide to create a centralized portal for stakeholders to access information and resources related to behavioral health.
3. Transition to a community-alternative model that emphasizes a regionally-developed, "no wrong door" access system. LMHAs would submit to DSHS a biannual regional "psychiatric emergency plan" for use of current and future funding. The plan would be approved by a regional coalition of key stakeholders including but not limited to LMHA, law enforcement, ER leaders, and advocates, judicial officials, and would include the following six components:
    a. Role of allocated state hospital beds in the regional plan;
    b. Alternatives to the state hospital as a one-stop front-door for system-of-care access;
    c. A mobile crisis team available to law enforcement and local emergency rooms;
    d. Seamless integration of emergent psychiatric, substance use and physical healthcare treatment;
    e. A plan for local, short-term management of pre and post arrest patients who are incompetent to stand trial; and
    f. Priorities for system development, including consideration of the regional needs and potential use of robust transportation and alternatives to acute care. Examples include residential facilities for non-restorable individuals, outpatient commitments, and other individuals needing long-term care, including geriatric patients with mental health needs.
4. Revise the system-wide treatment planning process to optimize the level of engagement and to minimize the chance of admission, readmission, or use of community-based crisis services.
    a. Implement a standardized, formulaic continuity of care document for use by state-funded providers and accessible online.
    b. Collect and analyze data on CANS/ANSA (mental health assessment) and ASSIST (substance use assessment) at all state-funded providers (contract beds, state hospital, LMHA's, NorthSTAR Specialty Provider Network SPN's, substance use providers).
    c. At state hospitals, incentivize:
        i. accountability for discharge planning;
        ii. development of deputized transportation to and from state hospitals by the state hospitals; and
        iii. provision of detoxification services and robust substance use services.
    d. At community providers, incentivize avoiding potentially preventable hospital admissions and readmissions by:
        i. promoting early and continuous engagement;
        ii. expanding use of person-centered recovery planning and peer providers;
        iii. monitoring and fostering housing stability;

iv. assuring that individuals see a prescriber within seven calendar days of service request or hospital discharge;
v. providing robust co-located substance use services; and providing intensive services for individuals discharged after multiple or long-term hospital stays.

4. Expand and enhance health information exchange among all providers.
5. Pursue possible statutory and regulatory changes that could promote more efficient and effective use of community and hospital capacity, including:
    a. Seeking authorization to pilot community programs for treatment and reintegration of forensic patients; and
    b. Drafting statutory language to require certification by state hospital patient and assigned legal counsel before waiving an annual commitment hearing.

DSHS Comments on Capacity

DSHS Comments on Inpatient Capacity Needs

The standard set forth in this document reflects the Advisory Panel's consensus that the state bears responsibility for providing inpatient care for forensic patients and for individuals who are medically indigent. However, DSHS recognizes that communities have long contributed to the care of indigent clients, and views this as a shared responsibility. DSHS also recognizes that communities differ widely in their resources and capacity to invest in mental health services, and the relative distribution of responsibility between the state and local communities is a policy question for state leadership to consider in dialogue with local stakeholders.

Determining current and ongoing need for acute inpatient beds, in general, and state hospital beds, specifically, is difficult. In its recent report on the role of the state hospital, the National Association of State Mental Health Program Directors specifically noted this issue and recommended more research in the area. In attempting to gauge current need, various models—including models provided by the DSHS consultants—showed some variation in the estimate of need. However, all of the models resulted in an estimated current inpatient need of between 4,000 and 5,000. In addition, projections of future demand will need to account for population growth, which is expected to increase the total beds needed by 50 beds per year. Regardless of the methodology for determining demand over the next 10 years, there are a number of services that, if implemented, would have the potential to markedly decrease need for high cost inpatient services. These services are noted in previous sections of this document.

It is important to note that the total need of 4,400 beds is comprised of several types of beds:

- State operated hospital beds (currently: approximately 2,463 beds)
- State contracted community inpatient beds (currently: approximately 456 beds)
- Locally supported inpatient beds for indigent care (currently: unknown)
- Unmet/latent need, such as those not receiving care or entering/leaving the criminal justice system (estimated: 570 beds)

As the system evolves toward the vision articulated in the HB 3793 Initial Plan and in the report by CannonDesign, the distribution of capacity will be driven in large part by patient needs. In this future system, state-operated hospital beds will be used primarily for patients with complex needs, including most forensic patients and civil patients requiring extended acute care beyond a 14-day stabilization period. Individuals needing short-term stabilization will be served primarily in the community, and patients who need long-term residential services will be moving into community settings. Planning must ensure sufficient capacity is available to serve individuals in the setting appropriate for their needs and level of acuity.

In addition to the difficulties calculating need, there are (as noted by the Advisory Panel) significant challenges to increasing capacity, including infrastructure need at the state hospitals, bed availability for contracting in the private sector, and workforce development issues. Given these challenges, DSHS recommends a more incremental approach than the Advisory Panel: adding approximately $10 million in new beds in FY16 and an additional $20 million in new beds in FY17 (approximately $40 million for the biennium), and using the dollars to purchase a mix of contracted forensic and acute care beds closer to people's homes. DSHS has also requested $36.8 million dollars to expand or enhance crisis alternative beds. Based on the data provided by the DSHS consultants, expansion of access to detoxification beds and substance abuse residential treatment beds may be appropriate for inclusion in the Ten Year State Hospital Plan as a cost-effective means of reducing demand for psychiatric hospitalization and decreasing re-admissions. Finally, the Ten Year Plan may also include increasing the availability of long-term residential options as a cost-effective alternative for long-term residents of our state hospitals. With this array of services, capacity at the state hospitals will also increase as services currently provided at the state hospital are shifted into purchased capacity. A reassessment of need versus capacity should be undertaken on at least a bi-annual basis after implementation to determine the impact of these efforts on unmet need and demand.

DSHS Comments on Outpatient Capacity Needs

Due to the significant investments made by the 83rd Legislature, individuals in most areas of the state can now be admitted into services without waiting. There are, however, a limited number of local services areas where waiting lists have not been fully eliminated and in isolated cases are growing. At this time, it appears that adequate access to outpatient services can be assured if relatively small, planned growth in resources sufficient to address basic population growth is coupled with the use of resource management approaches outlined in the "Access and Availability" section of this document. However, DSHS is monitoring its waiting list data and other metrics to identify any changes that might signal a need for reassessment.