State Hospital Bed Day Allocation Methodology and Utilization Review Protocol for Fiscal Year 2018

As Required by

Texas Health and Safety Code

Section 533.0515(e)

TEXAS
Health and Human Services

Health and Human Services

December 2018

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Executive Summary

Texas Health and Safety Code, Section 533.0515(e), directs the Health and Human Services Commission (HHSC) to submit a legislative report regarding a bed-day allocation methodology and utilization review protocol. This report provides information on:

1. Activities to update the bed-day allocation methodology and utilization review protocol;
2. The outcomes of the implementation of the bed-day allocation methodology by region;
3. The actual value of a bed-day for the two years preceding the report and the projected value for the five years following the report;
4. An evaluation of factors that impact the use of state-funded hospital beds by region;
5. The outcomes of the implementation of the bed-day utilization review protocol and its impact on the use of state-funded hospital beds; and
6. Any recommendations of HHSC or the Joint Committee on Access and Forensic Services (JCAFS) to enhance the effective and efficient allocation of state-funded hospital beds.

The bed-day allocation methodology and utilization review protocol was adopted in 2016. In 2018, the JCAFS recommended no changes to the allocation methodology and minor revisions to streamline the utilization review protocol.

Implementation of the updated bed-day methodology shifted additional bed days to areas with higher rates of poverty but did not result in a dramatic redistribution of beds.

Utilization review activities in fiscal years 2017 and 2018 examined overall patterns of bed-day utilization and readmissions. Evaluation of the 2017 cycle found no significant change in utilization data six months after utilization review. However, participants agreed the process was useful in identifying factors impacting utilization, strategies for addressing local and regional challenges, and resource needs and issues that need to be addressed at the state level. Evaluation of the 2018 review is pending.

A number of common themes emerged in both reviews. Based on these results and stakeholder input, the JCAFS recommends full implementation of the *Comprehensive Plan for State-Funded Inpatient Mental Health Services*[1] to address ongoing challenges in accessing inpatient care. In addition, the JCAFS recommends further investment in transitional and long-term community supports, including:

1. Affordable and supported community-based housing options;
2. Facility-based step-down services for patients discharged from state and local hospitals, including options that address the needs of forensic patients and patients with dementia and other neuropsychiatric disorders;
3. Substance use treatment and appropriate levels of mental health services;
4. A robust system of peer services within each service area;
5. Community-based options for individuals with co-occurring intellectual and developmental disabilities and behavioral health disorders; and
6. Strategies to address behavioral health workforce shortages at all levels in the public sector, including peers.

[1] Required by the 2018-19 General Appropriations Act, S.B. 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 147) to outline a three-phased approach to updating and expanding the state hospital system. Available at https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/comprehensive-inpatient-mental-health-plan-8-23-17.pdf

1. Background

Health and Safety Code, Section 533.0515, requires the JCAFS to provide recommendations to the HHSC executive commissioner for updating the bed-day allocation methodology and utilization review protocol by December 1 of every even-numbered year, and for the executive commissioner to adopt a bed-day allocation methodology and utilization review protocol. The bed-day allocation distributes available bed-days among local service areas, providing a benchmark that represents each area's "fair share" of the state's limited inpatient capacity. Utilization review compares actual utilization against allocated bed days.

The initial recommendations for an updated bed-day allocation methodology and utilization review protocol were submitted in February 2016, adopted by the executive commissioner in May 2016, and implemented in fiscal year 2017. This bed-day allocation methodology uses a poverty-weighted population to allocate state-funded beds to local authorities rather than a standard per capita formulation. The utilization review protocol includes a flexible framework that allows the process to be tailored to the specific focus of review. Rather than focusing exclusively on the number of bed days used by a local authority, the protocol is designed to understand and address the factors driving observed patterns of utilization. Informed by utilization data, the process solicits qualitative information from local authorities and state hospital representatives and includes discussion of local circumstances and issues. Together with the benchmark established by the bed-day allocation methodology, the utilization review protocol presents a problem-solving approach to support efficient and effective utilization of beds within the state hospital system.

2. Summary of Activities

The JCAFS Access subcommittee completed two cycles of utilization review. The fiscal year 2017 review examined overall bed-day utilization and the fiscal year 2018 review focused specifically on readmissions. The outcomes of these activities are described in the *Outcomes of Implementation – Utilization Review* section of this report.

The JCAFS also reviewed and updated its recommendations regarding the bed-day allocation methodology and utilization review protocol. Health and Safety Code, Section 533.0515(e), requires an evaluation of factors that impact utilization, including clinical acuity, prevalence of serious mental illness, and the availability of resources in a given region. The *Factors that Impact the Use of State-Funded Beds* section of this report provides an evaluation of these factors, and the updated JCAFS recommendations are found in Appendix A.

3. Outcomes of Bed-Day Allocation Methodology

Implementing the updated bed-day allocation methodology shifted additional bed days to areas with higher rates of poverty, but did not result in a dramatic redistribution of beds. The impact by region is detailed below in Table 1. Because the effect was modeled prior to implementation, the change in beds allocated to individual services areas aligned with expectations.

Table 1. Change in Allocated Bed Days by Region (Fiscal Year 2016 Allocation)

Local Authority	Allocation with Prior Methodology	Allocation with Updated Methodology	Change in Bed Days	Percent Change in Bed Days
Anderson Cherokee Community Enrichment Services	3,783	4,009	226	5.97%
Andrews Center	13,923	13,989	66	0.47%
Austin Travis County Integral Care	38,341	37,277	-1,064	-2.78%
Behavioral Health Center of Nueces County	11,838	12,047	209	1.77%
Betty Hardwick Center	6,069	6,137	68	1.12%
Bluebonnet Trails Community Center	31,070	28,493	-2,577	-8.29%
Border Region Behavioral Health Center	12,319	14,257	1,938	15.73%
Burke Center	13,169	13,888	719	5.46%

Local Authority	Allocation with Prior Methodology	Allocation with Updated Methodology	Change in Bed Days	Percent Change in Bed Days
Camino Real Community Centers	7,488	7,976	488	6.52%
Center for Healthcare Services	62,798	63,356	558	0.89%
Center for Life Resources	3,367	3,525	158	4.69%
Central Counties Services	16,357	16,237	-120	-0.73%
Central Plains Center	3,192	3,451	259	8.11%
Coastal Plains Community Center	7,666	7,972	306	3.99%
Community Healthcore	15,615	15,832	217	1.39%
Denton County Mental Health Mental Retardation (MHMR) Center	26,762	23,591	-3,171	-11.85%
Emergence Health Network	29,105	31,820	2,715	9.33%
Gulf Bend MHMR Center	6,024	5,940	-84	-1.39%
Gulf Coast Center	22,459	20,787	-1,672	-7.44%
Heart of Texas Region MHMR Center	12,078	12,602	524	4.34%

Local Authority	Allocation with Prior Methodology	Allocation with Updated Methodology	Change in Bed Days	Percent Change in Bed Days
Helen Farabee Centers	10,449	10,342	-107	-1.02%
Hill Country Mental Health and Developmental Disabilities Center	22,176	21,431	-745	-3.36%
Lakes Regional Community Center	5,515	5,728	213	3.86%
MHMR Authority of Brazos Valley	11,622	12,235	613	5.27%
MHMR Services for the Concho Valley	4,288	4,331	43	1.00%
MHMR Tarrant County	65,211	63,304	-1,907	-2.92%
NorthSTAR[2]	133,111	130,889	-2,222	-1.67%
Pecan Valley Centers for Behavioral and Developmental Health	14,704	13,978	-726	-4.94%
Permian Basin Community MHMR	11,262	10,935	-327	-2.90%
Spindletop Center	14,674	14,688	14	0.10%

[2] Now transitioned to North Texas Behavioral Health Authority and LifePath Systems

Local Authority	Allocation with Prior Methodology	Allocation with Updated Methodology	Change in Bed Days	Percent Change in Bed Days
Starcare Specialty Healthcare	11,113	11,422	309	2.78%
Texana Center	30,864	27,993	-2,871	-9.30%
Texas Panhandle Centers	13,876	13,931	55	0.40%
Texoma Community Center	6,711	6,657	-54	-0.80%
The Harris Center for Mental Health and Intellectual and Developmental Disabilities	149,025	150,738	1,713	1.15%
Tri-County Behavioral Healthcare	23,720	22,399	-1,321	-5.57%
Tropical Texas Behavioral Health	45,514	52,932	7,418	16.30%
West Texas Center for MHMR	7,393	7,533	140	1.89%

4. Value of a Bed Day

Information on the actual value of a bed day for each state hospital, as well as projected values for the five years following the date of the report, is provided in Tables 2 and 3, below. The values were generated using actual expenditures and historical inflation. The value represents the total cost to the state, including mandatory paid benefits for employees not directly paid by HHSC.

This value has been calculated to reflect the true total cost to the state of Texas when compared to private providers and might differ from previous reports. Historical bed day values listed in this report have been updated to reflect the current bed-day cost methodology. The rate is facility-specific, based on previous year's operating costs and patient count for different client groups (i.e., adults, geriatric patients, adolescents, and long-term, low-level residential care patients), as well as overhead and incidental costs.

Table 2. Historical State Bed Day[3] Costs by Hospital (Fiscal Years 2016 through 2018)*[4]

Adult Inpatient Services	2016	2017	2018
Austin State Hospital	$725	$699	$732
Big Spring State Hospital	$611	$642	$650
El Paso Psychiatric Center	$786	$764	$750
Kerrville State Hospital	$533	$525	$536
North Texas State Hospital	$587	$626	$684

[3] This value includes the total cost to HHSC and other costs to the state (i.e., benefit pay).

[4] Data for fiscal years 2014-2015 not available due to system changes.

Adult Inpatient Services	2016	2017	2018
Rio Grande State Center	$740	$737	$821
Rusk State Hospital	$608	$697	$620
San Antonio State Hospital	$696	$682	$684
Terrell State Hospital	$675	$644	$628

Table 3. Projected Bed Day Costs[5] by Hospital (Fiscal Years 2019 through 2023)

Adult Inpatient Services	2019	2020	2021	2022	2023
Austin State Hospital	$761	$791	$822	$854	$887
Big Spring State Hospital	$675	$701	$728	$756	$786
El Paso Psychiatric Center	$779	$809	$841	$874	$908
Kerrville State Hospital	$557	$579	$602	$626	$650
North Texas State Hospital	$711	$739	$768	$798	$829
Rio Grande State Center	$853	$886	$921	$957	$994
Rusk State Hospital	$644	$669	$695	$722	$683
San Antonio State Hospital	$711	$739	$768	$798	$829
Terrell State Hospital	$653	$679	$706	$734	$763

[5] This value includes the total cost to HHSC and other costs to the state (i.e., benefit pay).

5. Factors that Impact Use of State-funded Beds

As part of the process for developing an updated bed day allocation methodology, Health and Safety Code, Section 533.0515, requires an evaluation of factors that impact utilization, including clinical acuity, prevalence of serious mental illness, and the availability of resources in a given region. The JCAFS considered each of these factors in developing its recommendations, with the goal of having an equitable methodology based on consistent, reliable data that can be readily updated to reflect changes over time.

Clinical acuity is a key determinant in whether an individual needs inpatient care. However, several factors preclude incorporating a measure of acuity in the allocation of bed days. Clinical acuity is dynamic; individuals do not exhibit the same level of acuity over time. Even within a single year, a person's acuity might change significantly. There is no source of data to measure acuity among the population living within a local service area. HHSC does measure acuity of individuals receiving services, but this group might not be representative of the larger population. Less than 20 percent of individuals admitted to a state-funded hospital bed are receiving mental health services through a local authority at the time of admission, and only 30 percent received mental health services through a local authority during the prior year.

Similar challenges exist with regard to using prevalence as a factor. Data is not available to directly measure prevalence specific to local service areas. HHSC uses national prevalence data published by the federal Substance Abuse and Mental Health Services Administration to estimate the number of individuals with mental illness living in the state and within each local service area.

The availability of resources can have an impact on the utilization of inpatient beds. Areas with more resources for diversion, such as community-based crisis stabilization and outpatient competency restoration programs, are less reliant on inpatient services. Similarly, a robust system of community services and supports can help individuals maintain stability and avoid crises that require inpatient care.

Tables 4, 5, and 6, below, contain an inventory of HHSC-funded mental health programs in each service area. These programs include psychiatric emergency services center (PESC) projects, community mental health hospital (CMHH) and

purchased psychiatric beds (PPB), and outpatient competency restoration programs. HHSC-funded PESC projects include:

- **Crisis respite units** - a place where people at low risk of harm to self or others can stay for as long as seven days. Professional staff are available to provide counseling and medication.
- **Crisis peer respite programs** - staffed by peer providers and provide community-based, non-clinical support to help people find new understanding and ways to move forward.
- **Crisis residential units** - provides short-term crisis services in a home-like environment for people who might harm themselves or others.
- **Extended observation units** - a place where people who are at high risk of harm to self or others are treated in a secure environment for up to 48 hours. Professional staff are available to provide counseling and medication services.
- **Crisis stabilization units** - designed to treat symptoms of mental illness for those who are at high risk of admission to a psychiatric hospital. Treatments such as counseling and medication are provided in a secure environment with a stay of up to 14 days.
- **Rapid crisis stabilization beds** - inpatient beds in community hospitals for people who need short term stabilization services.
- **Mental Health Deputies** - certified peace officers with mental health training who respond to emergency calls involving mental health crises. They work with local mental health authorities to divert individuals from the criminal justice system and connect them with mental health services.
- **Triage** - provides clinical assessment at the point of entry to crisis services to identify the level of service required.
- **Mental Health Docket programs** - serves individuals with serious mental illness who have frequent interaction with the criminal justice system.

Table 4. Fiscal Year 2018 HHSC-Funded PESC Projects

Local Authority	Project Type	Funding
Andrews Center	Crisis Respite	$63,750
Austin Travis County Integral Care	Rapid Crisis Stabilization Beds	$1,884,619
	Crisis Respite	$1,535,273
Behavioral Health Center of Nueces County	Crisis Respite	$300,684
Betty Hardwick Center	Rapid Crisis Stabilization Beds	$1,179,159
Bluebonnet Trails Community Services	Extended Observation Unit 1	$783,549
	Extended Observation Unit 2	$508,377
	Crisis Respite	$563,816
Burke Center	Extended Observation Unit	$819,328
	Crisis Residential	$1,134,976
	Continuity of Care	$140,995
Camino Real Community Centers	Crisis Residential	$797,950
	Rapid Crisis Stabilization Beds	$232,298
Center for Health Care Services	Extended Observation Unit	$261,300
Center for Life Resources	Crisis Respite	$214,240
Central Plains Center	Crisis Respite	$43,538
	Rapid Crisis Stabilization Beds	$438,300
	Mental Health Deputy	$183,691
Coastal Plains Community Center	Rapid Crisis Stabilization Beds	$300,000

Local Authority	Project Type	Funding
Community Healthcore	Extended Observation Unit and Crisis Residential	$1,701,733
	Crisis Stabilization Unit and Rapid Crisis Stabilization Beds	$1,657,717
Emergence Health Network	Rapid Crisis Stabilization Beds	$805,200
	Crisis Residential	$658,045
Gulf Bend Center	Rapid Crisis Stabilization Beds	$325,282
	Mental Health Deputy	$258,891
Harris Center for Mental Health and Intellectual and Developmental Disabilities	Crisis Peer Respite	$825,737
	Psychiatric Emergency Services	$104,431
Heart of Texas Region MHMR Center	Crisis Respite	$1,233,406
	Extended Observation Unit, Crisis Residential, and Triage	$2,190,043
Helen Farabee Centers	Rapid Crisis Stabilization Beds	$746,831
	Crisis Respite	226,497
	Inpatient Substance Use Treatment and Detox Program	$1,204,500
Hill Country Mental Health and Developmental Disabilities Center	Crisis Stabilization Unit	$455,247
	Rapid Crisis Stabilization Beds and Mental Health Deputy	$102,458
LifePath Systems	Rapid Crisis Stabilization Beds	$273,161
MHMR Authority of Brazos Valley	Rapid Crisis Stabilization Beds	$304,968

Local Authority	Project Type	Funding
MHMR Services for the Concho Valley	Rapid Crisis Stabilization Beds	$928,002
	Crisis Respite	$626,258
MHMR Tarrant County	Crisis Respite	$1,298,262
	Crisis Residential	$1,693,981
	Adolescent Crisis Respite	$2,006,294
Pecan Valley Centers for Behavioral and Developmental Healthcare	Rapid Crisis Stabilization Beds	$481,800
Permian Basin Community Centers	Rapid Crisis Stabilization Beds and Triage	$2,042,625
Spindletop Center	Peer Crisis Respite/Crisis Residential	$451,804
	Extended Observation Unit	$685,057
	Crisis Stabilization Unit	$1,841,249
	Mental Health Deputy	$177,317
Texana Center	Substance Use Treatment (in a Crisis Residential)	$186,023
	Rapid Crisis Stabilization Beds	$1,340,280
Texas Panhandle Centers for Behavioral and Developmental Health	Rapid Crisis Stabilization Beds	$1,350,376
	Mental Health Docket	$286,527
Tri-County Behavioral Healthcare	Rapid Crisis Stabilization Beds	$166,666
	Crisis Stabilization Unit	$1,726,464
	Crisis Intervention Response Team	$143,336

Local Authority	Project Type	Funding
Tropical Texas Behavioral Health	Rapid Crisis Stabilization Beds	$980,513
	Co-Occurring Psychiatric and Substance Use Disorders Rapid Crisis Stabilization Beds	$546,312
West Texas Center for MHMR	Rapid Crisis Stabilization Beds	$351,024
	Crisis Respite	$789,248
	Mental Health Deputy	$294,905

CMHHs are established through legislative action, while local authorities purchase PPBs from private psychiatric hospitals.

Table 5. Fiscal Year 2018 Community Mental Health Hospital and Purchased Psychiatric Beds

Local Authority	Type of Bed	Beds
Anderson Cherokee Community Enrichment Services	PPB	20
Austin Travis County Integral Care	PPB	10
Betty Hardwick Center	PPB	3
Bluebonnet Trails Community Services	PPB	2
Burke Center	PPB	5
Camino Real Community Centers	PPB	1.6
Center for Health Care Services	PPB	30
Center for Life Resources	PPB	1

Local Authority	Type of Bed	Beds
Central Counties Services	PPB	0.8
Coastal Plains Community Center	PPB	5
Denton County MHMR Center	PPB	10.6
Emergence Health Network	PPB	0.5
Gulf Bend MHMR Center	PPB	2
Gulf Coast Center	Community Mental Health Hospital (CMHH)	20
Harris Center for Mental Health and Intellectual and Developmental Disabilities	CMHH	177
	PPB	22
Heart of Texas Region MHMR Center	PPB	3
Hill Country Mental Health and Developmental Disabilities Center	PPB	5
	Kerrville Crisis Stabilization Unit	16
Lakes Regional Community Center	PPB	1
LifePath Systems	PPB	7
MHMR Authority of Brazos Valley	PPB	6
MHMR Services of Tarrant County	PPB	28
North Texas Behavioral Health Authority	PPB	23.6
Pecan Valley Centers for Behavioral and Developmental Health	PPB	3.8

Local Authority	Type of Bed	Beds
Spindletop Center	PPB	9
Starcare Specialty Health System	CMHH	30
Texana Center	PPB	2
Texoma Community Center	PPB	2
Tri-County Behavioral Healthcare	PPB	7
Tropical Texas Behavioral Health	PPB	15
West Texas Center for MHMR	PPB	10

Table 6. Outpatient Competency Restoration Programs and Target Number Served for Each Program

Outpatient Competency Restoration Program	Target
Andrews Center	36
Austin Travis County Integral Care	36
Behavioral Health Center of Nueces County	12
Center for Health Care Services	40
Community Healthcore	3
Emergence Health Network	41
Heart of Texas Region MHMR Retardation Center	15
MHMR Services of Tarrant County	25
North Texas Behavioral Health Authority	36
Starcare Specialty Health System	16
Tri-County Behavioral Healthcare/Gulf Coast Center	15

However, this is only a partial representation of local resources. A wide range of services and supports are relevant to the need for inpatient care, and they are supported with local, state, and national funding sources, both public and private. These resources vary over time, compounding the challenges of compiling and maintaining a comprehensive and reliable inventory to use in an allocation methodology. Moreover, there is no consensus as to how the availability of resources should be considered in allocating bed days. From one perspective, it makes sense to allocate more bed days to areas with fewer resources. However, such an approach could serve as a disincentive for local stakeholders to invest in services and initiatives to reduce the need for inpatient care, leading to greater reliance on state-funded programs.

In considering an allocation methodology, one issue not specified in the statute is relevant--poverty. The overwhelming majority of individuals receiving HHSC-funded mental health services have incomes at or below 200 percent of the federal poverty level (FPL), and the majority of state hospital patients also fall into this category. Areas with a higher proportion of individuals living in poverty are likely to have a higher demand for state-funded inpatient beds.

These considerations informed the JCAFS's recommendation to maintain the bed-day allocation methodology adopted in 2016. This formula allocates hospital beds based on a poverty-weighted population (i.e., double weight is given to populations with incomes at or below 200 percent FPL). As a result, more beds are allocated to local service areas with higher rates of poverty.

6. Outcomes of Implementation - Utilization Review

The goal of the utilization review protocol is to bring key stakeholders together to identify factors contributing to patterns of inpatient utilization and barriers to timely discharge, successful and new strategies to address local and regional challenges, and systemic issues and resource needs to inform state policymakers.

The JCAFS Access subcommittee completed two cycles of utilization review. The 2017 review examined bed day utilization, while the 2018 review focused on readmissions. The JCAFS will be evaluating the 2018 process in the second half of fiscal year 2019.

Evaluation of the fiscal year 2017 utilization review process had two components: a review of data and a survey of JCAFS members, local authority executive directors, and state hospital superintendents who participated in the review. Six months after the review process, the data showed no meaningful changes in utilization. However, most respondents said the review achieved its purpose of providing a better understanding of factors affecting patterns of utilization, local barriers and challenges, successful strategies being used to manage utilization, and state-level issues and resource needs.

A number of common issues emerged in both the 2017 and the 2018 reviews:

- Geographic access to a state or community hospital appears to be a significant factor in bed-day utilization and readmission rates.
- The continued increase in forensic utilization is reducing access to state hospital care for civil and voluntary patients.
- Barriers to discharging long-term patients who no longer need hospital services restrict bed availability for individuals who need crisis stabilization.
- Local authorities often have difficulty accessing appropriate care for individuals needing extended acute psychiatric stabilization. These patients are increasingly being treated in community-based hospitals that might not be equipped to address their complex needs.

The two reviews underscored the value of investments made in programs that divert individuals from unnecessary hospital admission or incarceration, but noted that many communities still lack such alternatives. Increasingly, however, the greater challenge is appropriate and timely hospital discharge. A significant number of patients remain in the hospital when they no longer require this level of care due

to insufficient community services and supports that would enable discharge. In particular, the review highlighted a critical need for:

- Transitional step-down facilities, safe and affordable housing options, and other community supports necessary for individuals to engage in services and establish meaningful connections in the community;
- Substance use treatment;
- Peer services;
- Community-based options for forensic patients that satisfy the courts and appropriately address patient and community safety; and
- Appropriately supported settings for individuals with dementia and other neuropsychiatric conditions.

The reviews also highlighted continued workforce shortages at all staffing levels, including physicians and other professionals with prescribing authority, other licensed professionals, unlicensed staff, and peer providers. These shortages affect both inpatient and community service providers.

7. JCAFS Recommendations to Enhance the Effective and Efficient Allocation of State-Funded Hospital Beds

These recommendations reflect the views of the JCAFS and do not include separate recommendations from HHSC.

Inpatient capacity continues to be an urgent need across the state. The 85th Legislature invested substantial resources to address critical capacity and facility needs, appropriating additional funds to purchase private psychiatric beds and launching a multiyear project to expand, renovate, and transform the state hospital system. With funds appropriated last session, HHSC has begun the first of three phases of the redesign project, which is expected to add at least 338 state beds to the state hospital system, including a significant number of maximum security beds. The JCAFS supports full implementation of the *Comprehensive Plan for State-Funded Inpatient Mental Health Services*. In addition, the JCAFS recommends continued monitoring of capacity demands to ensure redesign plans address the need to provide timely access to appropriate inpatient care, whether in the community or in a state facility.

In the past decade, the Legislature and local governments have also made significant investments to develop crisis response and stabilization services across the state. Although many communities still lack community-based alternatives to inpatient care, these investments have enabled many individuals in crisis to be stabilized without hospitalization. The results of utilization review and reports from stakeholders suggest the most critical needs at this time are for transitional and long-term community housing and supports so that individuals can be successfully discharged from hospital services and maintain stability in the community. The JCAFS recommends further investment in the following areas:

1. Affordable community-based housing options and tenancy support services. The lack of safe and affordable housing may be one of the primary factors contributing to hospital admission and readmission, and the JCAFS identifies housing as a crucial and urgent deficit in the behavioral health service system. The JCAFS recommends expanding resources for a range of housing options for independent living and structured facility residences, including supports to help individuals obtain and maintain housing, such as housing navigators. In

addition, statutory authority is needed to provide appropriate regulation and oversight for a range of residential settings.

2. Facility-based step-down services for patients discharged from state and local hospitals, which can also be used to “step-up” services for individuals at risk of hospitalization.
   a. A significant number of patients remain in the hospital when they no longer need an inpatient level of care, often because there is no suitable community placement. Many of these individuals need continued 24-hour supervision and support for a period of time, but few alternatives exist. Transitional step-down facilities would allow these individuals to move out of the hospital and continue treatment in preparation for transition to outpatient services.
   b. Patients on forensic commitment, including those found not guilty by reason of insanity, face additional barriers to discharge. There is a need for community-based options that are satisfactory to the courts and appropriately address patient and community safety.
   c. Another group with serious barriers to discharge are those with dementia and other neurocognitive disorders. Many of these patients have a history of unsuccessful placement in nursing facilities and may require a setting with enhanced services.
3. Substance use treatment and appropriate levels of mental health services. The presence of co-occurring substance use disorders is another key factor leading to the need for inpatient care. Without appropriate treatment, these individuals are at high risk for continuing episodes of crisis and hospitalization. In addition, capacity is often limited in the more intensive levels of mental health services.
4. A robust system of peer services within each local service area. Without meaningful community connections, individuals with mental illness have difficulty achieving long-term stability. Peers play a vital role in helping individuals engage with needed services and begin a pathway to recovery.
   a. Many individuals do not successfully transition from inpatient care to outpatient services and supports. Peer bridgers, or navigators, are highly effective in helping patients engage with outpatient care, navigate and connect with needed supports, and begin to build meaningful connections in the community.
   b. Peer services continue to be an important element of support after the transition period, for it is only when people have meaningful relationships and lives that they achieve stable, long-term recovery. Peers have a unique ability to support the development of these critical long-term connections and systems of support in the community.

5. Community-based options for individuals with co-occurring intellectual and developmental disabilities and behavioral health disorders. These individuals face unique challenges in transitioning to the community, as they may not meet the criteria for services designed for single-diagnosis populations. Even when they are not disqualified by a co-occurring diagnosis, many providers are not equipped to meet their needs. Increasing the availability of Home and Community-based Services and other residential treatment options and expanding provider training in trauma-informed care could enable more of these individuals to move into community-based settings.
6. The behavioral health workforce. The state faces significant shortages of behavioral health professionals at all levels, and challenges recruiting and retaining staff in the public behavioral health system have at times hindered service delivery. In addition to prescribers and other licensed professionals, many areas have difficulty hiring unlicensed staff and peer providers. The public behavioral system would benefit from investments in strategies to attract and support staff. In particular, the JCAFS recommends robust loan repayment programs across the professions and competitive pay, particularly for staff at the lower end of the pay scale, including peer providers.

8. Conclusion

In 2018, the JCAFS recommended no changes to the allocation methodology and minor revisions to streamline the utilization review protocol adopted in 2016.

Based on the results of the utilization review and stakeholder input, the JCAFS recommends full implementation of the *Comprehensive Plan for State-Funded Inpatient Mental Health Services* to address ongoing challenges in accessing inpatient care. The JCAFS also recommends further investments in transitional and long-term community supports. In particular, members identified significant deficits in affordable and supported housing options, transitional step-down facilities, substance use treatment, and peer services.

To address challenges faced by special populations, the JCAFS recommends the development of specialized community placements to address the needs of individuals involved in the criminal justice system, individuals with dementia and other neuro-psychiatric disorders, and individuals with co-occurring intellectual and developmental disabilities and behavioral health disorders.

Finally, the JCAFS notes that workforce shortages continue to challenge service delivery in the public sector and recommends investments to attract and support behavioral health workers at all levels, including peers.

List of Acronyms

Acronym	Full Name
CMHH	Community Mental Health Hospital
FPL	Federal Poverty Level
HHSC	Health and Human Services Commission
JCAFS	Joint Committee on Access and Forensic Services
MHMR	Mental Health Mental Retardation
PPB	Private Psychiatric Bed
PESC	Psychiatric Emergency Services Center
THSC	Texas Health and Safety Code

Appendix A. JCAFS Recommendations for Updated Bed Day Allocation Methodology and Utilization Review Protocol

2018 recommendations from the JCAFS to the executive commissioner regarding an updated Bed Day Allocation Methodology and Utilization Review Protocol

Recommendations for an Updated Bed Day Allocation Methodology

In developing an updated bed day allocation methodology, Health and Safety Code, Section 533.0515, requires an evaluation of factors that impact utilization, including clinical acuity, prevalence of serious mental illness, and the availability of resources in a given region. As described in Section 5, the JCAFS considered each of these factors in making its recommendations.

The JCAFS's three recommendations related to the allocation of beds are unchanged from 2016. They include:

1. Continue to allocate beds based on the poverty-weighted population within each local service area
2. Retain the current exclusions for bed days in maximum security units and the Waco Center for Youth
3. Do not impose any sanction, penalty, or fine for utilization above allocated bed days

The current methodology allocates bed days based on the poverty-weighted population in each local service areas. A poverty-weighted population gives double weight to populations with incomes at or below 200 percent of the FPL:

$$\textit{Poverty-weighted Population} = \textit{Total Population} + \textit{Population} \leq 200\%\ \textit{FPL}$$

The committee based its recommendation to use the poverty-weighted population on the following:

- The overwhelming majority of individuals receiving HHSC Behavioral Health Services Section-funded services have incomes at or below 200 percent FPL.
- Beginning in the 84th legislative session, the Legislature has used the poverty-weighted population as the basis for comparing per capita funding among local authorities and appropriating funds to those below the statewide level of per

capita funding. Using the same metric for allocating funding and hospital beds allows for a consistent approach to resource allocation.

- The proposal to move to the poverty-weighted population in the 84th legislative session was supported by a broad group of stakeholders.

With respect to sanctions or penalties, the JCAFS recommended the state not impose sanctions, penalties, or fines on local authorities that use more than the allocated number of hospital bed days. Rather, the bed-day allocation methodology should continue to be used as a metric for analyzing bed-day utilization.

Recommendations for a Utilization Review Protocol

The goal of the utilization review protocol is to bring key stakeholders together to identify factors that contribute to patterns of inpatient utilization and barriers to timely discharge, successful and new strategies to address local and regional challenges, and systemic issues and resource needs to inform state policymakers.

The utilization review protocol recommended by the JCAFS in 2016 and adopted by the Executive Commissioner established a flexible framework that allowed the model to evolve. The 2018 recommendations maintain the basic framework, eliminating components that have not been utilized. Because the utilization review process has revealed successful and promising strategies being used to manage bed-day utilization, the JCAFS recommended compiling these strategies to serve as a statewide resource.

The JCAFS 2018 recommendations related to utilization review are as follows:

1. Continue distribution of the Hospital Bed Allocation Report to provide local authorities with detailed data regarding their bed day utilization
2. Assign responsibility for utilization review activities to the JCAFS Access subcommittee
3. Maintain the current utilization review protocol, which includes:
    a. a review of statewide and local data
    b. teleconferences with local authorities and state hospitals
    c. other review activities as needed
4. Conduct follow-up to assess the results of the utilization review protocol
5. Compile successful and promising strategies identified during utilization review activities for use as a statewide resource