State Hospital Bed-Day Allocation Methodology and Utilization Review Protocol for Fiscal Year 2020

As Required by

Health and Safety Code

Section 533.0515(e)

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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 were adopted in 2016. In 2018, the JCAFS recommended no changes to the bed-day allocation methodology and minor revisions to streamline the utilization review protocol. In 2020, the JCAFS is recommending no changes to the bed-day allocation methodology. The JCAFS will implement a revised utilization review protocol to include:

- The use of a JCAFS data dashboard for reporting and analyzing state hospital bed-day utilization; and
- A reassessment of the utilization review studies done in 2017, 2018, and 2019 to evaluate factors that impact bed-day utilization, readmissions, and length of stay.

Implementation of the 2020 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 were conducted in fiscal years 2017, 2018, and 2019. In fiscal year 2017, bed-day utilization rates were reviewed.

In 2018, readmission rates were reviewed and in fiscal year 2019 utilization review activities examined length of stay for persons with 46B Incompetent to Stand Trial (IST) commitments. The committee's ability to complete utilization review activities in 2020 was impacted by the COVID-19 pandemic and will be carried out through fiscal year 2021. Participants agree the utilization review process is 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.

Based on the results of the utilization review and stakeholder input, the JCAFS recommendations are as follows:

1. Create an Office of Forensic Services that is responsible for the coordination, contractual development, and management of all forensic services funded by the state;
2. Develop a comprehensive state-level strategic plan for the coordination and oversight of forensic services in Texas;
3. Expand and contract for diversion programs around the state;
4. Expand, improve and contract for Outpatient Competency Restoration (OCR) programs around the state;
5. Implement the JCAFS recommendations for the state hospital forensic program;
6. Implement the JCAFS recommendations for jail outreach; and
7. Contractually require a forensics and diversion coordinator from each local mental health authority/local behavioral health authority (LMHA/LBHA).

1. Introduction

Texas Health and Safety Code, Section 533.0515(e), directs HHSC to submit a legislative report regarding a bed-day allocation methodology and utilization review protocol. Per statute, the report is published and distributed to the Governor, Lieutenant Governor, Speaker of the House of Representatives, Senate Finance Committee, Senate Health and Human Services Committee, House Appropriations Committee, House Public Health Committee, and House Human Services Committee.

Additionally, the statute charges the JCAFS with developing and making recommendations to the HHSC Executive Commissioner or department, as appropriate, and monitoring the implementation of updates to a bed-day allocation methodology and making recommendations for the implementation of a bed-day utilization review protocol including a peer review process. The report is due December 1 of every even-numbered year.

2. Background

The JCAFS formed in 2015 by combining two statutorily-required advisory bodies which were the state bed-day allocation advisory panel established pursuant to H.B. 3793, 83rd Legislature, Regular Session, 2013, and the forensic workgroup authorized by S.B. 1507, 84th Legislature, Regular Session, 2015. Prior to HHS Transformation in 2016, the Department of State Health Services combined the advisory panel and workgroup to form the JCAFS because of shared membership and similar charges. The forensic workgroup's authority expired in November 2019; however, the JCAFS will not be abolished as long as its enabling statutes remain in effect.

Currently, the JCAFS is statutorily charged with developing and making recommendations to the HHSC Executive Commissioner or department, as appropriate, and monitoring the implementation of updates to a bed-day allocation methodology. The methodology allocates, to each designated region, a certain number of state-funded beds in state hospitals and other inpatient mental health facilities for voluntary, civil, and forensic patients. The JCAFS is further charged with making recommendations for the implementation of a bed-day utilization review protocol including a peer review process. 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.

The 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. The protocol is designed to understand and address the factors driving patterns of utilization instead of focusing exclusively on the number of bed days used by a local authority.

In 2018, the JCAFS recommended no changes to the bed-day allocation methodology and minor revisions to streamline the utilization review protocol. In 2020, the JCAFS is again recommending no changes to the bed-day allocation methodology. The JCAFS will implement a revised utilization review protocol to include:

- The use of a JCAFS data dashboard for reporting and analyzing state hospital bed-day utilization; and

- A reassessment of the utilization review studies done in 2017, 2018, and 2019 to evaluate factors that impact bed-day utilization, readmissions, and length of stay.

3. Summary of Activities

The JCAFS Access subcommittee completed one cycle of utilization review in 2019. The review focused on length of stay for persons with 46B IST commitments. The committee's ability to complete utilization review activities in 2020 was impacted by the COVID-19 pandemic. These activities will be carried out through fiscal year 2021. The outcomes of utilization review activities are described in the *Outcomes of Implementation – Utilization Review* section of this report. 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. The JCAFS recommendations regarding the bed-day allocation methodology and utilization review protocol are found in Appendix A.

4. Outcomes of Bed-Day Allocation Methodology

Implementing the 2020 bed-day allocation methodology, which was originally approved in 2016, shifted additional beds 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.

The change in beds allocated to individual services 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	3,782	-1	-0.03%
Andrews Center	13,923	13,536	-387	-2.78%
Austin Travis County Integral Care	38,341	36,699	-1,642	-4.28%
Behavioral Health Center of Nueces County	11,838	11,381	-457	-3.86%
Betty Hardwick Center	6,069	5,780	-289	-4.76%
Bluebonnet Trails Community Center	31,070	29,187	-1,883	-6.06%
Border Region Behavioral Health Center	12,319	14,065	1,746	14.17%
Burke Center	13,169	13,176	7	0.05%

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	7,704	216	2.88%
Center for Healthcare Services	62,798	61,757	-1,041	-1.66%
Center for Life Resources	3,367	3,334	-33	-0.98%
Central Counties Services	16,357	15,840	-517	-3.16%
Central Plains Center	3,192	3,256	64	2.01%
Coastal Plains Community Center	7,666	7,524	-142	-1.85%
Community Healthcore	15,615	15,025	-590	-3.78%
Denton County MHMR Center	26,762	24,349	-2,413	-9.02%
Emergence Health Network	29,105	30,960	1855	6.37%
Gulf Bend MHMR Center	6,024	5,601	-423	-7.02%
Gulf Coast Center	22,459	20,385	-2074	-9.23%
Heart of Texas Region MHMR Center	12,078	11,902	-176	-1.46%
Helen Farabee Centers	10,449	9,797	-652	-6.24%

Local Authority	Allocation with Prior Methodology	Allocation with Updated Methodology	Change in Bed Days	Percent Change in Bed Days
Hill Country Mental Health and Developmental Disabilities Center	22,176	21,549	-627	-2.83%
Lakes Regional Community Center	5,515	5,448	-67	-1.21%
MHMR Authority of Brazos Valley	11,622	11,896	274	2.36%
MHMR Services for the Concho Valley	4,288	4,038	-250	-5.83%
My Health My Resources Tarrant County	65,211	61,392	-3,819	-5.86%
North Texas Behavioral Health Systems and Life Path Systems	133,111	127,983	-5,128	-3.85%
Pecan Valley Centers for Behavioral and Developmental Health	14,704	13,862	-842	-5.73%
Permian Basin Community MHMR	11,262	10,419	-843	-7.49%
Spindletop Center	14,674	13,939	-735	-5.01%
Starcare Specialty Healthcare	11,113	10,880	-233	-2.10%

Local Authority	Allocation with Prior Methodology	Allocation with Updated Methodology	Change in Bed Days	Percent Change in Bed Days
Texana Center	30,864	28,724	-2,140	-6.93%
Texas Panhandle Centers	13,876	13,266	-610	-4.40%
Texoma Community Center	6,711	6,308	-403	-6.01%
The Harris Center for Mental Health and Intellectual and Developmental Disabilities	149,025	146,438	-2,587	-1.74%
Tri-County Behavioral Healthcare	23,720	22,781	-939	-3.96%
Tropical Texas Behavioral Health	45,514	52,410	6,896	15.15%
West Texas Center for MHMR	7,393	7,038	-355	-4.80%

5. Value of a Bed Day

Information on the actual value of a bed day for the state hospital system for the two years prior to this report, as well as projected values for the five years following the date of this report are provided in Tables 2 and 3 below.
The values were generated using actual expenditures and historical information.

The HHSC state hospital system bed-day costs reflect the average daily expenditures of the state hospital system and HHSC administrative functions that support state hospital system operations, divided by the state hospital system average daily census. The values will be calculated to reflect the true total cost to the state of Texas when compared to private providers and might differ from previous reports.

Table 2. Historical State Bed Day[1] Costs (Fiscal Years 2018 through Q3 2020)

Inpatient Services	2018	2019	2020
State Hospital System	$522	$542	$553[2]

Table 3. Projected Bed Day Costs[3] (Fiscal Years 2021 through 2025)

Inpatient Services	2021	2022	2023	2024	2025
State Hospital System	$561	$569	$578	$587	$596

[1] This value includes the total cost to HHSC and other costs to the state (i.e. benefit pay).
[2] State hospital system bed-day costs for fiscal year 2020 were calculated as of the third quarter.
[3] Projected state hospital system bed-day costs for fiscal years 2021 through 2025 are based on fiscal year 2020 assumptions, which assume annual cost increases related to inpatient hospitalization of 1.5 percent while maintaining the same average daily census.

6. Factors that Impact Use of State-Funded Beds

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 a part of the bed-day allocation methodology. The JCAFS has determined that several factors preclude incorporating a measure in the allocation of beds. Since clinical acuity is dynamic and there is no source of data to measure acuity among the population living within a local service area, it cannot be used as a measure in the allocation of beds. Prevalence of serious mental illness also cannot be used as a measure in the allocation of beds since data is not available to directly measure prevalence specific to local services. The JCAFS has determined that the availability of resources can have an impact on the utilization of inpatient beds, however, there is no consensus as to how the availability of resources should be considered in allocating bed days.

The JCAFS has also determined that poverty should be a relevant factor in the allocation of beds. The JCAFS determined that areas with a higher proportion of persons living in poverty are likely to have a higher demand for state-funded inpatient beds. The JCAFS chose to maintain the bed-day allocation methodology adopted in 2016 after considering each of the relevant factors that impact utilization. The bed-day allocation methodology uses a formula which allocates beds based on a poverty-weighted population (i.e. double weight is given to populations with incomes at or below 200 percent of Federal Poverty Level [FPL]). As a result, more beds are allocated to local service areas with higher rates of poverty.

Tables 4, 5, 6, and 7 below contain an inventory of HHSC-funded mental health programs in each service area. These programs include psychiatric emergency service center (PESC) projects, community mental health hospital (CMHH) and purchased psychiatric beds (PPB), OCR programs, and jail-based competency restoration (JBCR) programs. CMHHs are established through legislative action, while local authorities purchase PPBs from private psychiatric hospitals.

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.
- **Triage** - provides clinical assessment at the point of entry to crisis services to identify the level of service required.

Table 4. Fiscal Year 2020 HHSC-Funded PESC Projects

Local Authority	Project Type	Funding
Andrews Center	Crisis Triage and 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	$492,620
	Crisis Residential	$1,461,684
	Continuity of Care	$140,995

Local Authority	Project Type	Funding
Camino Real Community Centers	Crisis Residential Rapid Crisis Stabilization Beds	$797,950 $232,258
Center for Health Care Services	Extended Observation Unit	$261,300
Center for Life Resources	Crisis Respite	$214,240
Central Plains Center	Crisis Respite Rapid Crisis Stabilization Beds Mental Health Deputy	$43,538 $438,300 $183,691
Coastal Plains Community	Rapid Crisis Stabilization Beds	$300,000
Community Healthcore	Extended Observation Unit and Crisis Residential Rapid Crisis Stabilization Beds Triage	$1,701,733 $1,105,145 $552,572
Emergency Health Network	Rapid Crisis Stabilization Beds Crisis Residential EOU	$599,499 $447,058 $416,688
Gulf Bend Center	Rapid Crisis Stabilization Beds Mental Health Deputy and Continuity of Care Program	$292,752 $291,421
Harris Center for Mental Health and Intellectual and Developmental Disabilities	Peer Crisis Respite	$930,168

Local Authority	Project Type	Funding
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	$652,043
	Crisis Respite	$321,285
	Inpatient Substance Use Treatment and Detox Program	$1,204,500
Hill Country Mental Health and Developmental Disabilities	Crisis Stabilization Unit	$455,247
	Rapid Crisis Stabilization Beds	$48,000
	Mental Health Deputy	$54,458
LifePath Systems	Rapid Crisis Stabilization Beds	$273,161
MHMR Authority of Brazos Valley	Rapid Crisis Stabilization Beds	$304,968
MHMR Services for the Concho Valley	Rapid Crisis Stabilization Beds	$1,316,515
	Crisis Respite	$237,745
MHMR Tarrant County	Crisis Respite	$1,318,357
	Crisis Residential	$2,150,494
	Adolescent Crisis Respite	$1,529,686
Pecan Valley Centers for Behavioral and Developmental Healthcare	Rapid Crisis Stabilization Beds	$247,500
	Crisis Respite	$234,300
Permian Basin Community Centers	Rapid Crisis Stabilization Beds	$1,570,593
	Triage	$472,032

Local Authority	Project Type	Funding
Spindletop Center	Crisis Respite	$256,724
	Crisis Residential	$507,000
	Extended Observation Unit	$685,057
	Rapid Crisis Stabilization Beds	$864,170
	Mental Health Deputy	$842,476
Texana Center	Substance Use Treatment (in a Crisis Residential Unit)	$186,023
	Rapid Crisis Stabilization Beds	$1,340,280
Texas Panhandle Centers for Behavioral and Developmental Health	Rapid Crisis Stabilization Beds	$1,350,461
	Mental Health Docket	$286,442
Tri-County Behavioral Healthcare	Rapid Crisis Stabilization Beds	$166,666
	Crisis Stabilization Unit	$1,726,464
	Crisis Intervention Response Team	$143,336
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

Table 5. Fiscal Year 2020 Community Mental Health Hospital and Private Psychiatric Beds

Local Authority	Type of Bed	# of Beds
Anderson Cherokee Community Enrichment Services	PPB Forensic	20.0
Anderson Cherokee Community Enrichment Services	PPB	1.0
Andrews	PPB	0.8
Austin Travis County Integral Care	PPB	11.2
Betty Hardwick Center	PPB	3.6
Bluebonnet Trails Community Services	PPB	5.3
Border Region	PPB	2.9
Burke Center	PPB	5.9
Camino Real Community Centers	PPB	2.4
Center for Health Care Services	PPB	27.9
Center for Life Resources	PPB	1.5
Central Counties Services	PPB	3.5
Coastal Plains Community Center	PPB	5.7
Community Healthcore	PPB	1.0
Concho Valley	PPB	0.6
Denton County MHMR Center	PPB	11.7
Emergence Health Network	PPB	3.0
Gulf Bend MHMR Center	PPB	2.9
Gulf Coast Center	PPB	0.6
Gulf Coast Center	CMHH	20.0
Harris Center	PPB	24.0
Harris Center	CMHH	172.0

Local Authority	Type of Bed	# of Beds
Heart of Texas Region MHMR Center	PPB	4.4
Hill Country Community MHMR Center	PPB	6.5
Hill Country CSU	CMHH	16.0
Lakes Regional Community Center	PPB	2.3
LifePath Systems	PPB	9.6
MHMR Authority of Brazos Valley	PPB	6.6
MHMR Services of Tarrant County	PPB	29.9
North Texas Behavioral Health Authority	PPB	30.7
Nueces	PPB	1.5
Pecan Valley Centers	PPB	5.1
Permian Basin	PPB	0.8
Spindletop Center	PPB	9.0
Starcare Specialty Health System	PPB	0.8
Starcare Specialty Health System	CMHH	30.0
Texana Center	PPB	4.5
Texoma Community Center	PPB	3.0
Tri-County Behavioral Healthcare	PPB	8.4
Tropical Texas Behavioral Health	PPB	16.2
West Texas Center for MHMR	PPB	10.3

Table 6. Fiscal Year 2020 Outpatient Competency Restoration Programs and Target Number Served for Each Program

OCR Programs	Target
Andrews Center	32
Austin Travis County Integral Care	36
Behavioral Health Center of Nueces County	12
Center for Health Care Services	40
Central Counties	15
Community Healthcore	3
Emergence Health Network	41
Harris Center	80
Heart of Texas Region MHMR Center	15
MHMR Services of Tarrant County	25
North Texas Behavioral Health Authority	75
Starcare Specialty Health System	16
Tri-County Behavioral Healthcare	15

Table 7. Fiscal Year 2020 Jail-Based Competency Restoration Programs and Target Number Served for Each Program

Jail-based Competency Restoration Programs	Target
Harris Center	80
North Texas Behavioral Health Authority	60
Permian Care	9
StarCare	50
Tarrant	100

The above charts only provide 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. Most persons receiving HHSC-funded mental health services have incomes at or below 200 percent of the FPL, and the majority of state hospital patients also fall into this category. Areas with a higher proportion of persons 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.

7. Outcomes of Implementation - Utilization Review

These recommendations reflect the views of the JCAFS and may not reflect the position of HHSC.

The goal of the utilization review protocol is to bring key stakeholders together to identify factors contributing to patterns of 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 one cycle of utilization review in 2019. The review focused on length of stay for persons with 46B IST commitments. The 2019 utilization review process had two components which was a review of the length of stay data for forensic IST patients, and a review of opportunities to reduce the number of persons on the forensic wait list and length of time they spend on the wait list. The JCAFS Access subcommittee reviewed and heard presentations regarding innovative programs that have the potential to have a positive impact on the forensic wait list.

The JCAFS Access subcommittee identified common issues that are impacting the number of persons on the forensic wait list as well as the length of stay for persons who have IST commitments. Common issues identified are:

1. A need for placement of persons in a least restrictive competency restoration program setting.
2. A need for improved efficiencies in the state hospital competency restoration services.
3. A need for expansion of effective Jail Outreach programs.

The review of length of stay data for persons with IST commitments and the number of persons on the forensic wait list and the length of time they spend on the wait list revealed a critical need for:

1. The continuation and full implementation of the "562 review process." This clinical security review process, implemented as a result of S.B. 562 and H.B. 601, 86th Legislature, Regular Session, 2019, allows the state hospitals to determine the appropriate facility security level an individual who has been committed as incompetent to stand trial or acquitted as not guilty by reason of insanity should be admitted to, based on clinical, safety and programmatic

needs. The clinical security review process includes determining whether individuals who would have historically been admitted to a state hospital maximum security unit could be directly admitted to a non-maximum security unit or state supported living center.

2. The implementation of the new Competency to Stand Trial (CST) report template that was approved by the State Hospital Medical Executive Committee in November 2019.
3. The establishment and implementation of a mechanism to monitor the timeframes for each of the six steps of the competency restoration process for each of the state hospitals providing competency restoration.
    a. Date of admission to referral for CST evaluation.
    b. Referral for CST evaluation to assignment to an evaluator.
    c. Assignment of an evaluator to completion of evaluation.
    d. Completion of evaluation to report completion.
    e. Report completion to submission to the court.
    f. Submission to the court to discharge of the patient.
4. The identification of LMHAs/LBHAs with Jail Outreach programs that are having demonstrated success and where pilot programs have been implemented.
5. The identification of best practices from those programs and expand them to other areas of the state.

The committee's ability to complete utilization review activities in 2020 was impacted by the COVID-19 pandemic and will be carried out through fiscal year 2021.

In 2020, the JCAFS is implementing a revised utilization review protocol which will include the use of a JCAFS data dashboard for reporting and analyzing state hospital bed-day utilization and a reassessment of the utilization review studies done in 2017, 2018, and 2019 to evaluate factors that impact bed day-utilization, readmissions, and length of stay.

8. 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.

Like other states across the country, Texas faces a growing crisis in effectively serving Texans with mental illnesses that are involved with the criminal justice system. The number of persons found IST and added to Texas' waitlist for competency restoration services continues to increase, with over 1,100 persons on the forensic waitlist and 65 percent of state hospital beds in Texas currently utilized by the forensic population. A systematic approach to forensic and diversion services is needed to both reduce the number of persons entering the criminal justice system and more efficiently utilize resources for persons who need them. The JCAFS recommendations are as follows:

1. Create an Office of Forensic Services that is responsible for the coordination, contractual development, and management of all forensic services funded by the state. At present, no central office within HHSC coordinates forensic services across the Health and Human Services (HHS) system. A central coordinating office with input into all aspects of policy, service delivery, funding, and rulemaking will ensure a comprehensive, integrated, and strategic systems-level approach to the coordination and oversight of forensic and diversion services across HHS. The office would serve as a liaison for forensic services between state hospitals, state supported living centers and community-based mental health and intellectual and developmental disability services. It would also ensure that the responsibilities of S.B. 1507, 84th Legislature, Regular Session, 2015, are met, which is to utilize every opportunity to strengthen the position of the Forensic Director.

   A list of suggestions that would strengthen the position is outlined below. To accomplish the goals outlined in this set of recommendations it is essential that this position report at an appropriate level within the agency and that it has access to appropriate personnel to support the activities of the office. Responsibilities of the Forensic Director and core functions of the Office of Forensic Services should include:

a. Development of a statewide coordination plan that will address policy, services and funding needs of persons who are justice-involved to include the forensic population;
b. Policy and services development, implementation, analysis, and expansion;
c. Development of special initiatives at the state and national levels;
d. Training and technical assistance to LMHAs/LBHAs, courts, jails, and law enforcement, including the development of a "learning community" among these institutions to help facilitate the implementation of best practices for each region of the state.
e. Direction and coordination of data analyses to improve efficiencies and identify relevant trends related to the forensic population;
f. Provision of technical assistance and input regarding contract language and expected outcomes for all HHSC contracted forensic services;
g. Provision of input into the delivery of forensic services within the state hospital system by serving as a liaison to the state hospital leadership team and by serving as a member of the state hospital governing board;
h. Provision of consultation services to ensure coordination and integration between the local courts, jails, law enforcement and state hospitals; and
i. Provision of support services to the JCAFS in the development of policy and legislative proposals for the improvement of forensic services in the state.

2. Develop a comprehensive, state-level strategic plan for the coordination and oversight of forensic services in Texas. As of July 2020, the state forensic waitlist has grown to over 1,100 persons, and a comprehensive and coordinated plan to address the systemic drivers of this waitlist does not currently exist. A strategic plan would establish priorities, programs, and processes to improve forensic and diversion services, including how to reduce and triage the forensic waitlist; identify measures for quality and effectiveness; and ensure coordination internally and with multiple system stakeholders, external partners, settings, and disciplines. This new Forensic Plan should be attached to, or incorporated into, the *Texas Statewide Behavioral Health Strategic Plan*.

3. Expand and contract for diversion programs around the state. Pre-arrest and pre-booking diversion programs have demonstrated success in preventing persons with mental and substance use disorders from entering the criminal justice system and promoting alternatives to arrest, jail, and emergency room visits for law enforcement. First and foremost, diversion programs should identify mental health care as a medical need and be tailored to the community. Programs may include models based on The Harris Center and Crisis Intervention Teams as well as alternative models that incorporate mental health clinicians at 911 call centers, add clinical expertise to multidisciplinary field teams, and use appropriately shared care data for decision making and care

linkages. Diversion programs should also address the need for funding of crisis facilities and inpatient beds when needed at the time of diversion.

4. Expand, improve and contract for OCR and JBCR programs around the state. To reduce the number of people who end up on the waiting list for competency restoration services in state hospitals, OCR and JBCR are viable alternatives. HHSC currently funds some OCR and JBCR programs and should expand capacity across the state. Rigorous analyses of performance data will be necessary to provide oversight, monitor outcomes, and ensure effectiveness. Performance improvement practices may be needed to support growth in the number of OCR and JBCR programs. Additionally, standards of practice based on demonstrated successful programs should be written into contractual language for these programs.

5. Implement the JCAFS recommendations for the state hospital forensic program, which are as follows:

    a. Continue and fully implement the "562 review process" which is designed to allow the state hospital team to determine whether an individual requires placement in a maximum-security bed or a non-maximum-security bed.
    b. Implement throughout the state hospital system the new CST report template that was approved by the System Medical Executive Committee at their November 2019 meeting.
    c. Establish and implement a mechanism to monitor the timeframes for steps in the competency restoration process for state hospitals.
    d. Request funding to renovate and operationalize up to 180 beds that have been previously identified as currently unused and feasible to rehabilitate and utilize. If it is determined that it is more cost effective to construct new beds, then request funding for an equal number of new beds.

6. Implement the JCAFS recommendations for jail outreach programs**.** Collaborative jail outreach programs enable LMHAs/LBHAs (and other agencies providing mental health treatment) to partner with jails to start persons on medications as soon as possible after arrest, ensure persons are maintained on medication while they are in jail, re-evaluate these persons prior to transfer to the state hospital for competency restoration to ensure they are still incompetent, and provide post discharge support in jail after they are restored and returned. These programs are currently piloted at several jails and have been successful in both shortening lengths of stay in competency restoration programs and in removing persons from the forensic waitlist who are no longer found IST.

7. Contractually require a forensics and diversion coordinator to be located in each LMHA/LBHA. Locating a forensic coordinator in each LMHA/LBHA would ensure coordination with the state hospitals, courts, jails, law enforcement, community corrections, community health, and mental health providers. This position would also support an efficient flow of persons through the competency restoration process and improve continuity of care. JCAFS recommends dedicating a full-time forensics and diversion coordinator position to be located in each LMHA/LBHA. If this option is not currently feasible, it is recommended that each LMHA/LBHA assign an existing person to be the main point of contact with the new Office of Forensic Services. HHSC should consult with the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI) to ensure efforts are not duplicated with their services and that a forensics and diversion coordinator fulfills a need not already filled by TCOOMMI staff at each LMHA/LBHA.

9.Conclusion

In 2020, the JCAFS recommended no changes to the allocation methodology which was adopted in 2016. Revisions to the utilization review protocol were recommended which include the use of a JCAFS data dashboard for reporting and analyzing state hospital bed-day utilization and a reassessment of utilization review studies completed in 2017, 2018 and 2019 to evaluate factors that impact bed-day utilization, readmissions, and length of stay.

Based on the results of the utilization review in 2019 and stakeholder input, the JCAFS recommends addressing Texas' growing crisis in effectively serving Texans with mental illnesses that are involved with the criminal justice system. HHSC will continue to work with the JCAFS to ensure the continuum of inpatient psychiatric services meets the needs of Texans.

List of Acronyms

Acronym	Full Name
CMHH	Community Mental Health Hospital
CST	Competency to Stand Trial
FPL	Federal Poverty Level
HHS	Health and Human Services
HHSC	Health and Human Services Commission
IST	Incompetent to Stand Trial
JCAFS	Joint Committee on Access and Forensic Services
LBHA	Local Behavioral Health Authority
LMHA	Local Mental Health Authority
OCR	Outpatient Competency Restoration
JBCR	Jail-Based Competency Restoration
PPB	Private Psychiatric Bed
PESC	Psychiatric Emergency Services Center
TCOOMMI	Texas Correctional Office on Offenders with Medical and Mental Impairments
CMHH	Community Mental Health Hospital

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

2020 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 a 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 in 2020 related to the allocation of beds are unchanged from the previous recommendations made in 2016 and 2018. 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; and
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 persons 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 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 in 2018 adopted by the Executive Commissioner established a flexible framework that allowed the model to evolve.

The JCAFS 2020 recommendations related to utilization review are as follows:

1. Continue collection of data for the Hospital Bed Day Allocation Report but replace that report with the new JCAFS data dashboard as the primary tool for reporting and analyzing state hospital utilization. In addition to the data on the current dashboard, add two data points to the HBAR.
   a. LMHA's above and below their bed-day allocation.
   b. Readmissions by LMHA.
2. Assign responsibility for utilization review activities to the JCAFS Access subcommittee.
3. The 2020 utilization review protocol will include a reassessment of the studies done in 2017, 2018, and 2019.
   a. Reassess the 2017 utilization review protocol.

i. Identify the three LMHA's that are most above and most below their allocation and compare to those on these lists from 2017.
ii. Identify those new on each list and ask them the same survey questions. (What have been your successful strategies? What drives your higher utilization?).
iii. Identify those LMHA's with the largest change in utilization compared to their allocation (largest increases and largest decreases) and survey them as to what they think caused their changes.

b. Reassess the 2018 utilization review protocol.
i. Re-survey the top ten and bottom ten LMHA's in terms of readmission rates as well as each state hospital superintendent. Ask them to review and comment on the sub-committee's summary of findings from 2018 and identify any new factors contributing to high readmissions that were identified in the previous report. Also ask them for any suggestions they have for actionable items that might help reduce readmissions.

c. Reassess the 2019 utilization review protocol.
i. Ask the State Hospital leadership team for their feedback on the 2019 recommendations for reducing length of stay in the forensic population.
ii. Ask the state hospital leadership team for baseline data on the timeframes in the steps in the competency restoration program recommended by Dr. Matthew Faubion and the JCAFS in 2019.

4. Compile successful and promising strategies identified during utilization review activities for use as a statewide resource.