Sunset Advisory Commission

Staff Report with Commission Decisions

Department of State Health Services

August 2014

(Includes additional Commission Decisions made in December 2014)

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Cover Photo: The Texas State Capitol was completed in 1888. With the Goddess of Liberty atop the dome, the Texas State Capitol Building is 19 feet taller than the U.S. Capitol Building in Washington, D.C. The photo shows the north facade of the Capitol. The gardens in the foreground sit atop a 667,000 square foot underground structure, the Capitol Extension, which houses many legislators' offices and committee rooms. Photo Credit: Janet Wood

Department of State Health Services

Sunset Staff Report with Commission Decisions
August 2014

(Includes additional Commission Decisions made in December 2014)

This document is intended to compile all recommendations and action taken by the Sunset Advisory Commission for an agency under Sunset review. The following explains how the document is expanded and reissued to include responses from agency staff and the public.

- *Sunset Staff Report, May 2014* – Sunset staff develops a separate report on each individual agency, or on a group of related agencies. Each report contains both statutory and management recommendations developed after the staff's extensive evaluation of the agency.

- *Sunset Staff Report with Hearing Material, June 2014* – Adds responses from agency staff and the public to Sunset staff recommendations, as well as new issues raised for consideration by the Sunset Commission at its public hearing.

- *Sunset Staff Report with Decision Material, August 2014* – Adds additional responses, testimony, or new issues raised during and after the public hearing for consideration by the Sunset Commission at its decision meeting.

- *Sunset Staff Report with Commission Decisions, August 2014* – Adds the decisions of the Sunset Commission on staff recommendations and new issues. Statutory changes adopted by the Commission are presented to the Legislature in the agency's Sunset bill.

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Summary

Summary

In 2003, the Legislature began a grand experiment, creating one of the most complex agencies in Texas state government – the Department of State Health Services (DSHS). With more than 200 programs, 165 funding streams, and an ambitious mission to improve health and well-being in Texas, few, if any, state agencies have the breadth and scope of DSHS' responsibilities. Though this experiment was well-intentioned, in many ways DSHS was set up to be a "jack of all trades, and a master of none."

The DSHS executive management team must be experts at multi-tasking on an extreme scale, and often operate in crisis-management mode, putting out fires and dealing with the dilemma of the day instead of providing the strategic leadership and planning the Sunset review often found lacking. DSHS still carries out several of its duties in pre-consolidation silos, most obviously in its mental health and substance abuse programs, making it more of a nesting doll of agencies within agencies, instead of the truly integrated health services organization envisioned more than a decade ago. The Sunset review identified many instances where DSHS has struggled to address longstanding concerns, despite clear and repeated direction from the Legislature, stakeholders, and other outside reviews. For example, DSHS has not taken basic steps to differentiate clear roles and responsibilities between itself and local health departments; nor has it fully addressed a series of audit findings dating to 2009 to improve the security of the state's vital records system. As a result, several of the recommendations in this report simply reflect a need for the agency to simply do its job better.

DSHS' expansive role leads to constantly operating in crisis management mode.

In conducting the review, Sunset staff had to focus its efforts on a few key areas within the agency's vast scope. Staff looked closely at the state mental health hospital system and associated community mental health and substance abuse programs, as these have been of significant interest to the Legislature and risk to the State in recent years. The state mental health hospital system is dealing with enormous pressure from increased commitments from the courts, and the review found that a lack of communication and collaboration between DSHS and the judiciary only exacerbates the problem. The remote and outdated condition of state hospital facilities and critical shortages of clinical staff place additional pressures on the system as well. On the community side, DSHS has struggled to effectively distribute the Legislature's recent investment in mental health and substance abuse programs, and has not yet created a truly integrated, outcomes-focused system for addressing the state's significant and costly challenges in this area. On the most basic level, 11 years after consolidation, DSHS has still not integrated "front door" assessment, screening, and referral services for mental health and substance abuse, allowing people to more easily fall through the cracks.

The review also paid particular attention to DSHS' wide array of regulatory programs, since evaluating the continuing need for regulation is a key duty of the Sunset Commission and required by the Texas Sunset Act. Sunset staff identified numerous occupational licensing programs that could be deregulated with little risk to the public. Several others distract DSHS from its primary public health responsibilities and would be better placed at the Texas Department of Licensing and Regulation (TDLR). Attempts to scale back or streamline state regulation are oftentimes fought by those who enjoy business advantages from the perpetuation of regulatory programs. However, Sunset staff set aside such considerations and based its analysis on a series of criteria for assessing the actual need for the regulation and the effectiveness of the organizational structure to implement it.

As an enormous contract management organization, DSHS relies heavily on hundreds of local partners such as local mental health authorities, substance abuse providers, local health departments, community clinics, and others to carry out its functions and achieve its mission. In its dual role to both support and oversee these entities, DSHS has the difficult job to carefully balance the development of fragile provider networks with exerting oversight to ensure the effective use of limited funding and resources. Yet the review found DSHS tends to get mired in bureaucratic processes and meaningless outputs rather than working collaboratively with a clear focus on achieving specific, desired outcomes, particularly relating to how it distributes and evaluates funding to local mental health authorities and local health departments. Therefore, several recommendations direct DSHS to step back and reevaluate its approach, and assume the more focused leadership role it is expected to perform.

The issues discussed here beg bigger questions about DSHS' overall organizational structure, but this report does not address continuation of DSHS as a standalone agency. All of the health and human services agencies are under Sunset review this interim, providing the opportunity for a broader evaluation. The system review will be completed in the fall of 2014, allowing Sunset staff to base its structural recommendations on the most complete information. As part of this ongoing review, Sunset staff will look at the placement and management of direct-care facilities such as the state mental health hospital system as well as women's health programs operating at both DSHS and the Health and Human Services Commission. Also, the 83rd Legislature put a spotlight on the health care information collection program within DSHS, requiring Sunset to perform a specific review which is included in this report. While Sunset staff concluded this data collection program should continue, broader issues concerning the use of this type of information to improve healthcare quality and efficiency should also be evaluated as part of the ongoing health and human services system review.

A summary follows of Sunset staff's recommendations on the Department of State Health Services.

Issues and Recommendations

Please note: Summaries of Sunset Commission decisions on each of the following staff recommendations are located at the end of the detailed discussion of each issue.

Issue 1

Resolving the Current Crisis in the State Mental Health Hospital System Requires Action, Starting Now.

In fiscal year 2013, DSHS provided inpatient psychiatric services to more than 22,000 people with serious mental illness such as schizophrenia and bipolar disorder at the state's nine mental health hospitals and other facilities receiving state funding. Individuals may seek admission to the system voluntarily, or courts may order admission through civil or criminal commitment proceedings. In recent years, the number of patients committed through criminal proceedings has increased substantially, creating significant pressure on the system to provide services to a new population within already scarce resources. These issues have been compounded by the remote and outdated condition of the state hospital facilities, critical shortages of clinical staff, and a lack of effective communication with the judicial system. As a result, individuals needing treatment are at risk of not getting timely and appropriate services to best address their needs, presenting legal and financial risks to the State as evidenced by recent court activity.

The recommendations below would require DSHS to take first steps to improve the current situation, especially in regards to improving communication and collaboration with the judiciary and continuing to add capacity through community treatment alternatives. However, a broader evaluation of the best organizational structure for management and oversight of the state's mental health hospitals should continue as part of the ongoing Sunset review of the overall health and human services system.

Key Recommendations

- Require DSHS to work with the Court of Criminal Appeals to develop training to inform the judiciary about alternatives to inpatient mental health treatment, including developing a guide of alternative inpatient treatment options.
- DSHS and the Health and Human Services Commission should immediately review and streamline human resources policies to ensure state mental health hospitals are appropriately staffed, and continue expanding capacity by contracting with mental health providers in local communities whenever possible.
- Continue evaluating the management and oversight of the state mental health hospital system, including possible organizational alternatives, as part of the larger Sunset review of the health and human services system to be completed in the fall of 2014.

Issue 2

DSHS Has Struggled to Deliver Integrated, Outcomes-Focused Community Mental Health and Substance Abuse Services.

Behavioral health problems relating to both mental illness and substance abuse are a serious and growing issue in the state, with 500,000 Texans diagnosed with a serious mental illness and more than two million with substance abuse problems. These issues come with significant social costs such as reduced life expectancy, lost work productivity, and increased pressures on law enforcement and other government programs. The State has historically provided significant funding for community-based services to treat these issues by contracting with numerous community mental health centers and independent substance abuse providers. In fiscal year 2013, this funding totaled more than $750 million and the Legislature provided significant additional mental health funding for the 2014–2015 biennium.

The Sunset review revealed a number of ongoing challenges with DSHS' delivery of these services. On a basic level, 11 years after consolidation, DSHS has still not integrated "front door" assessment, screening, and referral services for mental health and substance abuse, allowing people with complex, co-occurring issues to more easily fall through the cracks. DSHS has also struggled to develop an effective approach

to funding and delivering behavioral health services that encourages best practices and provides clear outcomes-based information on which to base critical system decisions. Without a more integrated, streamlined, and performance-based approach to delivering mental health and substance abuse services that supports innovation, collaboration, and measureable results, DSHS will not be able to best move the state's behavioral health system forward.

Key Recommendations

- Require DSHS to integrate mental health and substance abuse hotline, screening, and assessment functions.
- Require DSHS to focus funding equity efforts for local mental health authorities on targeted capacity needs rather than narrow per capita funding.
- Require DSHS to overhaul regulations for community-based behavioral health treatment facilities, including creating new license types if necessary.
- Improve DSHS' behavioral health stakeholder input process by removing two advisory committees from statute and re-establishing another existing advisory committee.

Issue 3

The Unmanageable Scope of DSHS' Regulatory Functions Reduces Needed Focus on Protecting Public Health.

Few other entities in Texas state government match the scope and diversity of DSHS. In addition to its public and behavioral health responsibilities, the agency is also responsible for administering more than 70 regulatory programs, including emergency medical services providers, meat packing plants, hospitals, dieticians, and massage therapists, to name only a few. In fiscal year 2013, DSHS licensed more than 360,000 individuals, facilities, and other entities and carried out these responsibilities with about 750 full-time staff. State law requires the Sunset Advisory Commission to perform a critical examination of regulatory programs under review, based on the Commission's considerable experience from evaluating more than 100 licensing agencies during the last 37 years. Given the enormous scope of DSHS, Sunset staff took a broad view of DSHS' regulatory programs to first see how well they fit within the agency's overall mission and then developed a series of criteria that served as a basis for assessing the need for and organizational structure of these various programs.

Sunset staff concluded the expansion of DSHS' regulatory responsibilities combined with shrinking resources has made its regulatory functions unmanageable. Analysis of the agency's regulatory programs identified many that duplicate other efforts, have little regulatory activity, and could be safely eliminated. In addition, most of the occupational licensing programs DSHS administers have no connection to any of DSHS' larger public health regulatory responsibilities, serve as a distraction from these core efforts, and could be more effectively administered by the Texas Department of Licensing and Regulation. The ultimate goal of these recommendations is to streamline the multitude of DSHS' regulatory responsibilities so the agency can better perform its functions that clearly impact public health and welfare.

Key Recommendations

- Discontinue 19 regulatory programs currently housed at DSHS.
- Transfer 12 regulatory programs from DSHS to the Texas Department of Licensing and Regulation, and reconstitute associated independent boards as advisory committees.

Issue 4

DSHS Needs Additional Tools to Better Combat Fraud in the EMS Industry.

DSHS has a wide-ranging role to support the emergency medical services (EMS) and trauma system in Texas. DSHS regulates the EMS industry, including about 1,500 private and public 911 and non-emergency ambulance entities; designates levels of trauma care for the state's 686 hospitals; and provides grant funds to help develop local trauma systems. Recent issues regarding Medicaid billing fraud in the EMS industry have led to significant scrutiny on DSHS' regulation of EMS providers. These concerns culminated in a series of actions taken by the 83rd Legislature and the federal Centers for Medicare & Medicaid Services, including a moratorium on new licensees while the regulatory framework is studied and adjusted.

Using the recommendations DSHS and the Governor's EMS and Trauma Advisory Council provided the Legislature in February 2014 as well as the Sunset Commission's standards for effective licensing and regulation, several changes would strengthen this much needed regulation. These recommendations would ensure EMS providers and personnel are aware of requirements to protect public safety and comply with legitimate healthcare business practices; assist regulators and law enforcement in monitoring and investigating fraudulent or unlawful EMS activity; and ensure EMS complaints are promptly, consistently, and reliably addressed.

Key Recommendations

- Require an EMS provider to have a physical location for their business establishment and to show proof of ownership or a long-term lease agreement for all necessary equipment.
- Authorize DSHS to require jurisprudence exams for EMS licensees and to use findings from locally conducted inspections to take State enforcement action.
- Clarify that DSHS is required to collect, maintain, and make publicly available detailed statistical information on complaints regarding EMS licensees, including nonjurisdictional complaints.

Issue 5

DSHS Has Not Provided the Leadership Needed to Best Manage the State's Public Health System.

Public health services such as providing immunizations, investigating infectious diseases, and inspecting restaurants are focused on protecting the health of the population as a whole through prevention efforts. Texas has a complex and fragmented public health system with responsibility for providing services falling on DSHS and its eight Health Service Regions, as well as local health departments governed by cities and counties.

Texas' decentralized approach to delivering public health services, while providing local control and flexibility, has long presented challenges in coordinating public health efforts. The roles and responsibilities of DSHS and local health departments operating in the same areas are not clearly defined, leading to inefficiency and at times, confusion over who is doing what. Without a clear plan of action, DSHS cannot provide expected leadership and target limited resources to help build local capacity. Establishing clearly defined roles, responsibilities, and goals for the state's public health system overall would allow for evaluation of the current provision of public health services and inform what improvements may be needed. Also, having a categorized list of public health services would show how the responsibility for providing these services is currently shared between the State and local jurisdictions and help identify areas where significant gaps or overlap in duties exists.

Key Recommendations

- Require DSHS to develop a comprehensive inventory of the current roles, responsibilities, and capacity of DSHS central office, DSHS Health Service Regions, and local health departments.
- Require DSHS to establish clear goals for the state's public health system and to develop an action plan with regional strategies and milestones to meet these goals.
- Direct DSHS to develop a system to categorize different types of local health departments based on the services they provide.

Issue 6

DSHS Has Not Taken Needed Steps to Strengthen the Security of Vital Statistics.

Vital records are the official documents of every person's birth, death, marriage, or adoption in Texas. These important records, particularly birth certificates, are susceptible to fraudulent activity relating to personal identity theft, access to government benefits, and voting. This vulnerability is compounded by the fact that about 48,000 users have access to DSHS' electronic system for registering vital events and as a dual registration state, vital record information is maintained centrally by DSHS as well as locally in 422 designated local registration jurisdictions. The review found that despite a series of audit reports recommending needed improvements to the security and efficiency of the state's vital records system, DSHS has not yet fully implemented or prioritized needed changes to protect this critical information. Requiring DSHS to improve its data verification and monitoring activities and providing the agency clear authority to collect needed information would strengthen the security of vital records in such a decentralized system.

Key Recommendations

- Require DSHS to develop a formal desk audit policy and increase the use of desk audits in monitoring local registrars' offices based on their required self-assessments.
- Require identity verification through notarization for all mail-in vital records orders, and expand DSHS' authority to require fingerprint-based criminal history background checks for anyone with access to the state's electronic registration system.

Issue 7

The State Has a Continuing Need for the Texas Health Care Information Collection Program.

Originally created as a separate state agency in 1995, the duties of the Texas Health Care Information Council (THCIC) were transferred to DSHS when the agency was created in 2003. Today, the program exists as one responsibility within DSHS' Center for Health Statistics. DSHS collects data from hospitals and ambulatory surgical centers summarizing inpatient and outpatient stays, including information about patient demographics, procedures performed, payer type and charges, and discharge status. The information collected is used to produce data files available for public use and specialized research purposes, with the goal of better understanding and ultimately improving the quality and efficiency of the healthcare system.

The 83rd Legislature specifically directed the Sunset Commission to examine the mission and purpose of the program in conjunction with its review of DSHS, giving it a separate Sunset date and requiring consideration of specific questions regarding the collection and use of the data. Overall, the Sunset review determined that DSHS appropriately collects and handles the data, and that the information serves a useful purpose to help understand and improve the status of the state's healthcare system. However, the program has not yet met expectations to put the data to best use, including providing information to consumers, particularly the outpatient data. Also, this program should continue to be evaluated in the overall context of how the State collects and analyzes all types of healthcare data as part of the larger Sunset review of the health and human services system, scheduled for completion in the fall of 2014.

Key Recommendations

- Continue the healthcare information collection program, but evaluate how its functions fit within the broader health and human services system as part of the later Sunset review.
- Direct DSHS to continue its efforts to improve display and interpretation of healthcare data for consumers.

Issue 8

DSHS' Numerous Advisory Committees Lack Strategic Purpose, Limiting Their Effectiveness and Wasting Resources.

An agency as large and diverse as DSHS requires effective avenues for stakeholder input, but the Sunset review found the current approach unwieldy. DSHS has more than 55 advisory committees, councils, and independent boards with a wide variety of structures and duties. Almost 20 of these groups relate to DSHS' behavioral health and regulatory functions, which are addressed in Issues 2 and 3 of this report. Overall, the review found DSHS does not have a strategic approach to managing all of these advisory groups and that having so many statutorily created committees unnecessarily limits the agency's ability to meet evolving needs and changing conditions. Streamlining and requiring a more effective approach to managing advisory groups would give DSHS flexibility to better coordinate and effectively use stakeholder input.

Key Recommendations

- Remove eight of DSHS' advisory committees from statute and direct DSHS to re-establish active committee functions in rule as needed.
- Direct DSHS to review and revise its internal advisory committee policies and to regularly evaluate all of its advisory groups.

Issue 9

The State Should Continue Protecting Public Health and Providing Basic Health Services, but Decisions on DSHS' Structure Await Further Review.

DSHS is one of the largest and most complex state agencies in Texas, with a $3 billion annual budget, nearly 200 diverse programs, and more than 12,000 employees. The Sunset review concluded that DSHS' core public health duties such as ensuring a safe food supply, monitoring infectious disease, and preparing for disasters are critical to the effective functioning of the state's economy and society and should clearly continue. Further, DSHS receives over $1 billion in federal funding for services such as mental health and substance abuse treatment and safety net health care for families that the state cannot afford to forfeit. These funds help the state stay ahead of issues that when left unchecked, lead to more costly interventions in emergency rooms, jails, and other government programs. However, as described in Issue 3, the Sunset review did identify a number of regulatory programs that are no longer needed or that are not well placed within the health and human services system. While many of the agency's functions are clearly needed, the appropriateness of its organizational structure should be evaluated as part of the ongoing review of the entire health and human services system, scheduled for completion in the fall of 2014, to allow for a broader analysis of organizational options.

Key Recommendation

- Postpone the decision on continuation of DSHS' functions and structure until the completion of the Sunset review of the health and human services system.

Fiscal Implication Summary

The recommendations contained in Issue 3 would result in the loss of approximately $1.6 million per year to the General Revenue Fund. Other recommendations would help ensure the efficient and effective use of funds, but would not result in significant overall fiscal impact, as summarized below.

Issue 1 — The recommendation to develop training on alternatives to inpatient mental healthcare treatment would have a small cost, but the Legislature has already identified existing funding for judicial training through the Court of Criminal Appeals that could be used for this purpose. Targeted judicial training would help DSHS use state-funded inpatient psychiatric beds most efficiently and support treatment of forensic patients in community settings.

Issue 2 — Integration of front-door mental health and substance abuse services at the local level should reduce local operating costs, resulting in better use of funds for services instead of administration. However, costs to the State would not be reduced. Targeting some funding for interventions that reduce use of the state mental health hospital system would lead to more effective use of state funding, but actual cost reductions are unlikely given the overall demand for these services.

Issue 3 — Discontinuing 19 regulatory programs would result in the loss of approximately $1.6 million per year to the General Revenue Fund and a reduction of 45 full-time DSHS staff positions, beginning in fiscal year 2016. The loss would result from deregulated programs no longer collecting excess fees that are currently deposited in the General Revenue Fund. These programs generate about $4.3 million in annual fee revenue, and the Legislature appropriates DSHS $2.7 million to administer them, resulting in the $1.6 million in excess collections. Transferring 12 regulatory programs from DSHS to TDLR should be cost neutral. TDLR indicates the transfer would result in total one-time startup costs of $1.3 million, half of which would be needed in fiscal year 2016, and the remainder in fiscal year 2018 to pay for equipment and other capital expenses. TDLR should cover these costs by issuing a temporary surcharge on licensees in the transferred programs. On an ongoing basis, the recommendation would require the transfer of 53 full-time equivalent positions and continued annual appropriations of $3.1 million from DSHS to TDLR. TDLR may also need to request additional appropriations and staffing for indirect and support services positions related to the administration of these additional programs, such as additional legal counsel. If approved by the Legislature, these costs would be recovered through fees.

Issue 6 — The recommendation to require third party verification for mail-in orders could result in a small notary cost to individuals requesting these vital statisics records. Requiring criminal history background checks for users of the electronic registrar system would not result in a significant cost to DSHS, as the agency has already budgeted the approximately $7,000 to begin conducting checks on its employees. The vast majority of other system users are already required to obtain a background check as a condition of licensure as a physician, funeral director, or other professional, and DSHS could accept verification of current licensure as proof. Approximately 1,478 local registrar staff would have to pay for a background check at a cost of about $45 per person, which could be absorbed within the registrars' existing budgets.

Department of State Health Services

Fiscal Year	Loss to the General Revenue Fund	Change in the Number of FTEs From FY 2015
2016	($1,600,000)	-45
2017	($1,600,000)	-45
2018	($1,600,000)	-45
2019	($1,600,000)	-45
2020	($1,600,000)	-45

Agency at a Glance
May 2014

Agency at a Glance

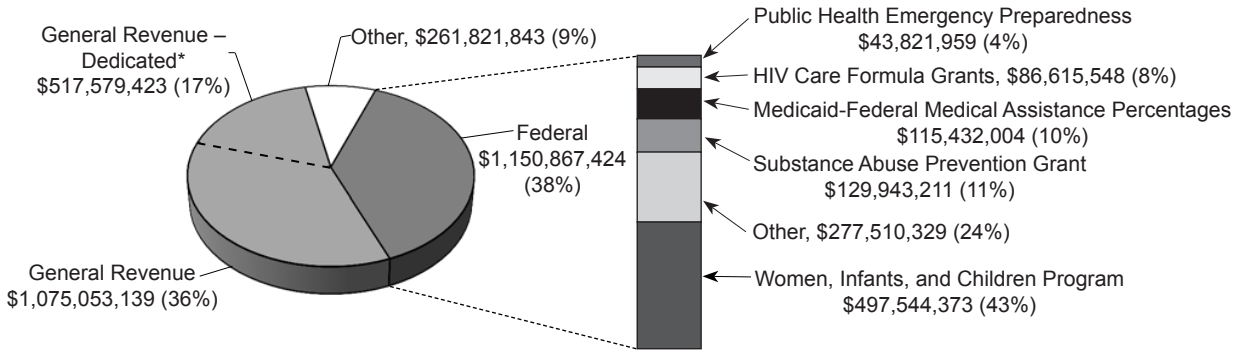
The Legislature created the Department of State Health Services (DSHS) in 2003 by consolidating the Texas Department of Health, Texas Commission on Alcohol and Drug Abuse, Texas Health Care Information Council, and mental health functions of the Texas Department of Mental Health and Mental Retardation. Broadly, DSHS aims to improve health and well-being in Texas and performs the following activities to achieve this mission:

- prevents and prepares for public health threats, including controlling the spread of infectious disease through immunizations, early detection, outbreak response, and public education;
- operates the state's public health laboratory, including the newborn screening program;
- contracts with providers and funds local health departments to improve community health by ensuring Texans have access to health services, prevention, and treatment;
- promotes recovery for people with substance use disorders, mental illness, and certain infectious diseases by funding services and providing inpatient hospitalization at the Texas Center for Infectious Disease, nine state mental health hospitals, the Waco Center for Youth, and the Rio Grande State Center;
- protects consumers by regulating a large array of healthcare professions and facilities, as well as consumer services and products such as food and drug manufacturers;
- regulates and supports development of the state's emergency medical services and trauma system; and
- collects, analyzes and disseminates public health data and information critical to health policy decision making, including maintaining the state's vital records such as birth and death certificates.

Key Facts

- **Agency Governance.** The executive commissioner of the Health and Human Services Commission (HHSC) appoints the DSHS commissioner to oversee the agency's operations. The governor appoints the nine-member State Health Services Council that assists the HHSC executive commissioner and the DSHS commissioner in developing rules and policies, provides a venue for public review and comment of agency rules, and makes recommendations regarding the management and operations of DSHS. More than 40 advisory committees and councils also assist the agency by providing advice and expertise on agency rules, policies, and programs. An additional 11 governor-appointed independent boards that license and regulate certain health professions are administratively attached to DSHS.
- **Funding.** In fiscal year 2013, DSHS spent a little more than $3 billion. As shown in the pie chart on the following page, *DSHS Revenues*, more than half of the agency's funding is general revenue, the majority of which is for behavioral health services. Other funds include Medicaid reimbursement payments ($73 million), interagency contracts ($88 million) and appropriated receipts ($66 million). DSHS receives this funding through 165 different funding streams.

DSHS Revenues
FY 2013

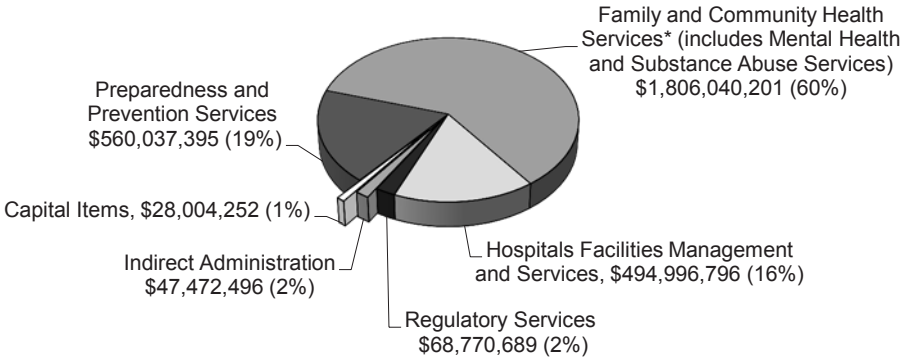


Total: $3,005,321,899

* Includes a one-time transfer of $137,860,100 to the EMS-Trauma General Revenue Dedicated Account for the Medicaid disproportionate share hospital program.

The pie chart, *DSHS Expenditures*, details the agency's expenditures in fiscal year 2013. The federally funded Women, Infants, and Children program represents about $781 million of DSHS' annual expenditures, with the agency's second largest expenditure being the community mental health program at approximately $562 million. Appendix A describes DSHS' use of historically underutilized businesses in purchasing goods and services for fiscal years 2011 to 2013.

DSHS Expenditures
FY 2013



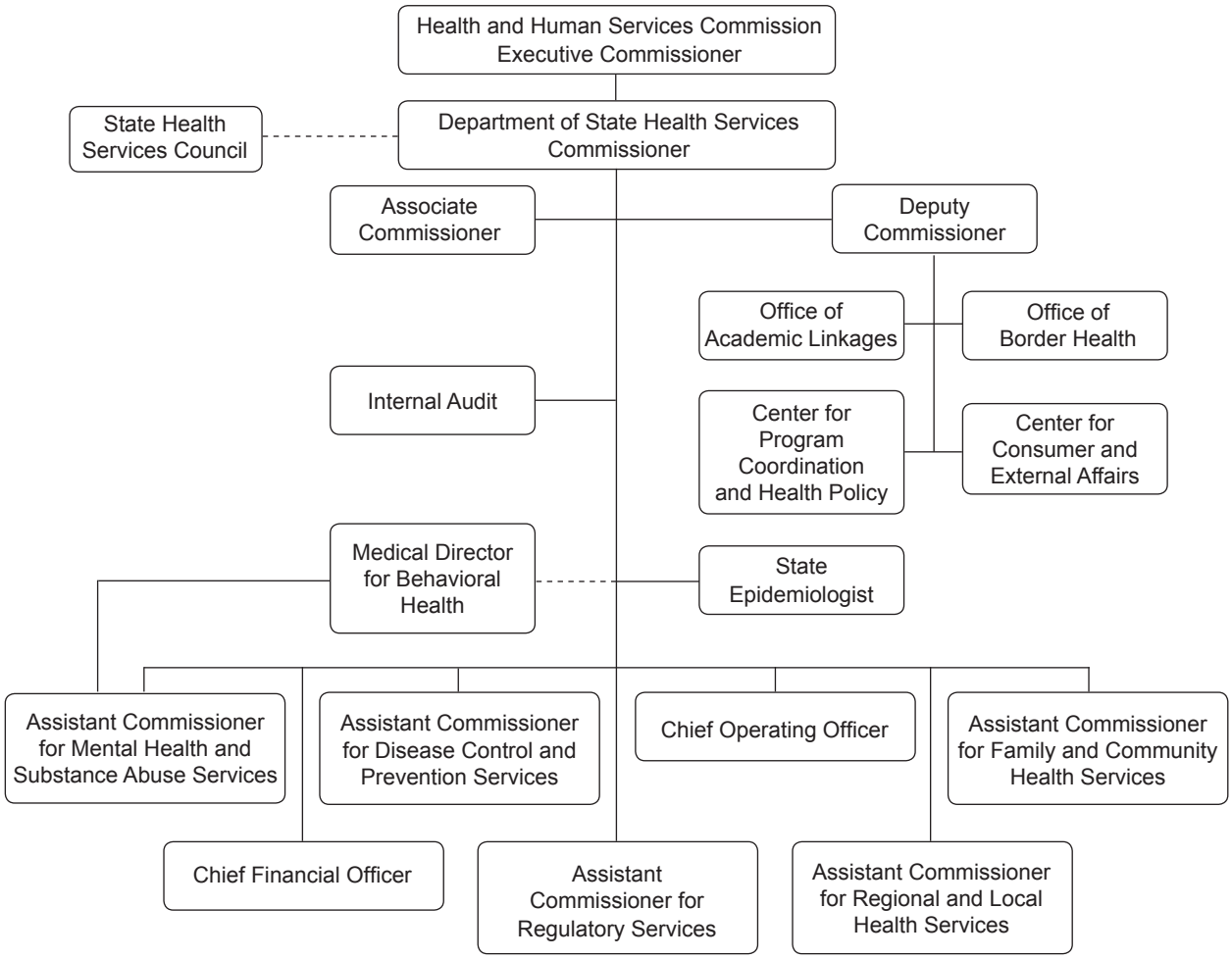
Total: $3,005,321,829

* Includes a one-time expenditure of $137,860,100 for the Medicaid disproportionate share hospital program.

The 83rd Legislature appropriated about $456 million in additional general revenue funding to DSHS for the 2014–2015 biennium, primarily to support new and existing mental health and substance abuse ($283 million) and women's health ($100 million) programs. Appendix B provides additional detail regarding the new mental health funding. With this additional funding, DSHS is the only health and human services agency in the enterprise that receives more general revenue than federal funding.

- **Staffing.** In fiscal year 2013, DSHS employed about 12,000 staff. More than 2,600 employees work at the state headquarters in Austin, and about 7,500 (63 percent) work at the agency's state facilities, including nine state mental health hospitals. The *Department of State Health Services Organizational Chart* depicts the agency's structure. Appendix C compares the agency's workforce composition to the minority civilian workforce over the past three years.

Department of State Health Services Organizational Chart



- **Preparedness and Prevention Services.**

  Disease Control and Prevention. DSHS provides prevention, control, and surveillance activities for a variety of infectious diseases, including providing about 14 million doses of vaccine each year as well as HIV medications, and conducting outbreak investigations on food-borne illnesses, tuberculosis, and other infectious diseases. The agency promotes community-based prevention programs for tobacco use and preventable chronic health conditions such as diabetes, heart disease, and obesity. DSHS also operates environmental epidemiology programs, oversees a variety of disease registries, and manages the Texas Center for Infectious Disease in San Antonio. The Center provides inpatient and outpatient care for tuberculosis treatment and other communicable diseases for patients from Texas and other states. The Center has a 45-bed capacity and served 269 patients in fiscal year 2013.

DSHS provides testing services to diagnose and investigate community health problems and health hazards at the Central Laboratory in Austin and the South Texas Laboratory in Harlingen. DSHS receives roughly 1.3 million specimens per year and conducts about 1.6 million tests per year for infectious diseases, newborn screening, and environmental chemistry. The Newborn Screening Program tests blood from the 400,000 babies born in Texas each year for 29 disorders, such as cystic fibrosis and other serious medical conditions.

Regional and Local Health Services. DSHS coordinates with local health departments to sustain public health activities, such as administering immunization programs and performing restaurant inspections. DSHS' eight Health Service Regions serve as the local health department where none exists in about 190 counties.

Community Preparedness. DSHS helps respond to natural disasters, epidemics, and other emergencies in Texas, including providing response and recovery assistance to local governments and coordinating the delivery of state and federal emergency assets and assistance. Examples of response events include hurricanes; the West fertilizer plant explosion; and H1N1, West Nile Virus, and pertussis outbreaks.

Vital Statistics and Health Information. Through its Vital Statistics Unit, DSHS manages the registration and maintenance of vital events in Texas, including all births, deaths, marriages, divorces, annulments, and certain adoptions. In fiscal year 2013, the Vital Statistics Unit registered about 900,000 vital events, processed more than 400,000 orders for copies of official records, and issued about 1.5 million records. DSHS' Center for Health Statistics collects, analyzes, and disseminates health data and information used to evaluate health in Texas, including Texas Health Indicators, an online collection of data about health trends in Texas. Within the Center, the Texas Health Care Information Collection program collects inpatient and outpatient data from more than 1,000 healthcare facilities, which is used to evaluate healthcare quality and investigate public health trends such as disease incidence.

- **Family and Community Health Services.** DSHS administers multiple programs targeted to improve the health of families, including uninsured and underinsured mothers, children, adolescents, and children with special healthcare needs. Many of these programs are funded through a combination of state and federal funding, including Title V of the Social Security Act. One of the largest programs is the Women, Infants, and Children supplemental nutrition program, which offers nutritious food; nutrition education and counseling; breastfeeding promotion and support; and referrals to other health, welfare, and social services. The program serves low-income pregnant, breastfeeding, or postpartum women and children at nutritional risk. About 60 percent of infants born in Texas are clients of the program during their first year. The program serves nearly 950,000 clients monthly and is funded through federal grants and manufacturer rebates.

- **Mental Health and Substance Abuse Services.**

  State Mental Health Hospital System. The state mental health hospital system provides inpatient psychiatric services to individuals with serious mental illness whose needs are not being met in a community setting. Individuals may seek admission to the system voluntarily, or courts may order admission through civil or criminal proceedings. DSHS operates nine state mental health hospitals with a capacity of about 2,395 beds. Construction of these buildings dates from 1857 to 1996, with an average age of 55 years old. In fiscal year 2013, state mental health hospitals handled 13,259 individual cases. DSHS currently contracts for 426 beds to provide additional inpatient psychiatric services at 10 community, private, and university hospitals around the state. In fiscal year 2013, DSHS served more than 9,000 unique patients through these contracted beds.

DSHS also operates the Rio Grande State Center in Harlingen that provides outpatient primary health care and mental health services to adults living in the lower Rio Grande Valley and clients of the co-located state supported living center. In fiscal year 2013, the Rio Grande State Center had 34,429 visits. Additionally, the 78-bed Waco Center for Youth provides psychiatric residential services to children and adolescents aged 12 to 18.

Community Mental Health Services. DSHS contracts with 37 local mental health authorities and NorthSTAR, a behavioral health managed care pilot program in the Dallas area, to provide mental health services to individuals in the community through local provider networks. An estimated 215,000 individuals received mental health services through the local mental health authorities and NorthSTAR in fiscal year 2013.

Substance Abuse Services. DSHS contracts with community providers to provide substance abuse prevention, intervention, and treatment services to eligible adults, adolescents, and children. Entities such as outreach, screening, assessment, and referral centers; NorthSTAR; and a few local mental health authorities serve as the first point of contact for persons seeking substance abuse treatment, and either directly provide or make referrals to services. Substance abuse services are principally funded by the federal Substance Abuse and Mental Health Services Administration. In fiscal year 2013, DSHS contracted with about 150 substance abuse providers for prevention, intervention, and treatment programs. That year, these providers distributed substance abuse prevention information to 2.5 million people, provided telephone counseling, referrals, and other intervention services to about 242,000 people, and treated about 58,000 people.

- **Regulatory Services.** DSHS licenses and regulates health-related businesses, equipment, facilities, and occupations through more than 70 regulatory programs. Through this regulation, DSHS aims to protect consumers and their surroundings. The wide range of DSHS' regulatory services impacts about 360,000 licensees. The textbox, *Key Regulatory Functions*, describes some of the primary areas of DSHS regulation. Approximately 1,000 fees support DSHS' regulatory programs, which brought in revenues of about $56 million in fiscal year 2013.

Key Regulatory Functions – FY 2013

- ***Emergency medical services and trauma care systems – 67,363 licensees***
  licensed paramedics, emergency medical technicians, first responder organizations
- ***Environmental health – 51,037 licensees***
  asbestos removal firms, lead abatement
- ***Food and drug safety – 48,317 licensees***
  meat inspections, drug manufacturers, medical devices
- ***Healthcare facilities – 2,540 licensees***
  hospitals, ambulatory surgical centers, end stage renal disease facilities
- ***Healthcare professionals – 164,491 licensees***
  midwives, social workers, professional counselors
- ***Radiation control – 27,189 licensees***
  nuclear disaster prevention, industrial radiography

Issues

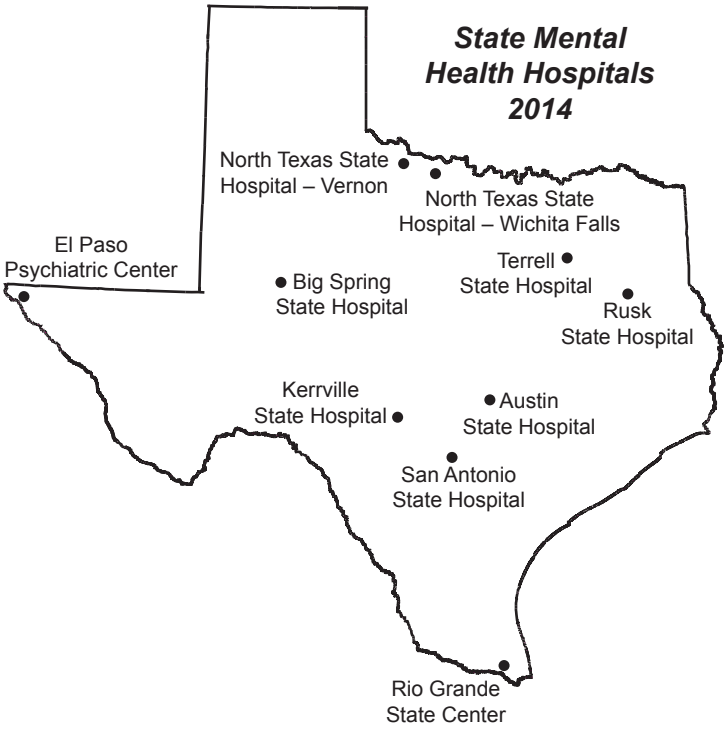
Issue 1

Resolving the Current Crisis in the State Mental Health Hospital System Requires Action, Starting Now.

Background

The state mental health hospital system treats people with serious mental illness who cannot obtain needed care in the community and/or have been committed through the court system. Such illness can include schizophrenia, bipolar disorder, and major depressive disorder, as well as other serious mental conditions. Individuals may seek admission to the state mental health hospital system voluntarily, or courts may order admission either through civil or criminal commitment proceedings. The system identifies patients committed through criminal proceedings as "forensic" patients who are deemed incompetent to stand trial, or who have been tried and found not guilty by reason of insanity.

The system began with the establishment of state mental health hospitals more than 150 years ago and more recently added contracted beds. Currently, the system includes nine Department of State Health Services (DSHS)-operated mental health hospitals located on 10 campuses, as shown on the *State Mental Health Hospitals* map, as well as 426 contracted beds in community, private, and university hospital facilities. The system handled about 22,276 individual cases in fiscal year 2013. The table, *Snapshot of the State Mental Health Hospital System*, depicts basic information about the various types of institutional settings funded by DSHS. State mental health hospital beds far outnumber beds in other state-funded settings, and not all contracted facilities accept forensic patients.



Snapshot of the State Mental Health Hospital System – FY 2014

Type of Institutional Setting	Date of Establishment	Bed Capacity	Patient Populations	DSHS Bed Cost per day
State Hospitals	First state hospital built in 1856	2,395	Adults, Adolescents, and Children; Civil and Forensic	$560–$955
Contracted Community Hospitals	1980s	225	Adults, Adolescents, and Children; Civil and Forensic	$377–$591
Contracted Private and University Hospitals	2012	201	Adults, Adolescents, and Children; Civil and Forensic	$449–$605

Findings

The state's mental health hospital system is in crisis.

Individuals waiting to enter the state mental health hospital system are at risk of not being treated in a timely manner or in ways that best address their needs. These issues result largely from a lack of capacity, patient population pressures, outdated facilities, and shortages of critical personnel. A system in this condition presents legal and financial risks that could increase in the future.

Texas communities were unable to access the state mental health hospital system for more than one-third of fiscal year 2013.

- **Capacity shortage.** State mental health hospitals do not have the capacity to meet the demand for inpatient psychiatric beds, and available beds in both DSHS-operated hospitals and contracted facilities are not keeping pace with Texas' population growth. Bed capacity decreased by 19 percent between 2001 and 2013 from 13.4 to 10.9 beds per 100,000 residents, while Texas' population increased 25 percent, from 21.3 million to 26.6 million in the same period.[1] Recent projections indicate the system will need to add roughly 17 beds annually to keep pace with current utilization trends, a figure that does not account for existing waiting lists for system beds.

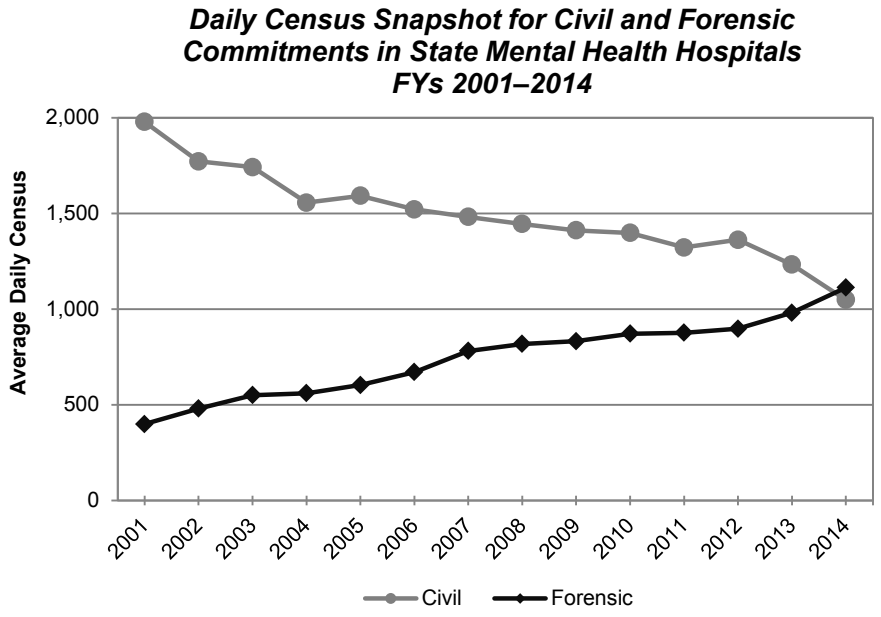
  In fiscal year 2013, the nine state mental health hospitals experienced, on average, 126 days when all beds were full, beds for specialty cases were not available, or staffing shortages necessitated leaving beds vacant. As a result, communities were unable to access inpatient psychiatric beds for more than one-third of the year, a significant obstacle to care particularly burdensome for rural communities without local options. DSHS does not maintain a waiting list for potential civil and voluntary state mental health hospital patients, so an estimate of the actual demand for this patient population is not available, though local mental health authorities report a regular inability to access state system beds, an indication of unfulfilled need. During the same period, on average, 107 forensic patients were waiting for admission to the state mental health hospital system each month.

  As detailed in Appendix B, the 83rd Legislature took steps to reduce the capacity pressure on state mental health hospitals by allocating an unprecedented $332 million to improve and expand the public mental health system in Texas. The majority of this new funding went to support community services, but the resulting impact of this investment on the state mental health hospital system cannot yet be evaluated, and significant capacity issues remain.

The average daily census of forensic patients exceeded civil for the first time in fiscal year 2014.

- **Forensic pressures.** For the first time in history, in fiscal year 2014, the average daily census of patients in DSHS' state mental health hospitals included more forensic than civil patients, as shown in the graph on the following page, *Daily Census Snapshot for Civil and Forensic Commitments in State Mental Health Hospitals*. The number of beds actually occupied by forensic patients has also significantly exceeded the number of beds DSHS planned for this patient population, reducing expected capacity for the system's traditional civil and voluntary commitments. This striking increase in the daily census of forensic commitments results in large part

from the longer length of stay of this group as compared to voluntary or civil commitments, which limits turnover of beds and restricts the system's ability to accept new patients. In fiscal year 2013, the average length of stay for state mental health hospital forensic patients ruled not guilty by reason of insanity was 370 days and 135 days for those judged incompetent to stand trial. In comparison, the average length of stay at discharge was 49 days for civil commitments and only 30 days for voluntary patients.



Part of this increasing forensic pressure on the system originated from a 2007 lawsuit that would have, if it had remained in effect, required prioritizing admission of individuals deemed incompetent to stand trial over voluntary or civil commitments.[2] The initial ruling was stayed, pending appeal, and eventually overturned in early May 2014, but would have required DSHS to make a bed available for a person deemed incompetent to stand trial no later than 21 days from the date DSHS received notice of the individual's criminal court commitment order.[3] While the ruling was stayed, DSHS worked to comply with the terms of the lawsuit, primarily by contracting with community, private, and university hospital facilities for additional capacity. Accordingly, the average wait time for incompetent to stand trial forensic patients to be admitted to the system decreased 78 percent, from 77 to 17 days between fiscal years 2011 and 2013. Although the ruling requiring admission within 21 days was overturned, ongoing management of wait times for incompetent to stand trial forensic patients is needed to continue to mitigate future legal risks to the State. However, prioritizing the forensic population means civil and voluntarily committed Texans in mental health crisis will remain unable to access needed care in a timely manner.

Prioritization of forensic patients delays timely care to other Texans in need.

- **Limited contracted facility beds.** DSHS has taken steps to use contracted facilities to help reduce pressure on state mental health hospitals and increase capacity, but this model needs further development. Since 2012,

DSHS has added about 200 state-funded beds in contracted community, private, and university hospital facilities, and this model shows potential for helping relieve the continued pressure on the system. However, these facilities still provide far less capacity than state-operated mental health hospitals and can only typically serve civil patient populations with less severe illness, restricting the flexibility of this resource. Also, DSHS has not yet developed clear and consistent measures for monitoring the use and performance of these contracts to provide information needed to monitor and compare the level of service occurring in state-operated mental health hospitals with private, contracted facilities. For example, DSHS cannot readily compare commitment types, injuries, or use of restraint and seclusion between state-operated and state-contracted beds. As DSHS continues the use of contracted beds in the community, the agency needs to better develop its ability to keep track of how well these options are working.

State hospitals need an estimated $210 million to address aging facility repairs.

- **Outdated and remote state mental health hospitals.** Old historic buildings in need of significant repairs and located on sprawling campuses often far from major population centers do not provide the most efficient or effective inpatient psychiatric treatment. Current estimates indicate state mental health hospital campuses require more than $210 million to address aging facility needs and repairs. Moreover, the need for additional capacity as well as community pressure to retain large employers makes relocating state mental health hospitals difficult. With the movement toward encouraging treatment as close to home as possible, remote locations unnecessarily complicate transportation and communication with families, the judiciary, and local providers when planning patient transitions into the hospitals and back into the community or criminal justice system following treatment.

- **Shortage of qualified personnel.** State mental health hospitals had an average vacancy rate of 11 percent among critical staff such as physicians, psychiatrists, and nurses in fiscal year 2013. These vacancies further limit capacity because regulatory standards require certain staff-to-patient ratios in order to keep beds open. The table, *Average Vacancy Rate of Critical Positions at State Mental Health Hospitals*, provides additional detail. DSHS' turnover rates were highest for psychiatric nursing assistants and licensed vocational nurses, both at 33 percent in the same year. The 83rd Legislature appropriated funds for a targeted salary increase for psychiatric nursing assistants at state mental health hospitals and reallocated the licensed vocational nurse job classification series to higher salary groups, but the impact of those changes remains to be seen.

Average Vacancy Rate of Critical Positions at State Mental Health Hospitals – FY 2013

Physician	16%
Psychiatrist	22%
Nurses (RN & LVN)	7.5%
Psychiatric Nursing Assistant	6%
Pharmacist	8%
Social Worker	8%

- **Increased severity of mental illness in state hospitals.** DSHS now treats a patient population with a higher risk of violence or other dangerous behavior than in the past, creating additional management challenges. Workers' compensation claims at state mental health hospitals increased by 35 percent between fiscal years 2009 and 2013.[4] During the same period, the number of claims in all other health and human services agencies, as well as the Texas Juvenile Justice Department and Department of Criminal Justice declined.[5] Reasons for the increased severity of illness in state mental health hospitals are complex, but can be partially explained by a nationwide movement to treat people in the least restrictive settings as close to home as possible, with the goal of returning to society, instead of spending extended periods of time in remote institutional settings. This may lead to people with less severe illness having better access to care in the community today than in the past, leaving more difficult cases concentrated in state care. Combined with other complex factors, such as the increased number of forensic commitments, this trend has resulted in additional challenges for the state mental health hospital system.

Workers' compensation claims at state mental health hospitals increased by 35 percent between fiscal years 2009 and 2013.

Numerous plans and studies attempting to correct pervasive state hospital system issues have yielded few results, and the success of future plans is questionable.

- **No decisive action from previous planning.** The State essentially operates the same mental health hospital system as during the last Sunset Advisory Commission review 15 years ago, despite years of planning and discussion. In 1999, legislation resulting from the Sunset review of the Texas Department of Mental Health and Mental Retardation required the agency to conduct long-range planning and make recommendations regarding the most efficient long-term use and management of the state mental health hospitals.[6] This plan was last updated in 2005.[7] More recently, the 2013–2017 Health and Human Services Commission (HHSC) System Strategic Plan acknowledges the need for increased state mental health hospital capacity, the impact of the forensic population on the system, and indicates each hospital will be master-planned with consideration of efficiencies of hospital campus infrastructure.[8] However, no comprehensive master plans yet exist.

The state hospital system is essentially unchanged from the last Sunset review 15 years ago.

- **Ineffectual results from recent legislative enactments.** In 2013, the 83rd Legislature directed DSHS to develop several additional plans and reports related to state mental health services and hospitals, but the results of these efforts are still pending. House Bill 3793 directed DSHS to develop a plan for appropriate and timely mental health services, including allocating mental health outpatient and state mental health hospital resources for forensic, civil, and voluntary commitments.[9] Implementation of the initial plan, released in January 2014, must begin in August 2014.[10] House Bill 1023 required DSHS to make recommendations on mental health workforce shortages.[11] Completed in February 2014, the draft report includes broad recommendations to address workforce shortages including

continuing to use telemedicine and expanding medical education to meet existing and future projected workforce needs, none of which completely address immediate workforce needs.[12] Finally, a rider in the current General Appropriations Act required DSHS to develop a 10-year plan for psychiatric inpatient hospitalization considering state mental health hospital infrastructure, capacity, and costs for recommended changes. DSHS has been slow to develop this plan despite the December 1, 2014 deadline. HHSC and DSHS released a request for proposal in January 2014 to complete an initial study to help inform the plan with a goal to commence work in April, but received only one response. As of May 1, HHSC and DSHS had begun contract negotiations with the sole respondent but had not yet made an award.

Deficiencies in judicial education and poor management of human resource issues contribute to capacity issues within the state's mental health hospital system.

- **Need for judicial education.** Through feedback from numerous stakeholders, the Sunset review found that judges and attorneys may be unaware of or lack confidence in alternatives to inpatient treatment at state mental health hospitals for forensic patients. These community placements are often less expensive than hospital settings and if used appropriately, help reduce demand on the state system. Currently, the system houses some forensic patients that could be served in alternative settings. An October 2013 snapshot of 201 forensic patients considered unlikely to regain competency found that 76 of the patients (38 percent) were recognized by clinical staff as suitable for placement in a less restrictive setting, such as a highly structured and heavily supervised group home or nursing facility, but their status as forensic commitments complicates community placement.

  Facilitating the development of judicial education on alternative treatment settings and fostering communication with the judicial system is needed to encourage the use of these alternatives for forensic patients. As recommended by the Legislative Budget Board's *Texas State Government Effectiveness and Efficiency Report* in 2013, the 83rd Legislature included a rider in the General Appropriations Act authorizing the Court of Criminal Appeals to use some existing annual judicial education funds to educate judges and attorneys about alternatives to inpatient mental health treatment, summarized in the textbox, *Rider 11, Court of Criminal Appeals*.[13] The rider also requires the Court of Criminal Appeals to take steps to make judges, prosecuting attorneys, and criminal defense attorneys involved with forensic commitment cases aware of these educational opportunities. However, a critical resource needed

Rider 11, Court of Criminal Appeals

Judicial Education: Alternatives to Inpatient Mental Health Treatment for Forensic Cases. Funds appropriated to the Court of Criminal Appeals for Judicial Education may be used to educate judges, prosecuting attorneys, and criminal defense attorneys on alternatives to inpatient mental health treatment that may be appropriate for certain individuals under forensic commitment. Alternatives to inpatient mental health treatment for individuals under forensic commitment may include outpatient competency restoration, jail-based competency restoration, residential rehabilitation units, and conditional release.

to assist this effort — a comprehensive inventory of basic information regarding local alternatives — does not yet exist. DSHS is the state's lead mental health agency and should assist in this effort.

- **Delayed human resources decisions compound workforce shortages and unused bed capacity.** DSHS has not been able to use nearly 100 beds available and funded to serve individuals in need. Despite a budget and plan to maintain 95 percent capacity, state mental health hospitals had an average daily census, which means beds actually serving patients, of only 93 percent in fiscal year 2013, and this number had dropped to 91 percent in the early part of fiscal year 2014. A goal to achieve 100 percent capacity would be unattainable due to various logistical factors such as patient transportation and matching specialty beds with suitable patients. However, delays in filling funded clinical staff positions have restricted DSHS' ability to provide planned and budgeted services, since DSHS cannot use funded beds if staff-to-patient ratios are not met.

  Though reasons for workforce issues are complex and some factors are outside of DSHS' control, ineffective internal human resources processes have compounded the problem. Hiring and other personnel actions in state mental health hospitals are the joint responsibility of DSHS as the requesting agency and HHSC as the approving support services agency. Sunset staff met with staff at six state mental health hospitals, who repeatedly noted human resources and administrative obstacles as the primary challenge in providing complex direct-care services within a contracting-oriented agency like DSHS. To address shortages of critical clinical staff such as physicians and psychiatrists, most state mental health hospitals have had to contract for needed personnel at a much higher cost. Meanwhile, Sunset staff heard several instances of interested applicants and existing employees eligible for promotions abandoning the hiring process or state employment altogether due to extended delays in hiring and retention decision-making. Also, some basic personnel actions can take months or even more than a year to complete. HHSC has explained various reasons for these delays, including possible actions at DSHS. Neither agency can seem to overcome the bureaucratic hurdles and quickly hire needed staff. The end result limits the ability of state mental health hospitals to recruit and retain the staff necessary to meet required staffing ratios to use current capacity and maintain accreditation. DSHS and HHSC have the ability and need to jointly bring this issue to quick resolution.

Some basic personnel actions can take months or even more than a year to complete.

Recommendations

The entwined structural problems in the state's mental health hospital system must be considered in context and conjunction with the overall health and human services system. Therefore, decisions on any structural changes to the state's mental health hospital system should wait until Sunset staff completes its evaluation of the entire health and human services system.

Deciding the best structure for these critical functions in the context of a comprehensive evaluation of the overall system will permit a broader analysis of organizational options than the review of DSHS

alone can provide. The Sunset review of the overall system and the resulting report scheduled to be completed in fall 2014 is the appropriate vehicle for addressing some of the more complex physical and administrative structural issues facing the state's mental health hospital system, and will allow for full consideration of these issues along with other health and human services system needs and improvements.

Change in Statute

1.1 Require DSHS to work with the Court of Criminal Appeals to develop training to inform the judiciary about alternatives to inpatient mental health treatment.

This recommendation would build off recent recommendations from the 83rd Legislature and the Legislative Budget Board to require DSHS and the Court of Criminal Appeals to develop a specific training curriculum related to alternatives to inpatient treatment at state mental health hospitals no later than March 1, 2016. This curriculum would include development of a guide to available alternative treatment settings, as detailed in Recommendation 1.2 below. By encouraging more communication and coordination between DSHS and the judiciary, this recommendation would help divert appropriate patients from inpatient hospitalization in the state mental health hospital system to other, less costly treatment settings in the community. This would also better inform the judiciary about the implications of civil versus forensic commitments to the state mental health hospital system.

Management Action

1.2 Direct DSHS to develop a guide for alternatives to inpatient mental health treatment in the state mental health hospital system.

This recommendation would direct DSHS to develop an online guide of available alternatives to inpatient mental health treatment in Texas. Local mental health authorities and the Texas Council of Community Centers should assist DSHS in gathering information on alternatives in individual service areas, including state and locally funded facilities and other resources available in the private market that are currently not well tracked. The information in the guide would include service type, targeted patient population, capacity, admissions process, and contact information for each alternative treatment setting. The first guide would be due no later than December 31, 2014 and would be updated regularly.

1.3 Direct DSHS and HHSC to immediately review and streamline hiring processes and improve other personnel actions needed to ensure state mental health hospitals are appropriately staffed.

Under this recommendation DSHS and HHSC would review hiring and other personnel action processes in relation to the state mental health hospital system to identify and address sources of process delays. The agencies should work together to set specific timeframes for processes that reclassify or reallocate existing positions and to measure their performance in completing them in a timely manner. Specifically, the agencies should establish highly streamlined timelines for critical shortage positions. The agencies should report their progress in resolving delays to the Sunset Advisory Commission no later than November 1, 2014. Streamlining these personnel processes would help DSHS become more competitive in the hiring and retention of critical state mental health hospital staff, particularly in areas where staff shortages have been noted. These changes would also help better ensure required staff-to-patient ratios and address associated safety issues. Finally, streamlining these processes to increase available staff would help DSHS better maximize the use of funded capacity in the state mental health hospitals.

1.4 Direct DSHS to continue expanding state mental health hospital system capacity for both forensic and civil patients by contracting with mental health providers in local communities whenever possible.

This recommendation supports continued efforts by the agency to use, whenever possible and within available resources, contracted inpatient psychiatric hospital options from community, private, and university hospitals as a means to increase capacity of the state mental health hospital system and provide needed services more effectively and efficiently. These efforts should continue as a means to relieve pressure on the current system and develop stronger relationships with and support of community options. As part of this effort, DSHS should work to address the gaps in patient data currently reported by contracted facilities, with an ultimate goal of having the same information available for all patients of the state mental health hospital system, whether served in state-operated or contracted facilities. Information collected should include, at a minimum, an itemization of patients by commitment type and information regarding staff and patient injuries and use of restraints and seclusion.

Fiscal Implication

Overall, these recommendations are intended to make better use of the capacity of the state's mental health hospital system and the funds that support the system. Implementation costs would be minimal, as discussed below.

The recommendation to develop training on alternatives to inpatient mental healthcare treatment would have a small fiscal impact to the State. While some cost to develop the inventory of alternatives is expected, the Legislature has already identified existing funding for judicial training through the Court of Criminal Appeals that could be used for this purpose. DSHS should use existing relationships with local mental health authorities to help catalog local treatment alternatives to placement in state mental health hospitals. Although development of new curriculum requires the Court of Criminal Appeals to invest some resources, targeted judicial training will help DSHS use state-funded inpatient psychiatric beds most efficiently and support treatment of forensic patients in community settings. Streamlining the process for hiring and taking other personnel actions for critical staff in the state mental health hospital system, and directing DSHS to continue existing efforts to expand capacity through contracted beds would not result in additional costs to the State.

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[1] "Population Data for Texas," Department of State Health Services Center for Health Statistics, accessed May 8, 2014, http://www.dshs.state.tx.us/chs/popdat/default.shtm.

[2] Lakey v. Taylor, No. D-1-GN-07-837, 2012 WL 6840143, at *1 (Tex. Dist., Feb. 02, 2012).

[3] Lakey v. Taylor, No. 03-12-00207-CV, (Tex. App. – Austin, May 2, 2014).

[4] State Office of Risk Management, Chief of Legal Services and Deputy General Counsel, email message to Sunset Advisory Commission staff, April 18, 2014.

[5] Ibid.

[6] S.B. 358, 76th Texas Legislature, Regular Session, 1999.

[7] Health and Human Services Commission, *HHS System Strategic Plan for FY 2005-2009 Attachment 1: Report Update for State Mental Health Facilities*, accessed April 9, 2014, http://www.hhs.state.tx.us/StrategicPlans/HHS05-09/final/Attch01.shtml.

[8] Health and Human Services Commission, Health and Human Services System Strategic Plan 2013-17 Volume 1, accessed April 15, 2014, http://www.hhs.state.tx.us/StrategicPlans/SP-2013-2017/SP-13-17.shtml.

[9] H.B. 3793, 83rd Texas Legislature, Regular Session, 2013.

[10] Ibid.

[11] H.B. 1023, 83rd Texas Legislature, Regular Session, 2013.

[12] Texas Department of State Health Services, *The Mental Health Workforce Shortage in Texas* (Austin: Texas Department of State Health Services, 2014).

[13] Rider 11, page IV-6, Article IV, (H.B. 1) Acts of the 83rd Legislature, Regular Session, 2013 (the General Appropriations Act).

Responses to Issue 1

Recommendation 1.1

Require DSHS to work with the Court of Criminal Appeals to develop training to inform the judiciary about alternatives to inpatient mental health treatment.

Agency Response to 1.1

DSHS supports this recommendation. Increasing judges' awareness and confidence in using alternate treatment settings will increase their use for forensic patients and reduce the demand on the state hospital system. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 1.1

John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin

Kathryn Lewis, Attorney – Disability Rights Texas, Austin

Bob Libal, Executive Director – Grassroots Leadership, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 1.1

None received.

Modification

1. Require training under this recommendation regarding alternatives to inpatient mental health treatment to inform not only the judiciary, but all players in the system in both criminal and civil courts, including judges, prosecutors, district attorneys, defense attorneys, public defenders, court-appointed attorneys, sheriffs, and probation and parole staff. (Kathryn Lewis, Attorney – Disability Rights Texas, Austin; Janie Metzinger, Public Policy Director – Mental Health America of Greater Dallas, Dallas; and Gyl Switzer, Public Policy Director – Mental Health America of Texas, Austin)

Recommendation 1.2

Direct DSHS to develop a guide for alternatives to inpatient mental health treatment in the state mental health hospital system.

Agency Response to 1.2

DSHS supports this recommendation. Over the past six years, DSHS has focused on crisis mental health services and alternatives to inpatient treatment. The agency will continue to collaborate with local mental health authorities, consumers and their families, and other providers on the delivery of these important services to Texans, and specifically to develop and maintain this guide. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 1.2

John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin

Kathryn Lewis, Attorney – Disability Rights Texas, Austin

Bob Libal, Executive Director – Grassroots Leadership, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 1.2

None received.

Modification

2. Instead of directing DSHS to develop the guide directly, require DSHS to contract out to a private firm with expertise in website design and development. (John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin)

Recommendation 1.3

Direct DSHS and HHSC to immediately review and streamline hiring processes and improve other personnel actions needed to ensure state mental health hospitals are appropriately staffed.

Agency Response to 1.3

DSHS supports this recommendation and recognizes that processes relating to hiring can be improved. Although the complex nature of the state hospital system necessitates, at times, additional review of job candidates, HHSC and DSHS will work to review these issues immediately. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 1.3

John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin

Kathryn Lewis, Attorney – Disability Rights Texas, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 1.3

None received.

Sunset Member Modification

3. Clarify that agency efforts to streamline hiring processes and improve personnel actions should allow local state hospital leadership to take a more active role in recruitment, hiring and retention of state hospital staff at their campus. Local involvement in these human resources functions should follow standards developed by HHSC in consultation with DSHS. (Senator Jane Nelson, Chair and Representative Four Price, Vice Chair – Sunset Advisory Commission)

Modification

4. Direct Sunset staff to review hiring processes at state hospitals associated with human resources changes directed by House Bill 2292 (78R) that diminished local, facility-based human resources leadership and support functions. (Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin)

Recommendation 1.4

Direct DSHS to continue expanding state mental health hospital system capacity for both forensic and civil patients by contracting with mental health providers in local communities whenever possible.

Agency Response to 1.4

DSHS supports this recommendation as it is consistent with the agency's ongoing practice of utilizing community and academic facilities to augment the state hospital system. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 1.4

Representative Ruth Jones McClendon, Member – Texas House of Representatives

John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin

Kathryn Lewis, Attorney – Disability Rights Texas, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 1.4

None received.

Sunset Member Modification

5. Clarify that DSHS should expand contracting with local communities for inpatient beds. When assessing adequacy of inpatient capacity in local communities, DSHS shall consider the capacity of community-based hospital alternatives as well as community, local, private and university hospitals, in addition to capacity at state hospitals. In implementing this recommendation, DSHS shall consider the State Hospital System Long-Term Plan as well as input of the HB 3793 (83R) Task Force. DSHS must provide rationale for including or excluding recommendations of the Task Force. (Senator Jane Nelson, Chair and Representative Four Price, Vice Chair – Sunset Advisory Commission)

Modifications

6. Direct DSHS to ensure that the information collected by contracted facility providers and reported to the agency are efficient and meaningful, of sound depth and quality, and equal to or better than the information being gathered at the state-operated facilities. This data reporting model needs thorough review and revision so that it reflects the effectiveness of the services in addition to efficiency measures. (Representative Ruth Jones McClendon, Member – Texas House of Representatives)

7. Direct DSHS to maintain a waiting list for potential civil and voluntary state mental health hospital patients to better manage capacity issues. (John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin)

8. Direct DSHS, in developing the common data set for state-operated and state-contracted facilities, to take into consideration the differences in scope of responsibility that may exist among state-operated facilities and locally-purchased inpatient services. (Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin)

9. In addressing gaps in data currently reported by contracted facilities, direct DSHS to track the use of other behavioral interventions, including emergency medication, and track outcomes by committing offense and offense classification, if applicable, to allow for better assessment of individuals using inpatient beds. (Kathryn Lewis, Attorney – Disability Rights Texas, Austin)

Commission Decision on Issue 1

The Sunset Commission adopted all of the staff recommendations in Issue 1. In addition, the Commission adopted the following modifications.

- On Recommendation 1.3, Modification 3 clarifies that DSHS' efforts to streamline hiring practices in state hospitals should allow local hospital leadership to take a more active role in recruitment, hiring, and retention of staff, following certain standards.
- On Recommendation 1.4, Modification 5 clarifies that DSHS should expand contracting with local communities for inpatient psychiatric beds, according to certain considerations and including input from the existing H.B. 3793 task force.

Issue 2

DSHS Has Struggled to Deliver Integrated, Outcomes-Focused Community Mental Health and Substance Abuse Services.

Background

Behavioral health problems relating to both mental illness and substance abuse are a serious and growing issue, as described in the textbox, *Behavioral Health Issues in Texas – By the Numbers*.[1]

Behavioral Health Issues in Texas – By the Numbers

- **500,000:** Number of adults with a serious mental illness, including schizophrenia, bipolar disorder, and major depressive disorder.
- **175,000:** Number of children with a severe emotional disturbance.
- **29 Years:** Reduced life expectancy of people with severe and persistent mental illness.
- **Two Million:** Number of Texans with substance abuse problems.
- **45 Percent:** Percent of adults with substance abuse issues who also have a co-occurring mental illness.
- **$33.4 Billion:** Estimated annual cost of substance abuse through lost work, crime, and premature death.

In 2003, the Legislature integrated the state's mental health and substance abuse programs at the newly-established Department of State Health Services (DSHS) by merging mental health functions from the Texas Department of Mental Health and Mental Retardation and the substance abuse functions from the Texas Commission on Alcohol and Drug Abuse.

The State has a clear interest in funding community-based behavioral health services for a mix of pragmatic and humanitarian reasons. Community services are typically more cost effective than services provided in state institutions, such as state mental health hospitals, and providing treatment closer to home helps improve outcomes by allowing people to more easily maintain ties to their family and other support structures. Effective community behavioral health services go a long way to reduce pressure on jails, emergency rooms, and limited state mental health hospital resources.

In fiscal year 2013, the Legislature provided more than $750 million in funding for community-based behavioral health programs. That year, DSHS-funded programs served about 215,000 people with mental health issues and provided substance abuse treatment to about 58,000 people. Additionally, DSHS' substance abuse contractors provided telephone counseling, referrals, and other intervention services to 242,000 people, and prevention information to 2.5 million people. The textbox, *Typical DSHS-funded Community Behavioral Health Services*, provides more information.

Typical DSHS-funded Community Behavioral Health Services

- Hotlines and referral services
- Screening and assessments
- Substance abuse prevention, intervention, and treatment
- Mental health crisis outreach teams
- Case management
- Counseling
- Jail diversion programs
- Rehabilitation and skills training

Last year, the 83rd Legislature provided significant additional mental health funding for the 2014–2015 biennium, described in more detail in Appendix B. DSHS manages hundreds of contracts to distribute this funding through 37 local mental health authorities, one behavioral health authority (NorthSTAR), and about 150 substance abuse prevention, intervention, and treatment providers. In this role, DSHS is responsible for oversight and performance evaluation of contractors to ensure that people receive high quality services and that state and federal funds are used to best effect.

Findings

DSHS has not seized obvious opportunities to integrate hotline, screening, and assessment functions for mental health and substance abuse services.

DSHS' inefficient, legacy approach of funding separate front-door entry points — hotline, screening, assessment, and referral services — into the behavioral health services system allows people with complex, co-occurring mental health and substance abuse issues to more easily fall through the cracks.

- **Lack of integration does not follow best practices.** When the Legislature merged the state's mental health and substance abuse agencies, the goal was to better integrate interrelated mental health and substance abuse services. However, 11 years later, the Sunset review found the same basic delivery structures in place as existed pre-consolidation, with little practical integration at the local level. Delivering these services in a disconnected way goes against best practices identified by the federal Substance Abuse and Mental Health Services Administration, as outlined in the textbox, *Federal Standards for Service Integration*.[2] While local providers may be more comfortable with the status quo funding approach, it is long past time for DSHS to take basic steps to better integrate front-door entry points to better ensure those in need can effectively access and receive services.

> ***Federal Standards for Service Integration***
>
> - Integrated screening for mental health and substance use disorders
> - Integrated assessment
> - Integrated treatment planning
> - Integrated or coordinated treatment
> - Continuing care

- **Uncoordinated regional service delivery.** DSHS continues to use a patchwork of regional administrative structures established by its predecessor organizations that do not sufficiently integrate delivery of behavioral health services. For mental health, DSHS delivers services through 37 local mental health authorities; for substance abuse, DSHS contracts with 13 different organizations with different substance abuse regions to perform similar outreach, screening, assessment, and referral services for substance abuse issues. In two of the substance abuse regions, a mental health authority also provides the substance abuse referral services. Sunset staff determined this administrative model works well and should be used as the goal to promote more integrated services statewide.

- **Separate hotlines.** Hotlines are a primary front door to receiving treatment, yet DSHS has failed to integrate administration of this basic function for mental health and substance abuse services. For example, if a person is

self-medicating to combat a mental health disorder (a common situation), they should not have to figure out whether to call a mental health hotline or a separate hotline number for substance abuse issues. Callers should be able to dial one number to receive help, regardless of whether their issue is primarily related to substance abuse or mental health. Instead, DSHS sets different standards for substance abuse and mental health hotline operations and also requires mental health authorities to maintain separate hotlines for routine and crisis services. Separate hotlines make service delivery less effective to people who are vulnerable and often reluctant to seek services.

Despite years of legislative direction, state funding to mental health regions continues to be inequitable and disconnected from performance.

- **Longstanding, irrational funding approach.** In fiscal year 2013, the Legislature provided $575 million to local mental health authorities and the NorthSTAR pilot project, which DSHS distributed through a byzantine funding structure. The local mental health authorities simply received "what they got last year" without a rational, fair, or performance-based plan. For more than a decade, the Legislature has attempted to correct this historical approach to funding, particularly as it relates to regions of the state receiving vastly different per-capita amounts for mental health funding.

  DSHS distributes local mental health funding without a rational plan.

  Generally, the Legislature has repeatedly instructed DSHS to make mental health funding distribution more equitable on a per-capita basis as new funding becomes available. These efforts, usually directed through riders in the General Appropriations Act, are described in more detail in Appendix D. Over time, attempts to adjust scarce funding have been met with a chorus of providers raising the specter of causing so much disruption in the system that efforts to correct the situation are rendered dead on arrival. As a result, per-capita mental health funding across the state still varies widely region-by-region and has actually diverged more over time by several measures, despite repeated efforts to make the funding more equitable.

  For example, in 2003 and again in 2005, the Legislature specifically directed DSHS to implement six-year plans to reduce per-capita inequity in mental health funding through targeted reductions to certain local mental health authorities, in addition to using new funds to provide additional funding to those on the low end of the scale. In 2006, DSHS committed to make these adjustments phased over several years, with the goal of reaching per-capita equity by 2013, but the agency failed to do so. Sunset staff reviewed changes in regional allocations of local mental health funding between 2006 and 2013 and found that per capita regional funding actually went in the opposite direction, becoming more inequitable, as shown in the textbox, *Persistent Disparity in Regional Mental Health Funding*. Even with the significant increase in

Persistent Disparity in Regional Mental Health Funding 2006 to 2013

- In 2006, mental health funding varied by region from $8.61 to $27.34 per capita — a difference of $18.73.
- By 2013, the regional variation had increased, with regional funding ranging from $10.82 to $31.45 per capita — a difference of $20.63.
- In 2013, 28 of 38 regions were farther away from the statewide average than in 2006.

funding provided to local mental health authorities by the 83rd Legislature, DSHS was only able to make slight improvements to this longstanding equity problem.

While attempts to distribute local mental health funding more equitably have repeatedly failed, continuing to focus solely on per-capita equity misses the point of how to best move the state mental health system forward, as discussed below.

Attempts to more equitably distribute local mental health funding have repeatedly failed.

- **Better oversight of regional resources needed.** The narrow focus on equity in per-capita regional funding sidesteps a larger discussion of how DSHS should better manage performance and use of other state resources by local mental health authorities. For the first time, the 83rd Legislature directed DSHS to hold back a small portion (10 percent) of the historical regional funding for local mental health authorities to focus on performance outcomes, but implementation has been rocky, as discussed later in this issue.

  Additionally, DSHS has not coordinated its management of regional funding allocations to identify and make needed improvements in regions that are overusing their allocated share of beds in the state mental health hospital system. Significant overuse of allocated state beds indicates a breakdown in local service delivery and capacity. In 2013, 21 of 38 regions received above average per-capita funding. Nine of those 21 regions also used more beds in the state mental health hospital system than originally allocated by DSHS. Together, these nine regions overused their bed allocations by more than 14,800 bed days, yet also received $17.4 million in funding above the statewide average. Clearly, the higher funding is not having its intended outcomes, and raises questions about both the current funding structure and use of state beds. Distributing so much funding without a clear rationale or goals for performance prevents DSHS from effectively managing limited resources and reduces the ability to incentivize the right outcomes.

Local mental health organizations do not receive the support they need to be effective.

  This combination of factors also indicates the need for DSHS to provide regions with technical assistance and evaluation to identify weaknesses in community capacity and inefficient use of funding, and help develop specific regional solutions to redirect existing resources to improve performance. However, the current structure largely continues to represent the worst of both worlds, where DSHS' hands are tied by historical funding structures and local organizations are not receiving the support they need to be effective. The state needs to continue moving in the direction of using limited resources in a more targeted way.

DSHS has not developed a streamlined, outcomes-focused approach to managing the state's mental health and substance abuse programs.

DSHS collects and reports copious data about the services it funds, but the Sunset review revealed that the agency struggles to use this information effectively to manage its own performance or that of its many local partners.

Without ready access to meaningful performance and outcome information, DSHS management, local partners, policymakers, and other stakeholders do not have the tools needed to understand the effectiveness of current programs, compare outcomes, and target limited funding to the most effective solutions.

- **Hundreds of measures, unclear outcomes and performance.** DSHS collects a total of more than 300 behavioral health measures for its various programs — at least 261 substance abuse measures, 41 mental health metrics, and 28 measures for the NorthSTAR pilot project. These measures include basic information such as number of clients served, specific contract requirements such as targets for counseling time provided to clients, and some outcome measures such as number of people diverted from jail. Some of these measures are required for state or federal budget and grant reporting, but the majority have been created and added by DSHS over time. The table, *Behavioral Health Performance Measures*, shows the total number of measures DSHS currently collects related to all its behavioral health programs.

Behavioral Health Performance Measures – FY 2014

Reason for Measure	DSHS Program Area		
	Substance Abuse	Mental Health	NorthSTAR Pilot
Created by DSHS	195	16	26
Required for State Budget Reporting	23	21	2
Required for National Outcome Measure	43	4	0
Total	**261**	**41**	**28**

Given the complexity of the many programs DSHS funds, numerous contract requirements and performance measures would be expected so the agency can hold contractors accountable and provide information to policymakers on the ultimate outcomes achieved through this funding. However, the review found this was not the case for many current requirements and measures that provide little information on actual performance and outcomes. Additionally, during the Sunset review, DSHS' partners repeatedly complained that the measures have become onerous, and in some cases, do not drive best practices or provide enough flexibility for clinicians who actually provide services. Combined with DSHS' difficulty in explaining their overall approach to performance management and providing basic overall data during the review, Sunset staff determined that the current structure needs a complete re-evaluation and overhaul.

Most DSHS data requirements provide little information on actual outcomes.

- **Pilot project design thwarts evaluation.** The design and management of the NorthSTAR pilot project in the Dallas area has limited comparisons of its performance and outcomes with the traditional model of service delivery through local mental health authorities in the rest of the state. The Legislature created the pilot project in 1999 to integrate the delivery of mental health and substance abuse services for both indigent and Medicaid clients in a seven-county region, using a managed care model. DSHS has been responsible for NorthSTAR since the 2003 consolidation. However, the structure and ongoing management of the pilot has not ensured DSHS and others can adequately evaluate whether it is delivering better results and should be expanded, or has failed to meet expectations and should be

reconsidered, the key goal for any pilot project. As a result, studies over the last decade have drawn conflicting conclusions about the effectiveness of the pilot model. In 2011, the Legislative Budget Board concluded that "inadequate measurement of behavioral health client outcomes prevents the state from determining NorthSTAR's overall effectiveness relative to the rest of the state."[3] Meanwhile, expansion of Medicaid managed care and other changes to delivery of behavioral health services in the rest of the state have been evolving disparately from the NorthSTAR model, which is typically exempted from any statewide changes. Fiscal year 2014 is the first year DSHS will be able to compare one key service, rehabilitation, between NorthSTAR and the rest of the state due to the recent implementation of a more detailed, accepted assessment tool. However, this comparison will only be valid for one year, as significant changes relating to the statewide carve-in of some behavioral health services into Medicaid managed care will again make future year evaluations difficult. Although NorthSTAR is not addressed directly in this report, Sunset staff will continue evaluating the model as part of a broader look at the state's approach to delivering behavioral health services through managed care.

- **Data issues limited Sunset staff's analysis.** At the time of the review, DSHS and its local partners were implementing several major changes and experiencing significant disruption. In September 2013, DSHS began requiring mental health contractors to use new assessment tools, including a new system for reporting information to DSHS. The transition was difficult for contractors who lost access to important reporting functions, had to work around the system's significant downtime, and spent additional resources resolving errors and reconciling mismatched and unreliable data. During this time, DSHS was also rushing to establish the Legislature's directive to implement new 10-percent performance funding holdback measures for local mental health authorities, but did so with little initial stakeholder input. Data problems stemming from the new system's bumpy rollout then resulted in a lack of reliable information to evaluate performance on the new measures for the first quarter of fiscal year 2014. By April 2014, DSHS had addressed many of the issues, but these significant challenges combined with the timing of the Sunset review in the midst of ongoing implementation prevented Sunset staff from evaluating progress towards the Legislature's recent performance goals.

The Sunset review occurred in the midst of major funding changes causing significant disruption.

- **Contracting issues further hinder outcomes.** Recently, DSHS has not been meeting basic expectations for being a responsible funder to the many local partners on whom it relies to deliver mental health and substance abuse services. DSHS recently experienced unacceptable contracting delays, executing only 1 percent of mental health contracts and 14 percent of substance abuse contracts by the beginning of fiscal year 2014. These delays kept many local partners in limbo and made planning for effective service delivery difficult, as new performance metrics and contract requirements were not set until mere days before local entities had to begin providing services to their clients.

DSHS cited a number of factors causing the delays, including new procurement processes at the Health and Human Services Commission (HHSC), negotiations with stakeholders, and internal funding decisions and approval processes to implement changes passed during the last legislative session. However, a contract management organization as large as DSHS, which expects to contract for $815 million in mental health and substance abuse services in fiscal year 2014, should have better anticipated and accounted for these issues.

Outdated regulations for community-based behavioral health treatment facilities stifle innovation and may not adequately protect vulnerable populations.

Encouraging development of robust community-based settings to provide services to people in behavioral health crisis is paramount to reducing the inevitable use of more expensive and less appropriate treatment in the state mental health hospital system, jails, and emergency rooms. However, current regulatory uncertainty has created risk for both the State and contracted providers, and potentially discourages new providers from entering the market.

Community-based facilities currently include a mix of licensed and non-licensed settings described in the textbox, *Community-based Behavioral Health Treatment Facility Types*. These facilities provide services such as short-term, residential crisis treatment or intensive interventions designed to relieve acute symptoms and restore a person's ability to function in a less restrictive setting. Examples of recently opened community mental health crisis facilities show the positive impact these resources can have. For example, two regions of the state recently opened new crisis facilities and both were able to reduce their use of state mental health hospital beds by 25 percent or more within the first year.

Community-based Behavioral Health Treatment Facility Types – FY 2013

Licensed through DSHS Regulatory

- Crisis Stabilization Units – 3
- Narcotic Treatment Programs – 84
- Psychiatric Hospitals – 44
- Substance Abuse Treatment Facilities (licensed) and Faith-based Substance Abuse Treatment Facilities (registration only) – 578

Unlicensed and funded through DSHS mental health contracts

- Crisis Residential Units – 4
- Crisis Respite Centers – 11
- Extended Observation Units – 6
- Psychiatric Emergency Service Centers – 3
- Rapid Crisis Stabilization – 12

Despite the obvious benefits to encouraging the development of such community-based resources, the state's regulatory framework governing local mental health and substance abuse treatment facilities has not kept pace with advancements in clinical best practices or new federal and state funding streams seeking to drive innovation in how these services are delivered. During the review, providers expressed particular concern about outdated limitations to treating patients with co-occurring psychiatric and substance abuse issues, and difficulty in meeting the stringent regulatory requirements of full licensure. Currently, a crisis stabilization unit is the only licensed facility type outside of a hospital setting allowed to provide these

services, but only three such facilities are now open. Use of crisis stabilization units by communities is likely hampered by an existing regulatory framework that is inconsistent with community needs and potentially burdensome.

DSHS is responsible for both regulatory oversight of healthcare facilities and encouraging development of successful community options for mental health and substance abuse treatment. However, DSHS has failed to update key rules in accordance with state law, including standards of care in the facilities requiring state licensure. State law requires agencies to review and update rules at least every four years, but many of the rules relating to facility licensure have not been updated since the creation of DSHS 11 years ago.[4] Meanwhile, as DSHS has been pressured to deliver more innovative community alternatives, it has essentially established five facility types through contract to get around the outdated regulations. However, these facilities lack the standard oversight and protection basic regulatory requirements would provide, including standard mechanisms for inspections or complaint investigation. Activities in these facilities can be high-risk, including administration of medications and in some cases, the use of restraint or seclusion.

Some DSHS-funded facilities lack standard oversight.

The benefits of clear, transparent regulation to protect the vulnerable populations served in these facilities will always have to be balanced with the need to provide flexibility and options for local communities to deliver services to individuals in crisis most effectively. The Sunset review revealed the current regulatory structure needs an overhaul with the goals of encouraging development of more community-based facilities while also ensuring that standards exist for safe, humane, and effective treatment of the people served in them.

DSHS' approach to engaging with behavioral health advisory committees lacks transparency and has unnecessarily limited public input.

The state and DSHS would benefit from a revised advisory committee structure to ensure stakeholder input is coordinated, transparent, and focused on improving behavioral health services funded through DSHS. The Texas Sunset Act requires consideration of the efficiency and effectiveness with which advisory committees operate as part of every agency's Sunset review.[5] Given the importance of mental health and substance abuse services and the amount of public interest in these functions, effective public involvement is critical. However, the overall approach to obtaining and using such input has become disjoined, and DSHS has poorly managed the three advisory committees charged with mental health and substance abuse roles, as discussed below. The textbox on the following page, *Key Behavioral Health Advisory Committees* describes the advisory committees' roles.

Key Behavioral Health Advisory Committees

Council for Advising and Planning for the Prevention and Treatment of Mental and Substance Use Disorders (CAP)

- Expanded in 2012 to include substance abuse disorders, this federally-required state mental health planning council reviews DSHS' mental health block grant plan; advocates for people with mental illness; and monitors, reviews, and evaluates allocation and adequacy of mental health services within the state.
- CAP has 24 members, including state agency representatives and mental health, substance abuse, and family member consumers or advocates.

Drug Demand Reduction Advisory Committee

- Created in 2001 to develop a comprehensive statewide strategy and legislative recommendations to reduce drug demand in Texas. Sixteen state agencies participate, as well as five at-large members.

Local Authority Network Advisory Committee

- Created in 2007 to review rules and provide advice on planning and provider network development for local mental health regions. The committee has 16 members with equal representation from eight stakeholder groups.

- **Council for Advising and Planning for the Prevention and Treatment of Mental and Substance Use Disorders (CAP).** To draw down federal mental health block grant funding, the state must have a mental health planning council. For many years, the Mental Health Planning and Advisory Council served this role, but rules authorizing the council expired in January 2012. Currently, CAP serves in this role under a 2011 memorandum signed by the HHSC executive commissioner.[6] DSHS committed to introducing rule changes that would formally define CAP's role and membership requirements in spring 2012, but rules have not yet been adopted. Updated rules would increase transparency for the public and committee members by clearly identifying this large and active committee's duties and membership.

Updated rules would increase transparency for the public and committee members.

- **Drug Demand Reduction Advisory Committee.** Statute requires the committee to meet quarterly; however, the committee has struggled to remain active, and did not meet between October 2010 to March 2014, limiting progress on key substance abuse issues.

- **Local Authority Network Advisory Committee.** This committee has been working to revise rules for the expansion of local mental health provider networks for several years, but DSHS has repeatedly put revisions on hold. DSHS has not updated rules since the committee's first work was adopted in 2007, and has not clearly communicated to committee members the outcomes of previous rulemaking efforts. In addition, this planning process is currently in question due to the upcoming carve-in of behavioral health services into Medicaid managed care, suggesting a separate committee for this purpose may no longer be needed.

Recommendations

Change in Statute

2.1 Require DSHS to integrate mental health and substance abuse hotline, screening, assessment, and referral functions.

This recommendation would require DSHS to better integrate substance abuse and mental health services by limiting eligibility for administration of substance abuse outreach, screening, assessment, and referral functions to a local mental health authority or a behavioral health authority. DSHS should not increase the current number of 13 contract awards for these services, but rather encourage regional collaboration and statewide coverage of these services by a limited number of local authorities to perform these substance abuse functions. As part of this recommendation, DSHS should require authorities to operate a single toll-free hotline for behavioral health instead of separate hotlines for mental health and substance abuse as exist today. This recommendation would encourage integrated delivery of behavioral health services in the most effective manner following national best practices.

2.2 Require DSHS to focus funding equity efforts for local mental health authorities on targeted capacity needs rather than narrow per capita funding.

To develop a more targeted approach to distributing significant community mental health funding, this recommendation would require DSHS to annually evaluate each mental health region's last year of state mental health hospital bed use as compared to the region's per capita community mental health funding. If a region receives more than the average per capita funding and also uses significantly more than its allocation of state mental health hospital beds, DSHS would work with the region to develop a plan to improve community capacity and ensure effective use of funding. Under this recommendation, DSHS could also consider factors such as the availability of local funding and resources when developing the plan.

Using all or a portion of a region's funding above the per capita average, DSHS and the local authority would create and commit to a plan to address the community's identified needs and objectives within a two-year period, including developing local alternatives to crisis care. If the local authority fails to meet the objectives outlined in the plan, DSHS would reduce funding to that region and use the money for targeted community improvements in other areas of the state. This recommendation would help increase community mental health capacity, decrease regional overuse of limited state mental health hospital resources, and trade longstanding inequitable funding for sustainable regional performance improvements.

Management Action

2.3 Direct DSHS to evaluate and improve its behavioral health performance measurement and contracting processes.

This recommendation would direct DSHS to complete a strategic review of mental health and substance abuse measures and metrics used to assess client outcomes, program effectiveness, and contractor performance no later than September 1, 2015. The review should ensure behavioral health measures reflect evidence-based practices and allow apples-to-apples comparisons of services provided to clients who receive services through a variety of DSHS and HHSC funding streams, programs, and providers. Under this recommendation, DSHS should work with HHSC, relevant advisory committees, contractors, and other stakeholders, including clients and their families, community, law enforcement, judicial, and criminal justice representatives to evaluate DSHS' performance measurement approach.

Specifically, DSHS should focus its efforts on refining the number of measures used and ensuring the measures facilitate comparison with similar efforts in other states and with services delivered in managed care and fee-for-service environments. This recommendation would direct DSHS to evaluate measures to improve client outcomes and handoffs, such as discharges from a state mental health hospital, within the system with a focus on areas where overlapping responsibilities may confuse responsibility, and clearly identify responsibility and targets for such measures. DSHS would prepare and submit a report to the HHSC executive commissioner and DSHS commissioner, providing an evaluation of the current measures, and suggesting modifications or new measures if needed. This strategic review will help to ensure that future service delivery to people in crisis and with ongoing long-term treatment needs is targeted, effective, and coordinated.

The recommendation would also direct DSHS and HHSC to jointly identify roadblocks to the timely processing of DSHS provider contracts and eliminate those barriers. The agencies should set clear timelines for processing contracts, and develop and publish criteria to be used in evaluating provider contract applications. DSHS should inform providers periodically on their pending contracts' status and establish a single point of contact for contract questions at the agency. DSHS staff should also provide the DSHS commissioner with updates on contracting progress at least monthly to ensure the agency is meeting its contracting targets.

Change in Statute

2.4 Require DSHS to overhaul regulations for community-based behavioral health treatment facilities, including creating new license types if necessary.

The recommendation would require DSHS to conduct a comprehensive review of current regulatory standards and contract requirements governing treatment facilities for people with mental health and substance abuse issues. Staff responsible for regulatory functions and behavioral health service delivery should work together, along with stakeholders, to identify best practices and unnecessary barriers to effective delivery of services. DSHS should develop updated rules for consideration by CAP, the State Health Services Council, DSHS commissioner, and HHSC executive commissioner by September 1, 2016. The recommendation would provide DSHS limited authority to create new crisis and treatment facility types for delivering community-based services according to best practices, and would require that state funding be prioritized to facilities that meet the new, updated regulatory standards. DSHS' authority to create such facility types would be limited to residential settings where the facility provides onsite mental health and/or substance abuse professional services. As updated rules are adopted, DSHS should refrain from creating additional facility types through contract. Updating the regulatory framework would ensure that facilities meet current standards for patient care and effective treatment, and would promote development of innovative services that provide the most effective and safe community-based treatment possible.

2.5 Remove two DSHS advisory committees from statute.

This recommendation would remove the Local Authority Network Advisory Committee and the Drug Demand Reduction Advisory Committee from statute. Removing the committees from statute would allow DSHS to carry forward certain responsibilities in rule in a more streamlined fashion, as described in Recommendation 2.6.

Management Action

2.6 Direct DSHS and HHSC to establish the Council for Advising and Planning for the Prevention and Treatment of Mental and Substance Use Disorders in rule.

This recommendation would clarify and revise the existing duties of CAP and streamline other efforts to receive stakeholder input regarding DSHS' mental health and substance abuse programs. No later than September 1, 2015, DSHS should propose rules clearly authorizing CAP to perform duties required to satisfy requirements for a mental health planning council under federal law, establishing membership, and reflecting duties.[7] The DSHS commissioner should make all appointments to CAP, except that representatives from other agencies should be appointed by their agency's executive officer. At the discretion of the commissioner of health, current members would be eligible for re-appointment to CAP. Rules should direct the state health services council to consider CAP's input, and clearly charge CAP with providing regular input to the state health services council, including an annual report recommending ways to improve outcomes for people receiving treatment through DSHS-funded or DSHS-operated behavioral health programs. Rules should direct DSHS to provide CAP with a written response to the recommendations included in its annual report to the agency.

While Recommendation 2.6 would remove the Drug Demand Reduction Advisory Committee from statute, this recommendation would direct DSHS to assign CAP with the Committee's current statewide strategy development, informational, and reporting roles.

While Recommendation 2.6 would remove the Local Area Network Advisory Committee from statute, this recommendation would direct DSHS to assign CAP with clear authority to advise the HHSC executive commissioner and DSHS regarding evaluation and coordination related to local mental health authority or local behavioral health authority operations.

Fiscal Implication

Overall, these recommendations would not result in a significant fiscal impact to the State. Integration of front-door mental health and substance abuse services at the local level should reduce local operating costs, resulting in better use of funds for services instead of administration. However, costs to the state would not be reduced. Targeting some funding for interventions that reduce use of the state mental health hospital system would lead to more effective use of state funding, but actual cost reductions are unlikely given the overall demand for these services.

[1] Figures provided by DSHS or based on the following: Federal Register, *Estimation Methodology for Adults with Serious Mental Illness (SMI)* (Washington, DC: Federal Register, 1999), pp. 33890-33897; National Association of State Mental Health Program Directors Medical Directors Council, *Morbidity and Mortality in People with Serious Mental Illness*, accessed May 9, 2014, http://nasmhpd.org/docs/publications/MDCdocs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *2010–2011 National Survey on Drug Use and Health* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012), Table 98; Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health, 2010*, accessed April 15, 2014, http://www.samhsa.gov/data/nsduh/2k10MH_Findings/2k10MHResults.htm.

[2] Substance Abuse and Mental Health Services Administration, *Integrating Mental Health and Substance Abuse Treatment*, accessed April 16, 2014, http://samhsa.gov/co-occurring/topics/healthcare-integration/index.aspx.

[3] Texas Legislative Budget Board, "A Comparison of Behavioral Health Data Across NorthSTAR and Other Selected Service Delivery Areas," in *Texas State Government Effectiveness and Efficiency* (Austin: Texas Legislative Budget Board, 2011), p. 275.

[4] Section 2001.039, Texas Government Code.

[5] Section 325.011, Texas Government Code.

[6] "The Council for Advising and Planning (CAP) for the Prevention and Treatment of Mental and Substance Use Disorders," Texas Department of State Health Services, last modified April 24, 2014, https://www.dshs.state.tx.us/mhsa/cap/.

[7] 42 C.F.R. Sections 300x–3 and 300x–4.

Responses to Issue 2

Recommendation 2.1

Require DSHS to integrate mental health and substance abuse hotline, screening, assessment, and referral functions.

Agency Response to 2.1

DSHS supports the recommendation to integrate mental health and substance abuse hotline, screening, and assessment functions. A single toll-free hotline for behavioral health should make it easier for the public to access services and ensure a comprehensive assessment of behavioral health needs. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 2.1

John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin

Janie Metzinger, Public Policy Director – Mental Health America of Greater Dallas, Dallas

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 2.1

Cynthia Humphrey, Executive Director – Association of Substance Abuse Programs Texas, Kerrville

Recommendation 2.2

Require DSHS to focus funding equity efforts for local mental health authorities on targeted capacity needs rather than narrow per capita funding.

Agency Response to 2.2

DSHS agrees that the targeted capacity approach will help to better focus the system on mental health needs in communities across the state. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 2.2

John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 2.2

Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin

Janie Metzinger, Public Policy Director – Mental Health America of Greater Dallas, Dallas

Sunset Member Modifications

1. Replace the staff recommendation with the following. Require a new process for developing the State Hospital Allocation Methodology (SHAM). Require that the current methodology be replaced by a regional state hospital bed allocation methodology developed by the Local Mental Health Authorities (LMHAs) on a regional basis. Regions should be determined by HHSC with input from LMHAs. The regional allocation must be approved by HHSC, and the agency may disapprove the allocation if it fails to demonstrate fairness across the state. HHSC must determine a daily use fee to be assessed on a quarterly basis for each bed day an LMHA goes over its allocation. All collections of daily use fees are to be distributed to LMHAs who underuse their bed allocation on a quarterly basis, in proportion to their underuse. The current SHAM shall continue to be used until a new allocation methodology is developed. (Senator Jane Nelson, Chair and Representative Four Price, Vice Chair – Sunset Advisory Commission)

2. Direct DSHS to review current methods for allocating regional mental health funding and determine whether the allocations match the prevalence of mental illness in associated regional populations. (Representative Harold V. Dutton, Jr., Member – Sunset Advisory Commission)

Modifications

3. Direct DSHS to continue addressing inequities in mental health funding by the state. Funding and outcomes should match the allocated GR funding and the DSHS assigned targets associated with that funding, as a direct correlation. Local communities should not be punished for providing additional resources to supplement state funding. The State's funding formulas should be evaluated from a scientific, actuarial standpoint, where actual need and appropriations have a strong correlation. (Representative Ruth Jones McClendon, Member – Texas House of Representatives)

4. Direct DSHS to base the state hospital allocation system on a rational funding approach. If there are wait lists for civil patients, plans should be developed to eliminate wait lists. DSHS should track the frequency, locality, and reasons for requests for state beds when the requests are not fulfilled, to monitor the need for greater capacity. (Representative Ruth Jones McClendon, Member – Texas House of Representatives)

5. Ensure that allocation methodologies used by DSHS do not increase inequity in regional mental health allocations. (The Honorable Nelson W. Wolff, County Judge – Bexar County on behalf of the Center for Health Care Services, San Antonio)

6. Use new funds to achieve equity, but do not achieve equity by cutting funds from one local mental health authority service area and redistributing the funds to other local mental health authorities. (Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin)

7. Direct DSHS to convene a task force to consider equitable distribution of mental health funding. (Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin)

8. Require DSHS to focus funding efforts for local mental health authorities by targeted capacity needs, such as developing alternatives to hospitalization, and a population-based per capita funding methodology that ensures access to basic mental health crisis and treatment services in urban and rural areas of the state. (Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin)

9. End the current method of allocating mental health funding and commission an independent actuarial analysis for allocating funding fairly. Require the results of the analysis to be reported to the Legislature and the Health and Human Services Commission. The analysis should include rural and urban concerns, such as the higher percentage of people with serious and persistent mental illness and higher acuity levels in urban areas, and the shortage of qualified personnel in rural areas, as well as the possible efficiencies of telemedicine, and telepsychiatry, particularly in rural areas. (Janie Metzinger, Public Policy Director – Mental Health America of Greater Dallas, Dallas)

10. Require funding equity in statute. Take into account considerations such as poverty, unemployment, growth, access to providers, rural versus urban issues, in addition to state hospital bed usage. (Gyl Switzer, Public Policy Director – Mental Health America of Texas, Austin)

Recommendation 2.3

Direct DSHS to evaluate and improve its behavioral health performance measurement and contracting processes.

Agency Response to 2.3

DSHS supports this directive and already includes incentives for achieving targets in performance contracts. DSHS will continue to work in coordination with HHSC on improvements to the contracting process, and will implement an ongoing reporting process to keep the Commissioner apprised of the status of contract execution across the department. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 2.3

Representative Ruth Jones McClendon, Member – Texas House of Representatives

John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin

Amy Granberry, CEO – Charlie's Place Recovery Center, Corpus Christi

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Janie Metzinger, Public Policy Director – Mental Health America of Greater Dallas, Dallas

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 2.3

None received.

Sunset Member Modification

11. Replace the staff recommendation with the following. Require HHSC, using third party expert assistance in the area of health purchasing, to conduct a strategic review to evaluate and improve its performance measures and payment mechanisms across all DSHS contractors of behavioral health services. Require the review and deliverables to take place in three phases.

    - ***Phase 1***: Review must identify performance measures that are not required by state statute or federal requirement, particularly those that measure inputs or processes, rather than outcomes, for elimination from contracts. The metrics and methodology associated with the 10 percent withhold for LMHAs must also be reviewed and refined. Consideration must be given to adopting similar strategies associated with MCO measures and accountability processes. Measures identified for elimination shall be deleted from contracts and the refined withhold metrics implemented no later than September 1, 2015.

    - ***Phase 2***: HHSC and the external entity shall develop outcome measures based on best practices in performance measures and contracting. HHSC must use a subset of priority outcome measures to develop and implement incentive payments and financial sanctions. Assessment of incentives and sanctions must be aligned with models used at HHSC to purchase healthcare services. DSHS and HHSC shall jointly identify roadblocks to the timely processing of behavioral health provider contracts and determine ways to eliminate those barriers, and streamline contracts and performance measure reporting requirements to minimize administrative burden. New outcomes-based purchasing requirements and streamlined contracts must be implemented no later than September 1, 2016.

    - ***Phase 3***: By December 1, 2016, HHSC shall develop a web-based dashboard available to the public to allow for comparisons across behavioral health providers.

    (Senator Jane Nelson, Chair and Representative Four Price, Vice Chair – Sunset Advisory Commission)

Modifications

12. Direct the reform effort to prioritize outcomes over process and eliminate all metrics currently not required by state rule or federal regulation. Direct HHSC to develop a priority subset of metrics — 10 should be the initial target — and streamline all remaining metrics. Wherever possible, DSHS should ensure that performance measures and contract requirements for mental health and substance abuse services be outcome-based and emphasize performance improvement. Process-based measures (or outputs) should be eliminated. (John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin)

13. Amend the 10 percent withhold to a sanction of 2 percent of the contract amount or less, tied to a core set of performance metrics, to both incentivize compliance and be credible. (John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin)

14. Direct DSHS to mirror contract requirements for general funds to Local Mental Health Authorities on contract requirements for other HHSC purchasing, and include performance incentives for reaching specific goals (decline in ER use, hospital readmissions, use of jails, etc.). (John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin)

15. Direct DSHS to use person-level, disease-independent quality of life outcome measures to guide service design and implementation rather than focusing on program or service integration. (Wayne Gregory, Chair – Subcommittee on Mental Health/Substance Abuse Integrated Outcomes, Council for Advising and Planning for the Prevention and Treatment of Mental and Substance Use Disorders, Woodway)

Recommendation 2.4

Require DSHS to overhaul regulations for community-based behavioral health treatment facilities, including creating new license types if necessary.

Agency Response to 2.4

DSHS supports this recommendation and will work together with stakeholders to identify needed changes to existing standards and identify new license types needed to implement best practices in service delivery. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 2.4

John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 2.4

None received.

Recommendation 2.5

Remove two DSHS advisory committees from statute.

Agency Response to 2.5

DSHS supports this recommendation. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 2.5

John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 2.5

Amy Granberry, CEO – Charlie's Place Recovery Center, Corpus Christi

Cynthia Humphrey, Executive Director – Association of Substance Abuse Programs Texas, Kerrville

Gyl Switzer, Public Policy Director – Mental Health America of Texas, Austin

Recommendation 2.6

Direct DSHS and HHSC to establish the Council for Advising and Planning for the Prevention and Treatment of Mental Health and Substance Use Disorders in rule.

Agency Response to 2.6

DSHS supports establishing this council in rule. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 2.6

John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 2.6

None received.

Sunset Member Modification

16. Replace the staff recommendation with the following. Direct HHSC to establish an enterprise-wide behavioral health advisory committee to provide regular input and recommendations to the Executive Commissioner regarding behavioral health programs and issues across the health and human services system.

    The Executive Commissioner shall adopt rules specifying the makeup and duties of the committee and appoint members by September 1, 2015. The rules shall clearly specify that the existing functions of the Council for Advising and Planning for the Prevention and Treatment of Mental and Substance Use Disorders (CAP) will continue as a sub-committee and meet requirements for a mental health planning council under federal law. Existing duties of the Drug Demand Reduction Advisory Committee regarding statewide strategy development, informational, and reporting roles shall also be incorporated into the enterprise-wide advisory committee's duties. Rules should require the Executive Commissioner to provide the committee with a written response to formal recommendations adopted by the committee. (Senator Jane Nelson, Chair and Representative Four Price, Vice Chair – Sunset Advisory Commission)

Modification

17. Direct DSHS to improve the effectiveness of CAP by providing significant staff support and mentoring; meetings on evenings and weekends; careful vetting of applicants with realistic presentation of requirements; and significant involvement of involved stakeholders/advocates. (Gyl Switzer, Public Policy Director – Mental Health America of Texas, Austin)

Commission Decision on Issue 2

The Sunset Commission adopted staff recommendations 2.1, 2.4, and 2.5 in Issue 2. In lieu of staff recommendations 2.2, 2.3, and 2.6, the Commission adopted the following modifications.

- On Recommendation 2.2, regarding funding for local mental health authorities, Modification 1 replaces the staff recommendation and requires a new process for allocating state hospital beds among local regions according to certain criteria; and Modification 2 as modified directs DSHS to review current methods for allocating regional mental health funding, including all related costs and other factors associated with providing mental health services in a given region, and determine whether the allocations match the prevalence of mental illness in associated regional populations.
- On Recommendation 2.3, regarding behavioral health performance measurement and contracting, Modification 11 replaces the staff recommendation and requires a three-phased plan for conducting a strategic review to evaluate and improve performance measures and payment mechanisms across all DSHS contractors of behavioral health services.
- On Recommendation 2.6, formalizing behavioral health advisory bodies, Modification 16 replaces the staff recommendation and directs HHSC to establish an enterprise-wide behavioral health advisory committee to provide regular input and recommendations to the Executive Commissioner regarding behavioral health programs across the health and human services system.

Issue 3

The Unmanageable Scope of DSHS' Regulatory Functions Reduces Needed Focus on Protecting Public Health.

Background

Few other entities in Texas state government match the scope and diversity of the regulatory functions at the Department of State Health Services (DSHS). With a fiscal year 2013 budget of about $70 million and approximately 756 full-time staff, DSHS administers more than 70 regulatory programs, with about 360,000 licensees. The textbox, *DSHS Regulatory Categories*, describes the broad categories of regulatory programs, and Appendix E provides information on each program. DSHS sets standards; issues licenses, certifications, and registrations; conducts compliance activities and complaint investigations; and takes enforcement actions when warranted.

DSHS Regulatory Categories

- Emergency medical and trauma services
- Environmental health
- Food and drug safety
- Healthcare facilities
- Healthcare professionals
- Radiation use

The Sunset Advisory Commission has a historic role in evaluating licensing and regulatory functions of state agencies, as the increase of occupational licensing programs served as an impetus behind the creation of the Commission in 1977. Since then, the Sunset Commission has completed more than 100 licensing agency reviews, guided by the Sunset Act's mandate to address the need for these agencies and possible reorganization to merge duplicative functions. Last session, the Legislature re-emphasized the need for a rigorous assessment of state licensing by adding specific criteria for reviews of occupational and professional programs, as summarized in the textbox, *Sunset Questions for Occupational Licensing*.[1]

Sunset Questions for Occupational Licensing

- Does the occupational licensing program serve a meaningful public interest and provide the least restrictive form of regulation needed to protect the public interest?
- Could the program's regulatory objective be achieved through market forces, private certification and accreditation programs, or enforcement of other law?
- Are the skill and training requirements for a license consistent with a public interest, or do they impede applicants, particularly those with moderate or low incomes, from entering the occupation?
- What is the impact of the regulation on competition, consumer choice, and the cost of services?

Typically, in these types of Sunset reviews, the consideration of the need for occupational regulation has rested on the State's legitimate interest in the way certain jobs are performed. The State establishes qualifications to determine who can perform these jobs and the standards by which they must be performed, and then enforces these standards. Such significant intrusions into the workplace must be justified by a clear threat to the health, safety, or welfare of the public. Because the nature of Sunset reviews is to determine the need for agencies and programs, the burden has always been on proving the need for the regulation. The assessment of need has occurred through a detailed analysis of the potential harm in discernable terms of death, injury, or illness, and also in more subjective terms of well-being, such as financial or economic loss. Sunset reviews also consider organizational alternatives to more efficiently or effectively provide regulation if needed.

Even with such detailed analysis, any attempt to scale back or streamline state regulation is difficult due to an array of factors that seem to favor the creation and perpetuation of regulatory programs. These factors include the active interest of the regulated community to be regulated and to exert control once regulation has been established; the compromises with other potentially affected practitioners that essentially buy their silence by allowing them to continue their work unabated, typically through exemptions from the regulation; the public's lack of awareness of these regulations until they are already in place; and the budgetary impact to the State of deregulation from lost fee revenue that regulatory programs routinely generate well in excess of the cost of their operations.

The Sunset review focused on streamlining the multitude of DSHS' regulatory responsibilities so the agency can better perform its functions that clearly impact public health. The goal is to focus regulatory efforts on areas of true state interest and to provide more effective regulation of these areas. Given the enormous scope of DSHS and the difficult task of the Sunset review to understand and identify its appropriate mission, goals, and objectives, the luxury of a detailed analysis of each regulatory program was simply not possible. Instead, Sunset staff took a broader view of DSHS' regulatory programs to see how they fit within the agency's important mission of protecting and promoting health for all of Texas. Sunset staff based its analysis on a series of criteria for assessing the need and organizational structure of DSHS' regulatory programs, and not simply rubber-stamping the existing approach because all of these programs have some relation to "health." As part of this effort, and to allow for the most fair and comprehensive analysis possible, Sunset staff also applied these criteria to occupational licensing programs administered by DSHS that have their own future Sunset dates. The material below describes the results of this analysis.

Findings

Continued regulatory expansion combined with shrinking resources has created an unmanageable undertaking and ineffective structure at DSHS.

Despite many distractions, DSHS' core mission has remained protecting and promoting public health.

- **Some regulatory programs support DSHS' primary role while others are distractions.** When the Legislature combined multiple agencies and functions into what is now DSHS in 2003, the result was the creation of a health services agency rather than a traditional public health agency. Even with the additional responsibility of providing behavioral health services, DSHS' core function has nevertheless remained protecting and promoting public health for the population as a whole. However, while certain regulatory responsibilities clearly fit with DSHS' overall public health mission, others more focused on providing health services to individuals distract from it. Preventing and controlling diseases are critical public health functions that DSHS accomplishes in part through regulating various facilities and products the public consumes or uses in mass quantity. DSHS regulatory staff also administers programs atypical of public health regulation that nevertheless have a significant impact on public health and safety. The textbox on the following page, *Additional Duties of DSHS Regulatory Staff*, lists these programs. In contrast, occupational licensing programs bearing no direct connection to any of the agency's larger public health regulatory responsibilities serve as a distraction from these core efforts. These programs deal with the concerns and complaints of individual

clients and practitioners that typically relate to practice issues involving the facts of a specific situation and not any overarching public health impact or outcome.

Additional Duties of DSHS Regulatory Staff

- Developing and coordinating the state's EMS and trauma system.
- Conducting radiological emergency preparation and response.
- Managing and maintaining reports of hazardous chemical inventories to ensure chemical manufacturers inform the public and facilitate emergency response planning.
- Administering the Medical Advisory Board, a panel of physicians with whom the Department of Public Safety consults to determine if certain individuals can safely be issued a driver or concealed handgun license.

- **Continued expansion has rendered DSHS a regulatory "dumping ground."** The 2003 reorganization of health and human services resulted in DSHS becoming an enormous administrative umbrella for numerous regulatory programs left over from predecessor agencies. Little rationale exists for placing many of the more than 70 regulatory programs at DSHS beyond a vague connection to health and a misguided attempt at administrative efficiency and improved regulatory effectiveness.

  The number of licensees in these programs grew by more than 44 percent from 2002 to 2012, outpacing the state's population growth of 20 percent during the same time period.[2] All of these additional responsibilities bring with them an increased need for resources to serve a meaningful, effective regulatory role, requiring labor-intensive inspections, investigations, and enforcement activities. Most regulatory programs at DSHS are designed to be self-funded through fees collected from the regulated businesses, but the Legislature routinely keeps more of the revenue these programs generate rather than appropriating it to strengthen the regulatory effort. In fiscal year 2013, the State kept more than one-third of fee revenue generated — $21 million.

Little rationale exists for placing more than 70 regulatory programs at DSHS.

- **Diverse programs complicate standardization, reducing efficiency.** The goal of achieving efficiency by streamlining administration of fundamentally different programs such as occupational licensing, radiation control, and healthcare facilities regulation in the same agency has proven to be an impossible task at DSHS. When regulatory functions are very similar, such as the streamlined occupational licensing programs at the Texas Department of Licensing and Regulation (TDLR) discussed below, cross training staff on standard processes across key functions has been successful. However, the diversity of programs at DSHS has presented numerous challenges to achieving such efficiencies, as the same employees must be experts in widely diverse and highly technical regulatory environments well beyond the regulatory demands of occupational licensing. As a result, many employees tend to become "jacks of all trades but masters of none"

to the detriment of both the efficiency and the quality of regulation. Not surprisingly, Sunset staff heard from many regulatory program stakeholders who find DSHS' responsiveness slow or lacking accuracy. Meanwhile, DSHS regulatory staff is always behind the curve in keeping regulations current. Each session, the Legislature passes 25 to 30 bills with changes to these regulatory programs, and DSHS struggles to update rules to implement the changes. DSHS is simply unable to effectively manage these numerous and diverse programs and must leave important efforts to keep regulatory best practices current on the back burner indefinitely.

DSHS struggles to effectively manage numerous and diverse regulatory programs.

- **Fulfilling multiple responsibilities with limited resources means high-risk programs are stretched thin and low-risk programs are forced to the margins.** Like all governmental entities with limited budgets, DSHS must focus on high-risk activities when faced with difficult resource decisions. Within its finite resources, DSHS must prioritize regulatory programs with the highest potential risk to public health, such as those designed to prevent foodborne illnesses and radiological disasters. In one example, federal requirements concerning radioactive materials inspections increased over the last few years, requiring DSHS to implement new duties with no additional resources, which in turn reduces resources for other programs that are important but bear a lower level of risk, such as inspecting facilities that use x-ray machines on patients.

  Meanwhile, other programs never reach a high enough level of risk to merit attention given the scope of DSHS' responsibilities and its need to prioritize resources. Occupational regulation will always receive less attention than inspections of the state's food supply because the direct risk to public health is much less. Due to limited resources, many of DSHS' regulatory programs are reactive and complaints-driven, including most environmental health regulation, such as inspections of public lodging and public swimming pools, and time between inspections must be extended. For example, the healthcare facility regulatory program experienced a more than 100 percent increase in its licensee population from 2002 to 2012. As a result, the frequency of healthcare facility inspections, which should occur every two to three years, now allows some facilities to operate for up to eight years without receiving an inspection from state regulators. More disturbing is the fact that, for several occupational licensing programs, DSHS does not have the resources to even investigate complaints at all, and instead only sends letters to alleged violators informing them of the purported noncompliance. For other programs, such as the inspection of indoor air quality at state office buildings, DSHS has simply discontinued performing any regulatory duties at all.

DSHS does not have the resources to investigate complaints for several programs.

Within DSHS, 19 regulatory programs duplicate existing safeguards, have little regulatory activity, and could be safely eliminated.

To assess the need for DSHS regulatory programs, Sunset staff gathered standard data on the more than 70 programs and developed criteria for analysis. The following material describes the criteria indicating a reduced

need for regulation and provides examples for how these criteria would apply to the different programs. Because of the magnitude of any potential decision to deregulate an activity or occupation, Sunset staff concluded that only programs meeting at least two criteria of lower regulatory need would be considered for deregulation. Most programs met three or more criteria. The results of this analysis are summarized in the chart, *Programs to Discontinue*, on the following page.

- **Low risk to public health.** For each regulatory area, DSHS uses a risk-based matrix to ensure programs posing the highest risk receive the most attention through inspections and investigations. These risk matrices compare license types against each other based on risk factors such as the primary consumers, number of consumers, and risk to consumers if an error occurs. In consultation with DSHS, Sunset staff studied these tools and identified programs that, if discontinued, would have little impact on public health or safety. All of the programs suggested for deregulation fit this category. For example, the bedding permit program prescribes requirements for manufacturing, sanitizing, and selling new and used bedding, including craft bedding, such as homemade quilts. The program's origins trace back to the 1930s when diseases like small pox were still a concern, but the program no longer has a direct relationship to public health, as the likelihood of serious disease transmission via bedding products is minimal.

  Discontinuing numerous programs would have little impact on public health or safety.

  Another example is DSHS' regulation of rendering — the handling and processing of primarily dead animals and plants and other raw materials into usable products such as lard, tallow, and source material for bio diesel. Renderers' products are not intended to be used for direct human consumption. Products that contain rendered materials, like soap and personal care items, are covered by other major regulations, such as those governing the manufacturing and distribution of drugs and cosmetics. Complaints in this program are frequently filed by license holders and relate to the theft of cooking grease or other renderable raw materials, which is a law enforcement issue.

  Theft of cooking grease should not be a state regulatory issue.

- **Practice takes place in a highly regulated environment.** As part of the risk analysis, Sunset staff considered the level of regulation in the environments in which licensees operate. Perfusionists, for example, perform the important role of operating a heart-lung machine during medical procedures like cardiac surgeries, so state regulation of this duty may at first glance seem essential. However, the environment in which these professionals work adequately ensures patient safety and obviates the need for a state license. Perfusionists always operate in healthcare facilities, such as hospitals, which must adhere to multiple federal and state regulatory requirements including proper training of the healthcare professionals they employ. Training of these professionals can be achieved through numerous private sector programs and does not require state licensure to implement. Perfusionists also work under the direct supervision of other highly trained healthcare professionals who are primarily responsible for the patient's outcome, such as cardiac surgeons, anesthesiologists, and nurses.

Programs to Discontinue

Criteria	Would deregulation have little impact on public health or safety?	Do practitioners operate in a highly regulated environment?	Is regulation also provided by another state or local regulatory program, or private sector accreditation?	Does the program generate little regulatory activity?	Can consumers access enough information to make informed choices regarding this industry or field?	Does the program merely prohibit the use of a title, making regulation optional?
Programs						
Occupational						
Bottled/ Vended Water	x		x	x	x	
Certified Food Handlers	x		x	x	x	
Certified Food Managers	x		x	x	x	
Code Enforcement Officers	x		x	x		x
Contact Lens Dispensers	x			x	x	
Dietitians	x		x	x		x
Dyslexia Therapists and Practitioners	x			x		x
Medical Physicists	x	x	x	x		
Medical Radiologic Technologists	x	x	x	x		
Mold Assessors and Remediators	x		x	x	x	
Opticians	x		x	x	x	x
Offender Education Providers	x			x	x	
Perfusionists	x	x	x	x		
Personal Emergency Response System Providers	x			x	x	
Respiratory Care Practitioners	x	x	x	x		
Non-occupational						
Bedding	x			x	x	
Indoor Air Quality in State Buildings	x			x	x	
Rendering	x			x	x	
Tanning Bed Facilities	x		x	x	x	

Medical radiologic technologists, sometimes referred to as x-ray technicians, are another group of professionals who operate in a highly regulated environment. These trained practitioners perform radiological procedures, such as mammograms, CT scans, and MRIs. Like perfusionists, they operate in healthcare facilities subject to numerous federal and state requirements, including separate regulation of the machines themselves, have private accreditation programs, and work in conjunction with several other highly trained healthcare professionals.

Little rationale exists for regulating some healthcare positions and not others.

Many other technical positions in the healthcare field are staffed by practitioners such as anesthesiologist assistants and dialysis, surgical, and laboratory technicians whose professions are not state-regulated. Although a state occupational license is not required in these examples, the scope of practice is subject to standards governing training credentials and the facilities, patients, and equipment with which they work. These examples suggest a similar arrangement is feasible for similar technical professions currently regulated by DSHS without lowering standards for these practices.

- **Additional, unnecessary layers of regulation.** In several instances, the regulation provided by DSHS is in addition to regulation already provided by another state regulatory program, a local regulation, or private, national accreditation. For example, companies that manufacture and sell bottled water in Texas are required to hold a DSHS-issued food manufacturer license and must also employ a person with a separate DSHS-issued bottled and vended water certification. DSHS also administers a program to accredit food safety education and training programs for food handlers such as restaurant workers, but state law already ensures safety of food establishments by requiring them to be licensed by a local government or DSHS.

Several indicators suggest mold regulation is redundant and unneeded.

Sunset staff also considered whether national standards or a nationally recognized accrediting body for the profession or practice exists when suggesting programs for deregulation. As discussed above, DSHS-licensed technical positions such as perfusionists and x-ray technicians have duplicative national accreditation programs available in the private sector. In the case of food safety training, a national entity provides online food safety education based on U.S. Food and Drug Administration principles. Another example is how Texas standards for the state dietitian regulatory program are entirely based on standards set by the American Dietetic Association; DSHS simply makes sure an individual has received this national accreditation to issue the state license. DSHS' mold assessment and remediation program is another case in point. While state law allows Texas homeowners and owners of properties with less than 10 residential dwelling units to take mold samples and perform mold clean up without a license, the State requires DSHS to license and regulate individuals, companies, and laboratories that perform this function. Texas is one of the few states to adopt licensing requirements for mold businesses, but several indicators suggest this program is redundant and unneeded.[3] The U.S. Environmental Protection Agency provides guidance for mold remediation in structures; the American Industrial Hygiene Association,

a national entity, provides certification of mold assessors; and multiple other private sector trade groups train and certify mold remediators.[4]

- **Little regulatory activity.** In addition to evaluating risk levels, Sunset staff considered the number of licensees, complaints, enforcement actions, and investigations for each program. Low numbers of complaints, investigations, and enforcement actions typically reflect a lower risk of harm. Likewise, a dwindling number of licensees may suggest a field in which professional or industry standards are static or where scope of practice is successfully governed by other regulatory means outside of state licensing and therefore, in less need of government oversight. As previously mentioned, all 19 programs suggested for deregulation have little impact on public health and safety, and 10 of them had little to no enforcement actions in the last three fiscal years. For example, the dyslexia therapist and practitioner program is a voluntary license that did not receive a single complaint or require a single investigation or enforcement action for the last three fiscal years. Contact lens dispensing saw its number of licensees decline for the last three fiscal years from 181 to 155, indicative of the changed marketplace in which non-licensed personnel can participate in this industry. DSHS also did not perform a single investigation or take any enforcement action related to contact lens dispensing in the last two years or for personal emergency response system providers in the last three years.

Low numbers of complaints, investigations, and enforcement actions typically reflect lower regulatory risk.

  Another program that experiences low regulatory activity relates to offender education providers. This program serves individuals who commit alcohol- and drug-related offenses and are must complete a court-mandated education course. Data suggest the occupational licensing aspect of this program is unneeded since DSHS conducted no investigations or enforcement actions in the last two fiscal years on the 2,475 people licensed to provide the education. However, as part of this unique program, DSHS should continue to establish statewide offender education curriculum standards the courts use in sentencing. Also, developing and approving curriculum is not resource-intensive, as the agency receives assistance for this task from universities.

- **Consumers can access enough information to make informed choices regarding the industry or field.** Some of the activities suggested for deregulation mostly relate to matters of consumer choice, which should be governed more by the open market than by state regulation. For the programs related more to fairness for consumers than protecting public health and safety, Sunset staff evaluated whether consumers could reasonably be expected to make informed decisions regarding the service the State is regulating. For some programs, consumers could just as well be served by consulting with the Better Business Bureau, or one of the many consumer-oriented online wiki tools, as by a state regulatory database. Technology has heightened competition for opticians and contact lens dispensers, for example, as customers can now purchase and compare product quality and cost online. Similarly, the personal emergency response system provider program is considered low-risk and DSHS conducted no investigations or enforcement activity relating to these providers in the last three years,

The open market, not state regulation, should govern matters of consumer choice.

indicating state regulation is not providing any real quality control for these services. The companies that DSHS licenses do not participate in the diagnosis or treatment of medical conditions, and consumers can use other information available on the free market to decide whether to purchase these services.

Tanning beds pose some danger to an individual's health related to skin cancer as a result of prolonged skin cell damage, and these risks are well-known by the general public. However, the risk of disease spread from physical contact with the equipment is minimal, making the purpose of state regulation of tanning beds questionable, since DSHS' inspections to ensure proper functioning of equipment is in no way related to the risk of skin cancer that may result from a consumer's choice to frequent such a facility. While state law prohibits tanning services from being provided to minors, as enacted by the 83rd Legislature, state regulation is not needed to enforce this requirement, and consumers have ample information to make informed decisions about whether to purchase these services or not.

Risk of disease spread from physical contact with tanning equipment is minimal.

- **Some programs merely prohibit the use of a title, making regulation optional.** Some regulatory programs' enabling laws prohibit non-licensed persons from providing the service or care a licensed practitioner is trained to provide, but statutes for other programs merely prohibit an individual from using the title of a licensed practitioner. In the case of DSHS' regulation of dyslexia therapists and practitioners, state law does not require a school district to employ a licensed individual, meaning educators may provide services to persons with dyslexia without being licensed. Also, statutes for regulatory programs, such as code enforcers, opticians, and dietitians, allow anyone to perform the work of these professions, as long as the person does not use these titles. In other words, individuals can operate as — and perform every duty of — a registered optician, but they are legally prohibited from identifying or advertising themselves as a "registered" optician. The need for the State to make this distinction is questionable, as is the public's ability to clearly discern any meaningful difference between practitioners with and without a title.

Of the 19 regulatory programs at DSHS identified as having low risk to public health, with little regulatory activity, or duplicative of other safeguards, 12 are health professions or occupations. The textbox, *Health Professions to Deregulate and Number of Licensees*, lists these professions that could be safely eliminated and shows the number of licensees in each program in fiscal year 2013.

Health Professions to Deregulate and Number of Licensees – FY 2013

- Code Enforcement Officers – 2,201
- Contact Lens Dispensers – 155
- Dietitians – 4,946
- Dyslexia Therapists and Practitioners – 1,050
- Medical Physicists – 607
- Medical Radiologic Technologists – 28,375
- Offender Education – 2,475
- Opticians – 112
- Perfusionists – 365
- Personal Emergency Response System Providers – 249
- Respiratory Care Practitioners – 14,568

The Texas Department of Licensing and Regulation can regulate health professions more effectively than DSHS.

- **Regulation of health professions is underserved at DSHS.** Many professions DSHS regulates have a health and safety purpose and should be continued. However, with no direct connection to any of DSHS' larger, public health regulatory activities, DSHS often de-prioritizes these programs and does not adequately address their needs. As listed in the textbox, *Health Professions to Transfer and Number of Licensees*, most of these professions relate more to care delivered at the individual level. Others have more of a connection to the business side of health care, reflected both in how regulations largely center on establishing standards for an industry, and in the types of complaints filed against licensees. For example, most complaints DSHS receives regarding hearing instrument fitters and dispensers are related to consumer fraud rather than consumer health.

Health Professions to Transfer and Number of Licensees – FY 2013

- Athletic Trainers – 3,003
- Chemical Dependency Counselors – 9,363
- Fitters and Dispensers of Hearing Instruments – 727
- Laser Hair Removal – 1,557
- Marriage and Family Therapists – 3,342
- Massage Therapists – 29,701
- Midwives – 219
- Orthotists and Prosthetists – 828
- Professional Counselors – 20,321
- Sanitarians – 1,251
- Social Workers – 22,418
- Speech-Language Pathologists and Audiologists – 17,689

- **TDLR specializes in streamlining occupational licensing.** TDLR's narrow focus on occupational and small industry regulation enables the agency to efficiently administer 25 different regulatory programs, 19 of which have advisory boards, and oversee more than 650,000 licensees. TDLR's uniform approach to occupational licensing allows the agency to accommodate a wide range of regulatory programs, which include the regulation of professions such as property tax professionals and cosmetologists. Additionally, the Legislature has shown a continuing desire to consolidate occupational licensing programs at TDLR, and such programs have historically fared well under the umbrella agency.

- **Independent boards prevent administrative streamlining.** The independent boards connected to 11 of these occupational regulatory programs make up the few autonomous rulemaking bodies at DSHS. Echoing the conclusion of a 2001 consultant report that "independent boards, functioning as quasi-agencies unto themselves, yet operating within the structure of a larger agency, are a fundamental organizational mistake," Sunset staff found that the 11 independent boards place an undue administrative burden on DSHS.[5] Statutes do not clearly define the relationship between the boards and DSHS, which blurs the lines of authority in certain circumstances. DSHS employees assigned to these

programs act as executive directors, reporting both to the independent board, but also to DSHS, essentially serving two masters. Further, no logic supports why some professional regulatory programs have an independent board while others do not. For example, Sunset staff found no reasoning behind why the radiation control program and the EMS program — two DSHS programs that involve regulation of professions — can rely upon advisory committees while the program regulating athletic trainers has an autonomous board with independent rulemaking authority.

- **Creating an independent health licensing agency would needlessly create additional bureaucracy.** In 2004, Sunset staff recommended establishing a Department of Health Professions Licensing, primarily composed of the health professions currently regulated by DSHS.[6] Sunset staff made this recommendation before TDLR had established itself as a proven regulatory model. In the decade since, TDLR has developed a strong record of administrative efficiency and effective regulation. Also, creating a separate health professions regulatory entity would add a new agency to the state budget requiring a separate appropriation of funds. A new agency would have to obtain all new staff for indirect services, such as accounting, purchasing, human resources, networking, information services, general counsel, and contact center personnel. TDLR, on the other hand, would be able to add to infrastructure the agency already has in place.

TDLR has developed a strong record of administrative efficiency and effective regulation.

- **Laser hair removal is not a DSHS priority.** The laser hair removal program is a professional and occupational regulatory program administered as part of the larger radiation control program within DSHS. The program licenses and regulates 1,557 personnel, facilities, and training programs. Laser hair removal is a lower-risk activity whose relevance to consumer protection rather than public health and safety often results in it being relegated below other more critical duties of DSHS' radiation control staff such as establishing and enforcing standards for the handling of radioactive materials and inspecting facilities that provide mammograms and x-rays to patients. Given some risk posed by the equipment used, and because of laser hair removal's close connection to the aesthetician and cosmetology industry already regulated by TDLR, regulation appears warranted but would be better positioned at TDLR.

Recommendations

Change in Statute

3.1 Discontinue 19 regulatory programs currently housed at DSHS.

This recommendation would discontinue state regulation for the following activities to streamline DSHS' operations and fulfill Sunset's charge to examine and eliminate programs that are not critical to ensuring public welfare. While an anecdotal argument can be made to illustrate harm by any program listed below, state regulation does not and cannot prevent such harm. Under this recommendation, all regulatory functions related to the following activities would cease on the effective date of the provision in the resulting Sunset bill:

a. Bottled and Vended Water

b. Certified Food Handlers

c. Certified Food Managers

d. Code Enforcement Officers

e. Contact Lens Dispensers

f. Dietitians

g. Dyslexia Therapists and Practitioners

h. Medical Physicists

i. Medical Radiologic Technologists

j. Mold Assessors and Remediators

k. Opticians

l. Offender Education Providers

m. Perfusionists

n. Personal Emergency Response Systems

o. Respiratory Care Practitioners

p. Bedding

q. Indoor Air Quality in State Buildings

r. Rendering

s. Tanning Bed Facilities

This recommendation would remove from state law the title acts and enabling statutes for the 19 programs as well as any references to the licensure, certification, or registration of any of the professions or practices. However, any requirements or regulations pertaining to the work settings in which these practitioners operate would continue in effect. Individuals who have met the requirements of the appropriate national accrediting organization would maintain their national certificates and their ability to practice in most other states. Eliminating the regulation of these practices would not affect the practice of other practitioners whose profession may be regulated, nor would the recommendation require other regulated professionals to perform any work currently performed by participants in these 19 programs.

While the State would no longer license and regulate providers in the offender education program, DSHS would continue to maintain standards for a uniform statewide offender education curriculum for courts to use in sentencing. Also, while this recommendation would remove the enabling statute for the tanning facility regulatory program, it would retain the restriction prohibiting facilities from allowing minors to use the equipment.

The recommendation would also direct Sunset staff to work with staff from the Texas Legislative Council and DSHS to draft legislation that ensures an orderly discontinuation and administrative wind-down of these programs. In addition, under this recommendation, any licensing or professional fees paid by license holders before the effective date of the resulting legislation would not be refunded. Any enforcement cases open before the effective date would be continued in effect under the terms that existed before the effective date until completion. The recommendation would also remove any licensing fees associated with these programs from statute and rule.

3.2 Transfer 12 regulatory programs from DSHS to the Texas Department of Licensing and Regulation, and reconstitute associated independent boards as advisory committees.

This recommendation would streamline DSHS' regulatory program by moving regulation of 12 occupations and practices to TDLR, where they are better suited and can be more effectively managed. Together, this transfer and the deregulation of the programs in Recommendation 3.1 would essentially end DSHS' involvement in administering occupational licensing programs unrelated to its core public health mission.

Transferring these programs to TDLR would improve the State's regulation of these professionals while keeping current categories of licensure intact. TDLR has the tools available to provide efficient administrative support services and provides a secure and knowledgeable agency structure to efficiently administer regulation while increasing licensee and consumer responsiveness.

- **Phased transfer.** A phased transfer over four years would allow TDLR to absorb the new programs in an orderly and controlled manner. For the following professional licensing programs, this recommendation would convert the independent boards to advisory committees, sever their administrative attachment to DSHS, and transfer all of their regulatory functions to TDLR in two phases occurring from 2015 to 2019. The phased-in approach would transfer professions with similarities in scope of practice, education requirements, and national examinations and professional certifications at the same time.

  Phase 1. The first phase would transfer the following six programs from DSHS to TDLR beginning on September 1, 2015 and would be completed by August 31, 2017.

  a. Chemical Dependency Counselors

  b. Fitters and Dispensers of Hearing Instruments

  c. Marriage and Family Therapists

  d. Orthotists and Prosthetists

  e. Professional Counselors

  f. Social Workers

  Phase 2. The second phase, beginning on September 1, 2017 and completed August 31, 2019, would transfer the remaining six programs from DSHS to TDLR.

  g. Athletic Trainers

  h. Laser Hair Removal

  i. Massage Therapists

j. Midwives

k. Sanitarians

l. Speech-Language Pathologists and Audiologists

- **Reconstitute independent boards as advisory committees to fit TDLR's successful administrative model.** Under this recommendation, the boards' existing authority for registering, certifying, licensing, and taking enforcement action against practitioners, including their rulemaking authority, would be transferred to TDLR. The Commission of Licensing and Regulation, with its all-public membership, would provide needed objectivity and would develop, with the advice of the relevant advisory committees, comprehensive rules to govern all aspects of the transferred regulations. TDLR would also develop a formal relationship with the relevant trade and industry associations and accrediting bodies. Each regulatory program would have its own statute and advisory committee, and TDLR and its Commission would adopt all rules and make all final regulatory decisions currently requiring board action, including decisions regarding the establishment of fees. TDLR would use Chapter 51 of the Texas Occupations Code as a guide in creating consistency of the transferred programs under TDLR's business model. In forming these advisory committees, TDLR should consider the composition of the current independent boards.

- **Remove separate Sunset provisions.** This recommendation would remove the Sunset provision in the enabling statutes of each of these programs, as they would be subject to review under TDLR's existing Sunset provision, currently set for September 1, 2019.

- **Coordinate to provide for a seamless administrative transition.** DSHS would be required to provide TDLR access to all systems and information needed to effectively absorb the programs, including licensing, revenue, and expenditure systems; rights to service contracts and licensing agreements; use of online renewal and new application systems; and review and resolution of pending judgments and outstanding expenditures. This recommendation would also direct Sunset staff to work with staff from TDLR, DSHS, and the Texas Legislative Council to draft legislation that accurately accounts for any other legal and administrative aspects a transfer of this magnitude entails.

Fiscal Implication

Recommendation 3.1 to discontinue 19 regulatory programs would result in the loss of approximately $1.6 million per year to the General Revenue Fund and a reduction of 45 full-time DSHS staff positions, beginning in fiscal year 2016. The loss would result from no longer collecting excess fees from the deregulated programs that are currently deposited in the General Revenue Fund. These programs generate about $4.3 million in annual fee revenue, and the Legislature appropriates DSHS $2.7 million to administer them, including salaries for the 45 full-time staff and other operating costs.

Overall, the fiscal impact of Recommendation 3.2 to transfer 12 regulatory programs from DSHS to TDLR should be cost neutral. TDLR indicates the transfer would result in total one-time startup costs of $1.3 million, half of which would be needed in fiscal year 2016, and the remainder in fiscal year 2018 to pay for equipment and other capital expenses. TDLR should cover these costs by issuing a temporary surcharge on licensees in the transferred programs. On an ongoing basis, the recommendation would require the transfer of 53 full-time equivalent positions and continued annual appropriations of $3.1

million from DSHS to TDLR. TDLR may also need to request additional appropriations and staffing for indirect and support services positions related to the administration of these additional programs, such as additional legal counsel. If approved by the Legislature, these costs would be recovered through fees.

Department of State Health Services (Discontinued Programs Only)

Fiscal Year	Loss to the General Revenue Fund	Change in the Number of FTEs From FY 2015
2016	($1,600,000)	-45
2017	($1,600,000)	-45
2018	($1,600,000)	-45
2019	($1,600,000)	-45
2020	($1,600,000)	-45

…….

1 Section 325.0115(b), Texas Government Code.

2 Division of Regulatory Services at the Department of State Health Services, *Rider 59 Report* (Austin: Department of State Health Services, 2013), p. 9.

3 "Mold: An Old Contaminant Creates New Concerns for Homeowners," Ohio State Bar Association, last modified April 25, 2013, https://www.ohiobar.org/forpublic/resources/lawyoucanuse/pages/lawyoucanuse-283.aspx.

4 "Mold Remediation in Schools and Commercial Buildings," United States Environmental Protection Agency, last modified April 18, 2013, http://www.epa.gov/mold/mold_remediation.html.

5 Elton Bomer, *Texas Department of Health – Business Practices Evaluation* (Austin: Texas Department of Health, 2001), p. 63.

6 Sunset Advisory Commission, *Licensing Reorganization Project* (Austin: Sunset Advisory Commission, 2004), p. 1.

Responses to Issue 3

Sunset Member Modifications to Issue 3

1. On July 24, Chair Nelson appointed a work group chaired by Vice Chair Price and including Senator Schwertner, Representative Dutton, and Dr. Buckingham, to consider Modifications to Recommendations 3.1 and 3.2 in the Sunset staff report on the Department of State Health Services (DSHS). The work group recommends replacing Recommendations 3.1 and 3.2 with the following modifications.

   - Transfer the following four regulatory programs from DSHS to the Texas Medical Board and create associated advisory committees and boards. (FY 2016–2017)

     a. Medical Physicists

     b. Medical Radiologic Technologists

     c. Perfusionists

     d. Respiratory Care Practitioners

     – Medical Physicist Licensure Advisory Committee. The President of the Medical Board would appoint the seven members of the advisory committee to two-year terms. Four members must be practicing medical physicists licensed in this state with at least five years' experience; two must be physicians licensed in this state with five years of related clinical experience; and one must be a member of the general public not licensed in a healthcare profession. Standard provisions for conflicts of interest and removal would apply. Chapter 2110 of the Government Code (general advisory committees) would not apply. The Committee would meet at the pleasure of the Medical Board, and all standard powers and duties relating to medical physicist licensure, including rulemaking, would be retained by the Medical Board.

     – Perfusionist Licensure Advisory Committee. The President of the Medical Board would appoint the seven members of the advisory committee to two-year terms. Four members must be practicing perfusionists licensed in this state with at least five years' experience; two must be physicians licensed in this state who supervise perfusionists; and one must be a member of the general public not licensed in a healthcare profession. Standard provisions for conflicts of interest and removal would apply. Chapter 2110 of the Government Code (general advisory committees) would not apply. The Committee would meet at the pleasure of the Medical Board, and all standard powers and duties relating to perfusionist licensure, including rulemaking, would be retained by the Medical Board.

     – Texas Board of Medical Radiologic Technology. The Board would consist of nine members appointed by the Governor to six-year staggered terms. The Governor would designate the Board's presiding officer. The Board would consist of four medical radiologic technologists licensed in this state with at least five years' experience; two physicians licensed in this state who supervise medical radiologic technologists; and

three members of the general public not licensed in a healthcare profession. The Board would be an advisory board to the Medical Board. Rules would be developed and recommended by the Board with final approval by the Medical Board. The Board would be required to convene at least three times per year. Standard provisions modeled on the Physician Assistant Board (Chapter 204, Texas Occupations Code) would also apply, including provisions regarding: appointments, conflict of interest, terms and vacancies, officers, grounds for removal, per diem, open meetings and administrative procedure, training, general powers and duties, and guidelines for early involvement in rulemaking process.

– Texas Board of Respiratory Care. The Board would consist of nine members appointed by the Governor to six-year staggered terms. The Board would consist of four respiratory care practitioners licensed in this state with at least five years' experience; two physicians licensed in this state who supervise respiratory care practitioners; and three members of the general public not licensed in a healthcare profession. The Board would be an advisory board to the Medical Board. The Governor would designate the Board's presiding officer. The Board would be required to convene at least three times per year. Rules would be developed and recommended by the Board with final approval by the Medical Board. Standard provisions modeled on the Physician Assistant Board (Chapter 204, Texas Occupations Code) would also apply, including provisions regarding: appointments, conflict of interest, terms and vacancies, officers, grounds for removal, per diem, open meetings and administrative procedure, training, general powers and duties, and guidelines for early involvement in rulemaking process.

- Retain the following four regulatory programs at DSHS and consider their placement during the Sunset review of the structure of the mental and behavioral health components of the health and human services system.

  a. Chemical Dependency Counselors
  b. Marriage and Family Therapists
  c. Professional Counselors
  d. Social Workers

- To allow DSHS to focus on public health matters instead of occupational licensing, transfer 12 regulatory programs from DSHS to the Texas Department of Licensing and Regulation (TDLR), and require TDLR to create associated advisory committees for each profession in place of existing boards and committees. In absorbing these functions, TDLR should create a focused health section to ensure development of related expertise.

  Phase 1 (FY 2016–2017)

  a. Athletic Trainers
  b. Dietitians
  c. Hearing Fitters and Dispensers
  d. Midwifery

e. Orthotics and Prosthetics
f. Speech-language Pathologists and Audiologists

Phase 2 (FY 2018–2019)

g. Code Enforcement Officers
h. Laser Hair Removal
i. Massage Therapists
j. Mold Assessors and Remediators
k. Offender Education Providers
l. Sanitarians

- Based on the lack of need for continued state intervention in certain activities and occupations, the Legislature should deregulate the following 11 programs:

  a. Bottled and Vended Water
  b. Certified Food Handlers
  c. Certified Food Managers
  d. Contact Lens Dispensers
  e. Dyslexia Therapists and Practitioners
  f. Opticians
  g. Personal Emergency Response Systems
  h. Bedding
  i. Indoor Air Quality in State Buildings
  j. Rendering
  k. Tanning Bed Facilities (retains equipment regulation and teen prohibitions)

- Retain all directly related instructional language from Recommendations 3.1 and 3.2 in the staff report that is not in conflict with this modification.

(Representative Four Price, Work Group Chair, Representative Harold V. Dutton, Jr., Senator Charles Schwertner, and Dawn Buckingham, M.D., Members – Sunset Advisory Commission)

2. For the professions transferred to the Texas Medical Board (TMB) by the work group modification to Issue 3, require TMB to conduct fingerprint-based criminal background checks, through DPS, on all applicants and licensees to review complete federal and state criminal histories of applicants. New prospective licensees would provide fingerprints at the time of application, and existing licensees would provide fingerprints at the next renewal of an active license. Inactive licensees would submit to the criminal background check before reactivating their licenses. Applicants and licensees would pay a one-time cost directly to the state's fingerprint vendor providing the fingerprint checks, and would not have ongoing

charges for these checks. (Professions transferred to TMB: Medical Physicists, Medical Radiologic Technologists, Perfusionists, and Respiratory Care Practitioners) (Representative Four Price, Vice Chair – Sunset Advisory Commission)

Recommendation 3.1

Discontinue 19 regulatory programs currently housed at DSHS.

Agency Response to 3.1

DSHS believes that narrowing the scope of programs will better focus the agency in its efforts to protect public health and safety. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

Summary of Responses For and Against 3.1

Due to the large number of public responses received regarding Issue 3, they are summarized below. All responses received to the DSHS report are posted online at www.sunset.texas.gov.

Recommendation 3.1	For	Against
a. Bottled and Vended Water	6	2
b. Certified Food Handlers	6	2
c. Certified Food Managers	6	2
d. Code Enforcement Officers	8	135
e. Contact Lens Dispensers	6	21
f. Dieticians	6	27
g. Dyslexia Therapists and Practitioners	6	185
h. Medical Physicists	11	128
i. Medical Radiologic Technologists	14	509
j. Mold Assessors and Remediators	9	211
k. Opticians	6	19
l. Offender Education Providers	7	34
m. Pefusionists	6	24
n. Personal Emergency Response Systems	6	1
o. Respiratory Care Practitioners	8	464*
p. Bedding	6	1
q. Indoor Air Quality in State Buildings	6	1
r. Rendering	6	1
s. Tanning Bed Facilities	6	5

* An additional 13,137 names were collected and submitted through an online survey.

Modifications

3. Keep all of these regulated professions under the umbrella of DSHS and rework the relationship of their respective boards with DSHS staff, including implementing uniformity in board-structure and agency staff, and making staff directly accountable to the licensing boards. (Senator Robert L. Nichols, Member – Texas Senate)

4. Instead of discontinuing state regulation of these professions, transfer licensure functions to the Texas Medical Board, the Texas Department of Licensing and Regulation, or a newly-created, independent board or healthcare licensing agency. (numerous respondents)

5. Instead of discontinuing state regulation of these professions, seek alternatives to streamlining the programs, such as combining license types or discontinuing certain registration programs. (numerous respondents)

6. For the professions suggested for deregulation with independent private sector accrediting organizations, statutorily require these certifications to practice the profession in Texas. (numerous respondents)

Recommendation 3.2

Transfer 12 regulatory programs from DSHS to the Texas Department of Licensing and Regulation, and reconstitute associated independent boards as advisory committees.

Agency Response to 3.2

DSHS is prepared to coordinate with TDLR to ensure a seamless transition of the programs. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

Affected Agency Response to 3.2

The Texas Department of Licensing and Regulation appreciates the confidence you and your staff have shown in us by recommending that 12 programs be transferred from DSHS to our agency. Below are reasons why Recommendation 3.2 can be fully implemented by TDLR as well as key challenges and recommended modifications regarding the Recommendation.

Key Points Supporting Sunset Recommendation 3.2

- Alignment with TDLR's Mission. Sunset Recommendation 3.2, proposing to transfer 12 DSHS programs to TDLR, fits our mission as the state's premier occupational licensing agency. Our expertise is in managing and developing programs that have seemingly little or no affinity, yet we make them work due to our functional alignment business model. Programs with a history of neglect or ongoing problems will find that TDLR is relatively small enough to pay close attention to their needs, yet large enough to offer the experience, expertise and services to make the programs more efficient and effective.

- TDLR's Agility and Flexibility. One of TDLR's greatest strengths is our size. We are a relatively small agency, but we take on big responsibilities. While we currently serve over 650,000 licensees (and do so efficiently and capably) we do so with less than 400 employees

statewide. We are not a large government bureaucracy; we are lean, nimble, and responsive to the changing needs of Texas lawmakers, our licensees, consumers, and the public. Our flexibility and functional alignment model allows us to absorb certain types of licensing programs with little to no disruption or negative effect to the individual licensee.

- TDLR's Experience with Program Transfers. TDLR has achieved excellent results from consolidating large license-based programs from existing agencies. The Barbering and Cosmetology programs came to us in 2005 from independent commissions that were poorly managed and financially challenged. Using our functional alignment model, we have improved services, streamlined the licensing process, lowered fees, and strengthened enforcement for these programs, while keeping pace with the rapid growth of the licensee population (now 290,216 combined). The Towing Program was transferred to us in 2007 from the Texas Department of Transportation, where the program lacked oversight, had no inspection authority, and was unresponsive to licensee's needs. Today, the Towing, Vehicle Storage Facility, and Booting programs (36,381 combined licensees) are streamlined and well-run, earning TDLR trust and respect from the towing industry and the motoring public.

- TDLR's Cooperation with Industry Experts and Professionals. TDLR's success in consolidating programs is a direct result of the communication and cooperation between industry subject matter experts and our program professionals to create a robust compliance program, regardless of the industry or profession. We listen to the people we regulate, and we count on them to share industry best practices so we can have a better-informed regulatory structure. We involve industry experts and professionals in the beginning of any new process or transfer so that lines of communication are established early and relationships can grow over time.

- TDLR Has Recruited Talented Employees. Another key to TDLR's success in rehabilitating programs transferred to us is recruiting and retaining talented employees from those programs so they can continue working with the program using their valuable knowledge and established industry relationships. We have had great success in bringing over program experts and trained professionals within our Cosmetology, Barber, Property Tax Professional, and Towing programs. Recently TDLR hired a former DSHS employee who worked closely in the development and implementation of key inspection and compliance elements for the massage therapists program. This new TDLR employee will undoubtedly help us develop inspection and compliance frameworks for these new programs.

- TDLR Has An Experienced Education and Examination Division. The Education and Examination Division is responsible for developing continuing education and pre-license education requirements for a wide variety of TDLR programs. Our Education and Examination staff ensures that schools and continuing education providers comply with our laws and rules by evaluating and approving schools, providers and courses, and by providing technical support and assistance to applicants. The Division uses educational reporting software to simplify how licensees and providers report completed pre-license and licensing continuing education courses. We feel that our existing education and examination model makes TDLR an ideal fit for the Massage Therapy Program and its schools, instructors, and establishments, as well as other programs with an educational component or pre-license certification requirement.

- TDLR Uses Independent Advisory Boards. TDLR's advisory board structure allows for independence in judgment and review of license applications and consumer complaints by our agency by removing any specter of industry conflict of interest or favoritism. At the same time, our advisory board members work closely with TDLR leadership and staff to establish examination, education, ethics, and practice standards and to provide our staff with industry perspective. The advisory board system at TDLR is an inclusive process; we listen closely to the advice and opinions of our board members. TDLR's advisory board model also reinforces Sunset's preferred model of "advisory committees." While we understand there may be some resistance to moving away from an independent board governance structure, it has been our experience that the Advisory Board model has been successful in promoting effectiveness, transparency, and independence.

- TDLR Can Manage the Transfer. TDLR has worked closely with Sunset Commission staff in crafting our recommendations for the transfer of these 12 programs. We purposely chose a controlled-growth, phased-in approach so that we can pay careful attention to each program as it comes over and give each of them the attention they deserve and will require. Speed is not the goal; successful integration of programs into TDLR's business model is. The combined population of programs allows for greater economy of scale using our shared-services model and presents a favorable revenue-to-cost ratio.

Key Challenges Facing TDLR with Recommendation 3.2

What TDLR Will Need To Succeed. To implement these changes TDLR will need the following.

- Support, involvement, and cooperation from the affected professionals and associations to develop, plan, and implement the ongoing programs' operation.

- The talent and experience of key DSHS employees currently supporting and serving these professions joining TDLR's team.

- Coordination with the Texas Legislature, the Legislative Budget Board, and the Governor's office to ensure proper resources and staffing, including appropriations for such indirect services as accounting, purchasing, human resources, network and information services, general counsel, and customer service.

- Ongoing communication and collaboration with our colleagues at DSHS, the Department of Information Resources, the Office of the Comptroller, the Texas Facilities Commission, and the Office of Attorney General.

- Continued support from the Texas Legislature to streamline and standardize affected program statutes so they better fit TDLR's regulatory business model.

Texas Department of Licensing and Regulation Modifications

7. The Midwives Program Should Remain at DSHS. TDLR believes that the Midwife program is better housed at DSHS because of its proximity to the Bureau of Vital Statistics. Midwifery has a close relationship to the medical profession, and midwives are in frequent contact and consultation with doctors, hospitals, and other medical professionals outside the scope of TDLR's mission. We believe their specialized requirements fall closer within the DSHS mission.

Staff Comment: While births are reported to the Bureau of Vital Statistics, this is a very small component of a midwife's job. The goal of these transfers is to remove all occupational licensing programs that do not directly relate to a remaining regulatory program at DSHS. Leaving any unrelated licensing programs at DSHS would exacerbate the existing problems that led to this series of recommendations.

8. The Laser Hair Removal Program Should Remain at DSHS. TDLR believes that the Laser Hair Removal program should remain with DSHS. While laser hair removal may appear to have an affinity with TDLR's Cosmetology program, we feel that the use of lasers is more closely aligned with the medical and health mission of DSHS rather than the occupational and professional licensing mission of TDLR.

   Staff Comment: See the staff comment under Modification 7.

(William H. Kuntz, Jr., Executive Director – Texas Department of Licensing and Regulation)

Summary of Responses For and Against 3.2

Due to the large number of public responses received regarding Issue 3, they are summarized below. All responses received to the DSHS report are posted online at www.sunset.texas.gov.

Recommendation 3.2	For	Against
a. Chemical Dependency Counselors	3	228
b. Fitters and Dispensers of Hearing Instruments	4	1
c. Marriage and Family Therapists	3	529
d. Orthotists and Prothetists	3	5
e. Professional Counselors	4	304
f. Social Workers	3	294
g. Athletic Trainers	3	37
h. Laser Hair Removal	3	2
i. Massage Therapists	3	1
j. Midwives	3	227
k. Sanitarians	5	1
l. Speech-Language Pathologists and Audiologists	3	3

Modifications

9. Pend the decision on whether to transfer associated health licensing boards to another agency until after their next Sunset reviews to provide additional opportunity for review and comment. (numerous respondents)

10. Leave these programs at DSHS and address problems with oversight, management, and efficiency in place. (numerous respondents)

11. Create independent agencies instead of transferring these functions to TDLR. (numerous respondents)

12. Transfer the existing boards into TDLR, but maintain their existing form, independence, and current licensing standards. (numerous respondents)
13. Create a health professions section within TDLR to ensure appropriate focus on these professions. (numerous respondents)
14. If these functions are transferred to TDLR, ensure TDLR has sufficient expertise in place to appropriately manage the new healthcare professions. (numerous respondents)
15. Create a separate and independent umbrella agency for mental health licensing programs such as social workers, professional counselors, and marriage and family therapists. Retain the mental health licensing programs at DSHS while creating a Mental Health Licensing Division. (numerous respondents)
16. Do not require licensees to pay the cost of any transfer or change in regulation. (numerous respondents)

Commission Decision on Issue 3

In lieu of Recommendations 3.1 and 3.2, the Sunset Commission adopted Modification 1 that contained the Sunset Commission work group's recommendations. The modification transfers four regulatory programs to the Texas Medical Board; retains four regulatory programs at DSHS; transfers 12 regulatory programs to the Texas Department of Licensing and Regulation in two phases; and discontinues 11 regulatory programs.

In addition, the Sunset Commission adopted Modification 2, requiring fingerprint-based background checks for the four regulatory programs transferred to the Texas Medical Board by Modification 1.

Issue 4

DSHS Needs Additional Tools to Better Combat Fraud in the EMS Industry.

Background

The Department of State Health Services (DSHS) has a wide-ranging role to support the emergency medical services (EMS) and trauma system in Texas. DSHS regulates the EMS industry, designates levels of trauma care for 268 out of the state's 686 hospitals, and provides grant funds to help develop local trauma systems. An active, governor-appointed advisory committee, the Governor's EMS and Trauma Advisory Council (GETAC), provides stakeholder input to DSHS on EMS regulation and overall strategies for improving trauma systems and emergency services across the state.

In its regulatory role, DSHS licenses individual EMS personnel and EMS providers, such as ambulance companies, described in the textbox, *EMS Regulation*. DSHS also approves all EMS training and continuing education programs. In fiscal year 2013, DSHS collected about $2.2 million in EMS licensing fees and spent close to $1.9 million to carry out EMS regulatory functions, employing about 50 related staff. That year, DSHS received 1,738 complaints, conducted 2,287 inspections and investigations, and took 158 enforcement actions against EMS personnel and providers.

EMS Regulation – FY 2013

EMS Providers – 1,493 licensees

- Both public and private, including 911 responders and non-emergency ambulance transportation providers
- First Responder Organizations – EMS personnel associations that provide staffing services to EMS providers
- Exemptions from fees for volunteer providers
- Current moratorium on new licensees due to fraud concerns

EMS Personnel – 61,611 licensees

- Licensed Paramedics
- Emergency Medical Technicians – basic, intermediate, and paramedic
- Emergency Care Attendants

Recent concerns regarding Medicaid billing fraud in the EMS industry, particularly in the Houston area, have led to significant scrutiny on DSHS' EMS provider regulation.[1] In 2013, the 83rd Legislature imposed a moratorium on the issuance of new EMS provider licenses, which expires on August 31, 2014.[2] The federal Centers for Medicare & Medicaid Services followed suit, issuing a moratorium on new ambulance provider enrollment in the greater Houston area, currently set to expire on July 31, 2014.[3] The Legislature also required DSHS, the Health and Human Services Commission, and the Texas Medical Board to study and make recommendations about how to reduce fraud, waste, and abuse among nonemergency transportation providers.[4] As a result of this effort, DSHS and GETAC provided several recommendations to the Legislature in February 2014.[5]

In light of these serious concerns, Sunset staff identified EMS regulation as an area of focus in its review of DSHS' regulatory programs. The Sunset Commission has completed more than 100 licensing agency reviews and has documented standards for effective licensing and regulation. The following material highlights areas where EMS regulation differs from Sunset's model standards and should be changed, and also supports a number of the recent recommendations to further strengthen this much needed regulation.

Findings

DSHS lacks adequate regulatory tools necessary to most effectively regulate the EMS industry.

One DSHS investigation identified 62 EMS providers that were not located at the physical address of record.

- **Ineffective licensure requirements.** The current approach to EMS licensing fails to prevent creation of fraudulent "providers." An EMS provider is not required to show proof of ownership or lease of a physical location of its primary place of business when submitting a licensing application. To obtain an EMS provider license, an applicant proposes a service area and address for each location the applicant intends to operate within that service area. Regulators found that many fraudulent EMS providers were operating out of disposable structures, such as mobile units located in vacant lots, as a means to avoid detection and to quickly evade investigations by the State. Many providers also shared the same operation location, which allowed them to claim ownership of the same equipment required to pass DSHS safety inspections. In 2011, one DSHS compliance effort in Houston identified 62 EMS providers that were not located at the physical address of record. Requiring a physical location, as recommended by DSHS and GETAC, would create an additional barrier for potentially fraudulent providers, making it more difficult for them to operate multiple EMS entities simultaneously and evade detection for fraudulent billing practices.

  EMS providers are also not required to provide proof of ownership or lease of capital equipment necessary to operate a legitimate EMS service, such as ambulances, defibrillators, and stretchers. Some unscrupulous providers have circumvented compliance by borrowing or sharing the required equipment, presenting it to regulators during inspections, and returning it afterwards. Requiring proof of ownership or lease of necessary items, as recommended by DSHS and GETAC, would enable regulators to determine the provider being inspected actually has the equipment necessary to provide EMS services.

EMS providers should have knowledge of the legal requirements of their industry.

- **Lack of jurisprudence exam.** The required training for EMS licensure and certification provides a general overview of medical and legal issues, but does not require EMS providers or personnel to show competency in the state laws and regulations related to the actual profession, such as licensure requirements, standards of conduct, disciplinary procedures, or scope of practice. Licensing agencies typically have latitude to decide how applicants should demonstrate this knowledge, but a written exam is the most common approach to testing a candidate's knowledge. DSHS and GETAC recommended adding a Texas EMS regulations exam to combat fraudulent activity by ensuring both providers and personnel understand the legal requirements relating to the industry. Knowledge of the law will not deter bad actors who knowingly circumvent it, but would better enable legitimate EMS providers to identify illicit acts committed by other participants in their industry. In addition, equipping EMS personnel with knowledge of rules and regulations related to every aspect of EMS, including the business aspect of the industry, would prevent personnel from unwittingly aiding and abetting unscrupulous providers by providing an "extra set of eyes" to recognize any unlawful practices of their employers.

- **Unclear enforcement authority.** Currently, DSHS does not have clear authority to take action against an EMS provider if a local inspection, rather than a state inspection, identifies the provider's noncompliance. This question over enforcement authority stems from a law allowing DSHS to delegate ambulance inspections to a city or county if the local entity requests such authority. In several instances, DSHS has had to re-investigate an EMS provider identified as noncompliant by a local investigation, only to come to the same conclusion. As recommended by DSHS and GETAC, clearly authorizing DSHS to take disciplinary action when a local entity delegated to conduct inspections uncovers noncompliance would allow for faster enforcement and more efficient use of limited resources.

DSHS' complaints procedures for EMS regulation do not ensure appropriate follow-up or adhere to model licensing practices.

- **Nonjurisdicitional complaints.** Without comprehensive tracking and referral of EMS-related allegations that fall outside of DSHS' limited regulatory scope, a complete picture of all of the issues in this regulatory environment does not exist and DSHS cannot assist in efforts to address systemic problems that span the jurisdiction of multiple entities. Fraud-related complaints concerning EMS providers often relate to billing, an issue investigated by the Health and Human Services Commission's Office of Inspector General. EMS fraud could also involve a healthcare practitioner, such as the licensed physicians who act as medical directors for EMS providers and are regulated by the Texas Medical Board, or could involve issues governed by the Texas Department of Insurance. DSHS does not have a formal process in place to appropriately refer nonjurisdictional EMS complaints to other agencies, nor does the agency's tracking system allow for clear categorization and reporting of all allegations and complaints received regarding EMS providers. Given the recent concerns relating to fraud and the complexity of the EMS regulatory environment, DSHS should have a more formalized process to track and refer these types of complaints. This additional data would allow for the identification of trends, help identify gaps in the regulatory framework, and better ensure that actionable complaints are addressed by the appropriate parties.

Additional data would help identify gaps in the EMS regulatory framework.

- **Complaint data.** Agencies should maintain adequate information about complaints, including detailed statistics about complaints received and resolved each year, and provide this information to the public. Tracking complaints helps an agency promptly, consistently, and reliably address complaints, and analysis of complaint information is useful in identifying regulatory problem areas. The 83rd Legislature required DSHS to periodically report on the number of complaints made against licensed EMS providers.[6] While DSHS collects and maintains complaints data internally, including the number, types, and disposition of complaints received, it does not publicly report this data. Maintaining and publishing detailed complaint data would provide a more complete picture of EMS regulation to help identify problem areas and ensure DSHS, other regulatory agencies, and the public have a useful tool to monitor the industry.

Recommendations

Change in Statute

4.1 Require an EMS provider to have a physical location for its business establishment to obtain a license.

This recommendation would require an applicant for an EMS provider license to provide proof of a physical location for the business. The physical location of the business establishment could be owned or leased, as long as the provider maintains the physical location for the duration of the licensure period. The physical location provided must be the provider's primary place of business, and providers would be required to maintain all patient care records at this location unless DSHS approves an alternative location. Only one EMS provider would be allowed to be licensed to operate from one physical location. Requiring a physical location would assist regulators and law enforcement in monitoring and investigating any fraudulent or other unlawful activity.

4.2 Require an EMS provider to provide proof of ownership or a long-term lease agreement for all equipment necessary for safe operation of an EMS company.

Under this recommendation, EMS providers must demonstrate they own or have a long-term lease arrangement for their required equipment. This requirement would apply to ambulances, heart rate monitors, defibrillators, stretchers, and any other equipment necessary to operate as an EMS provider. Proof of ownership would ensure providers actually possess the equipment needed to administer any medically necessary service expected of an EMS provider and help prevent fraudulent businesses from entry into the EMS industry.

4.3 Authorize DSHS to require jurisprudence examinations for all EMS licensees.

Under this recommendation, DSHS would determine how best to develop and administer an examination for EMS providers and personnel to ensure adequate knowledge of the EMS regulatory structure. The examination requirement would apply both to in-state and out-of-state applicants for licensure. Familiarity with laws and regulations relating to the EMS industry in Texas would ensure both providers and personnel are aware of requirements to protect public safety and comply with legitimate healthcare business practices.

4.4 Clearly authorize DSHS to take disciplinary action against EMS providers or personnel based on findings by a governmental entity with delegated authority to conduct inspections.

This recommendation would give DSHS explicit authority to take enforcement action against EMS providers or personnel based on findings from local inspections or investigations delegated by DSHS. This recommendation would make the process of conducting compliance and enforcement based on complaints filed with entities other than DSHS easier and faster, and ensure efficient use of limited resources.

4.5 Require DSHS to develop a formal process to refer nonjurisdictional complaints relating to EMS to appropriate organizations.

This recommendation would require DSHS to have a formal procedure to refer EMS-related complaints not within the agency's jurisdiction to the appropriate organization. DSHS would also be required to keep track of the number and type of nonjurisdictional EMS complaints to ensure a complete picture of

the problems and concerns within the EMS regulatory environment. As part of this recommendation, DSHS should ensure nonjurisdictional EMS complaints relating to potential billing fraud are separately tracked and made available to other entities with jurisdiction over these issues.

4.6 Require DSHS to collect, maintain, and make publicly available detailed statistical information on complaints regarding EMS licensees.

Under this recommendation, statute would clearly require DSHS to track and publicly report statistical information detailing the number, source, and types of EMS complaints received and the disposition of EMS complaints. Improving DSHS' current efforts in this area would ensure EMS complaints are promptly, consistently, and reliably addressed. Also, analysis and public reporting of EMS complaint information would assist the agency and others in identifying regulatory problem areas. The information should include, at a minimum:

- the reason and basis for the complaint, especially distinguishing practice-related complaints brought by consumers from more administrative complaints typically brought by the agency;
- the origin of the complaint;
- the average time to resolve the case from the date the agency initially receives the complaint;
- the outcome of the cases, including the number of cases dismissed and reason for dismissal;
- the number of cases resulting in disciplinary action, the disciplinary action taken, and how that action was taken; and
- the number, type, and age of all open cases at the end each fiscal year.

Fiscal Implication

These recommendations would not have a significant fiscal impact to the State. DSHS could implement the recommendations within current resources. Clarifying DSHS would not have to duplicate local regulatory efforts should create additional efficiencies in inspections.

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1 Langford, Terri, "DA says Medicare ignores evidence of EMS transport fraud," Houston Chronicle October 17, 2011, http://www.chron.com/news/houston-texas/article/Largest-Medicare-fraud-takedown-includes-4-EMS-2-3527944.php.

2 S.B. 8, 83rd Texas Legislature, Regular Session, 2013.

3 Centers for Medicare & Medicaid Services, "CMS imposes first Affordable Care Act enrollment moratorium on Houston-area ground ambulance suppliers to combat fraud and safeguard taxpayer dollars," news release, July 26, 2013, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-07-26-2.html.

4 S.B. 8, 2013.

5 Health and Human Services Commission, Department of State Health Services, and Texas Medical Board, Recommendations to the Legislature Related to the Provision of Non-Emergency Transportation Services by Ambulance Providers, as required by S.B. 8, Sections 13–15, 83rd Legislature, Regular Session, 2013 (Austin: Health and Human Services Commission, Department of State Health Services, and Texas Medical Board, 2014), p. 6.

6 H.B. 3556, 83rd Texas Legislature, Regular Session, 2013.

Responses to Issue 4

Recommendation 4.1

Require an EMS provider to have a physical location for its business establishment to obtain a license.

Agency Response to 4.1

DSHS supports the recommendation to require an EMS provider to have a physical location for its business establishment to obtain a license. This requirement will assist regulators and law enforcement in monitoring and investigating fraudulent and unlawful activity. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 4.1

G.K. Sprinkle, Public Policy Strategist – Texas Ambulance Association, Dallas

Dudley Wait, EMS Director – City of Schertz EMS and Board Member – Texas EMS Alliance, Schertz

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 4.1

None received.

Recommendation 4.2

Require an EMS provider to provide proof of ownership or a long-term lease agreement for all equipment necessary for safe operation of an EMS company.

Agency Response to 4.2

DSHS supports the recommendation and believes it will ensure providers have the equipment needed to administer medically necessary services and help prevent fraudulent activity. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 4.2

Dudley Wait, EMS Director – City of Schertz EMS and Board Member – Texas EMS Alliance, Schertz

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 4.2

None received.

Recommendation 4.3

Authorize DSHS to require jurisprudence examinations for all EMS licensees.

Agency Response to 4.3

DSHS supports the recommendation as it will ensure providers and personnel are aware of legal requirements relating to their license. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 4.3

Dudley Wait, EMS Director – City of Schertz EMS and Board Member – Texas EMS Alliance, Schertz

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 4.3

None received.

Modification

1. Amend Recommendation 4.3 so that the jurisprudence requirement only applies to EMS personnel, as statute already requires an EMS provider's administrator of record of to take an education course that must include information about the laws and rules that affect EMS providers as well as continuing education courses that must include information about changes in laws and rules that affect EMS providers. (Darryl Quigley, Chief Operating Officer – Texas LifeLine and Board Member – Texas Ambulance Association, Dallas)

Recommendation 4.4

Clearly authorize DSHS to take disciplinary action against EMS providers or personnel based on findings by a governmental entity with delegated authority to conduct inspections.

Agency Response to 4.4

DSHS supports the recommendation to authorize the agency to take disciplinary action against EMS providers or personnel based upon findings by a governmental entity with delegated authority. This requirement will increase the efficient use of limited resources. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 4.4

Dudley Wait, EMS Director – City of Schertz EMS and Board Member – Texas EMS Alliance, Schertz

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 4.4

None received.

Modifications

2. Clarify which governmental entities' investigations could lead to disciplinary actions by DSHS. (G.K. Sprinkle, Public Policy Strategist – Texas Ambulance Association, Dallas)

3. Ensure an EMS provider would still go through the full formal disciplinary process, starting with receiving a notice from DSHS about the complaint investigation, and going through all appeals offered by the state. (G.K. Sprinkle, Public Policy Strategist – Texas Ambulance Association, Dallas)

4. Ensure that a provider would not be disciplined for a complaint submitted by another governmental entity that went beyond the state's authority in its rules and regulations for ambulance providers. (G.K. Sprinkle, Public Policy Strategist – Texas Ambulance Association, Dallas)

5. Ensure that the only actions taken by DSHS on the basis of a governmental entity's investigation are complaints and that the state performs all initial, renewal, and random inspections of ambulance providers. (G.K. Sprinkle, Public Policy Strategist – Texas Ambulance Association, Dallas)

Recommendation 4.5

Require DSHS to develop a formal process to refer nonjurisdictional complaints relating to EMS to appropriate organizations.

Agency Response to 4.5

DSHS supports the recommendation to develop a process to refer nonjurisdictional complaints relating to EMS to the appropriate organization. DSHS currently tracks nonjurisdictional complaints and refers them to other organizations when appropriate. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 4.5

Representative Ruth Jones McClendon, Member – Texas House of Representatives

G.K. Sprinkle, Public Policy Strategist – Texas Ambulance Association, Dallas.

Dudley Wait, EMS Director – City of Schertz EMS and Board Member – Texas EMS Alliance, Schertz

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 4.5

None received.

Modifications

6. The system for tracking nonjurisdictional complaints should include the date and time as well as the locality and a reference to those authorities having proper jurisdiction. These tracking reports should be made available to the public. (Representative Ruth Jones McClendon, Member – Texas House of Representatives)

7. Clarify to which entities DSHS must refer non-jurisdictional complaints. (G.K. Sprinkle, Public Policy Strategist – Texas Ambulance Association, Dallas)

Recommendation 4.6

Require DSHS to collect, maintain, and make publicly available detailed statistical information on complaints regarding EMS licensees.

Agency Response to 4.6

DSHS supports the recommendations to collect, maintain, and make publicly available detailed statistical information on complaints regarding EMS licensees. DSHS currently collects and maintains the statistical information discussed in this recommendation, but does not report the data to the public. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 4.6

G.K. Sprinkle, Public Policy Strategist – Texas Ambulance Association, Dallas.

Dudley Wait, EMS Director – City of Schertz EMS and Board Member – Texas EMS Alliance, Schertz

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 4.6

None received.

Commission Decision on Issue 4

The Sunset Commission adopted all staff recommendations in Issue 4.

Issue 5

DSHS Has Not Provided the Leadership Needed to Best Manage the State's Public Health System.

Background

While no single definition of public health exists, it encompasses a wide range of *Essential Public Health Services*, as described in the textbox.[1] These services are generally focused on protecting the health of the population as a whole through prevention efforts, unlike publicly funded health care, which provides direct care to individuals. Several recent events in Texas illustrate the importance of having a well-functioning public health system — from containing infectious diseases such as West Nile and H1N1 and limiting foodborne outbreaks such as salmonella, to providing emergency response to disasters such as hurricanes and the explosion in West.

Texas has a complex and fragmented public health system, with responsibility for the provision of public health services falling mainly on the Department of State Health Services (DSHS) and its eight Health Service Regions, and local health departments governed by cities and counties. The textbox, *Typical Public Health Activities*, provides examples of the services these entities provide.[2] In fiscal year 2013, DSHS funded 65 local health departments; however, the total number of local health departments in Texas is unclear as DSHS does not track those it does not fund. The most recent estimate is 129, with many of these organizations either providing a single service, such as sanitation inspections, or existing as a department within another local agency.[3]

DSHS' eight Health Service Regions act as the provider of last resort where no local health department exists, a significant responsibility as shown on the map, *State and Local Public Health Coverage*, on the following page.[4] The Health Service Regions are the primary providers of public health services for about 20 percent of the

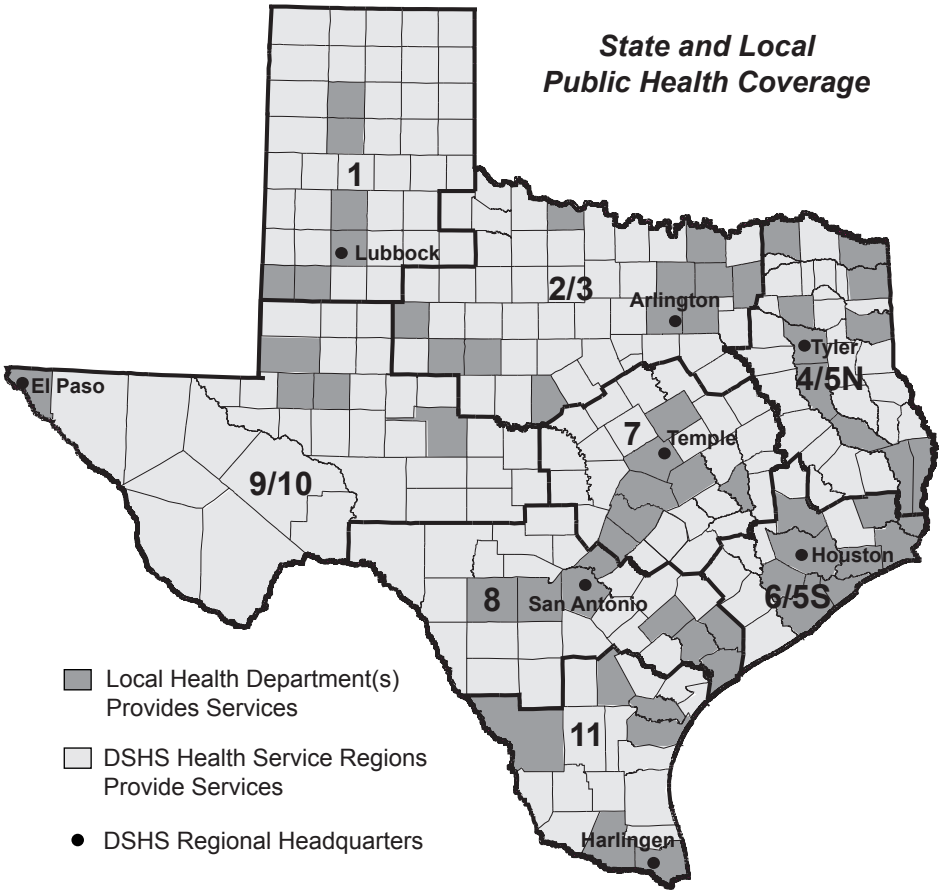
Essential Public Health Services

- Monitor the health status of individuals to identify community health problems.
- Diagnose and investigate community health problems and health hazards.
- Inform, educate, and empower the community about health issues.
- Mobilize community partnerships to identify and solve health problems.
- Develop policies and plans that support individual and community efforts to improve health.
- Enforce laws and regulations that protect public health and ensure safety.
- Link people with community and personal health services needs to providers.
- Ensure a competent public health workforce.
- Research new insights and innovative solutions to community health problems.
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services in a community.

Typical Public Health Activities

- Operating clinics to provide immunizations and screen for sexually-transmitted diseases.
- Conducting restaurant inspections.
- Performing case management for individuals with tuberculosis.
- Monitoring and investigating diseases such as rabies.
- Conducting public awareness campaigns.
- Coordinating disaster response planning.

state's population in 190 counties with no local health department. In areas that have a local health department, DSHS provides varying services to ensure the basic public health services the local health department does not provide are available. In fiscal year 2013, DSHS employed about 900 staff and expended about $47 million to operate the Health Service Regions.



Findings

Despite long-standing efforts, the roles and responsibilities of DSHS and local health departments remain undefined, hindering the effective delivery of public health services in Texas.

Texas' decentralized approach to delivering public health services, while providing local control and flexibility, has long presented challenges in coordinating public health efforts as detailed in the textbox on the following page, *Texas Public Health Timeline*.[5] Efforts to address these challenges have repeatedly recommended establishing minimum standards for public health delivery and clarifying the roles of DSHS and local health departments, but these changes have never been made, and numerous problems remain.[6]

- **No minimum standards or requirements for local health departments.** Regional variations in public health service delivery are expected and even encouraged in a state as large and diverse as Texas, but the current

structure presents numerous challenges that ultimately leave core services to the mercy of local economies and politics. On a basic level, no standard definition of the services a local health department must provide exist. As a result, a "local health department" can be a few staff conducting restaurant inspections and animal control duties, or a large agency directing sophisticated disease surveillance, operating a public health laboratory, and providing direct services to citizens.

Texas Public Health Timeline

1983 The Legislature codified the basic structure and expectations for public health service delivery in Chapter 121, Texas Health and Safety Code, the Local Public Health Reorganization Act.

1998 An interim study directed by the Legislature noted "a lack of clear assignment of responsibilities for public health in Texas." A Sunset staff review of the former Department of Health suggested that the state "needs to improve its interaction with and the input received from local health departments."

1999 The Legislature enacted House Bill 1444 based on the 1998 interim study, which codified the 10 essential public health services, allowed grants for public health services based on the availability of funds, and created a public health consortium tasked with public health research and training.

2011 The Texas Association of Local Health Officials assessed the public health system in Texas and recommended establishing minimum requirements for local health departments. Senate Bill 969 established the Public Health Funding and Policy Committee to define the core public health services a local entity should provide, establish public health priorities for the state, identify available funding necessary for local health departments to perform core functions, and annually make formal recommendations.

2013 The Public Health Funding and Policy Committee's first annual report recommended bundling DSHS contracts for local health departments to decrease administrative burden and pursuing national accreditation for local health departments. The Committee also began a process to evaluate and define local public health, including surveying public health stakeholders.

Local jurisdictions have clear authority to decide which public health services they want to provide and at what level of support. However, they are not required to clearly document or provide a specific list of these services and it is not clear which services DSHS would have to assume if a local area stopped providing them. Any service delivered locally helps DSHS provide public health services overall, so requiring small, cash-strapped jurisdictions to meet one-size-fits-all standards would not be effective as it would likely result in many local health departments ceasing to exist. However, the lack of any requirements can lead to problems when local jurisdictions change public health services without any notification to DSHS or consideration of DSHS' ability to take responsibility for these additional services in a short period of time.

When one city cut its public health budget in half, DSHS became responsible for discontinued services.

For example, as a budget saving measure, one Texas city severely cut funding for its health department in fiscal years 2011 to 2013, reducing the budget by nearly 48 percent, from $1.2 million to $628,000, and the number of staff from 23 to 13. As required by law, the DSHS Health Service Region became responsible for the public health services that the city discontinued, but received no additional funding to provide these services. These situations

can directly impact community health. In this example, DSHS took over performing sexually-transmitted disease contact investigations including HIV, which require staff to follow up with every person who was exposed to the infected person, with the goal of treating and stopping the disease from spreading. The stretched resources could delay the amount of time needed to conduct contact investigations, putting more people at risk.

- **Unclear roles.** Currently, no requirement exists for a written plan or agreement between DSHS and local health departments outlining roles and responsibilities in areas where both are operating. This lack of an organized and agreed upon division of labor creates unnecessary confusion and inefficiencies.

Lack of clearly defined roles leads to overlap and inconsistency of public health services.

While some of DSHS' Health Service Regions and local health departments have developed informal documents describing who is doing what, in most cases, these relationships are worked out informally through gentlemen's agreements. This lack of clearly defined roles between DSHS and local health departments can lead to overlap of services, duplication of effort, and in some cases, inconsistencies in public health messaging. For example, in one city, both the local health department and DSHS conducted uncoordinated immunization clinics at the same time, providing conflicting information and phone numbers to residents in the community. Confusion also resulted in another area when the local health department and the DSHS Health Service Region distributed inconsistent information regarding the H1N1 pandemic.[7]

Without clearly defined roles, DSHS also may not know when and if it needs to fill in public health service gaps as required by law. In the example of the city that significantly cut its local health department's budget, DSHS had no role in directing what services were most important to keep and which to eliminate. After the budget cuts, the city did not have to report any information to DSHS about reduced services or formally establish which services DSHS needed to start providing.

Further complicating matters, DSHS central office staff sometime communicates directly with local health departments regarding contracts and programs managed directly from Austin, without making DSHS Health Service Regions aware. This lack of coordination within DSHS highlights the disjointed nature of public health service delivery, even at the state level. A standardized scheme for documenting and explaining roles and responsibilities should be a basic expectation of organizing local public health delivery between DSHS central office, regional offices, and local partners.

Without an overall vision or clear goals for the state's public health system, DSHS cannot provide expected leadership to target limited resources and help build local capacity.

- **Lack of leadership.** In recent years, DSHS' relationship with local health departments has been strained. During the Sunset review, these key

stakeholders consistently expressed frustration that DSHS does not provide the kind of statewide leadership and support expected, and instead view DSHS as "just another funding source" with rigid requirements that sometimes run counter to delivering effective public health services. For example, local health departments consistently complained that DSHS does not provide access to data that would help analyze local health trends and target limited resources to achieve statewide goals, such as specific information about immunization rates or disease incidence. DSHS has recently taken steps to develop a statewide system for tracking disease occurrence, but this effort has taken years to implement.[8] The Legislature acknowledged these issues in 2011, and created the Public Health Funding and Policy Committee to provide a forum for DSHS to receive and act upon stakeholder input. While the initial efforts and report from this committee have had positive results, the committee is still developing its role.[9]

DSHS' disjointed distribution of grant funding to local health departments has been a source of particular frustration, and DSHS has struggled to complete a recent Legislative directive to more strategically and efficiently allocate this funding.[10] DSHS distributes about $200 million per year to 65 local health departments in mostly federal funds through 31 different funding streams and 420 individual contracts. An average health department might have five contracts with DSHS, all with different requirements, contract managers, and timelines. Based on a recommendation by the Public Health Funding and Policy Committee, DSHS bundled 289 of the 420 contracts in the fiscal year 2013 contracting period to reduce the administrative burden on local health departments.[11] The bundled contracts helped, but the funding is still typically distributed based on historical levels, not present-day factors or need, and a local match is only required for three of the funding streams.

DSHS distributes $200 million per year to 65 local health departments.

In 2013, the Legislature directed DSHS to rethink how it distributes funding, including developing updated funding formulas. DSHS chose to only target funding streams distributed exclusively to public health departments, which include updating funding formulas for just four programs — tuberculosis, preparedness, sexually-transmitted diseases, and immunizations. To date, DSHS and the Public Health Funding and Policy Committee have only updated the tuberculosis funding formula, and will likely not be able to update the other three by the October 1, 2014 deadline established in the legislation.[12] The complexity of developing these formulas makes the delay understandable, but DSHS should not abandon this or other efforts to evaluate and make more effective use of limited funds to incentivize progress towards statewide goals.

- **No clear plan or clearly stated goals for the state's public health system.** DSHS does not have an action plan for developing the state's public health delivery system, making it too easy to get bogged down in bureaucratic processes or distracted by the numerous crises that develop daily. DSHS' coordination of locally delivered public health services, whether through DSHS regions or local health departments, is spread amongst myriad

Elements of a Well-Functioning Public Health System

- Strong partnerships where partners recognize they are part of the public health system
- Effective channels of communication
- System-wide health objectives
- Resource sharing
- Leadership by governmental public health entity
- Feedback loops among state, local, tribal, territorial, and federal partners

programs without a clear overarching vision or goals of what the state is hoping to accomplish through them.

The textbox, *Elements of a Well-Functioning Public Health System*, provides basic concepts for establishing such planning efforts as suggested by the Centers for Disease Control and Prevention.[13] Coordinating Texas' highly decentralized public health system will always present challenges, but as the state's public health agency, DSHS must do more to outline its vision, including developing and measuring progress toward specific goals and strategies for improving the system.

Recommendations

Change in Statute

5.1 Require DSHS to develop a comprehensive inventory of the current roles, responsibilities, and capacity of DSHS central office, DSHS Health Service Regions, and local health departments.

This recommendation would require DSHS to thoroughly document and analyze the current state of public health delivery in Texas to achieve better organization, inform the planning requirements described in Recommendation 5.2, and assist the development of categories in Recommendation 5.3.

DSHS would comprehensively document the current division of labor between DSHS central office, each DSHS Health Service Region, and each local health department, district, and authority in the state. This inventory of public health services should include the specific services and programs each entity currently provides and the level of service provided. DSHS should prepare a clear matrix of duties specific to each region indicating which duties are performed by each entity. The matrix should also include a description of the responsibilities of DSHS central office versus Health Service Region staff. To ensure the accuracy of this inventory, local jurisdictions would be required to report any significant change in the public health services they provide to DSHS once the matrix is completed. This information would allow DSHS to evaluate the current provision of public health services and identify areas where significant gaps or overlap in duties or service provision exists.

DSHS would be primarily responsible for completing these tasks, but should solicit input from the Public Health Funding and Policy Committee and local health departments before commencing the effort. DSHS staff should present the results of this evaluation to the Public Health Funding and Policy Committee and DSHS Council in open meetings. DSHS should complete the inventory and analysis by March 1, 2016, and update it by September 1 of each even-numbered year after.

5.2 Require DSHS to establish clear goals for the state's public health system and to develop an action plan with regional strategies and milestones to meet these goals.

This recommendation would require DSHS, with input and advice from the Public Health Funding and Policy Committee, to create an action plan for developing and improving the public health delivery system in Texas. Using information gathered in the evaluation required by Recommendation 5.1, DSHS would be required to establish an overarching vision for DSHS central office, DSHS Health Service

Regions, and local health departments, and statewide priorities for improving the public health delivery system. DSHS would develop region-by-region goals and strategies with milestones, dates, performance measures, and resources needed.

As part of this recommendation, DSHS and the Public Health Funding and Policy Committee should identify any changes to DSHS policies or procedures needed to achieve the established goals, including changes to data sharing, contract administration, or other efforts to improve working relationships. DSHS should continue progress towards developing formulas and other strategies for improving effective distribution of funding, such as incentivizing local investment in public health services through local match requirements or other mechanisms. DSHS should also identify any statutory barriers and develop recommendations for legislative changes needed to meet the goals.

DSHS would be required to complete the first plan and associated report by November 30, 2016. DSHS would develop an updated plan by November 30 of each even-numbered year, and present this plan, including progress on previous goals, to the Public Health Funding and Policy Committee, DSHS Council, and House Public Health and Senate Health and Human Services committees of the Legislature. As part of this recommendation, the current annual reporting requirements for the Public Health Funding and Policy Committee should be changed to a biennial report due at the same time to align planning efforts.

Management Action

5.3 Direct DSHS to develop a system to categorize different types of local health departments based on the services they provide.

Under this recommendation, along with the information developed in Recommendation 5.1 and input from the Public Health Funding and Policy Committee and local health departments, DSHS should develop a list of the full array of services, separated into categories. The lowest category would only include the most basic and needed local public health services, like restaurant inspections. The highest category would include the full array of public health services that could be provided locally, like having a fully operational public health laboratory.

Local health departments would not be required to provide the full array of services in any of these categories. They would continue to provide any services they choose, regardless of the categories. The purpose in having these categories would be to show how the responsibility for providing these public health services is currently shared between the state and local jurisdictions and inform what improvements may be needed. The categories would act as guidelines to give DSHS, locals, and average citizens a basic understanding of how a local health department and its services fit into the state's overall public health system, and would provide goals for specific steps that could be taken to increase the scope or quality of local services. The categorized list of services would also provide useful information to local officials to help make decisions on the public health services needed in their local jurisdictions.

DSHS should present the categorized system along with the report required in Recommendation 5.2 to the State Health Services Council, and the House Public Health and Senate Health and Human Services committees of the Legislature by November 30, 2016.

Fiscal Implication

These recommendations would not have a fiscal impact to the State, but would help focus public health planning efforts currently underway. These ongoing efforts include those of DSHS' division of Regional and Local Health Services, which is tasked with serving the needs of local health departments, DSHS regional offices, and local communities in building and maintaining public health capacity, as well as those of the Public Health Funding and Policy Committee, which has an $87,000 annual budget and dedicated staff support.[14]

1 Section 121.002, Texas Health and Safety Code; "The Public Health System and the 10 Essential Public Health Services," Centers for Disease Control and Prevention, last modified July 3, 2013, http://www.cdc.gov/nphpsp/essentialservices.html.

2 Public Health Funding and Policy Committee (PHFPC), *2013 Public Health Funding and Policy Committee Annual Report* (Austin: February 2013), http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589975847.

3 PHFPC, *2013 Public Health Funding and Policy Committee Annual Report*, p. 20.

4 Texas Department of State Health Services, *Local and Regional Public Health Coverage* (Austin: 2006), http://www.dshs.state.tx.us/regions/state.shtm.

5 S.B. 109, 68th Texas Legislature, Regular Session, 1983; Texas Department of Health et al., *The State of Public Health: Local and State Government Issues in Texas* (Austin: Texas Department of Health, December 1998), p. viii; Texas Sunset Advisory Commission, *Texas Department of Health and Center for Rural Health Initiatives: Staff Report* (Austin: 1998), p. 24, https://www.sunset.texas.gov/public/uploads/files/reports/Department%20of%20Health%20Staff%20Report%201998%2076%20Leg.pdf; H.B. 1444, 76th Texas Legislature, Regular Session, 1999; Catherine Troisi et al., *The Future of Public Health in Texas* (Austin, TX: Texas Association of Local Health Officials (TALHO) 2011), p. 29; S.B. 969, 82nd Texas Legislature, Regular Session, 2011; PHFPC, *2013 Public Health Funding and Policy Committee Annual Report*, p. 9.

6 Catherine Troisi et al., *The Future of Public Health in Texas*, p. 29; PHFPC, *2013 Public Health Funding and Policy Committee Annual Report*.

7 Catherine Troisi et al., *The Future of Public Health in Texas*, p. 31.

8 PHFPC, March 24, 2014, meeting agenda, http://www.dshs.state.tx.us/phfpcommittee/agendas/032414/PHFP-Committee-Meeting-Agenda-March-24-2014.aspx.

9 Chapter 117, Texas Health and Safety Code.

10 S.B. 127, 83rd Texas Legislature, Regular Session, 2013.

11 PHFPC, *2013 Public Health Funding and Policy Committee Annual Report*, p. 23.

12 PHFPC, December 12, 2013, meeting minutes, http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589985570.

13 Centers for Disease Control and Prevention, *United States Public Health 101* (Atlanta, GA: November 2013), www.cdc.gov/stltpublichealth/docs/usph101.pptx.

14 Texas Department of State Health Services, *Self-Evaluation Report for the Sunset Advisory Commission* (Austin: Texas Department of State Health Services, 2013), p. 397.

Responses to Issue 5

Recommendation 5.1

Require DSHS to develop a comprehensive inventory of the current roles, responsibilities, and capacity of DSHS central office, DSHS Health Services Regions, and local health departments.

Agency Response to 5.1

DSHS supports this recommendation. During the past six months, DSHS initiated a strategic planning process for public health that will help to complete the inventory envisioned in the recommendation. As part of this initiative, DSHS will identify gaps and work with local governments to prioritize service delivery. DSHS will continue its work with the Public Health Funding and Policy Committee and local health departments in undertaking this task. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 5.1

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

William "Chip" Riggins, M.D., Member – Texas Medical Association's Council on Science and Public Health

Jennifer Smith, Public Health Consultant – Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 5.1

None received.

Modification

1. Expand the charge of the Senate Bill 969 (82nd Legislative Session) committee to provide oversight of the of the public health inventory developed by DSHS and aid in the identification of gaps in local public health services. Broaden the committee's composition to include other public representatives and stakeholders to assess the public health structure in Texas. (William "Chip" Riggins, M.D., Member – Texas Medical Association's Council on Science and Public Health)

Recommendation 5.2

Require DSHS to establish clear goals for the state's public health system and to develop an action plan with regional strategies and milestones to meet these goals.

Agency Response to 5.2

DSHS supports this recommendation. The strategic planning process as described in 5.1 will help build goals for the system and identify the actions necessary to achieve them. DSHS will work collaboratively with stakeholders to establish statewide priorities for improving the public health delivery system, including milestones, outcome measures, and needed resources. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 5.2

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

William "Chip" Riggins, M.D., Member – Texas Medical Association's Council on Science and Public Health

Jennifer Smith, Public Health Consultant – Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 5.2

None received.

Modification

2. Require DSHS to convene partners, especially local health departments, to establish the state public health system goals objectives, and outputs to ensure partners will be included in the beginning of any planning process. (Jennifer Smith, Public Health Consultant – Austin)

   Staff Comment: Recommendation 5.2 requires DSHS to solicit input and advice from the Public Health Funding and Policy Committee when creating the public health action plan.

Recommendation 5.3

Direct DSHS to develop a system to categorize different types of local health departments based on the services they provide.

Agency Response to 5.3

DSHS supports the recommendation to develop a system that categorizes health departments based on the services they provide. DSHS will seek input from the Public Health Funding and Policy Committee, local health departments, and other stakeholders to help develop a categorization system that provides meaningful information about local health departments

and the overall public health system. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 5.3

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

William "Chip" Riggins, M.D., Member – Texas Medical Association's Council on Science and Public Health

Jennifer Smith, Public Health Consultant – Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 5.3

None received.

Commission Decision on Issue 5

The Sunset Commission adopted all staff recommendations in Issue 5.

Issue 6

DSHS Has Not Taken Needed Steps to Strengthen the Security of Vital Statistics.

Background

Vital statistics are the official records of every person's birth, death, marriage, or adoption in Texas. Within the Department of State Health Services (DSHS), the state registrar directs the Vital Statistics Unit (Unit) that, among other duties, creates and maintains the Texas Electronic Registrar system to electronically register birth, death and marriage events. DSHS maintains about 50 million records, with about 38 million accessible electronically and about 7.5 million in the process of being converted to electronic files.

Each year, DSHS registers about 400,000 births and about 200,000 deaths in Texas. A birth certificate provides proof of age, citizenship, and identification, and is considered a "breeder" document in that it leads to obtaining other forms of identification such as driver licenses, Social Security cards, and passports.[1] A birth certificate in the wrong hands can allow fraudulent activity relating to personal identity theft, access to government benefits, and voting. In 2000, an investigation discovered an employee at a local registrar's office in Texas created more than 300 fraudulent birth certificates and then sold those records for at least $8,500 each.[2]

Death certificates play an important role in medical research and are also used to close an open birth certificate, confirming that a person is deceased and preventing further activity based on their birth certificate. When a match between a birth and death certificate is complete, federal and state agencies such as the Social Security Administration and Texas Secretary of State will stop providing other benefits and will remove the person's name from the voter rolls.

Texas is a dual registration state, meaning data about selected vital events is maintained centrally by DSHS, as well as locally, in statutorily designated local registration jurisdictions. Texas currently has 422 jurisdictions overseen by local registrars who may also serve as justices of the peace, county clerks, city secretaries, or municipal clerks. When a birth or death occurs, about 48,000 authorized users such as doctors, midwives, nurses, funeral directors, and justices of the peace enter the information in the Texas Electronic Registrar system, which is then sent to a local registrar. All local registrars approve the registration of vital events, retain a copy of each record locally, and submit the original to the state registrar's office.

Findings

Despite repeated recommendations to improve the security of the state's vital records system, DSHS has not implemented needed changes to protect this critical information.

Since 2009, several evaluations of the Unit and the state's vital records system have resulted in numerous recommendations to improve the security and efficiency of the system, as shown in the chart on the following page, *Audit Reports on Vital Statistics*.[3] DSHS has not implemented the majority of the

approximately 460 different recommendations contained in these reports. Many of the identified security concerns stem from and are compounded by the Unit's limited capability to oversee and monitor 422 local registrars across the state. The Unit's five field services staff must train each local registrar and inspect the security of each office, as well as licensed institutions that register vital events such as hospitals and birthing centers. According to the Unit's site visit monitoring policy, staff should inspect all local offices every five years, but in the past five years, the Unit has only inspected half of the offices. Fiscal year 2013 was the first year the Unit inspected hospitals, inspecting just four.

Audit Reports on Vital Statistics

Report	Year Completed	Purpose	Summary
State Auditor's Office, *An Audit Report on The Department of State Health Services' Issuance of Birth Certificates (Report No. 10-011)*	November 2009	To determine whether the Unit has controls to ensure birth certificates are issued for legally authorized purposes.	Recommended improving the monitoring of local registrars and increasing security measures for the Texas Electronic Registrar system. Overall, the State Auditor's Office made 14 recommendations.
DSHS, *Strengthening the Texas Birth Record Information System*. Report required by Rider 72, page II-75, Article II (H.B. 1), Acts of the 82nd Legislature, Regular Session, 2011 (the General Appropriations Act)	September 2012	To assess the effectiveness and security of the state's birth record information system to reduce vital records fraud.	Called for the establishment of a workgroup to assess the effectiveness and security of the Texas Electronic Registrar system to protect Texas residents from identity theft and reduce fraud related to vital records. The report made 30 recommendations, 21 of which are in progress and nine that are delayed because they require legislative action. For example, the background check policy requires a legislative change, but no such legislation has been authored.
DSHS Internal Audit, *Department of State Health Services' Vital Statistics Unit (Audit #2012-08)*	June 2012	To assess the internal controls over billing, contracting, and revenue management, and the level of compliance with the Health and Human Services Commission's human resources policy.	Recommended creating a business operations group to help the Unit complete other recommendations. The report also recommended improving human resources performance management.
State Auditor's Office, *A Follow-up Audit Report on the Issuance of Birth Certificates at the Department of State Health Services (Report No. 13-013)*	December 2012	To determine the implementation status of the 2009 State Auditor's Office recommendations.	As of December 2012, eight of the 14 recommendations were complete after three years. A recommendation to conduct desk audits of local registrars was not complete.
DSHS Internal Audit, *Background Check Procedures (Project #2013-16)*	August 2013	To determine whether DSHS programs authorized to conduct criminal background checks conducted them or had a documented decision for not doing so.	Recommended completing the development, approval, and implementation of criminal history background check policies.

The information below highlights several key problems in the oversight and overall security of the state's vital records. Most of these problems and solutions have been identified numerous times over the past five years, but the Unit and ultimately DSHS have failed to make needed changes.

- **No desk audit policy.** In 2009, the Unit, based on a recommendation by the State Auditor's Office, developed a risk-based approach to monitoring local registrars to ensure they were following statutory obligations.[4] The audit recommended a risk-based monitoring policy; performing desk audits based on information reported by local registrars; conducting on-site visits of local registrars requiring more supervision; and having staff follow up with locals on any issues identified through an audit. The Unit developed a site visit monitoring policy based on some of these recommendations.[5] However, a follow-up audit by the State Auditor's Office in 2012 indicated that the Unit had not implemented desk audits, and the Sunset review found that the Unit had made little additional progress since that time.[6]

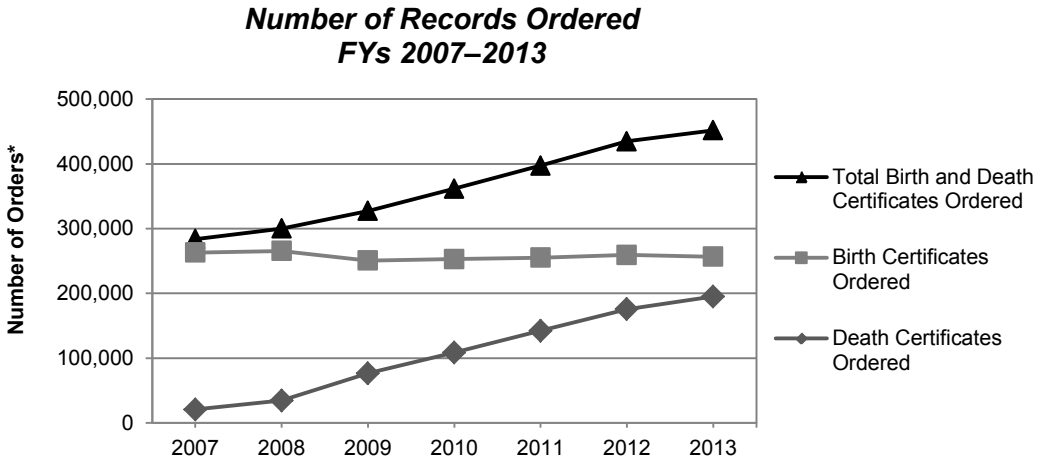
  The Unit does not have access to the information needed to conduct effective desk audits and still does not have an established desk audit policy. Currently, the Unit asks all local registrars to submit a self-assessment containing the needed information, but most do not comply. In fiscal year 2013, only 101 of 422 local registrars responded. The Unit reviewed only 10 of the 101 self-assessments submitted to assess compliance with vital statistics laws, rules, policies, and procedures. Having needed information to perform desk audits and a clear policy directing such reviews would allow the Unit to better assess risk and determine which local registrars need an on-site monitoring visit.

In fiscal year 2013, only 101 of 422 local registrars completed a self-assessment.

- **Limited reconciliation of records.** The Unit does not consistently perform records reconciliation for each local registrar's office. Records reconciliation compares birth records from the originating institution, such as a hospital, to the birth records maintained by the local registrar in the Texas Electronic Registrar system. These comparisons act as a double check to help detect fraud by ensuring fake births are not registered. Because local registrars do not consistently submit the required self-assessments that would provide the information needed for these comparisons, the Unit must perform them manually during on-site monitoring visits. However, as discussed previously, the Unit has only inspected about half of the local registrars in the state in the past five years due to limited resources, greatly limiting the number of these comparisons.

DSHS has only inspected about half of local registrars in the last five years.

- **Weak verification of identity.** The 2012 evaluation of the state's birth record system concluded current requirements are weak for verifying a person's identity before issuing a copy of their records, which increases opportunities for the wrong people to gain access to this important information.[7] The graph on the following page, *Number of Records Ordered*, shows the Unit processed 451,687 requests for birth and death certificate records in fiscal year 2013, a dramatic increase since fiscal year 2007.



* Numbers do not include multiple copies of the same certificate.

When requesting a copy of a birth or death certificate in person, the requestor must provide one form of government issued identification, such as a driver's license or passport, or two approved forms of supplemental documentation, such as an organizational identification card or a credit card.[8] These identification documents allow the registrar to match the identity of the person ordering the record with the record being requested. However, most people order records online or by mail, not in person. In fiscal year 2013, more than 86 percent of birth records orders were conducted online or by mail, but procedures for verifying identity for these orders are weak compared to in-person orders. The 2012 evaluation of the state's birth record system recommended that applications by mail require legible photocopies of identification and suggested adding the use of a third party to establish identity, such as a notary.[9] For online applications, the report recommends requiring scanned copies of legible identification documents or adding a series of authentication questions. DSHS intends to upgrade online verification when it moves to a planned new electronic registration system, but mail-in orders will continue to lack this important security step.

About 48,000 users have access to the state vital records system.

- **Lack of background checks.** The 2012 evaluation of the state's birth record system recommended that the people with access to physical or electronic vital records be required to have a criminal background check to improve security of these records.[10] While DSHS can require background checks for the Unit's employees and anyone who contracts with the Unit, it has been slow to implement this requirement.[11] Additionally, DSHS is not explicitly authorized to require background checks for others with access to the vital records system, currently about 48,000 authorized users including doctors, midwives, and employees of local registrar's offices.[12]

DSHS has not prioritized needed changes to the Vital Statistics Unit and the state vital records system.

As previously discussed, many important recommendations to improve the state's vital statistics functions have languished due to a lack of attention and emphasis. DSHS is a large agency with many important functions, but maintaining the state's vital records should be considered a critical duty of the state's health agency and prioritized as such. However, DSHS has minimized the importance of these functions over the years. In 1903, the Texas Legislature renamed the Texas Quarantine Department the Department of Public Health and Vital Statistics indicating the importance of vital statistics to public health.[13] Today, the Unit operates as a program within DSHS Chief Operating Officer's Division along with the division's other more administrative functions, such as legal, information technology, and contract and oversight services.

DSHS has been extremely slow to implement needed changes.

DSHS has been extremely slow to implement needed changes to the Unit. For example, DSHS received the authority to require background checks for the Unit's employees and contractors in 2009 to improve the security of the state's vital records.[14] However, DSHS chose not to begin implementing this requirement until 2012 when the evaluation of the state's birth record system again recommended background checks.[15] The Unit began developing a background check policy in 2012, but an August 2013 internal audit once again pointed out the lack of such a policy.[16] As of April 2014, DSHS began final review of the policy, almost five years after receiving authority to perform these background checks.

Although DSHS has begun upgrading to a newer, more efficient electronic registration system, it has not prioritized the completion of this long-overdue project. The current electronic registration system has been outdated, costly to maintain, and inefficient for many years, requiring many processes to be performed manually. The 2012 evaluation of the state's birth record system recommended long-needed upgrades to a new system with advanced capabilities, and half of the report's recommendations to improve security depend on the implementation of this new system.[17] On August 30, 2013, DSHS began work on the new system, called the Texas Electronic Vital Events Registrar system, which will be developed through the Department of Information Resources' contract for Texas.gov and is expected to be funded through user fees. In May 2014, DSHS and the Department of Information Resources were still finalizing the business case for procurement of the new system, which the agency estimates should be in place by January 2016.

Recommendations

Change in Statute

6.1 Require all local registrars to submit a self-assessment report to DSHS annually.

Management Action

6.2 DSHS should develop a formal desk audit policy and increase the use of desk audits in monitoring local registrars' offices.

Under these recommendations, statute would require local registrars to submit a self-assessment report to the state registrar annually. The Unit, with input from local registrars, would develop the self-assessment to ensure it provides the information necessary to conduct a thorough desk audit of a local registrar. As a management action, DSHS would be directed to develop a formal desk audit policy to assess a registrar office's compliance with vital statistics laws, rules, and policies, and to conduct more desk audits. By requiring the self-assessments, the Unit would have information from all local registrars' offices, which would improve the efficiency of the Unit's monitoring process, enabling more local registrars' offices to be monitored more frequently. DSHS should ensure the self-assessment includes the information necessary to conduct a reconciliation of records and elevate the risk of any entity whose records do not reconcile appropriately.

Change in Statute

6.3 Require identity verification through notarization for all mail-in vital records orders.

To decrease the likelihood of fraud, this recommendation would require a person to prove their identity through third party verification, or notarization, to receive vital records by mail. The recommendation would apply to records ordered from DSHS or a local registrar's office.[18] In order to validate a notary's signature for these applications, the recommendation would ensure DSHS could gain access to the Secretary of State's list of notary signatures for validation. The recommendation would be in addition to, not instead of existing requirements such as photocopies of legible identification for mail-in orders.

6.4 Expand DSHS' authority to require fingerprint-based criminal history background checks for anyone with access to the state's electronic registration system.

This recommendation would expand DSHS' existing authority to require fingerprint-based criminal background checks, through the Department of Public Safety, for all persons with access to vital records and the vital records electronic registration system, including DSHS employees, contractors, local registrars, medical professionals, funeral directors, and others. The state's fingerprint vendor would collect and submit the fingerprints to the Department of Public Safety. DSHS should develop a policy to implement this recommendation. New employees, contractors, and other system users would provide fingerprints when they are offered a job, and existing contractors would provide fingerprints upon contract renewal. However, DSHS should work with licensing agencies such as the Texas Medical Board to verify the status of individuals who have passed a fingerprint-based background check as part of their licensure requirements, and could accept proof of current licensure as meeting this requirement. DSHS should complete pending policies relating to its own staff under existing authority immediately, and update policies and procedures to implement this expanded authority by March 1, 2016.

Management Action

6.5 DSHS should prioritize and regularly report on its progress implementing the Texas Electronic Vital Events Registrar system.

This recommendation directs DSHS to prioritize the development and implementation of the Texas Electronic Vital Events Registrar system to ensure this important project is not unnecessarily delayed. DSHS should regularly report its progress in developing and implementing the system to the Health and Human Services Commission and the State Health Services Council. Implementation of this system will help ensure needed security of the state's vital records and provide efficiencies in the Unit's operations. These progress reports should include a specific description of current and future needs of the project, along with target dates of completion for all steps in the process and DSHS' status in meeting them. These reports should be provided at least quarterly. The first progress report should be made available by November 1, 2014.

Fiscal Implication

These recommendations would not have a fiscal impact to the State. The recommendation to require third party verification for mail-in applications could result in a small notary cost to individuals requesting mail-in records, but the impact would be minimal, and individuals could still choose to order vital records online or in person if the minimal cost of notarization is prohibitive. The recommendation for DSHS' expanded authority to require criminal history background checks would not result in a significant cost to DSHS, as the agency has already budgeted the approximately $7,000 it will cost to begin conducting checks on its employees. The vast majority of other system users are already required to obtain a background check as a condition of licensure as a physician, funeral director, or other professional, and DSHS could accept verification of current licensure as proof. Approximately 1,478 local registrar staff would have to pay for the background check at a cost of about $45 per person, which could be absorbed within the registrars' existing budgets.

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[1] Office of Inspector General (OIG), Department of Health and Human Services, *Birth Certificate Fraud*, published September 2000, p. 7, http://oig.hhs.gov/oei/reports/oei-07-99-00570.pdf.

[2] Mark DiFraia, Moderator, "The 'State' of Identity Records: Who owns, protects, and uses vital identity documents issued by the State," (panel, ID360 Conference, The Center for Identity, Austin, TX, April 9, 2014), http://identity.utexas.edu/id360.

[3] State Auditor's Office (SAO), *An Audit Report on The Department of State Health Services' Issuance of Birth Certificates: Report No. 10-011*, published November 2009, pp. 3–4, http://www.sao.state.tx.us/reports/report.aspx?reportnumber=10-011; Texas Department of State Health Services (DSHS), *Rider 72: Strengthening The Texas Birth Record Information System*, published September 1, 2012, pp. 51–54, https://www.dshs.state.tx.us/vs/rider72.shtm; DSHS Internal Auditor, *Department of State Health Services' Vital Statistics Unit (Audit #2012-08)*, published June 2012; SAO, *A Follow-up Audit Report on the Issuance of Birth Certificates at the Department of State Health Services: Report No. 13-013*, published December 2012, p. 5, http://www.sao.state.tx.us/reports/report.aspx?reportnumber=13-013; DSHS Internal Auditor, *Background Check Procedures (Project #2013-16)*, published August 30, 2013.

[4] SAO, *An Audit Report on The Department of State Health Services' Issuance of Birth Certificates: Report No. 10-011*, pp. 3–4, http://www.sao.state.tx.us/reports/report.aspx?reportnumber=10-011.

[5] SAO, *An Audit Report on The Department of State Health Services' Issuance of Birth Certificates: Report No. 10-011*, pp. 3–4.

[6] SAO, *A Follow-up Audit Report on the Issuance of Birth Certificates at the Department of State Health Services: Report No. 13-013*, published December 2012, p. 5, http://www.sao.state.tx.us/reports/report.aspx?reportnumber=13-013.

[7] DSHS, *Rider 72: Strengthening The Texas Birth Record Information System*, pp. 51–54, https://www.dshs.state.tx.us/vs/rider72.shtm.

[8] 25 T.A.C. Section 181.28(i)(9-12).

[9] DSHS, *Rider 72: Strengthening The Texas Birth Record Information System*, pp. 51–54.

[10] DSHS, *Rider 72: Strengthening The Texas Birth Record Information System*, pp. 25–28.

[11] Section 411.110(a)(5)(A), Texas Government Code.

[12] Section 411.110(a)(5)(A), Texas Government Code.

[13] DSHS, *Self-Evaluation Report*, published August 2013, p. 43, https://www.sunset.texas.gov/reviews-and-reports/agencies/department-state-health-services-dshs.

[14] Section 411.110(a)(5)(A), Texas Government Code.

[15] DSHS, *Rider 72: Strengthening The Texas Birth Record Information System*, pp. 25–28.

[16] DSHS Internal Auditor, *Background Check Procedures (Project #2013-16)*, p. 1.

[17] DSHS, *Rider 72: Strengthening The Texas Birth Record Information System*.

[18] Ibid., pp. 51–54.

Responses to Issue 6

Recommendation 6.1

Require all local registrars to submit a self-assessment report to DSHS annually.

Agency Response to 6.1

DSHS supports the recommendation to require all local registrars to submit a self-assessment report to DSHS annually. Having the self–assessments will allow DSHS to conduct desk audits and better assess risk and determine the need for onsite monitoring visits. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 6.1

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 6.1

None received.

Recommendation 6.2

DSHS should develop a formal desk audit policy and increase the use of desk audits in monitoring local registrars' offices.

Agency Response to 6.2

DSHS supports the use of desk audits as an additional tool in monitoring local registrars' offices. Performing these audits will increase the efficiency of the monitoring process, enabling DSHS to monitor local registrars' offices more frequently. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 6.2

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 6.2

None received.

Recommendation 6.3

Require identity verification through notarization for all mail-in vital records orders.

Agency Response to 6.3

DSHS can use this requirement as a method of decreasing fraud. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 6.3

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 6.3

None received.

Recommendation 6.4

Expand DSHS' authority to require fingerprint-based background criminal history background checks for anyone with access to the state's electronic registration system.

Agency Response to 6.4

DSHS supports the recommendation and is prepared to work with local registrars, the Department of Public Safety, and licensing agencies to develop policy and procedures to implement this recommendation. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 6.4

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 6.4

None received.

Recommendation 6.5

DSHS should prioritize and regularly report on its progress implementing the Texas Electronic Vital Events Registrar system.

Agency Response to 6.5

DSHS supports the recommendation and will make quarterly progress reports to HHSC and the State Health Services Council. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 6.5

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 6.5

None received.

Commission Decision on Issue 6

The Sunset Commission adopted all staff recommendations in Issue 6.

Issue 7

The State Has a Continuing Need for the Texas Health Care Information Collection Program.

Background

The Legislature created the Texas Health Care Information Council (THCIC) in 1995 to develop a statewide healthcare data collection system to promote the accessibility of good quality, cost-effective healthcare. Statute specifically required THCIC to collect data on healthcare charges, utilization, provider quality, and outcome of care.[1] As part of the 2003 consolidation of health and human services agencies, the Legislature transferred the Council's powers and duties to the Department of State Health Services (DSHS) and abolished its independent board.[2]

THCIC now exists as a program within DSHS' Center for Health Statistics. DSHS contracts with a vendor to collect both inpatient and outpatient discharge data from certain healthcare facilities. The data DSHS collects is based on claims information healthcare providers use for billing purposes, submitted in a standard format established by the American National Standards Institute. The textboxes, *Healthcare Data Collected by DSHS* and *Discharge Data Explained*, provide more information.[3] DSHS makes public use data files of this information available for purchase, with personal identifiers removed, and also prepares specialized files for approved research purposes.[4] Revenue collected totals about $525,000 per year, which is used to partially offset the $1.15 million annual cost of the data collection contract.

The 83rd Legislature directed the Sunset Commission to examine the mission and purpose of the health care information collection program in conjunction with its review of DSHS. House Bill 1394 placed a separate Sunset date on the program and required consideration of whether DSHS is limiting the patient information it collects to the information necessary for performing its duties; maintaining appropriate privacy and security standards for patient information; and achieving the Legislature's intent of empowering consumers with information to make informed healthcare decisions.

Healthcare Data Collected by DSHS

Inpatient data – discharge data from about 580 hospitals totaling three million records annually.

Outpatient data – surgical and imaging discharge data from about 811 hospitals and ambulatory surgical centers totaling 11 million records annually.

Discharge Data Explained

Discharge data are a summary of patient and provider information from a stay in a healthcare facility. Information typically includes:

- patient demographics;
- payer type;
- charge for the care delivered;
- procedures performed during the stay;
- admission source;
- discharge status; and
- provider and facility identifiers.

Findings

DSHS appropriately collects and handles healthcare data following statutory guidelines, internal policies, and contract requirements.

Numerous requirements in federal and state law protect the personal information contained in the discharge data collected by DSHS, as described in the following textbox, *Key Laws Protecting Healthcare Data*. Sunset staff determined that DSHS has appropriate rules, internal policies, and contract requirements in place to safeguard personal information. The program's most commonly distributed information, public use data files, does not include identifiable personal data. DSHS only releases identifiable personal information for approved research purposes after such requests are vetted through an Institutional Review Board and approved by DSHS executive management.[5] DSHS' data collection contractor must develop an annual Information System Security Plan following rules meeting Texas Department of Information Resources guidelines, and conducts an annual web vulnerability scan to test the data collection system. During the review, Sunset staff did not identify any significant incidents regarding inappropriate release of THCIC data.

Key Laws Protecting Healthcare Data

Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) Act

- Defines federal privacy and security standards to protect the confidentiality and integrity of individually identifiable health information.
- Applies federal civil and criminal penalties for noncompliance.

Chapter 108, Texas Health and Safety Code

- Restricts access to and use of healthcare data collected by DSHS.
- Requires Institutional Review Board approval for release of research data.
- Applies state civil and criminal penalties for noncompliance.

DSHS complies with statutory direction to use an industry-standard claims format whenever possible to collect the information.[6] This claims format is regularly used by and exchanged between healthcare providers, insurance companies, and other parties. Statute also specifically requires DSHS to collect additional information about patient race and ethnicity.[7] This information, not standard to the claims format, provides valuable information for research purposes, but increases the complexity of reporting requirements.

DSHS collects healthcare data from fewer sources than allowed by law.

In terms of information necessary for performing its duties, DSHS collects data from fewer sources than allowed for by law. The program could require information from a broader range of healthcare facilities such as birthing centers and renal dialysis facilities, but resources have never allowed collection from all types of facilities. Currently, DSHS prioritizes data collection efforts to hospitals and ambulatory surgical centers as directed by the Legislature.[8] Recently,

the Legislature expanded the program's funding and authority to allow data collection from previously exempted rural facilities and emergency departments, which will begin in January 2015. DSHS anticipates the emergency department data will be particularly useful as a source for evaluating healthcare utilization trends.

The health care information collection program is the state's primary source for data used to understand and improve the status of the healthcare system.

State agencies, hospitals, health departments, universities, academic researchers, and others use the discharge data collected by DSHS to evaluate healthcare quality and investigate public health trends such as disease incidence. The textbox, *Examples of Discharge Data Use*, provides more information. Since 2003, more than 300 entities have purchased or received public use or research data files through the program.[9]

Examples of Discharge Data Use

- DSHS-produced reports such as *Indicators of Inpatient Care in Texas* and *Preventable Hospitalizations*.
- Applied public health research such as *Hospitalizations of Children from Peanut Allergies* and *Trends in Occurrence of Preeclampsia and Eclampsia in Texas*.
- Market analysis by reporting facilities and others in the healthcare industry.

Both inpatient and outpatient data are beneficial to the program, but the use of outpatient data is not as developed. In recent years, about 30 applied research articles using the program's inpatient data have been published, but the outpatient data have not yet proved as useful for academic research.[10] National standards for using inpatient data to develop hospital quality indicators are well developed as a result of decades of interest and work, but these standards are not as clear for using outpatient data, which DSHS only began collecting in 2009. However, efforts on both the national level and within DSHS are currently underway to put the outpatient data to better use, including identifying agreed-upon quality indicators. Overall, while the use of outpatient data needs some additional development, all of the data sets collected through the program are reliable and useful sources of information to better understand issues affecting the healthcare industry, and the program continues to serve a useful purpose.

Use of outpatient data is not as well developed as inpatient data.

Both inpatient and outpatient discharge data collected by DSHS includes unique information not collected or duplicated in other systems. While other programs such as Medicaid and Medicare have access to claims data for enrollees in those programs, DSHS has complete information on all payers for the categories of data it collects, including patients with private insurance and the uninsured. This information fills an important data gap, allowing comparisons and analysis among various programs and populations.

DSHS' data collection efforts follow national trends. Across the country, 48 states and the District of Columbia collect inpatient hospital discharge data.[11] At least 10 states collect far more data than Texas in the form of all-payer claims databases that require reporting from all healthcare providers, insurers, and facilities.[12] Data collected in Texas and across the states are fairly uniform, allowing aggregation and analysis by federal programs such as the Agency for Healthcare Research and Quality.[13]

DSHS has not met expectations to provide useful consumer data to guide informed healthcare choices.

Information provided by DSHS is not user-friendly or relevant.

A key goal of the health care information collection program is to provide consumers with information about healthcare quality and costs to encourage informed decision making, but DSHS has not yet met this challenge. Currently, DSHS provides some basic quality information targeted to consumers on its website, such as a database of hospital-level inpatient quality indicators by geographic area.[14] However, this information is not particularly user-friendly or relevant, since it is based on several years-old data. Additionally, the information is in a complex format an average person would have difficulty using, with no interpretation or analysis provided to help consumers understand the practical meaning of the data presented. Currently, DSHS provides no consumer information based on the outpatient data it collects.

Recently, DSHS has taken steps to improve how information is displayed for the general public, and plans to release a new website in June 2014 to display inpatient data using nationally developed quality indicators. The system, developed by the Agency for Healthcare Research and Quality, is used in other states such as Arizona and Maine to standardize and display discharge data in a more user-friendly format.[15] While this effort should improve consumer access to more easily understood information, it is only a first step. Given the many ongoing changes in the healthcare industry and the growing interest in this type of information, DSHS must continue to focus on improving the usefulness and understandability of both inpatient and outpatient data for the general public.

The State's approach to the collection and analysis of healthcare quality and cost data should be evaluated as part of the later Sunset review of the overall health and human services system.

Efforts to collect, coordinate, and use healthcare data are scattered throughout agencies and programs.

The health care information collection program at DSHS is just one part of several data collection and analysis efforts within the Texas health and human services system. Other than elimination of the program's independence and board, its enabling statute has not been significantly revised since its establishment in 1995. Since that time, the Legislature has expressed a clear and continuing interest in better collecting, coordinating and using data to understand healthcare cost drivers and improve quality, but the resulting efforts are scattered among several different initiatives and programs throughout the system.

In 2011, the Legislature created the Texas Institute of Health Care Quality and Efficiency "to improve health care quality, accountability, education, and cost containment in this state," a mission that seems similar to the original goals of THCIC, though the Institute's goals are much broader.[16] In 2013, the Legislature directed all agencies within the health and human services system to share data to facilitate quality improvements and cost savings.[17] Additionally, the Health and Human Services Commission contracts with an external quality

review organization to analyze Medicaid claims information and report on quality outcomes and costs. As the Sunset Commission continues its evaluation of the health and human services system, it should continue examining how this program's mission fits within this broader context.

Recommendations

Change in Statute

7.1 Continue the health care information collection program, but evaluate how its functions fit within the broader health and human services system as part of the later Sunset review.

This recommendation would continue the state's efforts to collect inpatient and outpatient discharge data. This valuable data aids in research and policy purposes that can help promote the accessibility of good quality, cost-effective healthcare. Under this recommendation, the program would not have a separate Sunset date, but would be subject to Sunset review at the same time as DSHS, should the program remain at DSHS.

While the discharge data collected is needed, the Sunset Commission should continue evaluating the state's overall approach to collecting, sharing, and using healthcare data as part of the ongoing review of the entire health and human services system, scheduled to be completed in the fall of 2014. Assessing healthcare data collection and dissemination in the context of a comprehensive evaluation of the health and human services system would permit a broader analysis of improved coordination and structural options than the review of DSHS alone can provide.

Management Action

7.2 Direct DSHS to continue its efforts to improve the display and interpretation of healthcare data for consumers.

While Sunset staff concluded the discharge data collected by DSHS is important for research and policy purposes and the program should continue, the review also revealed a need to better translate this data for consumer and policymaking use, particularly outpatient data. This recommendation would direct DSHS to continue to work towards providing the data in formats that are timely, useful, accurate, and understandable, particularly to consumers and policymakers.

Fiscal Implication

This recommendation would not have a significant fiscal impact to the State. Continued appropriations of approximately $1.65 million per year would be needed to support the program's operations. This amount includes about $525,000 in appropriated receipts generated from fees collected each year from purchases of the public use data files created by the program.

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[1] Section 108.006(a), Texas Health and Safety Code.

[2] Section 108.0026, Texas Health and Safety Code.

[3] Denise Love and Barbara Rudolph, *Health Data Systems at a Crossroads* (Salt Lake City, Utah: National Association of Health Data Organizations, 2012), p. 2.

[4] Section 108.002(17), Texas Health and Safety Code, defines "public use data" as "patient level data relating to individual hospitalizations that has not been summarized or analyzed, that has had patient identifying information removed, that identifies physicians only by use of uniform physician identifiers, and that is severity and risk adjusted, edited, and verified for accuracy and consistency."

[5] Section 108.0135, Texas Health and Safety Code.

[6] Section 108.009, Texas Health and Safety Code.

[7] Section 108.009(k), Texas Health and Safety Code.

[8] Sections 108.002(10) and 108.006(b)(3), Texas Health and Safety Code.

[9] Texas Department of State Health Services, *Organizations Receiving Data from THCIC*, accessed April 15, 2014, https://www.dshs.state.tx.us/thcic/DataPurchasers.pdf.

[10] Texas Department of State Health Services, *Published articles using the Texas Hospital Inpatient Discharge Data*, accessed April 14, 2014, http://www.dshs.state.tx.us/thcic/GeneralInfo/AppliedResearch.shtm.

[11] Love and Rudolph, *Health Data Systems at a Crossroads*, p. 2.

[12] National Conference of State Legislatures, "Collecting Health Data: All-Payer Claims Databases," *NCSL Briefs for State Legislators No. 4* (May 2010): p. 2.

[13] Love and Rudolph, *Health Data Systems at a Crossroads*, pp. 2–3.

[14] Texas Department of State Health Services, *Hospital Level Inpatient Quality Indicators*, accessed April 14, 2014, www.prod.dshs.state.tx.us/THCIC/Publications/Hospitals/IQIReport/IQIquerybyareatest.shtm.

[15] For examples of other states using the AHRQ's system to display consumer data, see: Arizona Department of Health Services, *2011 AZ Hospital Compare*, accessed April 14, 2014, pub.azdhs.gov/hospital-discharge-stats/2011/index.html; Maine Health Data Organization's MONAHRQ Website, accessed April 14, 2014, gateway.maine.gov/mhdo/monahrq/index.html.

[16] Section 1002.002, Texas Health and Safety Code.

[17] Section 531.024(a-1), Texas Government Code.

Responses to Issue 7

Recommendation 7.1

Continue the health care information collection program, but evaluate how its functions fit within the broader health and human services system as part of the later Sunset review process.

Agency Response to 7.1

DSHS agrees that there is a continued need for data collection to support research and provide information for policy development to promote quality health care. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 7.1

Barbara Cherry, Professor and Department Chair – Texas Tech University Health Sciences Center, Lubbock

Margie Dorman-O'Donnell, President – Texas Nurses Association, Austin

Bill Hammond, CEO – Texas Association of Business, Austin

John Hawkins, Senior Vice President of Advocacy & Public Policy – Texas Hospital Association, Austin

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Mari Tietze, Associate Professor – Texas Woman's University, Irving

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Stephanie Woods, Associate Dean, College of Nursing – Texas Woman's University, Dallas

Cindy Zolnierek, Executive Director – Texas Nurses Association, Austin

Against 7.1

Representative Susan L. King, Member – Texas House of Representatives

Stephen Blake, CEO Administrator – Central Park Surgery Center

Anthony German, Executive Director – Texas Ambulatory Surgery Center Society, Austin

Isiah Gordon, Administrator – Northwest Surgery Center

Austin King, M.D., President – Texas Medical Association, Austin

Bruce Levy, CEO – Texas Ambulatory Surgery Center Society, Austin

William "Chip" Riggins, M.D., Member – Texas Medical Association's Council on Science and Public Health

Jill Sluder, Administrator – Texas Ambulatory Surgery Center Society, Austin

Sunset Member Modifications

1. Require DSHS to create a waiver process in rule to exempt facilities that conduct less than 600 procedures annually and lack information technology systems capable of automated reporting of most of their claims to THCIC. Rules should require each facility seeking exemption to annually certify the number of procedures performed in the previous year, and the current technological capabilities of their reporting system. (Senator Charles Schwertner, Member – Sunset Advisory Commission)

2. Direct DSHS to provide the claims data collected through the THCIC program to the state's current Medicaid External Quality Review Organization (EQRO) in a manner that can be analyzed by the EQRO. Direct HHSC to expand the current EQRO database used to aggregate Medicaid data to include all-payer data collected by THCIC no later than September 1, 2015. (Senator Charles Schwertner, Member – Sunset Advisory Commission)

3. Direct DSHS to replace the current THCIC data certification process with an optional data validation process that gives submitting facilities a 30-day period to verify the accuracy of their data submissions. (Senator Charles Schwertner, Member – Sunset Advisory Commission)

4. Clarify that providers required to submit data to THCIC are not liable for damages or penalties relating to inappropriate use or disclosure of data by the state after being received by THCIC. (Senator Charles Schwertner, Member – Sunset Advisory Commission)

Modifications

5. Require the removal of all identifying elements in the current healthcare information stored by THCIC. Eliminate data collection programs within DSHS, such as parts of THCIC, Annual Survey of Hospitals, and Annual Statement of Community Benefits that do not accomplish the legislative objective to provide patients with information that will allow them to make informed healthcare decisions. (Austin King, President – Texas Medical Association, Austin)

6. Remove the THCIC reporting requirement for Ambulatory Surgical Centers. (Stephen Blake, CEO Administrator – Central Park Surgery Center)

Recommendation 7.2

Direct DSHS to continue its efforts to improve the display and interpretation of healthcare data for consumers.

Agency Response to 7.2

DSHS supports the recommendation and is committed to improving the timeliness, usefulness, accuracy, and clarity of data for consumers and policymakers. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 7.2

Barbara Cherry, Professor and Department Chair – Texas Tech University Health Sciences Center, Lubbock

Margie Dorman-O'Donnell, President – Texas Nurses Association, Austin

Bill Hammond, CEO – Texas Association of Business, Austin

John Hawkins, Senior Vice of President Advocacy & Public Policy – Texas Hospital Association, Austin

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Mari Tietze, Associate Professor – Texas Woman's University, Irving

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Stephanie Woods, Associate Dean, College of Nursing – Texas Woman's University, Dallas

Cindy Zolnierek, Executive Director – Texas Nurses Association, Austin

Against 7.2

Stephen Blake, CEO Administrator – Central Park Surgery Center

Anthony German, Executive Director – Texas Ambulatory Surgery Center Society, Austin

Isiah Gordon, Administrator – Northwest Surgery Center

Austin King, M.D., President – Texas Medical Association, Austin

Bruce Levy, CEO – Texas Ambulatory Surgery Center Society, Austin

Jill Sluder, Administrator – Texas Ambulatory Surgery Center Society, Austin

Modifications

7. Provide modest additional funding to develop online tools to improve consumer access to information on healthcare costs and quality, and make the public use data file accessible to more organizations by reducing user fees. (Bill Hammond, CEO – Texas Association of Business, Austin)

8. As data from the Texas Health Care Information Collection Program becomes more available in an electronic format, require the data to be produced with less lag time so it is more relevant to the consumer in the moment. (Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin)

Commission Decision on Issue 7

The Sunset Commission adopted all staff recommendations in Issue 7. In addition, the Sunset Commission adopted the following modifications to Recommendation 7.1, regarding the continuation of the health care information collection program.

- Modification 1, requiring DSHS to create a waiver process for small facilities required to submit data.
- Modification 2, providing THCIC data to the Medicaid external quality review organization.
- Modification 3, replacing the current data certification process with an optional data validation process.
- Modification 4, clarifying that providers required to submit data are not liable for inappropriate data use or disclosure by THCIC.

Issue 8

DSHS' Numerous Advisory Committees Lack Strategic Purpose, Limiting Their Effectiveness and Wasting Resources.

The use of advisory groups to provide avenues for stakeholder input is critical in an agency as large and diverse as the Department of State Health Services (DSHS). The agency has more than 55 advisory committees, councils, and independent boards with a wide variety of structures and duties. These entities became a part of DSHS as a result of the health and human services consolidation in 2003, legislative additions over time, and DSHS' own actions. State law requires 50 of these groups and DSHS established the others in rule under its general authority.[1] For groups with available fiscal year 2014 budgets, DSHS estimates it will spend about $450,000 and dedicate time equal to 45 full-time staff to manage these efforts.

While state law requires agencies to meet basic standards for public input to ensure open and responsive government, the Legislature has also acknowledged the need to regularly assess whether such input is effective. The Texas Sunset Act directs the Sunset Commission and staff to consider the effectiveness and efficiency of advisory committees as part of every agency's Sunset review.[2] Other laws and Health and Human Services Commission (HHSC) policies also require ongoing evaluation and review of such committees, as shown in the textbox, *Key Advisory Committee Laws and Policies*.

Key Advisory Committee Laws and Policies

- **Section 325.011, Texas Government Code:** Outlines criteria for the Sunset review of agencies or their advisory committees.
- **Chapter 2110, Texas Government Code:** Requires regular evaluation of state agency committee costs, effectiveness, and duration.
- **Section 11.016, Texas Health and Safety Code:** Authorizes DSHS to appoint advisory committees in rule as needed.
- **HHSC Circular C-022:** Establishes system-wide guidelines for all health and human services agencies' advisory committees, including a biennial report to evaluate continued usefulness of committees.

Sunset staff looked at DSHS' advisory committees created in law to determine whether they are still active or not, and if so, whether they still need to be established specifically in law. To focus the analysis, Sunset staff excluded advisory groups recently created by the Legislature and those whose appointing entities or purpose extend beyond the administration of DSHS programs. The analysis also excluded discussion of 19 behavioral health and regulatory advisory groups, which are addressed separately in Issues 2 and 3 of this report.

Findings

Statutorily created advisory groups are difficult for DSHS to modify to meet evolving needs and changing conditions.

The Legislature creates advisory committees to provide information or expertise to agencies on select matters. Statutorily created groups often have built-in feedback mechanisms, such as reporting requirements, but establishing them in statute can lock agencies into narrowly defined ways of obtaining input without the flexibility to change or abolish groups as needs, priorities, and conditions

evolve. DSHS has general authority to appoint advisory committees by rule, which allows the agency to create groups as needed without the perpetuity and limitations imposed by statutory requirements.[3]

In addition to the recommendations in Issues 2 and 3 of this report, the Sunset review identified eight additional advisory groups that should be removed from statute to provide DSHS needed flexibility, as described in the textbox, *DSHS Committees to Remove From Statute*. Half of these groups are currently active, while the others are inactive or have achieved their original purpose, indicating they are no longer necessary. The active ones serve a valuable purpose and should continue in some form, but should be removed from statute to allow DSHS to adjust their purposes and duties as conditions warrant.

DSHS Committees to Remove From Statute

Inactive Committees – eliminate

- **Arthritis Advisory Committee:** Has not met since 2007; completed one-time duties in 2007.
- **Texas Medical Child Abuse Resources and Education System (MEDCARES) Advisory Committee:** Has not met since 2010; completed one-time duties in 2010.
- **Youth Camp Training Advisory Committee:** Has not met since 2005; a 2012 DSHS review did not recommend continuation of the committee.
- **Sickle Cell Advisory Committee:** Established in 2011; Governor never made appointments.

Active Committees – direct DSHS to create in rule as needed

- **Advisory Panel on Health Care Associated Infections and Preventable Adverse Events:** Guides implementation, development, maintenance, and evaluation of the Texas Health Care-Associated Infection and Preventable Adverse Events Reporting System.
- **Newborn Screening Advisory Committee:** Advises regarding strategic planning, policies, rules, and services, and reviews the necessity of requiring additional screening tests for newborn babies.
- **Worksite Wellness Advisory Board:** Advises on statewide worksite wellness issues.
- **Youth Camp Advisory Committee:** Advises and makes recommendations to develop standards, procedures, and rules relating to the Youth Camp Act.

Without a clear strategy, use of advisory groups at DSHS is haphazard, wasting stakeholder and DSHS resources.

DSHS lacks an overall, strategic approach to managing advisory committees and other groups for obtaining stakeholder input. Responsibilities, appointment structures, and evaluation requirements of these groups vary considerably, making a consistent overall approach that ensures effective use of DSHS and stakeholder resources difficult. When looking broadly at DSHS' functions, some narrow interests that have advisory committees, such as youth camps, seem to receive a disproportionate amount of agency resources and attention as compared to other major programs without formal advisory groups such as the regulation of hospitals. DSHS also collects stakeholder input through informal means for many programs, convening ad hoc groups as needed.

Valuable time and effort is dedicated to supporting advisory groups, in the form of both tangible state resources and donated stakeholder time, but the outcome of much of this activity is unclear. During the Sunset review, DSHS stakeholders, including advisory committee members, often cited confusion about their roles and a lack of understanding about how their input actually influences policy and operations.

DSHS does not have a unified vision for the use of all its committees.

Simply identifying and cataloging all the groups that exist is a challenge, as DSHS and HHSC provided inconsistent information regarding the groups during the Sunset review. The lack of clarity regarding basic committee information indicates the agency as a whole does not have a unified vision for the purpose and use of all these groups, much less a systematic approach to their management. HHSC Circular C-022 establishes several criteria on which to evaluate advisory committees, but this policy alone is not enough to ensure a full review and effective management of DSHS' numerous avenues for stakeholder input. In fact, a 2012 DSHS review conducted under guidance from the Circular did not look at all advisory groups, and did not result in meaningful changes to their number or management.

Recommendations

Change in Statute

8.1 Remove eight of DSHS' advisory committees from statute and direct DSHS to re-establish active committee functions in rule as needed.

The recommendation would eliminate several inactive advisory groups and provide DSHS the flexibility to change others as needed by removing the following groups from statute:

a. Arthritis Advisory Committee (inactive)

b. Texas Medical Child Abuse Resources and Education System (MEDCARES) Advisory Committee (inactive)

c. Youth Camp Training Advisory Committee (inactive)

d. Sickle Cell Advisory Committee (inactive)

e. Advisory Panel on Health Care Associated Infections and Preventable Adverse Events (active)

f. Newborn Screening Advisory Committee (active)

g. Worksite Wellness Advisory Board (active)

h. Youth Camp Advisory Committee (active)

The recommendation would also direct DSHS, to re-create any active advisory committees in rule as needed using its existing authority to create formal committees or other informal stakeholder groups. DSHS should seek input from existing committee members and other stakeholders when updating committee duties, and work to streamline functions whenever possible.

Management Action

8.2 Direct DSHS to review and revise its internal advisory committee policies and to regularly evaluate all of its advisory groups.

This recommendation would direct DSHS to review, revise, and streamline its internal policies and overall use of advisory groups and other avenues for stakeholder input. DSHS should consult with the State Health Services Council and HHSC executive commissioner to ensure consistency with HHSC policies on use of advisory committees. DSHS should revise policies to include clear, agencywide goals for the creation, use, and expiration of advisory committees and informal stakeholder groups, including how their duties and input should be managed and reported to DSHS executive staff and the State Health Services Council.

This recommendation would also direct DSHS to conduct a comprehensive inventory and evaluation of its advisory groups to ensure key agency functions have effective avenues for regular stakeholder input. The evaluation would also provide the opportunity for DSHS to streamline these groups when possible, especially those with narrow or overlapping scope. This evaluation would apply to all advisory groups and would not be limited to those subject to Chapter 2110, Texas Government Code or HHSC Circular C-022. As a matter of policy, DSHS should conduct this evaluation each biennium, with the first inventory and evaluation due no later than November 1, 2014.

If this evaluation identifies additional opportunities for reducing the number of statutory advisory groups or barriers to effective management of stakeholder input, DSHS should provide recommendations for any needed legislative action. DSHS should initially provide these recommendations to the Sunset Advisory Commission no later than November 1, 2014. In future biennia, DSHS should provide this information to the Senate Health and Human Services and House Public Health and House Human Services committees, in coordination with HHSC.

Fiscal Implication

This recommendation would not have a significant fiscal impact to the State.

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[1] Section 11.016, Texas Health and Safety Code.

[2] Section 325.011, Texas Government Code.

[3] Section 11.016, Texas Health and Safety Code.

Responses to Issue 8

Recommendation 8.1

Remove eight of DSHS' advisory committees from statute and direct DSHS to re-establish active committee functions in rule as needed.

Agency Response to 8.1

DSHS accepts the recommendation and agrees it will give the agency flexibility to meet the evolving needs of stakeholder input. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 8.1

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

For 8.1(c) – Relating to the Youth Camp Training Advisory Committee

Brian Colbrath, Manager – Circle Six Ranch Baptist Camp, Lenorah

Joseph Domino, Vice President of Outdoor Adventures – Boy Scouts of America Southern Region, Beaumont

William Hinton, Executive Director – YMCA Camp Flaming Arrow, Hunt

Nicia Oakes, Director – Camp Honey Creek, Hunt

Kurt Podeszwa, Camp Director – Camp for All, Burton

Allen Smith, Austin

Against 8.1(f) – Relating to the Newborn Screening Advisory Committee

Bill Morris, Chairman – Texas Newborn Screening Advisory Committee, Canyon Lake

Mark Ward, M.D., FAAP, President and Laura Blanke, Education Manager – Texas Pediatric Society, Austin

Against 8.1(h) – Relating to the Youth Camp Advisory Committee

Susan Alter, Camp Specialist – Baptist General Convention of Texas, Dallas

Rod Anderson, Director – Victory Camp, Alvin

Steve and Susan Baskin, Directors – Camp Champions, Marble Falls

David Baur, Area Director – Boy Scouts of America, Spring

Alton Belew, Executive Director – Riverbend Retreat Center, Glen Rose

Paul Biles, Executive Director – Tejas Ministries, Giddings

Brian Colbath, Manager – Circle Six Ranch Baptist Camp, Lenorah

Britt Darwin-Looney, Vice President of Youth Development Services – Praesidium Inc., Arlington

Danny Dawdy, Executive Director – Highland Lakes Camp and Conference Center and CEO – Texas Baptist Camping Association, Spicewood

Joseph Domino, VP Outdoor Adventures – Boy Scouts of America Southern Region, Beaumont

Dick and Tweety Eastland – Camp Mystic for Girls, Hunt

Jeff Edmonds, Executive Director – Camp Buckner, Burnet

Tommy Ferguson – Camp Olympia, Trinity

Art Hawkinson, Business Manager – Camp Peniel, Inc., Marble Falls

Amber Hicks, Development Director – Stoney Creek Ranch, Houston

Charles Hill, Executive Director – Chaparral Baptist Assembly, Inc., Iowa Park

William Hinton, Executive Director – YMCA Camp Flaming Arrow, Hunt

Andy Hockenbrock, Executive Director – YMCA Camp Carter, Fort Worth

Tim Huchton, Executive Director – American Camp Association, Kerrville

Ron Hunt, Camp Executive Director – Camp Wilderness Ridge, Smithville

Shirley Jamieson, Director – Camp Cedarbrook, Rosebud

Ken Lamb, Hunt

Andrew Martin, Executive Director – Panfork Baptist Encampment, Wellington

Ashley MacKenna, Director – Camp Longhorn and Camping Association for Mutual Progress, Burnet

Jered Meeks, Assistant Director – Hidden Falls Ranch, Wayside

Susan Merrill, Director of Programs – Camp Fire Camp El Tesoro, Granbury

Robert Miller, Camp Assessment Chairman – Boy Scouts of America Southern Region, Cibolo

Nicia Oakes, Director – Camp Honey Creek, Hunt

John Pfalser, Operations Manager – Sky Ranch, Van

Kurt Podeszwa, Camp Director – Camp for All, Burton

Matt Raines, Executive Director – Frontier Camp, Grapeland

Rhonda Roberts, Executive Director – Heart of Texas Baptist Camp, Brownwood

John Robertson, General Partner – Camp Longhorn, Burnet

Peter Schmidt, Director – CrossView Christian Camp, Dickens

Ann Sheets, Sr., Vice President – Camp Fire First Texas, Fort Worth

Rand Southard, Founder – Charis Hills Camp, Sunset

Allen Smith, Austin

Blake Smith, Director – Camp La Junta, Hunt

Aimee Sproles, Chief Operating Officer – GSSJC, Houston

Charles Stark, Director of Outdoor Ministry – Slumber Falls Camp, New Braunfels

Caroline Thomas – Stoney Creek Ranch, Houston

Ed Walker, Director of Camp/Sport Leadership – Dallas Baptist University, Rockwall

Mike Wentz, Executive Director – Ceta Canyon Camp & Retreat Center, Happy

Mike Wilson, CEO – Latham Springs Camp and Retreat Center, Aquilla

Edward Woodlock, Retired National Director Health/Safety – Boy Scouts of America and Lead Camp Visitor – American Camp Association, Flower Mound

Sunset Member Modifications

1. Modify staff recommendation 8.1 by striking part (h) relating to the Youth Camp Advisory Committee. This change would keep the functions and duties of the Youth Camp Advisory Committee in state law as currently exist today. (Dawn Buckingham, M.D., Member – Sunset Advisory Commission)

2. Modify staff recommendation 8.1 by striking part (f) relating to the Newborn Screening Advisory Committee. This change would keep the functions and duties of the Newborn Screening Advisory Committee in state law as they currently exist today. (Senator Charles Schwertner, Member – Sunset Advisory Commission)

Modification

3. Abolish the Youth Camp Act and establish a new department to oversee camps, recreation organizations, fun parks, and other seasonal activities. (Danny Dawdy, Executive Director – Highland Lakes Camp and Conference Center and CEO – Texas Baptist Camping Association, Spicewood)

Recommendation 8.2

Direct DSHS to review and revise its internal advisory committee policies and to regularly evaluate all of its advisory groups.

Agency Response to 8.2

DSHS supports the recommendation and believes it will ensure key agency functions have effective avenues for stakeholder input, while improving the efficiency of such efforts. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 8.2

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 8.2

None received.

Modification

4. Direct DSHS to seek and include stakeholder input when reviewing advisory groups. (Gyl Switzer, Public Policy Director – Mental Health America of Texas, Austin)

Commission Decision on Issue 8

The Sunset Commission adopted Recommendation 8.1(a), (b), (c), (d), (e), and (g), and Recommendation 8.2. The Sunset Commission did not adopt Recommendation 8.1(f) relating to the Newborn Screening Advisory Committee or Recommendation 8.1(h) relating to the Youth Camp Advisory Committee.

Issue 9

The State Should Continue Protecting Public Health and Providing Basic Health Services, but Decisions on DSHS' Structure Await Further Review.

Background

With a $3 billion annual budget, nearly 200 diverse programs, and more than 12,000 employees, the Department of State Health Services (DSHS) is one of the largest and most complex agencies in Texas. The Legislature created DSHS in its current form in 2003 by consolidating all or part of four agencies: the Texas Department of Health, the Texas Department of Mental Health and Mental Retardation, the Texas Commission on Alcohol and Drug Abuse, and the Texas Health Care Information Council. The agency's broad mission is to improve health and well-being in Texas, which it carries out through the following key activities:

- prevents and prepares for public health threats, including controlling the spread of infectious disease through immunizations, early detection, outbreak response, and public education;
- operates the state's public health laboratory, including the newborn screening program;
- contracts with providers and funds local health departments to improve community health by ensuring Texans have access to health services, prevention, and treatment;
- promotes recovery for persons with substance use disorders, mental illness, and certain infectious diseases by funding services and providing inpatient hospitalization at the Texas Center for Infectious Disease, nine state mental health hospitals, the Waco Center for Youth, and Rio Grande State Center;
- protects consumers by regulating a large array of healthcare professions and facilities, as well as consumer services and products like food and drug manufacturers;
- regulates and supports development of the state's emergency medical services and trauma system; and
- collects, analyzes and disseminates public health data and information critical to health policy decision making, including maintaining the state's vital records such as birth and death certificates.

Findings

The State has a continuing need to protect public health by ensuring the provision of essential public health services to all Texans.

DSHS impacts every Texan through its core public health programs, from ensuring the state's food supply is safe to being prepared to respond to disasters and disease outbreaks. DSHS also serves as the local health department in areas of the state without one — without DSHS' eight Health Service Regions, 20 percent of the state's population would lack basic protections such as restaurant inspections, tuberculosis control, and access to vaccines for many children

and adults. These public health duties are critical to the effective functioning of the state's economy and society and should clearly continue as essential government responsibilities.

Without an entity to run DSHS' many programs, Texas would lose more than $1 billion each year in federal funds.

DSHS is not only a traditional public health agency, as it also provides certain direct healthcare services, including mental health and substance abuse services and nutritional support for women, infants, and children. Without a state entity to administer these programs, Texas would lose more than $1 billion annually in federal funds. Additionally, thousands of DSHS partners such as local health departments, community mental health centers, substance abuse programs, and public health clinics would lack critical funding to serve people in need. One of DSHS' most critical and costly functions is operating the state's nine mental health hospitals, which served more than 13,000 Texans in fiscal year 2013. These hospitals are essential to ensure the State meets its duty to provide treatment to these individuals, many of whom pose a danger to themselves or others.

A number of DSHS programs may seem small or tangential to essential government services, such as providing services to people with specific health conditions such as kidney disease. However, the federal government and Legislature have continued to fund these efforts to stay ahead of issues that when left unchecked, lead to much more costly problems. Providing services to a person with a complex and costly health condition such as kidney failure can both improve individual health outcomes and significantly reduce government costs by preventing visits to emergency rooms and dependence on other, more costly government programs. For these reasons, the Sunset review concluded that DSHS' safety net programs should generally continue, though opportunities for considering their organizational placement to increase efficiency and effectiveness should be considered as part of the larger Sunset review of the health and human services system, as discussed below.

Finally, while the overall evaluation of DSHS concluded that its core functions should continue, Sunset staff identified several regulatory programs that are no longer needed or should be placed at another agency outside the health and human services system to allow DSHS to focus on its core public health functions. Issue 3 of this report provides detailed analysis and recommendations relating to DSHS' more than 70 regulatory programs.

DSHS' organizational structure must be evaluated in conjunction with the health and human services system overall.

DSHS operates under the oversight of the Health and Human Services Commission (HHSC) and is part of the larger health and human services system. The breadth and scope of DSHS' many programs beg immediate questions about its organizational arrangement, but these issues are best evaluated as part of the larger Sunset review of the overall system, scheduled for completion in fall 2014. Therefore, this report does not include findings regarding the appropriateness of DSHS' current structure within the system.

Certainly, the Sunset Commission should evaluate whether the consolidation of so many functions into one agency in 2003 still makes sense 11 years later. As noted throughout this report, the sheer scope and complexity of DSHS' many responsibilities poses challenges to its management and focus. Obvious questions include looking at DSHS' role to run nine state mental health hospitals, as discussed in Issue 1. In addition, Sunset staff determined that an analysis of the State's approach to women's health services would be more appropriate when programs operated by both DSHS and HHSC can be considered together. Finally, evaluating the continued placement of some health services programs at DSHS may be warranted, given the considerable changes taking place due to healthcare reform and Texas' continued expansion of Medicaid managed care. However, delaying decisions on broader organizational questions relating to DSHS will allow Sunset staff to finish its work on the system overall and base its recommendations on the most complete information.

The sheer scope and complexity of DSHS pose challenges to its management and focus.

All but one of DSHS' reporting requirements continue to be useful.

The Sunset Act establishes a process for the Sunset Commission to consider if reporting requirements of agencies under review need to be continued or abolished.[1] The Sunset Commission has interpreted these provisions as applying to reports required by law that are specific to the agency and not general reporting requirements that extend well beyond the scope of the agency under review. Reporting requirements with deadlines or that have expiration dates are not included, nor are routine notifications or notices, posting requirements, or federally mandated reports. Reports required by rider in the General Appropriations Act are also omitted under the presumption that the appropriations committees have vetted these requirements each biennium. Appendix F lists DSHS' statutory reporting requirements, all of which Sunset staff found are useful and should be continued, except for the report on state agency indoor air quality that would no longer be needed if the related program is discontinued as recommended in Issue 3.

Recommendation

9.1 Postpone the decision on continuation of DSHS' functions and structure until the completion of the Sunset review of the health and human services system.

While DSHS' core functions are clearly needed, the Sunset Commission should not decide on continuation of DSHS and its functions until Sunset staff completes its evaluation of the health and human services system in the fall of 2014. Deciding the best structure for DSHS' functions in the context of a comprehensive evaluation of the system would permit a broader analysis of organizational options than the review of DSHS alone can provide.

Fiscal Implication

This recommendation would not have a fiscal impact to the State.

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[1] Sections 325.0075, 325.011(13), and 325.012(a)(4), Texas Government Code.

Responses to Issue 9

Recommendation 9.1

Postpone the decision on continuation of DSHS' functions and structure until the completion of the Sunset review of the health and human services system.

Agency Response to 9.1

DSHS agrees that agency functions are vital to ensuring a healthy Texas. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

For 9.1

Cindy Hielscher, President and Ken Pool, M.D., Vice President – Texas e-Health Alliance, Austin

Steven Williams, Director – Houston Department of Health and Human Services, Houston

Against 9.1

None received.

Modification

1. Continue DSHS for two years to evaluate the degree to which recommendations adopted by the Sunset Advisory Commission have been successfully implemented or are meeting implementation benchmarks before the 2017 Legislative Session. (Representative Ruth Jones McClendon, Member – Texas House of Representatives)

Commission Decision on Issue 9

August 2014

The Sunset Commission adopted the staff recommendation in Issue 9.

December 2014

The Sunset Commission adopted a recommendation to continue the basic functions of the health and human services agencies for 12 years in a single, reconstituted Health and Human Services Commission organized along functional lines. For additional information, see the Sunset staff report on the Health and Human Services Commission.

New Issues

New Issues

The following issues were raised in addition to the issues in the staff report. These issues are numbered sequentially to follow the staff's recommendations.

Sunset Member New Issues

10. Transfer the responsibility for adopting rules and regulating the transport and routing of low-level radioactive waste (Section 401.052, Health and Safety Code) from DSHS and HHSC to the Texas Commission on Environmental Quality. (Representative Four Price, Vice Chair – Sunset Advisory Commission)

11. Direct DSHS to examine current services funded for homeless individuals with mental illness and identify any barriers to providing medication services to these individuals with the goal of avoiding episodes of crisis and criminal justice involvement. (Representative Harold V. Dutton, Jr., Member – Sunset Advisory Commission)

12. Direct DSHS to conduct a feasibility study for creating a single registry for births, deaths, marriages and divorces in Texas. DSHS should provide an analysis of current systems, and an estimate of cost and any statutory changes that would be required to implement such a system. (Representative Harold V. Dutton, Jr., Member – Sunset Advisory Commission)

Additional New Issues

Agency New Issue

13. Consolidate statutory references related to accepting gifts, grants, and donations. More than 60 chapters in the Health and Safety Code reference the agency's authority to accept gifts, grants, and donations. Beyond the numerous occurrences, these statutory references are inconsistent giving some program areas direct authority and the agency authority elsewhere. Other health and human service agencies' statutes give broad authority to the agency for this purpose. As such, DSHS would like to streamline these references, retaining program-specific language when necessary. (Kyle Janek, M.D., Executive Commissioner – Health and Human Services Commission and David Lakey, M.D., Commissioner – Department of State Health Services)

Mental Health and Substance Abuse

14. Conduct a broad, systems-level strategic planning process for the integration of mental health and substance abuse services. (Cynthia Humphrey, Executive Director – Association of Substance Abuse Programs Texas, Kerrville)

15. Establish a regular rate review and rate setting process for substance abuse services. (Cynthia Humphrey, Executive Director – Association of Substance Abuse Programs Texas, Kerrville)

16. Prohibit certain forensic patients who do not present a public safety risk, such as Class A and Class B misdemeanants, from being committed to an inpatient setting for restorative treatment under Article 46B of the Code of Criminal Procedure. (Kathryn Lewis, Attorney – Disability Rights Texas, Austin)

17. Prohibit the privatization of state hospitals and increase transparency in requests for proposal related to state hospitals. (Bob Libal, Executive Director – Grassroots Leadership, Austin)

18. To address a significant gap in the public health system, direct DSHS to promote communications with physicians on mental health prevention and public resources so physicians know of available referrals for their patients, especially services for pregnant women with substance abuse issues. (William "Chip" Riggins, M.D., Member – Texas Medical Association's Council on Science and Public Health)

19. Require a plan to reform the state hospital system that includes a focus on prevention and early intervention, community services, jail diversion, education of judges and other actors in the criminal justice system, high quality care that leads to recovery and timely release from state hospitals with adequate support services for as long as needed. Require significant stakeholder input in state hospital redesign. (Gyl Switzer, Public Policy Director – Mental Health America of Texas, Austin)

20. Require an independent review by Sunset staff or other relevant entity of the NorthSTAR model and require action based on findings. Require stakeholders play a significant part of the review, and ensure that relevant outcome data for comparison be published in a user-friendly format. (Gyl Switzer, Public Policy Director – Mental Health America of Texas, Austin)

21. Require the State to abide by the 21-day rule for transferring individuals deemed incompetent to stand trial to a state mental health hospital facility. (Gyl Switzer, Public Policy Director – Mental Health America of Texas, Austin)

22. Direct DSHS to address and improve staff training and appropriate staff to patient ratios as a significant reason for the increase in worker's comp claims in state mental health hospitals. (Gyl Switzer, Public Policy Director – Mental Health America of Texas, Austin)

23. Discontinue any expansion of jail-based competency restoration programs and clarify that the State's goal is to place all persons in the least restrictive setting. (Gyl Switzer, Public Policy Director – Mental Health America of Texas, Austin)

24. Require that the state guide mental health and substance-use disorder investment in DSRIP projects, and consider pursuing statewide projects. (Gyl Switzer, Public Policy Director – Mental Health America of Texas, Austin)

25. When creating requests for proposal for the privatization of state mental health hospitals, require HHSC to be transparent and notify surrounding communities, stakeholders, and local officials prior to posting the request for proposal. (R.T., Dallas)

26. Require special problem-solving courts to use evidence-based practices established for such courts to reduce recidivism of program participants. (Janie Metzinger, Public Policy Director – Mental Health America of Greater Dallas, Dallas)

27. Require a study of how other states similar to Texas handle all separate disciplines within the Mental Health Agencies. (Claudia Savio, LPC – American Counseling Association and private practice, Austin)

28. Support the Texas Youth Suicide Prevention and Postvention Program with state funds and expand the program to include high-risk groups including people who are middle-aged or seniors. (Merily Keller, Past Chair, Founding Board Member, and Current Executive Committee Member – Texas Suicide Prevention Council, Austin)

29. Require DSHS to contract for a statewide license to make the at-risk for suicide elementary school program available to all educators and school administrators for both public and non-public schools. Provide that DSHS must allocate funds for the continued purchase of licenses for the program for middle- and high-school employees (Merily Keller, Past Chair, Founding Board Member, and Executive Committee – Texas Suicide Prevention Council, Austin)

30. Reverse the consolidation of mental health and substance abuse services by restoring a single state authority to oversee, license, and fund chemical dependency treatment that is dedicated to understanding addictive diseases and treatment. (Glenn Richaedson, LCDC – Austin)

31. Identify alternate incentive strategies to promote achievement of performance-based outcomes for mental health, as opposed to withholding operating funds needed for service delivery. (Lee Johnson, Deputy Director – Texas Council of Community Centers, Austin)

32. Expand mental health certified peer training programs and recovery opportunities in local communities, including crisis peer respite and peer run crisis services, to prevent hospitalization. Establish that recovery through person-centered recovery planning is the expected outcome of all mental health treatment. Include Texas Catalyst for Empowerment and people who have been diagnosed with a psychiatric disorder on every decisionmaking body that addresses mental health services issues. (Anna Gray, President – Texas Catalyst for Empowerment, Austin)

33. Provide that DSHS should measure outcomes, pay for performance, and ensure complete and accurate audits. Re-audit DSHS expenses to identify waste and form a leaner organization. (Adam Slosberg, Managing Director – Beyond Today, Austin)

34. Provide that DSHS should work with the Substance Abuse and Mental Health Services Administration, integrate care, work with LMHAs to ensure local mental health authorities can be reimbursed for jail-based interventions, create a competitive market place for mental health and substance abuse services, and provide for local mental health authorities to work with housing, substance abuse, and criminal justice groups. (Adam Slosberg, Managing Director – Beyond Today, Austin)

35. Decriminalize Class C Misdemeanors. (Adam Slosberg, Managing Director – Beyond Today, Austin)

36. Reform statutes relating to clients' rights to ensure clients understand their rights. (Adam Slosberg, Managing Director – Beyond Today, Austin)

37. Provide that DSHS should fund training and licensure of integrated care peer specialists and mental health peer support specialists. (Adam Slosberg, Managing Director – Beyond Today, Austin)

38. Ensure that DSHS legislative appropriations strategies for mental health list the numbers served per year, rather than using a mix of monthly and annual measures. (Janie Metzinger, Public Policy Director – Mental Health America of Greater Dallas, Dallas)

39. Ensure that DSHS' legislative appropriations strategies for mental health focus on desired outcomes for healthier lives for people receiving services, including engagement and follow-up in therapeutic services; engagement in the community and socialization; housing stability; engagement in employment or education; reduced repeat hospitalization; reduced arrest rate, criminal justice system involvement; reduced incarceration recidivism; and nationally normed and vetted outcome and quality of life measures. (Janie Metzinger, Public Policy Director – Mental Health America of Greater Dallas, Dallas)

40. Re-think how we develop and pay for psychiatric hospital beds since best practices recommend hospital services close to family and community supports when hospitalization is needed. Provide that DSHS expand the use of local psychiatric hospital beds and incent the development of psychiatric beds where none currently exist. Rehabilitate existing state hospital structures where cost effective, bring structures up to current codes, and repurpose structures to meet the mental health and substance abuse residential and outpatient needs of smaller catchment regions. (Janie Metzinger, Public Policy Director – Mental Health America of Greater Dallas, Dallas)

41. Improve training in de-escalation techniques and mental health crisis intervention to decrease injuries to state hospital staff. (Janie Metzinger, Public Policy Director – Mental Health America of Greater Dallas, Dallas)

42. Examine DSHS' estimates for adults with severe and persistent mental illness, which significantly underestimate the number of such adults and prevent reality-based state planning and programs. (Janie Metzinger, Public Policy Director – Mental Health America of Greater Dallas, Dallas)

43. Provide greater local control to the North Texas Behavioral Health Authority Board in governing NorthSTAR as it may allow greater participation in the 1115 waiver program. (Janie Metzinger, Public Policy Director – Mental Health America of Greater Dallas, Dallas)

Regulatory Programs

General

44. Require a full review of the need for all remaining regulatory programs, including the 12 recommended for transfer to the Texas Department of Licensing and Regulation. (John Davidson, Senior Policy Analyst – Center for Health Care Policy, Texas Public Policy Foundation, Austin)

Dyslexia Therapists and Practitioners

45. Require renewal of dyslexia licensure on a yearly basis. (Melinda Bankston, LDT, CALT, and MRT – Bastrop Intermediate School, Bastrop)

46. Include dyslexia education in the teacher certification process at the university level. (Sarah Warren, LDT, Special Education Teacher, and CALT – ALTA, Sanger)

47. Require dyslexia therapists to have a Master's degree. (Anna Marie Finley, LDT and CALT – Dripping Springs Elementary, Austin)

48. Study whether dyslexia therapy should be covered by health insurance if provided by a licensed individual. (Jo Ann Handy, LDT, CALT, and Qualified Instructor – The READ Center, Alamo)

49. Decrease the cost of professional hours and licensure of dyslexia therapists and Practitioners. (Clara Lauber, M.Ed., CALT – ALTA and International Dyslexia Association, Houston)

50. Make the dyslexia therapist license a requirement for any person providing dyslexia services. (Goldie Tappan, CALT – ALTA, Pleasanton)

51. Provide Educational Diagnosticians with licensure so that they also can be recognized as highly qualified teachers for the evaluation of Special Education and Dyslexia. (Carla Proctor, Ph.D., Nationally Certified Educational Diagnostician and LDT – Dallas ISD and private practice: Family Educational Diagnostic Services, Dallas)

52. Require a license to be a Certified Academic Language Therapist. (Regina Staffa, LDT and CALT – Academic Therapy Center LLC, Austin)

53. Require school districts to employ Licensed Dyslexia Therapists or Practitioners to service their dyslexic students. (Goldie Tappan, CALT – ALTA, Pleasanton; Kimberly Stern, LDT – Temple ISD, Temple)

54. Require all teachers of grades K–12 to obtain certification for teaching students with dyslexia within the next five years. (Susie Wolbe, Owner – Dr. Susie Wolbe Educational Services, Rowlett)

Respiratory Care Practitioners

55. Reinstate respiratory therapy externs who are responsible to licensed respiratory therapists. (Denise Spencer, R.N. – Long-term Acute Care Hospital, Tyler)

56. Require respiratory therapists to have at least an associate degree. (Kaytlyn Matchett, Student – University of Arkansas Medical Science, Dallas)

Chemical Dependency Counselors, Marriage and Family Therapists, Professional Counselors, and Social Workers

57. Remove the Texas State Board of Examiners of Professional Counselors from being subject to Sunset. (Kaylene Brown, Ph.D., LPC – Private Practice, Lubbock)

58. Require the Board of Social Work Examiners to afford licensees sufficient time to present their case when they appeal disciplinary actions in person. (Crystal Graham, LMSW – Waco)

59. Social Workers should be part of the board review process to hear complaints, rule on those complaints, and decide the disciplinary actions to be taken. (Lisa Lashley, Family Services Coordinator – San Antonio ISD, San Antonio)

60. Increase funding for investigators who investigate complaints against Licensed Marriage and Family Therapists, Licensed Professional Counselors, and Licensed Social Workers in order to expedite the process and increase public safety. (Jennifer Smothermon, LPC Supervisor and LMFT Supervisor – Abilene)

61. Prohibit individuals with multiple licenses (e.g., LMFT and LPC) from serving on a profession's occupational licensing board. (Mary Green, Ph.D., Denton)

62. Provide the Texas State Board of Examiners of Professional Counselors more budget and resources. (Adrian Ramirez, LPC – Laurel Ridge Treatment Center, Boerne)

63. Allow DSHS to review its licensing procedures and requirements as compared to the recommendations of the American Counseling Association. (Jose J. Sanchez – TCA, San Antonio)

Midwives

64. Require midwives to complete a midwifery education program accredited by the Accreditation Commission for Midwifery Education, to successfully complete the American Midwifery Certification Board, Inc. certification examination, and to adhere to the same professional standards as Certified Nurse Midwives for licensure. (R. Moss Hampton, M.D., Chair, and Virginia Rauth, M.D., President – District XI, American Congress of Obstetricians and Gynecologists and Texas Association of Obstetricians and Gynecologists, Odessa and Galveston)

65. Change the composition of the Texas Midwifery Board by reducing the number of licensed midwife members from five to two and filling the remaining three positions by Certified Nurse Midwives. (R. Moss Hampton, M.D., Chair, and Virginia Rauth, M.D., President – District XI, American Congress of Obstetricians and Gynecologists and Texas Association of Obstetricians and Gynecologists, Odessa and Galveston)

EMS Regulation

66. Require DSHS to verify the accuracy of information provided by new EMS licensure applicants, including background checks to determine whether the applicant is a previous violator that incorporated under a new name or identity. (Dinah S. Welsh, Chief Executive Officer – Texas EMS Trauma & Acute Care Foundation, Austin)

67. Require DSHS to conduct unannounced on-site inspections of EMS license holders. (Dinah S. Welsh, Chief Executive Officer – Texas EMS Trauma & Acute Care Foundation, Austin)

68. Conduct a legislative study of individuals who market their services to EMS licensure applicants for which these individuals serve as a bonding agent and provide the applicants a medical director and the needed equipment to pass inspections, known as EMS "consultants." (Dinah S. Welsh, Chief Executive Officer – Texas EMS Trauma & Acute Care Foundation, Austin)

69. Require DSHS to follow the recommendations of the trauma professionals who DSHS hires to conduct Level III and Level IV trauma designation surveys. (Dinah S. Welsh, Chief Executive Officer – Texas EMS Trauma & Acute Care Foundation, Austin)

70. Require regional advisory councils to create the process for designating levels of care for neonatal and maternal services provided at hospitals. (Dinah S. Welsh, Chief Executive Officer – Texas EMS Trauma & Acute Care Foundation, Austin)

71. Prohibit hospitals located in counties with populations of 50,000 or less that use telemedicine services in place of physicians from being designated as Level IV trauma facilities. (Dinah S. Welsh, Chief Executive Officer – Texas EMS Trauma & Acute Care Foundation, Austin)

Public Health System and Programs

72. Direct DSHS to develop healthcare programs to prevent infectious diseases for which there currently are no preventive vaccines, such as HIV-AIDS and Hepatitis C. (Representative Ruth Jones McClendon, Member – Texas House of Representatives)

73. Eliminate the requirement that DSHS fill in during local disease outbreaks when local officials decide they can discontinue key services. (William "Chip" Riggins, M.D., Member – Texas Medical Association's Council on Science and Public Health)

74. Expand the state's tobacco control program operated by DSHS and ensure DSHS has the ability to make tobacco control a high priority, providing evidence-based tobacco prevention and cessation to more communities throughout the state. (Cam Scott, Senior Director of Texas Government Relations – American Cancer Society Action Network)

Miscellaneous

75. Require that DSHS create a standard protocol for involving stakeholders in important plans, changes, investments, etc. (Gyl Switzer, Public Policy Director – Mental Health America of Texas, Austin)

76. Require a task force of legal counsel and others to address overdue rules within a timeframe assigned by the Legislature. Direct DSHS to make final determinations when stakeholders disagree based on the health of the people of Texas. (Gyl Switzer, Public Policy Director – Mental Health America of Texas, Austin)

77. Establish state licensure requirements and create an occupational licensing program for clinical laboratory professionals that perform lab testing in clinical and public health labs. (89 individuals, plus an additional 517 names collected and submitted through an online survey)

78. Transfer DSHS' architectural review of healthcare facilities to TDLR. (Audrey Efseroff, LMSW Emeritus, Retired Department of Family and Protective Services, and Patient Safety Advocate – Dallas)

79. Apply the statutory criteria of licensing programs to the End Stage Renal Disease Facility licensure program to determine if a more efficient approach is possible. (Joe Carlucci, CEO and Co-Founder – American Renal Associates, Beverly, Massachusetts)

80. Combine the state licensure and Medicare certification process for dialysis units in Texas. (Stan Langhofer, Regional Vice President – American Renal Associates)

81. Require in statute that a Texas-licensed dentist serve as program manager for the DSHS Oral Health Program. (David H. McCarley, DDS, President – Texas Dental Association, Austin)

82. Adequately fund DSHS' Traumatic Brain Injury registry. (Larry Swift, Member – Texas Traumatic Brain Injury Advisory Council, Austin)

Commission Decision on New Issues

The Sunset Commission adopted the following new issues.

- New Issue 11 directing DSHS to examine certain services for homeless individuals with mental illness.
- New Issue 12 directing DSHS to conduct a feasibility study relating to a single registry for births, deaths, marriages, and divorces in Texas.

APPENDICES

Appendix A

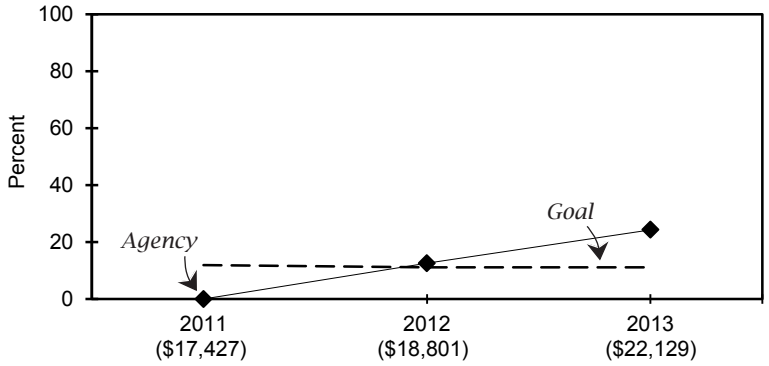
Historically Underutilized Businesses Statistics 2011 to 2013

The Legislature has encouraged state agencies to increase their use of historically underutilized businesses (HUBs) to promote full and equal opportunities for all businesses in state procurement. The Legislature also requires the Sunset Commission to consider agencies' compliance with laws and rules regarding HUB use in its reviews.[1]

The following material shows trend information for the Department of State Health Services' (DSHS) use of HUBs in purchasing goods and services. DSHS maintains and reports this information under guidelines in statute.[2] In the charts, the dashed lines represent the goal for HUB purchasing in each category, as established by the comptroller's office. The diamond lines represent the percentage of agency spending with HUBs in each purchasing category from 2011 to 2013. Finally, the number in parentheses under each year shows the total amount the agency spent in each purchasing category.

From 2011 to 2013, DSHS did not meet statewide HUB purchasing goals in two of its three largest purchasing categories — commodities and professional services — due to the medical nature of these purchases that offer little opportunity for HUB participation. During this same time, DSHS exceeded the statewide goal for its second largest purchasing category — other services. DSHS complies with all other HUB-related requirements, including adopting HUB rules and a HUB forum program; having a HUB coordinator; and creating HUB subcontracting plans for large contracts.

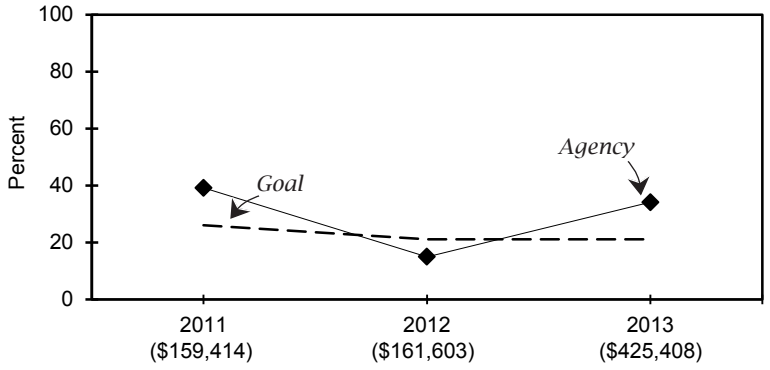
Heavy Construction



DSHS spent less than $60,000 in this category in all three years combined. In 2011, DSHS did not spend any HUB money in this category and therefore did not meet the statewide goal, but increased its HUB purchases in 2012 and 2013, exceeding the statewide goal in both years.

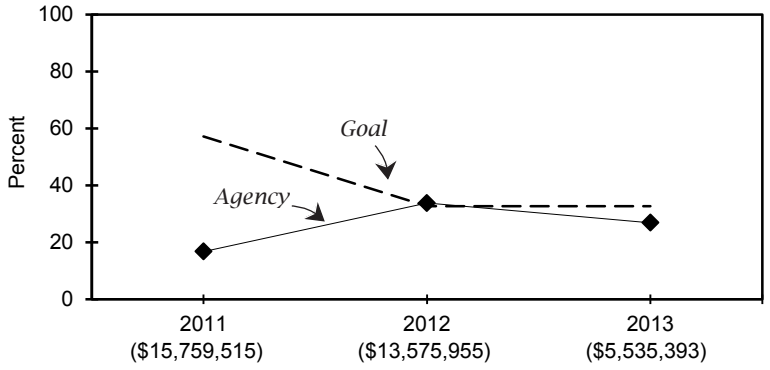
Appendix A

Building Construction



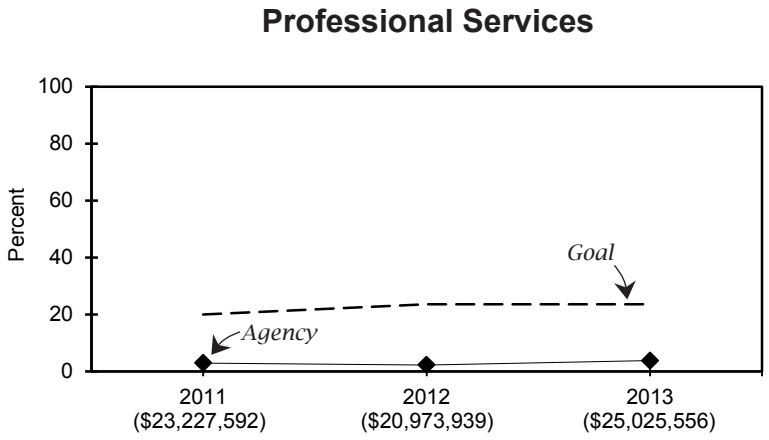
DSHS exceeded the statewide goal for HUB purchasing in the building construction category in 2011 and 2013, but did not meet the goal in 2012.

Special Trade

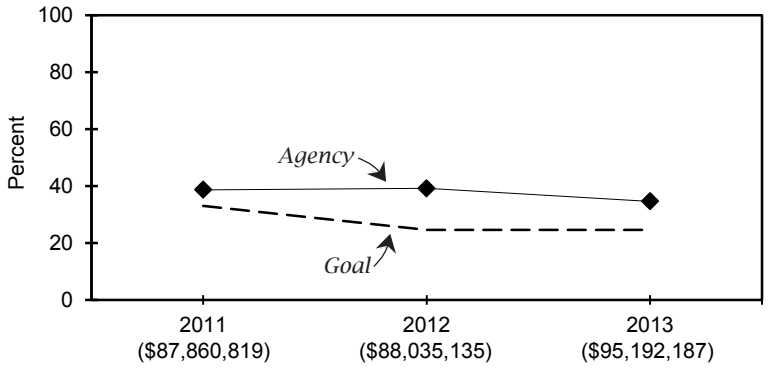


DSHS' HUB purchases for this category fell significantly below the statewide goal in 2011, but improved in 2012, exceeding the goal. However, DSHS' spending in this category declined significantly in 2013 and the agency fell slightly below the statewide HUB purchasing goal.

Appendix A

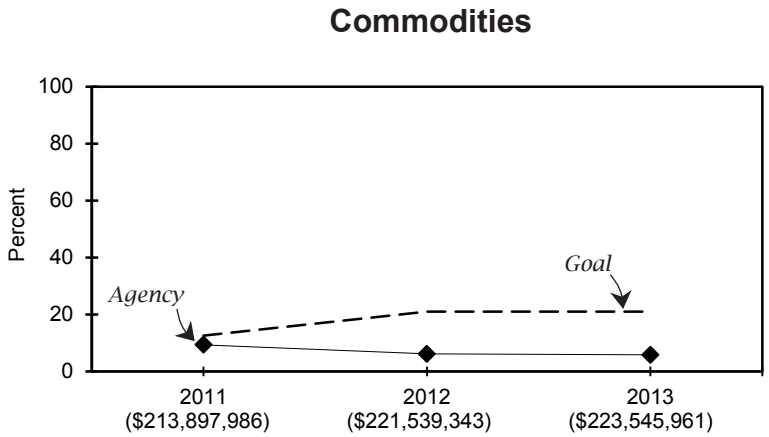


DSHS failed to meet the statewide goal for HUB purchasing in the professional services category in all three years. Medical services account for the majority of the agency's purchases in this category. According to the Health and Human Services Commission, medical services offer limited opportunities for subcontracting since medical professionals perform the work themselves and typically are not HUB certified.



DSHS exceeded the statewide goal for HUB purchasing in the other services category in all three years.

Appendix A



DSHS failed to meet the statewide goal for HUB purchasing in the commodities category in all three years. A large portion of DSHS' expenditures for commodities is spent on pharmaceuticals, accounting for almost 70 percent of total expenditures in this category in 2013. According to the Health and Human Services Commission, these contracts offer no potential for HUB participation because pharmaceuticals are purchased directly from manufacturers without the use of subcontractors.

1 Section 325.011(9)(B), Texas Government Code.

2 Chapter 2161, Texas Government Code.

Appendix B

Expanded DSHS Mental Health Funding FYs 2014–2015

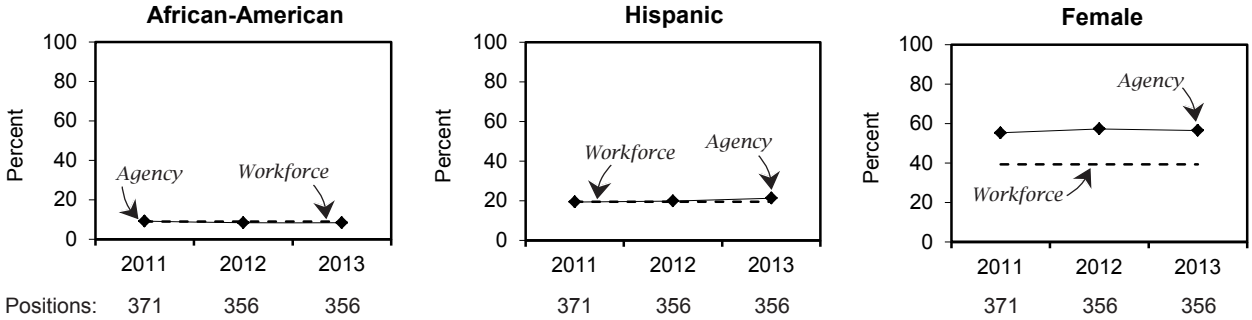
Funded Items	General Revenue Related	All Funds
School-based Training on Prevention/Early Identification	$5,000,000	$5,000,000
Public Awareness Campaign	$1,600,000	$1,600,000
Crisis Services	$25,000,000	$25,000,000
Community Mental Health Treatment Services for Youth and Adults	$20,000,000	$20,000,000
Youth Empowerment Services Waiver	$24,375,000	$58,611,348
Collaborative Projects (Public/Private Partnerships)	$25,000,000	$25,000,000
Projected Costs for Underserved at Local Mental Health Authorities	$17,000,000	$17,000,000
NorthSTAR	$6,000,000	$6,000,000
Veteran's Mental Health	$4,000,000	$4,000,000
Harris County Contracted Beds	$2,400,000	$2,400,000
Harris County Jail Diversion Pilot Program	$10,000,000	$10,000,000
Jail-based Competency Restoration, Contingency for S.B. 1475	$3,050,250	$3,050,250
Patient Safety Initiative (S.B. 152)	$1,300,000	$1,300,000
State Hospital Resident Stipends	$ 2,000,000	$2,000,000
Mental Health for Children – Wait List	$2,095,600	$2,095,600
Mental Health Adults – Wait List	$46,103,128	$46,103,128
Substance Abuse Capacity Expansion	$4,941,828	$4,941,828
Substance Abuse Provider Rate Increase	$10,696,478	$10,696,478
Substance Abuse Set Aside Slots for Department of Family and Protective Services	$10,136,707	$10,136,707
Behavioral Health – Oxford House	$1,140,000	$ 1,140,000
Behavioral Health – Relinquishment Slots	$2,056,262	$2,056,262
Behavioral Health – Rental Assistance	$20,017,406	$24,840,940
General Obligation Bonds for State Hospitals	N/A	$10,000,000
Psychiatric Nursing Assistants	$14,790,336	$14,790,336
Health and Human Services Commission Enterprise – State Hospital Laundry Facility Equipment	$253,260	$253,260
Victory Field Renovation (North Texas State Hospital)	$4,429,436	$4,429,436
Repairs at State Hospitals	$20,000,000	$20,000,000
Department of State Health Services Mental Health Expansion Total	**$283,385,691**	**$332,445,573**

Appendix C

Equal Employment Opportunity Statistics 2011 to 2013

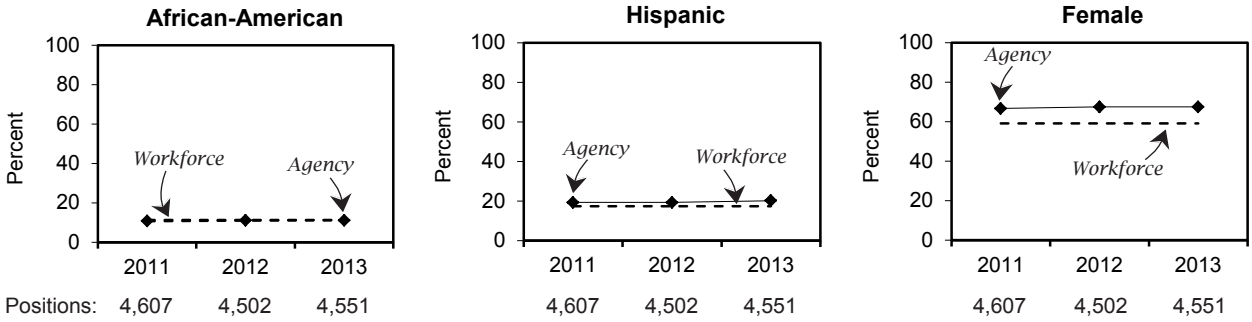
In accordance with the requirements of the Sunset Act, the following material shows trend information for the employment of minorities and females in all applicable categories by the Department of State Health Services (DSHS).[1] The agency maintains and reports this information under guidelines established by the Texas Workforce Commission.[2] In the charts, the dashed lines represent the percentages of the statewide civilian workforce for African-Americans, Hispanics, and females in each job category.[3] These percentages provide a yardstick for measuring agencies' performance in employing persons in each of these groups. The diamond lines represent the agency's actual employment percentages in each job category from 2011 to 2013. DSHS has generally performed well, though it fell below civilian workforce percentages for Hispanics in the service/maintenance and skilled craft categories in all three years.

Administration



DSHS fell just below civilian workforce percentages for African-Americans in 2012 and 2013, but exceeded percentages for Hispanics and females in most years.

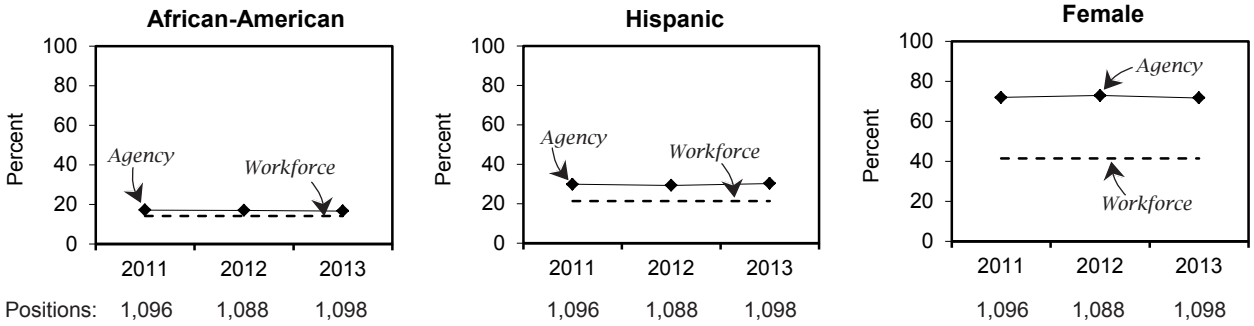
Professional



DSHS fell just below civilian workforce percentages for African-Americans, and exceeded percentages for Hispanics and females in all three years.

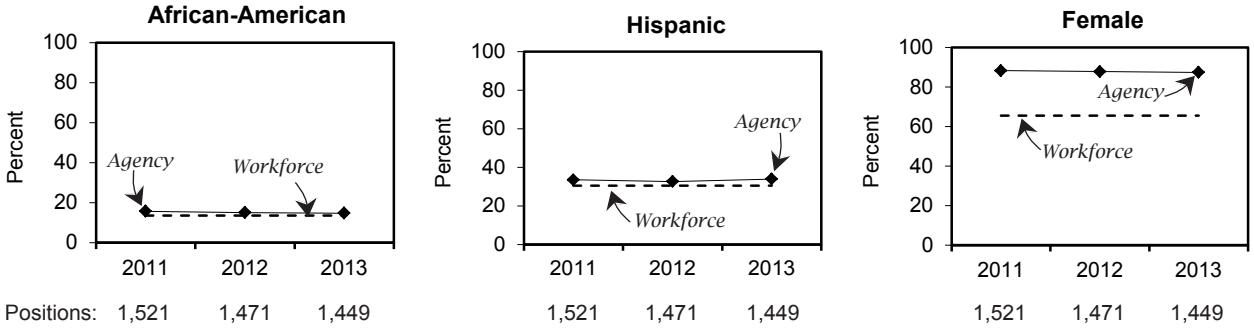
Appendix C

Technical



DSHS exceeded civilian workforce percentages for minorities and females in all three years.

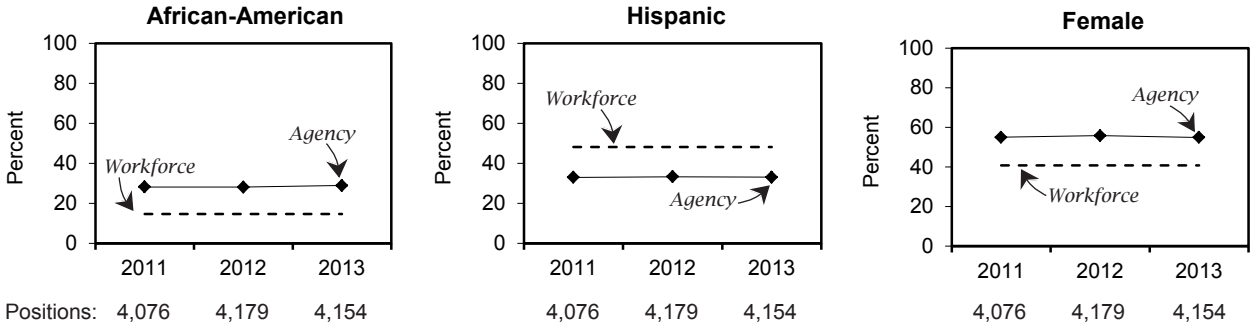
Administrative Support



DSHS exceeded civilian workforce percentages for minorities and females in all three years.

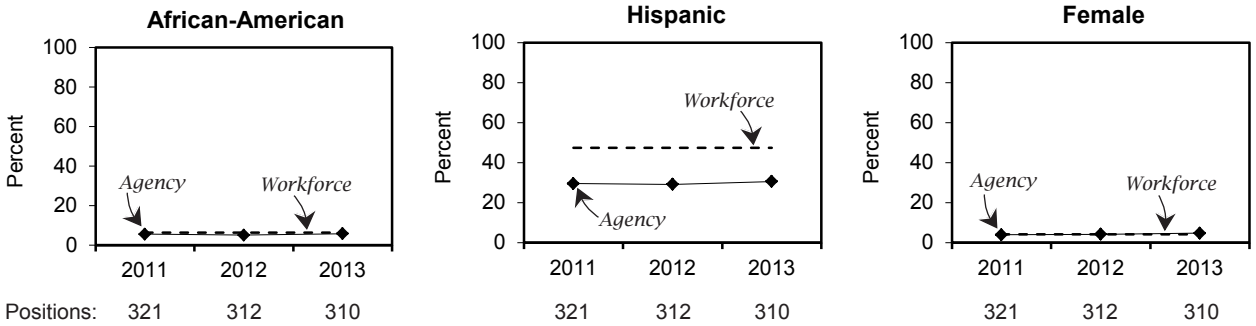
Appendix C

Service/Maintenance[4]



DSHS exceeded civilian workforce percentages for African-Americans and females in all three years, but fell below for Hispanics.

Skilled Craft



DSHS met or nearly met civilian workforce percentages for females in all three years, but fell below for African-Americans and Hispanics.

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1 Section 325.011(9)(A), Texas Government Code.

2 Section 21.501, Texas Labor Code.

3 Because the Texas Workforce Commission has not released statewide civilian workforce percentages for fiscal years 2012 and 2013, this analysis uses fiscal year 2011 percentages for those two years.

4 The service/maintenance category includes three distinct occupational categories: service/maintenance, para-professionals, and protective services. Protective service workers and para-professionals used to be reported as separate groups.

Appendix D

Attempts to Achieve Equity in Regional Mental Health Funding Allocations FYs 2002–2015

Biennium	Description
2014–2015 General Appropriations Act (GAA), Page II-78, Rider 85	**Mental Health Program Allocation.** Directs the Department of State Health Services (DSHS) to use $43,000,000 in General Revenue to expand or improve statewide community mental health services. States legislative intent that DSHS allocate these funds equitably to local mental health authorities and NorthSTAR considering the per capita spending of each organization, among other funding parameters. Requires DSHS to allocate to NorthSTAR an amount not less than $6,000,000 in General Revenue to increase the per person funding available to adult and child enrollees and increase mental health related services provided to clients through the program.
2014–2015 GAA, Page II-80, Rider 92	**Community Mental Health Services Wait List Funding.** Directs DSHS to use $48,198,728 in General Revenue funds to eliminate the waiting list for mental health services. States legislative intent that any funds not used for that purpose shall be allocated among local mental health authorities with below average per capita funding levels to increase equity in funding allocations.
2014–2015 GAA, Page II-124, Section 20	**Community Centers.** If DSHS or the Department of Aging and Disability Services (DADS) determine that a community center is unable or unwilling to fulfill its contractual obligations to provide services or to exercise adequate control over expenditures and assets, the agencies may take necessary steps to protect appropriated funds and ensure the continued provision of services. Any recouped funds shall be used to achieve equity.
2012–2013 GAA, Page II-122, Section 24	**Community Centers.** If DSHS or DADS determine that a community mental health and mental retardation center is unable or unwilling to fulfill its contractual obligations to provide services or to exercise adequate control over expenditures and assets, the agencies may take necessary steps to protect appropriated funds and ensure the continued provision of services. Any recouped funds shall be used to achieve equity.
2010–2011 GAA, Page II-71, Rider 65	**Community Mental Health Crisis Services.** Requires DSHS to allocate $109,368,602 in funds for Community Mental Health Crisis Services for enhanced services, using a methodology that allocates a portion of the funds to achieve equity in state funding among local mental health authorities, a portion on a per capita basis, and a portion using a competitive process. Requires DSHS to submit an allocation plan to the Legislative Budget Board and the Governor prior to distributing funding in the strategy. Requires DSHS to allocate $55,000,000 in funds for Community Mental Health Crisis Services for transitional and on-going services, using a methodology that allocates the funds in such a way to achieve equity in state funding among local mental health authorities to the greatest extent possible by using a per capita equity formula that allocates one-half (1/2) of new funds to those below the statewide average in per capita funding and allocates the remaining funds on a per capita basis across all local mental health authorities. DSHS shall submit an allocation plan to the Legislative Budget Board and the Governor prior to distributing this new funding.
2010–2011 GAA, Page II-116, Section 23	**Community Centers.** If DSHS or DADS determine that a community mental health and mental retardation center is unable or unwilling to fulfill its contractual obligations to provide services or to exercise adequate control over expenditures and assets, the agencies may take necessary steps to protect appropriated funds and ensure the continued provision of services. Any recouped funds shall be used to achieve equity.
2008–2009 GAA, Page II-64, Rider 69	**Community Mental Health Crisis Services.** Requires DSHS to allocate funds for Community Mental Health Crisis Services, using a methodology that allocates a portion of the funds to achieve equity in state funding among local mental health authorities, a portion on a per capita basis, and a portion using a competitive process. Requires DSHS to submit an allocation plan to the Legislative Budget Board and the Governor prior to distributing this funding.

Appendix D

Biennium	Description
2008–2009 GAA, Page II-104, Section 25	**Community Centers.** If DSHS or DADS determine that a community center is unable or unwilling to fulfill its contractual obligations to provide services or to exercise adequate control over expenditures and assets, the agencies may take necessary steps to protect appropriated funds and ensure the continued provision of services. Any recouped funds shall be used to achieve equity.
2006–2007 GAA, Page II-106, Section 29	**Funding Equity Among Local Authorities**. Requires DSHS and DADS to implement a long-term plan to achieve equity in state funding allocations among local authorities. Requires the plan to be implemented from fiscal years 2006-2013. Requires the goal to be achieving equity to the greatest extent possible by fiscal year 2013, but prohibits any funding reductions to a local authority for the purpose of achieving equity from exceeding 5 percent of allocated general revenue in a fiscal year. Requires the plan to provide for improving funding equity to be a priority in distributing any new state or federal funds that may become available for allocation to community centers. Authorizes DSHS and DADS, in assessing the equity of funding, to use alternatives other than basing equity calculations solely on the total population served by each local authority. Additional factors, such as incidence of poverty, may be considered if they help to provide a better estimate of the need for state funded mental health or mental retardation services in the areas served by each local authority. Requires the agencies to submit the long-term equity plan by December 31, 2005, and to include in legislative appropriations requests a table showing how implementation of the equity plan will affect projected allocations to community centers at the baseline current services funding level.
2004–2005 GAA, Page II-91, Rider 15	**Funding Equity Among Local Authorities.** Requires the Department of Mental Health and Mental Retardation to develop and implement a long-term plan to achieve equity in state funding allocations among local authorities. Requires the plan to be implemented from fiscal years 2006–2011 and sets the goal of achieving equity to the greatest extent possible by fiscal year 2011, but prohibits any funding reductions to a local authority for the purpose of achieving equity from exceeding 5 percent of allocated general revenue in a fiscal year. Requires the plan to make improving funding equity a priority in distributing any new state or federal funds that may become available for allocation to community centers. Authorizes the Department to use alternatives other than basing equity calculations solely on the total population served by each local authority. Authorizes additional factors, such as incidence of poverty, to be considered if they help provide a better estimate of the need for state funded mental health or mental retardation services in the areas served by each local authority. Requires the Department to submit its long-term equity plan by December 31, 2003, and include in its legislative appropriations requests a table showing how implementation of the equity plan will affect projected allocations to community centers at the baseline current services funding level.
2002–2003 GAA, Page II-94, Rider 16	**Enhanced Equity.** Requires the Department of Mental Health and Mental Retardation to distribute funds by applying the allocation methodology recommended in the department's Equity Task Force Report until all local authorities are brought up to the state average in per capita funding. The Equity Task Force Report was adopted by the board and submitted to the Legislature in December of 2000. Prohibits allocations to local mental health and mental retardation authorities from being reduced for the purpose of redistribution to other authorities to enhance equity. Requires the department to evaluate its progress at enhancing equity in funding and provide an impact analysis of any change to the previous year's funding, by local authority, by January 15 of each year.

Appendix E

Overview of DSHS Regulatory Programs

*The term "licensees" includes individuals, facilities, training programs and schools, and instructors who hold a DSHS-issued license, certificate, or permit, or are registered with DSHS.

Program Name	Description	Number of Licensees* FY 2013
Programs to Transfer to TDLR		
Athletic Trainers	Working under the direction of a physician, licensees prevent, recognize, assess, manage, treat, dispose of, and recondition athletic injuries. Athletic trainers work in high schools, colleges or universities, professional or amateur athletic organizations, athletic facilities, and healthcare facilities.	3,003 licensees
Chemical Dependency Counselors	Licensees provide counseling services that address substance abuse or dependence and its impact on the individual receiving the counseling.	9,363 licensees
Fitters and Dispensers of Hearing Instruments	Licensees measure an individual's hearing for the purpose of making selections, adaptations, or sales of hearing instruments. Fitters and dispensers make impressions for ear molds to be used as a part of the hearing instruments and any necessary post-fitting counseling.	727 licensees
Laser Hair Removal	Licensees use laser or pulsed light devices for hair removal procedures. Licensees also include the individuals operating the devices, facilities where the procedure occurs, and programs that train the practitioners.	1,557 licensees
Marriage and Family Therapists	Using family systems theories and techniques, licensees provide professional therapeutic services — including evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction or processes — to clients, individually or in groups.	3,342 licensees
Massage Therapists	Licensees manipulate soft tissue by hand or through a mechanical or electrical apparatus. They may also use oil, salt glows, heat lamps, hot and cold packs, and tub, shower, or cabinet baths. Licensees include schools, establishments, instructors, and therapists.	29,701 licensees
Midwives	Licensees are nonmedical, non-nursing practitioners who supervise, care for, and advise women during normal pregnancy, labor, and the postpartum period. They conduct normal deliveries and provide normal newborn care, meaning they do not perform caesarean sections, episiotomies, or any invasive procedures, nor do they use medicine or mechanical devices.	219 licensees

Appendix E

Program Name	Description	Number of Licensees* FY 2013
Orthotists and Prosthetists	Orthotists design, assemble, and fit for patients medical devices designed to support, align, prevent, or correct neuromuscular or musculoskeletal disease, injury, or deformity. Facilities are also licensed. Prosthetists design, assemble, and fit for patients medical devices that are not surgically implanted but used to replace a missing limb, appendage, or other external human body part. Facilities are also licensed.	828 licensees
Professional Counselors	Licensees apply mental health, psychotherapeutic, and human development principles to prevent, assess, evaluate, and treat mental, emotional, or behavioral disorders; conduct assessments and evaluations to establish treatment goals and objectives; and plan, implement, and evaluate treatment plans.	20,321 licensees
Sanitarians	Licensees evaluate, plan, design, manage, organize, enforce, or implement services that protect public health and the environment. The scope of practice also includes educating communities about factors that may adversely affect the general health and welfare. The scope of practice may be in the areas of food quality and safety, on-site wastewater treatment and disposal, solid and hazardous waste management, ambient and indoor air quality, drinking and bathing water quality, insect and animal vector control, recreational and institutional facility inspections, consumer health, and occupational health and safety.	1,251 licensees
Social Workers	Licensees' perform a variety of tasks to restore or enhance social, psychosocial, or bio-psychosocial functioning of individuals, groups, and communities. Examples of such tasks are client case work, community organizing, and counseling and therapy.	22,418 licensees
Speech-Language Pathologists and Audiologists	Speech-language pathologists examine, counsel, and provide habilitative or rehabilitative services for persons with disorders related to speech, voice, language, oral pharyngeal function, or cognitive processes. Audiologists examine, counsel, and provide habilitative or rehabilitative services for persons with disorders related to hearing or vestibular function. Audiologists can also fit, dispense, and sell hearing instruments.	17,689 licensees
Programs to Discontinue		
Bedding Permits	Licensees manufacture, treat, and sell new and used bedding – mattresses, box springs, sofa beds, pillows, bolsters, comforters, and quilts.	4,829 licensees
Bottled and Vended Water	Licensees produce and sell bottled water according to prescribed methods of production, processing, treatment, and distribution. Businesses are required to hold a food manufacturer license and are also required to have a person who holds the certificate of competency supervise the processing and bottling activities.	6,386 licensees

Appendix E

Program Name	Description	Number of Licensees* FY 2013
Certified Food Managers	Licensees are training programs, instructors, and examination sites for individuals seeking management careers in the retail food industry.	17 licensees
Certified Food Handlers	Licensees are training and education programs on food safety for people who prepare and serve food in retail food establishments.	49 licensees
Code Enforcement Officers	Licensees are agents of the state or its political subdivisions who inspect and rehabilitate environmental hazards in public and private premises by determining the presence of fire or health hazards, nuisance violations, unsafe building conditions, and violations of any fire, health, or building regulation.	2,201 licensees
Contact Lens Dispensers	Licensees are opticians who fit, dispense, and sell to consumers contact lenses prescribed by a licensed physician or optometrist.	155 licensees
Dietitians	Licensees use principles of nutrition to ensure proper nourishment, care, and education of individuals or groups.	4,946 licensees
Dyslexia Therapists and Practitioners	Licensees provide individuals with dyslexia and related disorders a treatment called multisensory structured language education.	1,050 licensees
Indoor Air Quality of State Buildings	DSHS sets regulations for investigating and testing indoor air quality in state buildings. DSHS also investigates and tests indoor air quality in state buildings upon request.	No activity
Mold Assessors and Remediators	Licensees are companies and individuals who inspect structures for and remove mold. Licensees are also laboratories that analyze mold samples.	4,295 licensees
Medical Physicists	Licensees apply concepts, theories, and methods of physics to medicine and healthcare, including the performance of diagnostic radiological physics, therapeutic radiological physics, medical nuclear physics, and medical health physics.	607 licensees
Medical Radiologic Technologists	Under the direction of certain healthcare practitioners, licensees administer radiation to other persons for medical purposes.	28,375 licensees
Offender Education	Licensees provide educational seminars to persons who, because of convictions for offenses related to drugs and DWI, must complete coursework to retain their driver license. Some of these licensees provide approved courses to minors convicted of offenses for possession of alcoholic beverages. Other licensees teach approved courses designed to assist minors to cease their tobacco use.	2,475 licensees
Opticians	Licensees fill prescriptions for and dispense eyeglasses and/or contact lenses to consumers but are prohibited from performing eye examinations or issuing prescriptions. (To fill prescriptions for and dispense contact lenses requires opticians to also obtain a contact lens dispensing permit.)	112 licensees
Perfusionists	Licensees operate the heart-lung machine during major medical procedures, such as cardiac surgeries, under the supervision of a medical team.	365 licensees

Appendix E

Program Name	Description	Number of Licensees* FY 2013
Personal Emergency Response Systems	Licensees, including companies and their employees, furnish and maintain alarm systems designed to signal a medical or personal emergency.	249 licensees
Rendering	Licensees are businesses that handle and process primarily dead animals and plants and other raw materials into usable products such as lard, tallow, and source material for bio diesel.	197 licensees
Respiratory Care Practitioners	Licensees treat, manage, control, evaluate, and care for patients who have deficiencies and abnormalities associated with the cardiorespiratory system.	14,568 licensees
Tanning bed facilities	Licensees are facilities that operate equipment that emits electromagnetic radiation within certain levels to tan human skin.	1,577 licensees
Programs to Remain at DSHS – Healthcare Facilities		
Abortion Facilities	Licensees are facilities designed for the sole purpose of allowing authorized healthcare practitioners to terminate a patient's pregnancy.	32 licensees
Ambulatory Surgical Centers	Licensees are facilities that provide surgical services as their primary service, and provide outpatient care only.	423 state licensees; 357 Medicare certifications
Architectural Review	DSHS conducts inspections and architectural plan reviews for hospitals, ambulatory surgical centers, end stage renal dialysis facilities, freestanding emergency facilities, and special care facilities.	1,056 reviews
Birthing Centers	Licensees are facilities that are an alternative means for delivering a child in a setting other than at home or in a hospital.	62 licensees
Clinical Laboratory Improvement Amendments (CLIA) Laboratories	Laboratories that test materials derived from the human body to inform the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of human beings. These laboratories are not state licensed, but CLIA requires federal registration.	23,239 Medicare certifications
Comprehensive Outpatient Rehabilitation Facilities	Nonresidential facilities that only provide diagnostic, therapeutic, and restorative services to patients by or under the supervision of a physician. These facilities are not state licensed but can be certified to participate in Medicare.	57 Medicare certifications
End Stage Renal Disease Facilities	Licensees are facilities that operate dialysis machines (devices that remove waste and excess water from the blood) for patients with poor or completely lost kidney function.	561 state licensees; 561 Medicare certifications
Freestanding Emergency Centers	Licensees are facilities, structurally separate and distinct from a hospital, that provide emergency care.	64 licensees
Hospitals	Licensees offer services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals requiring diagnosis, treatment or care for illness, injury, deformity, abnormality or pregnancy. These facilities are also required to regularly maintain, at a minimum, clinical laboratory services, diagnostic x-ray services, treatment facilities including surgery or obstetrical care or both, and other definitive medical or surgical treatment of similar extent.	686 state licensees; 590 Medicare certifications

Appendix E

Program Name	Description	Number of Licensees* FY 2013
Narcotic Treatment Programs	Licensees are specialized medical clinics that treat patients addicted to heroin or other opiates.	80 licensees
Outpatient Physical Therapy Facilities	These facilities include rehabilitation agencies, clinics, and public health agencies. Rehabilitation agencies provide integrated, multi-disciplinary care to upgrade physical functions of individuals with disabilities. Clinics provide out-patient physician services and must function in a group of at least three physicians practicing medicine together. Public health agencies are government-established to provide environmental health services, preventive medical services, and therapeutic services. These facilities are not state-licensed but can be certified to participate in Medicare.	219 Medicare certifications
Portable X-Ray Facilities	Facilities where physicians and the technologists working under them conduct diagnoses and therapy through x-rays. These facilities are not state licensed but can be certified to participate in Medicare.	47 Medicare certifications
Private Psychiatric Hospitals (including crisis stabilization units)	Licensees are facilities that provide inpatient mental health services to individuals with mental illness or with a substance use disorder. Crisis stabilization units are mental health facilities operated by a community center or other entity designated by DSHS that treat individuals who are the subject of a protective custody order.	40 state licensees; 48 Medicare certifications
Rural Health Clinics	These facilities, located in rural areas designated as shortage areas, only provide outpatient primary care services and basic laboratory services. They may not exist as a rehabilitation agency or function primarily as a care and treatment facility for mental illness. These facilities are not state licensed but can be certified to participate in Medicare.	308 Medicare certifications
Special Care Facilities	Licensees are facilities that provide a continuum of nursing or medical care, or services primarily to persons with AIDS or other terminal illnesses, and also provide residential care.	14 licensees
Substance Abuse Treatment Facilities	These facilities offer treatment for persons with chemical dependency. DSHS also registers faith-based chemical dependency treatment programs that are exempt from licensure and offer only nonmedical treatment and recovery methods.	578 licensees
Transplant Hospitals	Hospitals certified to participate in Medicare to provide organ transplant services.	State-licensed as hospitals; transplant certifications issued by Centers for Medicare & Medicaid Services
Programs to Remain at DSHS – Environmental Health		
Abusable Volatile Chemical Permits	Licensees are retail vendors who sell chemicals, including aerosol paint packaged in a container subject to federal labeling requirements and nitrous oxide.	21,823 licensees
Asbestos Removal	Licensees are contractors, supervisors, workers, consultants, management planners, inspectors, air monitors, laboratories, transporters, and training providers for the inspection and removal of asbestos.	17,138 licensees

Appendix E

Program Name	Description	Number of Licensees* FY 2013
Community Right to Know (Tier II Chemical Reporting)	DSHS is required to receive and maintain chemical reports and inspect them for accuracy.	69,691 chemical reports received
Community Sanitation	A partial regulatory program where DSHS conducts complaint investigations and inspections of colonias, playgrounds, public swimming pools, public schools, public health nuisances, public lodging, recreational sanitation, field sanitation, and vector control.	N/A
Hazardous Products Manufacturing	Licensees manufacture, re-package, sanitize, import, wholesale, and distribute a broad range of commonly used consumer items including automotive products, household cleaners, polishes and waxes, paints and glues, infant items, children's toys, and sleep wear.	1,007 licensees
Lead Abatement	Licensees conduct lead inspections, lead risk assessments, and lead abatements. Licensees include individuals and companies. DSHS also accredits training programs.	1,391 licensees
Youth Camps	Facilities or properties, not licensed by the Department of Family and Protective Services, that provide supervision, instruction, recreation, and overnight stay for children who are apart from their legal guardians. These facilities operate during school vacation periods, not more than 120 days per year.	554 licensees
Programs to Remain at DSHS – Radiation Control		
Emergency Response Exercises, Radiation	DSHS conducts exercises at nuclear utility facilities and one nuclear weapons facility.	10 exercises total, one at a fixed nuclear facility
Environmental Monitoring, Radiation	DSHS analyzes environmental samples collected outside nuclear power plants for the purpose of monitoring accidental radiation releases.	1,850 samples tested
Industrial Radiographers	Licensees use radioactive material or x-ray machines during nondestructive testing activities, such as checking the integrity of wells in oil pipes and inspecting ships and aircraft.	4,059 licensees
Laser Registrations	Licensees include any individuals who receive, possess, acquire, transfer, or use lasers that emit or may emit laser radiation. The environments in which licensees operate are the healing arts; veterinary medicine; industry; academic, research and development institutions; and businesses that provide laser services.	2,095 licensees
Mammography Systems	Licensees are facilities required to adhere to federal guidelines for use of low-energy X-ray devices specifically to examine patients' breasts to screen, detect, and diagnose breast cancer.	691 licensees
Radioactive Materials Licenses	Licensees are any person who receives, possesses, uses, transfers, owns, or acquires radioactive material.	1,813 licensees
Waste Shipper and Transporter Radiation	Licensees include any person or entity who ships and transports low level radioactive material, including radioactive waste.	39 licensees
X-Ray Registrations	Licensees include any owner of an x-ray machine.	16,935 licensees

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Program Name	Description	Number of Licensees* FY 2013
Programs to Remain at DSHS – Food, Drug, and Device Safety		
Drug, Device, and Cosmetic Salvage	Licensees are individuals or businesses that import, salvage, and recondition distressed (adulterated or misbranded) drugs, devices, or cosmetics to distribute and sell.	313 licensees
Drug Manufacturers and Distributors	Licensees are businesses that manufacture, distribute, and sell retail drugs, devices and cosmetic products.	3,843 licensees
Food Manufacturing	Licensees are companies that produce food products; companies that hold or sell any type of food product, including raw materials, to any entity other than the final consumer; businesses and their facilities that recondition, buy, or sell distressed food products; and food warehouse operators.	17,619 licensees
Food Service Establishments	Licensees are mobile food units, retail food establishments, and temporary food establishments. DSHS inspects, but does not license, school cafeterias.	10,925 licensees
Meat Safety	Licensees are producers of various kinds of meat who must receive grants of custom exemption, inspections, poultry/rabbit exemption, and voluntary inspection from DSHS. Licensees include the "Talmadge Aiken" meat and poultry plants DSHS inspects on behalf of the USDA.	580 licensees
Medical Device Manufacturers and Distributors	Licensees manufacture instruments, apparatuses, implements, machines, contrivances, implants, in vitro reagents, and other similar or related articles intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease.	1,571 licensees
Milk and Dairy Products	Licensees are frozen dessert manufacturers; milk and dairy product processors; dairy product manufacturers; milk tank truck operators; dairy producers; raw dairy retailers; and dairy transfer and receiving stations.	2,971 licensees
Seafood and Aquatic Life	Licensees are crab meat producers and importers, and shellfish producers.	179 licensees
Tattoo and Body Piercing Studios	Facilities where artists perform tattooing, permanent cosmetics, or certain body piercing where they create an opening in an individual's body, other than in an individual's earlobe, to insert jewelry or another decoration.	2,353 licensees
Programs to Remain at DSHS – Other		
Council on Sex Offender Treatment, and Sex Offender Treatment Providers	Licensees assess and provide appropriate treatment to sex offenders. This does not include program for the civil commitment of sexually violent predators, which is under the purview of the Office of Violent Sex Offender Management. The Council designs and provides training and continuing education for licensees. The Council also develops the mechanism by which licensees assess sex offenders and approves licensees to evaluate sex offenders who request deregistration.	526 licensees

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Program Name	Description	Number of Licensees* FY 2013
Emergency Medical Services	Licensees are individuals, firms, first responder organizations, instructors, coordinators, and education programs.	67,363 licensees
EMS and Trauma Care System	DSHS provides statewide coordination and grant funding, and designates trauma, stroke, and neonatal intensive care unit facilities, to develop the statewide EMS-trauma system.	120 stroke facility designations and 269 trauma facility designations
Medical Advisory Board	The Board evaluates medical histories, provides medical opinions, and makes recommendations upon request to the Department of Public Safety regarding driver licensees and concealed handgun and private security licensees.	N/A

Appendix F

DSHS Reporting Requirements

Report Title	Legal Authority	Description	Recipient	Sunset Evaluation
1. School Based Health Centers	Section 38.064, Texas Education Code	Requires a report covering the efficiency of services and measures of increased academic success due to the school based health centers.	Legislature	Continue
2. Report on Exemptions from Immunizations	Section 51.9192(d-5), Texas Education Code; and Section 161.0041(e), Texas Health and Safety Code	Requires Department of State Health Services (DSHS) to report how many immunization exemption forms were requested in the previous year. Also requires an annual report of the number of exemption forms requested using the Internet-based process for public junior college students.	Legislature	Continue
3. Border Health Institute Strategic Plan	Section 151.008, Texas Education Code	Requires DSHS to produce a long-term strategic plan including goals and objectives for providing healthcare services, healthcare education, and public health research about the border.	not specified	Continue
4. State Child Fatality Review Team Report	Section 264.503(f), Texas Family Code	Requires DSHS to report on aggregate child fatality data, recommendations to Child Protective Services, and recommendations on preventing injuries and fatalities.	Governor, Lieutenant Governor, Speaker of the House of Representatives, DSHS, Department of Family and Protective Services, and the general public	Continue
5. Report on Indoor Air Quality	Section 2165.302, Texas Government Code	Requires DSHS to conduct any necessary investigations and testing of indoor air quality in state buildings on request or referral of an entity with charge and control of the state building. Also requires DSHS to report all findings and test results related to indoor air quality in state buildings that are obtained directly by DSHS or under a contract with a private entity.	State Office of Risk Management	Eliminate per Recommendation 3.1
6. Report on Primary Health Care Program	Section 31.015(c), Texas Health and Safety Code	Requires DSHS to report on primary health care including the number of unduplicated individuals receiving care; total cost of the program, delineating administrative costs and cost for each service; average cost per recipient; and number of unduplicated individuals who received services in each health service region.	Governor and Legislature	Continue

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Report Title	Legal Authority	Description	Recipient	Sunset Evaluation
7. Maternal Mortality and Morbidity Task Force Findings	Section 34.015, Texas Health and Safety Code	Requires DSHS and the task force to issue a joint report with findings, including the task force's recommendations.	Governor, Lieutenant Governor, Speaker of the House of Representatives, and appropriate committees of the Legislature	Continue
8. Kidney Health Care Report	Section 42.016, Texas Health and Safety Code	Requires DSHS to report on findings, progress, activities, and the state's total need in the field of kidney health.	Governor and Legislature	Continue
9. Interagency Coordinating Council for human immunodeficiency virus (HIV) and Hepatitis Report	Section 81.010(h)(i), Texas Health and Safety Code	Requires DSHS to report on policy recommendations relating to the prevention of acquired immunodeficiency syndrome (AIDS), HIV, and hepatitis, and the delivery of health care services to individuals who have these conditions.	Governor and Legislature	Continue
10. HIV Program Annual Report	Section 85.041, Texas Health and Safety Code	Requires DSHS to provide information on the type, level, quality, and cost-effectiveness of services targeted at treating HIV.	general public	Continue
11. Report of the Texas Traumatic Brain Injury Advisory Council	Section 92.061(b), Texas Health and Safety Code	Requires DSHS to report on the Council's responsibilities and performance in addressing legislative goals for persons with traumatic brain injury.	Governor and Legislature	Continue
12. Diabetes Mellitus Registry	Section 95.056, Texas Health and Safety Code	Requires DSHS to provide an evaluation of the registry's effectiveness and number of public health districts participating.	Governor, Lieutenant Governor, Speaker of the House of Representatives, and appropriate standing committees of the Legislature	Continue
13. State Diabetes Plan and Agency Response	Section 103.013(f), Texas Health and Safety Code	Requires DSHS to submit a report in response to the Diabetes Council's State Diabetes Plan. The plan includes need assessments and recommendations for addressing diabetes. The plan also requires DSHS to respond with information on resources needed to implement the plan, how or if DSHS will seek the resources, and explanations of and justifications for any deviations.	Texas Diabetes Council, Legislative Budget Board, and Governor's Office of Budget and Planning	Continue

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Report Title	Legal Authority	Description	Recipient	Sunset Evaluation
14. Assessment of Programs to Prevent and Treat Diabetes	Section 103.0131(b), Texas Health and Safety Code	Requires DSHS, in conjunction with the Diabetes Council and the State Diabetes Plan, to conduct a statewide assessment of existing programs for the prevention of diabetes and treatment of individuals with diabetes, including the number of clients and providers and areas where the programs are unavailable.	Governor, Lieutenant Governor, and Legislature	Continue
15. State Health Plan	Section 104.024, Texas Health and Safety Code	Requires DSHS, along with the Statewide Health Coordinating Council, to develop the State Health Plan, which must identify statewide health concerns; availability of resources; and future health service information technology, and facility needs of the state.	Governor	Continue
16. Report on Cost Data to Implement State Health Plan	Section 104.026(c), Texas Health and Safety Code	Requires DSHS, along with the Statewide Health Coordinating Council, to submit a report with cost data from agencies directly affected by the State Health Plan.	Legislative Budget Board and Governor's Budget Office	Continue
17. Nursing Workforce Center Licensure	Section 105.008, Texas Health and Safety Code	Requires DSHS, along with the Texas Higher Education Coordinating Board and the Nursing Workforce Center, to study pre-licensure nursing programs.	Governor, Senate Committee on Health and Human Services, and House Committee on Public Health	Continue
18. Report of Interagency Obesity Council	Sections 114.006 and 114.007, Texas Health and Safety Code	Requires DSHS to post information on effective strategies for employers to use to promote workplace wellness, including information on the projected costs and benefits. Requires the Interagency Obesity Council to report on agency obesity programs, the progress towards reaching the goals of each program, recommendations for future goals or legislation, and the cost and benefits of the evidence-based public health awareness plan.	Governor, Lieutenant Governor, and Speaker of the House of Representatives	Continue
19. Report of the Public Health Funding and Policy Committee	Section 117.103, Texas Health and Safety Code	Requires the Public Health Funding and Policy Committee to make recommendations to DSHS on how to improve public health systems in Texas, and report on the status of the committee's other duties, such as defining core public health services and identifying funding and policy initiatives.	Governor, Lieutenant Governor, and Speaker of the House of Representatives	Continue - Make biennial (even-numbered years) per Recommendation 5.2

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Report Title	Legal Authority	Description	Recipient	Sunset Evaluation
20. DSHS Response to Public Health Funding and Policy Committee Recommendations	Section 117.151, Texas Health and Safety Code	Requires DSHS to report on the implementation of the recommendations of the Public Health Funding and Policy Committee and an explanation of any recommendations not implemented.	Governor, Lieutenant Governor, and Speaker of the House of Representatives	Continue - Make biennial (even-numbered years) per Recommendation 5.2
21. Report on the Immunization Registry and Rate Information	Section 161.0074, Texas Health and Safety Code	Requires DSHS to report on state immunization rates by region with a focus on regions with low pre-school immunization rates; approaches for increasing immunization rates; services provided and performance measures for contracts in underserved areas; exemption data; complaints about requests for exclusion from the registry; and recommendations for coordination with local registries and increasing provider participation.	Governor, Lieutenant Governor, Speaker of the House of Representatives, Legislative Budget Board, and appropriate committees of the Legislature	Continue
22. Report on Epidemiologic or Toxicologic Investigations	Section 161.0211(b), Texas Health and Safety Code	Requires DSHS to conduct investigations to determine the nature and extent of disease or environmental exposure believed to be harmful to public health. Requires any findings or determinations from the investigations that relate to environmental exposures believed to be harmful to the public to be reported in writing to the Texas Commission on Environmental Quality and that the two agencies coordinate corrective measures as appropriate.	Texas Commission on Environmental Quality	Continue
23. Report of the Office of Smoking and Health (Texans and Tobacco)	Section 161.0901, Texas Health and Safety Code	Requires DSHS to report on the status of smoking and the use of tobacco and tobacco products in Texas.	Governor, Lieutenant Governor, and Speaker of the House of Representatives	Continue
24. Community Benefits and Charity Care Requirements Report	Section 311.0455(a), Texas Health and Safety Code	Requires DSHS to report a list of each nonprofit hospital or hospital system that did not meet requirements for providing community benefits under Section 311.045, Texas Health and Safety Code. Also requires DSHS to issue a press release regarding the availability of the report.	Attorney General and Comptroller	Continue
25. Annual Statement of Community Benefits Report	Section 311.0455(b), Texas Health and Safety Code	Requires DSHS to report the number of hospitals that have not submitted their Annual Statement of Community Benefits Report and/or did not meet their standard, and additional information about the amount of charity care.	Attorney General and Comptroller	Continue

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Report Title	Legal Authority	Description	Recipient	Sunset Evaluation
26. Eligibility and Certification for Limited Liability of Hospitals	Section 311.0456, Texas Health and Safety Code	Requires DSHS to report the certification of a hospital for limited liability.	not specified	Continue
27. Drug Demand Reduction Advisory Committee	Section 461.017(h), Texas Health and Safety Code	Requires DSHS, along with the Drug Demand Reduction Advisory Committee, to report progress toward developing and coordinating the goal of reducing drug demand, status and funding of related programs, and recommendations for related legislation.	Governor, Lieutenant Governor, and Speaker of the House of Representatives	Continue
28. Report on Persons Found Not Guilty by Reason of Insanity	Section 533.0095(c), Texas Health and Safety Code	Requires DSHS to report the names of individuals found not guilty by reason of insanity, the name of the facility to which and the length of time for which the person is committed, and any post-release outcome.	Presiding officer of each house of the Legislature	Continue
29. Plan for Allocation of Outpatient Mental Health Services and Beds in State Hospitals	Section 533.051(f), Texas Health and Safety Code	Requires DSHS, in conjunction with an advisory panel, to report on the allocation method for outpatient mental health services and the separate allocation of beds in state hospitals for both civil and forensic patients.	Governor and Legislature	Continue
30. Local Mental Health Authority Audit Report	Section 534.068(f), Texas Health and Safety Code	Requires DSHS to submit a summary of the significant findings of audits of local mental health authorities.	Governor, Legislative Budget Board, and Legislative Audit Committee	Continue
31. Report on Electroconvulsive and Other Therapies	Section 578.008(b), Texas Health and Safety Code	Requires DSHS to report on information reported by psychiatric hospitals, physicians, and facilities about equipment registration, electroconvulsive and similar therapy use, payment, outcomes, and side effects.	Governor and the presiding officer of each house of the Legislature	Continue
32. Annual Report on Emergency Medical Service Providers	Section 773.05713, Texas Health and Safety Code	Requires DSHS to report on Emergency Medical Service providers including the number of applications received; number denied, approved, suspended and revoked; number of incidents of fraud; number of complaints; and information on Texas Medical Board and DSHS coordination.	Lieutenant Governor, the Speaker of the House of Representatives, and standing committees of the Senate and House with jurisdiction over DSHS	Continue
33. Medcares Report	Section 1001.155, Texas Health and Safety Code	Requires DSHS, along with the Medcares Advisory Committee, to report on grant program activities, recipients, results, and outcomes.	Governor and Legislature	Continue

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Report Title	Legal Authority	Description	Recipient	Sunset Evaluation
34. Report on Veterans Mental Health Programs	Section 1001.204, Texas Health and Safety Code	Requires DSHS to report on the number of veterans who received services; number of peers and volunteer coordinators trained; summary of the grants awarded and services provided through those grants; evaluation of the services provided under the Mental Health Program for Veterans; and recommendations for program improvements.	Governor and Legislature	Continue
35. Mental Health First Aid Training Report	Section 1001.205, Texas Health and Safety Code	Requires DSHS to report on the number of mental health first aid trainings completed by local mental health authority employees and contractors, educators, and non-educator individuals.	Legislature	Continue
36. Report of the Council on Sex Offender Treatment	Section 110.160, Texas Occupations Code	Requires DSHS, along with the Council on Sex Offender Treatment, to report on recommendations related to treatment strategies for sex offenders, treatment standards for licensure, and program improvements.	Governor, Lieutenant Governor, and Speaker of the House of Representatives	Continue

Appendix G

Staff Review Activities

During the review of the Department of State Health Services (DSHS), Sunset staff engaged in the following activities that are standard to all Sunset reviews. Sunset staff worked extensively with agency personnel; met with staff from key legislative offices; conducted interviews and solicited written comments from various interest groups, stakeholders, and the public; reviewed agency data, documents and reports, state statutes, previous legislation, and literature; and performed background and comparative research.

In addition, Sunset staff also performed the following activities unique to DSHS.

- Attended meetings and spoke with members of the State Health Services Council.
- Conducted an online survey of DSHS stakeholders and evaluated the approximately 400 responses.
- Attended numerous advisory committee, task force, and stakeholder meetings, including the Local Authority Network Advisory Committee, Council for Advising and Planning for the Prevention and Treatment of Mental and Substance Use Disorders, House Bill 3793 Advisory Panel, Drug Demand Reduction Advisory Committee, Governor's EMS and Trauma Advisory Council, Public Health Funding and Policy Committee, and others.
- Visited four DSHS Health Service Regions and interviewed staff in Region 1 (Lubbock), Region 6/5 South (Houston), and Region 8 (San Antonio); interviewed additional regional office staff by phone and at meetings in Austin.
- Toured and met with staff at six DSHS-operated state mental health hospitals in Austin, El Paso, Harlingen, Kerrville, San Antonio, and North Texas (Vernon and Wichita Falls campuses); the Texas Center for Infectious Disease in San Antonio; and two DSHS-funded community mental health hospitals in Houston and Lubbock.
- Visited and interviewed staff at 10 local mental health and behavioral health authorities across the state, toured locally operated mental health facilities, and met with numerous mental health stakeholders.
- Toured three state supported living centers operated by the Department of Aging and Disability Services in El Paso, Mexia, and San Antonio.
- Visited and met with staff at three substance abuse outreach, screening, assessment, and referral centers and three substance abuse treatment facilities across the state; and met with numerous substance abuse stakeholders.
- Observed an inspection of an end-stage renal disease treatment facility conducted by DSHS regulatory staff and an inspection of a county registrar's office conducted by DSHS vital statistics staff.
- Visited and interviewed staff at seven city and county local health departments and two DSHS-funded community health clinics, and met with numerous public health stakeholders.
- Toured the Central Laboratory operated by DSHS in Austin and interviewed staff.

Sunset Staff Review of the *Department of State Health Services*

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