



TEXAS HOUSE OF REPRESENTATIVES  
**RUTH JONES McCLENDON**  
State Representative, District 120

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**June 27, 2014**

The Honorable Jane Nelson  
Chair, Sunset Advisory Commission  
Capitol Building, 1E.5  
Austin, Texas 78701

Dear Madame Chair and Members of the Commission,

First, thank you for your hard work and dedication on the Sunset Advisory Commission. As a former member, I know how much extra time and effort goes into your work as a member of the SAC. This is an important process, and I appreciate your perseverance.

Upon review of the Sunset Advisory Commission Staff Report recommendations for the Department of State Health Services, I have some comments and recommendations of my own regarding changes for the Department of State Health Services.

I realize that this is the initial report, so I would like to reserve the option of submitting additional comments at a later time prior to the Commission's actions following the decision meeting.

Thank you for your full consideration of my comments on these particular issues. Should you have any questions, please feel free to contact me or my staff in Austin.

Respectfully submitted,



Ruth Jones McClendon

cc: Individual Members of the Sunset Advisory Commission; The Honorable Joe Straus, Speaker of the House; Executive Commissioner Kyle Janek, HHSC; Commissioner David Lakey, DSHS; Mr. Ken Levine; Ms. Jennifer Jones; Ms. Katharine Teleki



*Issue 1: Resolving the Current Crisis in the State Mental Health Hospital System Requires Action, Starting Now.*

**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." [p. 25]

COMMENTS:

Given the population increase that Texas has experienced, an increase in the state mental health hospital system service capacity has become essential and is overdue. This could be done at the state hospitals and in additional service program locations supported by and through the state hospital system.

Contracting with mental health providers in local communities is ongoing and should be augmented over present levels. Current service gaps have shown that existing service levels and locations have proved insufficient, as indicated by referring civil mental health patients to emergency rooms and jails, and creating wait lists. According to the U.S. Census, the Texas population grew from 18.4 million in 1994 to 26.5 million in 2014. Yet, according to data provided by the Health and Human Services Commission, the total number of psychiatric beds in the state has decreased from 3,343 in 1994 to 2,900 in 2014. Similarly, HHSC data shows that the state-funded psychiatric beds per 100,000 population has decreased from 18.2 in 1994 to 10.8 in 2014, which is a decrease from the 11.3 number in 2013.

Implementation by DSHS of Section 3 of H.B. 3793 needs to continue with immediacy. For mental health patients who have permanent or temporary conditions needing treatment in the state system, the state's responsibility is to assure that these placements occur at the proper time, in the proper location, for the proper level of care and at the proper cost. There should be no "wrong door" for these services.

Past use by DSHS of administrative sanctions against the local mental health authorities has been counterproductive, and is unresponsive to the national and statewide increase of the number of mental health patients needing competency restoration in regard to criminal proceedings. The increase in the number of forensic mental health patients has created a dilemma for civil patients because local community centers have no control over the growth in additional forensic placements. Because the courts control the number and pace of forensic patient placements, the LMHA's need additional state help and support in placing civil mental health patients with temporary or permanent mental health needs for the use of a secure state hospital bed or state-supported bed. DSHS should not impose monetary penalties on community centers for any 'over-use' of bed allotments when the increased number of court-ordered forensic placements is causing that result.

Page 25. *DSHS should "Work to address gaps in patient data currently reported by contracted facilities to have the same information available for all patients whether served in state operated or contracted facilities."*

COMMENT:

Data gathered by providers that contract with the state for treatment of mental health patients must also include patient outcome-based measures or the data falls short of being useful. DSHS should ensure that the information collected by these providers and reported to the agency should be 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.

*Issue 2: DSHS Has Struggled to Deliver Integrated, Outcomes-Focused Community Mental Health and Substance Abuse Services.*

**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." [p. 36]

COMMENTS:

Addressing inequities in mental health funding by the state should continue. Previous budget riders have attempted to provide Legislative direction to DSHS to address the inequities. Advancements in funding plans still are needed to ensure that all Texans are treated equally by the state. The meaning of "targeted capacity needs" is unclear; there needs to be a statewide assessment of patient needs and evaluation of that data, in order to establish a practical funding model that serves LMHA's well across the state, whether in urban or non-urban locations.

Funding and outcomes should match the allocated GR funding and the DSHS assigned targets associated with that funding, as a direct correlation. For example, 2% of general revenue funding should equate to 2% of the state's performance target. Local communities should not be punished for providing additional resources to supplement state funding. It does not address the need in a particular LHMA catchment area to assess monetary penalties against the LMHA and move that funding to another area of the state.

The State's funding formulas should be evaluated from a scientific, actuarial standpoint, where actual need and appropriations have a strong correlation. The LMHA's in urban areas serve patients who have more acute needs than are reflected in the statewide average. Because these patients are uninsured and economically disadvantaged, they tend to rely more heavily on the public safety net. The development of state targets based on average statewide costs and severity of illness actually distorts the data for the patients needing services in more heavily populated areas.

This pattern was documented recently in a study commissioned by the Texas Council of Community Centers and conducted by former HHSC Actuarial Director, David Palmer. The study evaluated the level of severity and the costs associated with each level of care. Using statewide weighted uniform cost data, the findings indicate that if state targets were based on the severity of illness using statewide average costs, it would actually lower the number of individuals to be served in some areas, sinking below the contractual requirements. For example, using statewide averages, the LMHA in Bexar County would be serving 933 fewer adults and 362 fewer children than its current contractual mandate. State policy and funding should incentivize systems of care that treat those persons with the highest and most acute levels of need and who are most costly to help, without penalizing other areas in the state serving a population with a different set of needs and cost levels.

The DSHS state hospital allocation system for patient placements should be based 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. In 2013, for example, DSHS provided more funding in some areas where there were waiting lists than those areas where services surpassed expectations on its state mandated targets. As an example,

Harris County received over \$7 million although it did not meet its DSHS targets, and instituted a waiting list. In contrast, Bexar County exceeded its service target goals and received funding of just over \$300,000.

**Recommendation 2.3.** "Direct DSHS to evaluate and improve its behavioral health performance measurement and contracting process." [Pp. 36-37]

COMMENT:

DSHS needs to develop an outcomes-focused approach in evaluating performance measurements and contract services standards. Mentally ill patients would be better served if DSHS developed meaningful performance and outcome measures rather than simply measuring how many times a patient is seen by a clinician. These effectiveness measures would ensure that DSHS targets its limited funding to programs that actually help patients improve their mental health, not just complete the boxes on the reporting forms as measures of efficiency.

*Issue 3: The Unmanageable Scope of DSHS' Regulatory Functions  
Reduces Needed Focus on Protecting Public Health*

**Recommendation 3.1.** "Discontinue 19 regulatory programs currently housed at DSHS." [See item o. Respiratory Care Practitioners] [Pp. 51-53]

COMMENT:

DSHS should not discontinue licensing of respiratory care practitioners, or the licensure should continue at an agency charged with oversight of public health and safety. Apparently, respiratory therapists can administer certain types of medication and take arterial blood gases, among other medical services, and it seems entirely proper for these functions to be subject to state regulation for public health safety. Additionally, it would promote a more uniform and acceptable level of care to have the state oversee and ensure a minimum statewide standard, rather than allowing each individual hospital to set a different standard to determine what is necessary in terms of continuing education, competency and skill levels. Higher standards within a hospital would be acceptable, but a standard lower than the state standard should not be allowed.

Hospitals rely in part on licensure agencies to ensure that a practitioner is competent, maintains their skills by receiving continuing education, is required to maintain an acceptable quality of care, and is subject to a complaint review process. This licensure is especially important to clinics, physicians, and hospitals in making sound hiring decisions. Having no state-based credential could shift more risk to hospitals and physicians, which might increase the cost of professional liability insurance coverage.

While hospitals and medical professionals are affected, deregulation of the Respiratory Care Practitioner Licensing Program ultimately affects those in the public who need respiratory care. These medical patients have mild to severe respiratory deficiencies, and need safe and reliable Respiratory Care Practitioners available to them. Without state regulation of this profession, hospitals, physicians, and consumers will be left with inadequate information to guide their choice of a Respiratory Care Practitioner. Considering the potential negative effects on the safety of, in some cases, critically ill respiratory patients, the RCP Licensing Program

should continue under the Department of State Health Services, or as an alternative, be transferred to the Texas Medical Board or other capable state medical oversight agency.

*Issue 4: DSHS Needs Additional Tools to Better Combat Fraud in the EMS Industry.*

**Recommendation 4.5.** "Require DSHS to develop a formal process to refer nonjurisdictional complaints relating to EMS to appropriate organizations." [Pp. 60-61]

COMMENT:

Calls for EMS assistance also encompass services by physicians, nurse practitioners and hospital personnel, as well as firefighters and other first-responders. Therefore, DSHS should have a clearly stated formal referral procedure for EMS-related complaints. This would help individuals to address their complaints to the proper authorities in a timely manner. There have been actual instances when a complaint to DSHS about EMS services under its oversight were simply rejected as being outside the DSHS scope of authority, with no explanation and no effort made to refer the matter to the proper authority, such as the Texas Medical Board. That approach did not help resolve the problem at hand, and contributed to delays and confusion for the complainant. It would improve public safety to have an efficient system for tracking the number and type of nonjurisdictional EMS complaints. This system should also 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 as well.

*Issue 5: DSHS Has Not Provided the Leadership Needed to Best Manage the State's Public Health System.*

**Recommendation 5.4 (new and additional recommendation) 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.**

COMMENTS:

Because there are no preventive vaccines available for HIV and Hepatitis C, there is no cure for HIV, and the costs for treating HIV and Hepatitis C are substantial, statewide prevention efforts are crucial. The state has a need to expand evidence-based, behavioral interventions, including structural interventions to reduce the spread of HIV and viral hepatitis. Prevention and care services emphasize both physical and mental health care and adherence to treatment, and substance abuse is one reason these diseases are transmitted even to non-users. Preventing the instance and spread of these diseases and eliminating disparities among diverse populations includes the role of treatment as a form of prevention, and reduction of health disparities as a result of improved access to treatment.

DSHS responsibilities for HIV/AIDS and hepatitis include surveillance and epidemiology, public education, vaccine distribution for prevention of hepatitis A virus and hepatitis B virus, coordination and funding of local disease intervention specialist activities, hepatitis prevention and services associated with treatment and care for persons living with

HIV, including the AIDS Drug Assistance Program (ADAP). DSHS presently provides targeted services to people who are at risk for and those living with HIV/AIDS and hepatitis.

DSHS activities to control the spread of HIV-AIDS and hepatitis C are currently supported by research and reporting provided by the Interagency Coordinating Council for HIV and Hepatitis, and the Infectious Disease Control Unit (IDCU). The Interagency Coordinating Council is required to provide DSHS with reports and information required under Sec. 81.010 of the Health & Safety Code, which is part of the Communicable Disease Prevention and Control Act enacted in 1989. The IDCU is responsible for assisting local or regional public health officials in investigating outbreaks of acute infectious disease or any report of isolated cases of rare or unusual disease; this program conducts routine and special morbidity surveillance of reportable diseases.

DSHS programs for prevention and services associated with treatment and care of these particular infectious diseases should be revived. Previously existing DSHS programs designed to prevent the spread of hepatitis C have been eliminated or rendered ineffectual by decreased funding over time. For example, funding in 2000 was \$326,495 and increased to \$2,068,623 in 2001 as a result of a contingency rider; \$1.5 million was expended in 2002, and after that funding was reduced to \$200,000 per year. Although DSHS has funded behavioral interventions through contracts with local health departments and community-based organizations, the resources available for such efforts have limited the scale and scope of these interventions, even if agency leadership might have been able to develop and oversee these programs successfully.

*Issue 9: The State Should Continue Protecting Public Health and Providing Basic Health Services, but Decisions on DSHS' Structure Await Further Review.*

**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."  
[p. 91]

COMMENT:

DSHS should continue for a term of two years in order 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. At that time, the Commission and the Legislature would be in a better position to reassess the effectiveness and efficiency of the Department's ability to protect the health and safety of the public and determine whether or how long to continue the existence of the agency.