

**Schedule E: Health and Human Services  
System Coordinated Strategic Plan**

## **E.1 Executive Summary**

### **E.1.1 Introduction**

The State of Texas provides health and human services to millions of Texans through the efforts of more than 58,000 state employees operating more than 200 programs from more than 1,000 locations around the state. Together, the Health and Human Services (HHS) System programs account for approximately \$37.9 billion in fiscal year (FY) 2016 (all funds), approximately one-third of state spending.

Together, the HHS System agencies support and improve clients' health, safety, and well-being through many services, including: physical and behavioral health care; transition to self-sufficiency; food benefits; rehabilitation; help when disaster strikes; and protection from abuse, neglect, or exploitation. The HHS System agencies also have regulatory functions, proactively working toward health and safety in public establishments, such as restaurants, medical facilities, nursing homes, day care centers, and facilities operated or contracted by the state.

First through the enactment of House Bill (H.B.) 2292, 78<sup>th</sup> Legislature, Regular Session, 2003, and most recently through the passage of several bills to implement recommendations from the Sunset Advisory Commission, the Legislature and the Governor have directed the HHS System agencies to streamline organizational structures and eliminate duplicative administrative systems, in an effort to continue to improve services and enhance efficiencies.

Transformation efforts also address further streamlining and consolidation of administrative support services, including legal, financial, contract procurement, information technology, human resources, and other administrative functions.

While the Sunset review and related legislation provided the impetus for restructuring the HHS System, this transformation will go beyond that initial direction, changing not only the system's organization, but also the way it delivers services.

Transformation activities will produce an accountable, restructured system that:

- Is easier to navigate for people seeking information, benefits, or services;
- Aligns with the HHS mission, business, and statutory responsibilities;
- Breaks down operational silos to create greater program integration;
- Creates clear lines of accountability within the organization; and
- Develops clearly defined and objective performance metrics for all organizational areas.

To ensure a coordinated approach to planning and delivering health and human services, the Texas Government Code (Tex. Gov't Code) Section 531.022 requires

that the Health and Human Services Commission (HHSC) Executive Commissioner submit a strategic plan for the HHS System. Schedule E, the HHS System Coordinated Strategic Plan is submitted to fulfill that requirement. The six System goals, as well as the individual agency goals, address: the desire to create a continuum of care for families and individuals in need of health and human services; the integration of health and human services; the maximization of existing resources; the effective use of management information systems; the provision of system-wide accountability through effective monitoring mechanisms; the promotion of teamwork among health and human services agencies; the fostering of innovation at the local level; and the encouragement of full participation of fathers in programs and services relating to children. This plan is grounded in the System Vision, Mission, and Values, presented below.

At the publishing of this document in June 2016, five agencies comprise the HHS System:

- HHSC,
- The Department of Aging and Disability Services (DADS),
- The Department of Assistive and Rehabilitative Services (DARS),
- The Department of Family and Protective Services (DFPS), and
- The Department of State Health Services (DSHS).

Since DADS and DARS will be consolidated into HHSC in accordance with S.B. 200, 84<sup>th</sup> Legislature, Regular Session, 2015, this Plan reflects the new structure with three agencies.

In the planning period of 2017–2021, there may be greater demand for services from increasing numbers of individuals and families, as discussed in Part E.2 and throughout the Plan. Part E.3 highlights transformation of the HHS System in accordance with legislative direction based on Sunset recommendations. Part E.4 describes significant coordination initiatives.

## **E.1.2 Health and Human Services System Vision**

Making a difference in the lives of the people we serve.

## **E.1.3 Health and Human Services System Mission**

Improving the health, safety, and well-being of Texans through good stewardship of public resources.

## **E.1.4 Health and Human Services System Values**

- **Accountability:** We operate in a manner that reflects honesty, integrity and reliability.
- **Collaboration:** We work with clients, stakeholders, public and private partners, elected officials, and our employees to make informed decisions and achieve excellence in service design and delivery.
- **Client-Focused:** We exist because people have needs, and we respect each and every person.
- **Independence:** Our services and supports allow clients to reach their full potential.
- **Stewardship:** We are focused on the appropriate use of resources entrusted to our care and use them efficiently, effectively, and in a manner that builds public trust.
- **Transparency:** We build confidence in our operations by being open, inclusive and holding ourselves accountable.
- **Diversity:** We offer programs and services that value and respect the diversity of the State of Texas.

## **E.1.5 Health and Human Services System Goals**

**HHS System Goal 1: Improve the delivery of health and human services through a transformed system that is easier to navigate for people seeking information, benefits, or services.**

### ***HHSC Strategic Goals***

- Goal 1: Provide efficient, effective medical and behavioral health services.  
Goal 4: Provide efficient, effective services for individuals in 24-hour state facilities.

### ***DSHS Strategic Goals***

- Goal 1: Improve health through prevention and population-health strategies.  
Goal 2: Enhance public health response to disasters and disease outbreaks.  
Goal 4: Expand the effective use of health information.

**HHS System Goal 2: Create opportunities that lead to increased self-sufficiency and independence.**

### ***HHSC Strategic Goals***

- Goal 2: Provide efficient, effective social services.  
Goal 3: Coordinate with diverse communities and organizations to strengthen and to support the provision of a spectrum of medical, health, and social services.

### **HHS System Goal 3: Improve and protect the health, safety, and well-being of Texans.**

#### ***HHSC Strategic Goals***

Goal 5: Promote consumer health and safety through focused regulatory and licensing activities.

#### ***DFPS Strategic Goals***

Goal 1: Protect children, families, older adults, and people with disabilities from abuse, neglect, and exploitation through quality investigations.

Goal 2: Work with community partners to strengthen family systems and improve outcomes through effective service delivery.

Goal 3: Work with Texas communities to provide services that prevent child abuse and neglect and promote positive child, youth, and family outcomes based on analysis of community risk and protective factors as well as local needs assessments.

Goal 4: Provide 24/7 intake operations to capture vital information needed to respond to vulnerable Texans.

#### ***DSHS Strategic Goals***

Goal 3: Reduce health problems through public health consumer protection.

### **HHS System Goal 4: Implement an efficient and effective consolidated administrative support structure for the HHS System.**

#### ***HHSC Strategic Goals***

Goal 7: Improve the effectiveness and efficiency of system oversight and program support.

### **HHS System Goal 5: Make informed decisions through collaboration with external partners.**

The HHS System works with independent boards, advisory committees, and interagency task forces that take public comment at posted meetings and work with stakeholders to improve policy and outcomes.

There are more than 50 advisory committees across the HHS system, consisting of public members who advise on a wide range of topics and program areas including Medicaid and social services programs, managed care service delivery, health care quality initiatives, services to persons with disabilities, behavioral health, regulatory matters, public health and many more. Advisory committees are comprised of public

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members who represent consumers, service providers, and others affected by or interested in HHS programs, and they reside in communities across the state. With their individual knowledge and experience, advisory committee members assist HHS program staff in making informed policy recommendations and decisions.

A cross-agency workgroup reviewed the ongoing needs of all advisory committees, with the goal of achieving a more effective way for stakeholders to provide meaningful input on system programs. The workgroup developed criteria to evaluate the committees. Based on the evaluation, the workgroup prepared a summary of findings to post for stakeholder and public input. In September 2015, stakeholders provided feedback that was gathered, evaluated and presented to the Executive Commissioner, whose final decisions were posted to the Texas Register on October 30, 2015. Staff drafted the necessary rules, gathered additional feedback from stakeholders, and presented them to each agency’s advisory council for approval. These rules become effective July 1, 2016.

## **HHS System Goal 6: Ensure the integrity of health and human service providers.**

### ***HHSC Strategic Goals***

Goal 6: Ensure the integrity of health and human services programs through the Inspector General.

## **E.2 Trends in the Operating Environment**

### **E.2.1 Statewide Demographic, Economic, and Health Trends**

Key demographic trends and changing economic conditions affect the complex environment in which the HHS System agencies operate.

Below is a list of race/ethnic terms, with their respective definitions, as used in the Plan:

- African American—Black, non-Hispanic;
- Anglo—White, non-Hispanic;
- Hispanic—Cultural identification, can include persons of any race; and
- Other—All other non-Hispanic population groups combined, including Chinese, Vietnamese, Native American, Eskimo, and others.

### **Demographic Trends**

Demographic trends that could impact HHS System programs include changes in the size, composition, and geographical distribution of the population.

## **Population Growth**

Since becoming a state in 1845, Texas has consistently experienced some of the highest population growth in the nation. According to the 2010 Census of Population, Texas is the second-most populous state, with 25.1 million residents,<sup>1</sup> and has continued to experience strong population growth.

The United States (U.S.) Census Bureau estimates that between 2010 and 2015 the state's population grew at a significantly higher rate compared to the U.S. as a whole, at 9.2 percent versus 4.1 percent.<sup>2</sup> Both natural increase (the amount by which the number of births exceeds the number of deaths) and positive net migration (the amount by which in-migrants outnumber out-migrants) have contributed strongly to recent population growth. The Census Bureau estimates that positive net migration, or in-migrants, accounted for 52 percent of the total population growth in the state during this period.<sup>3</sup>

The state's population is projected to increase by 3.7 million or 15 percent between 2010 and 2017. The population is projected to reach to 28.8 million in 2017, when it will comprise close to 9 percent of the total U.S. population. The State Data Center (SDC) projects that between 2017 and 2021 the population will grow by another 2.4 million or 8 percent, reaching 31 million in 2021.<sup>4</sup>

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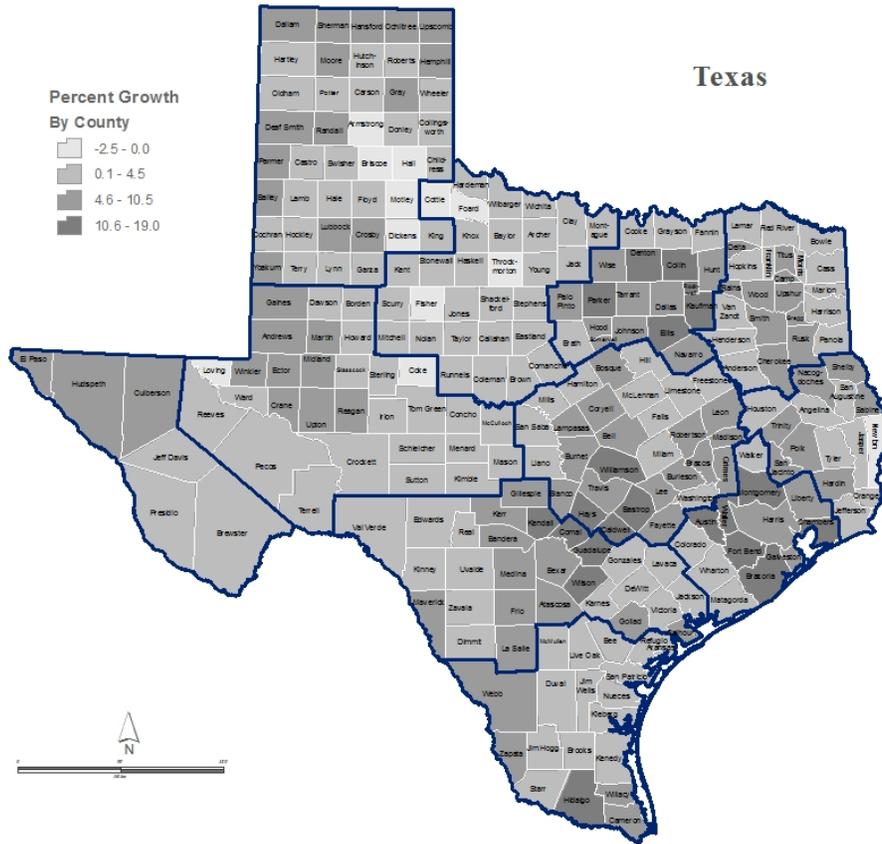
<sup>1</sup> U.S. Census Bureau. 2010 Census, Summary File 1.

<sup>2</sup> U.S. Census Bureau. Population Division, National and State Population Estimates, April 2010-July 2015.

<sup>3</sup> Ibid.

<sup>4</sup> The population projections for Texas cited throughout this Plan are derived from the SDC's 2000–2010 Migration Growth Scenario, which uses the 2010 Census counts and 2000–2010 migration and natural increase trends for producing population projections.

**Figure E.1: Percent Population Growth by Texas County, 2017–2021**



**Sources: SDC, Population Projections for Texas According to the 2000–2010 Migration Scenario; HHSC, Strategic Decision Support. March 2016.**

Most of the population growth is projected to occur in and around the major metropolitan regions of the state, such as Houston, Dallas-Fort Worth, San Antonio, Austin, and McAllen.

***Ageing of the Population***

Key projected long-term trends are important. The age composition of the Texas population will change between now and the year 2050. Much of the change will be associated with the aging of the baby boom generation. The oldest of the baby boomers, persons born between 1946 and 1964, will turn 71 in the year 2017. That year, the population age 65 and older will make up 12 percent of the total population. The percent share of the population age 65 and older is projected to increase during the foreseeable future. With continued advances in medicine and health care, those who reach age 65 will have a greater chance of living to age 85 and beyond.

Between 2017 and 2050, the percent share of the population age 65 and older will increase. In 2050, older females will continue to outnumber older males, particularly among those aged 85 and older.

The population age 65 and older is projected to grow from 3.5 million in 2017 to 9.4 million in 2050. This group's share of the total population is projected to increase from 12 percent in 2017 to 17 percent in 2050. The population age 85 and older is projected to quadruple during the 2017–2050 period, growing from 371,000 in 2017 to approximately 1.6 million in 2050.

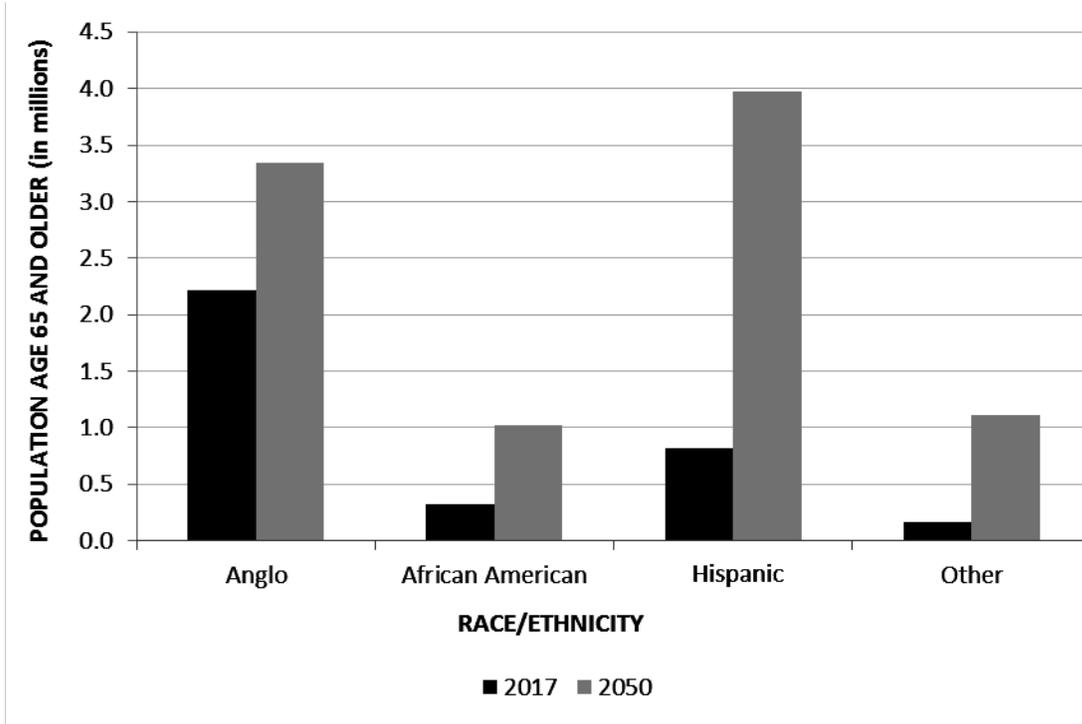
The old-age dependency ratio will also be impacted by changes in the age composition of the population. This ratio represents the number of people age 65 and older per 100 working-age people (ages 18–64). Higher values for this measure suggest a potential for more economic and other dependency of older adults on younger adults. The old-age dependency ratio for Texas is projected to increase from 20 to 29 between the years 2017 and 2050. This could mean that a greater proportion of the income and resources of younger working adults might be needed to provide income support and other forms of assistance to older retired adults who cannot work any longer due to health-related limitations or permanent disabilities.

While the population age 65 and older is projected to grow across all race/ethnic groups, the growth will be more noticeable in the non-Anglo groups. Between 2017 and 2050, the following growth rates are projected in the population age 65 and older according to race/ethnicity:

- Anglos—51 percent,
- African Americans—219 percent,
- Hispanics—390 percent, and
- All other groups (combined)—578 percent.

Figure E.2 compares the populations age 65 and older in 2017 and 2050 according to race/ethnicity. The Anglo population is projected to grow from 2.2 million to 3.3 million; the African-American population is projected to grow from 319,000 to 1 million; and the Hispanic population is projected to grow from 811,000 to 4 million. For all other groups combined, the age 65 and older population is projected to grow from 164,000 to 1.1 million.

**Figure E.2: Texas Population Age 65 and Older by Race/Ethnicity, 2017 and 2050**



Sources: SDC, Population Projections for Texas According to the 2000–2010 Migration Scenario; HHSC, Strategic Decision Support. March 2016.

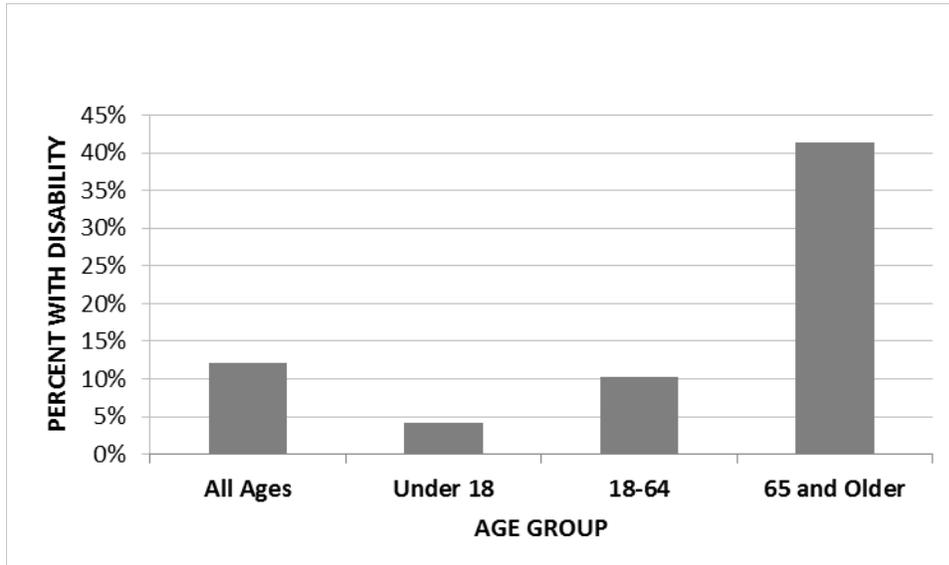
### ***Prevalence of Disability***

The gradual aging of the population will likely result in an increase in the number of people living with a disability and/or other chronic health condition. The presence of these conditions can cause difficulties in performing basic activities of daily living, such as working, bathing, dressing, cooking, and driving. People with one or more disabilities, especially those with a severe disability, are more likely to need and to use health and human services, which means that the anticipated growth trend for this population could result in a greater demand for many of the services offered by HHS System agencies.

Results from the U.S. Census Bureau's 2010–2014 American Community Survey (ACS) for Texas show that, on a yearly average basis, 3.1 million or 12 percent of Texans lived with a disability. The percentage living with a disability was higher among adults age 65 and older. During that period, 10.3 percent of adults age 18–64 and 41.4 percent of adults age 65 and older had a disability.

Figure E.3 illustrates the percent of the population with a disability according to age group.

**Figure E.3: Percent of Texans with a Disability During the 2010–2014 Period, by Age Group**



Source: U.S. Census Bureau, 2010–2014 ACS for Texas; HHSC, Strategic Decision Support, March 2016.

### ***Race/Ethnic Composition of the Population***

Texas is becoming more racially and ethnically diverse over time. While the Anglo population has been the largest group for decades, its proportion is changing as the non-Anglo populations are experiencing higher growth rates than the Anglo population in recent years.

According to the most recent Census, in 2010 Anglos accounted for 45 percent of the population and Hispanics for 38 percent. It is projected that the size of the Anglo and Hispanic populations will be approximately the same in 2017, when each of these groups will account for 41 percent of the total population. African Americans will account for 11 percent, and all the other groups, combined, will account for the remaining 7 percent.

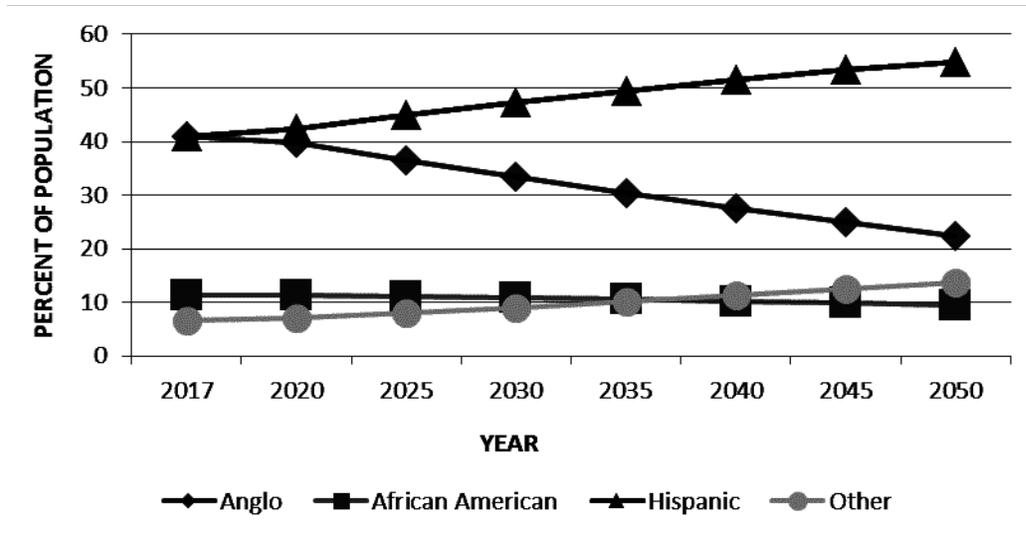
The SDC projects the following growth trends between 2017 and 2021.

- The Anglo population is projected to grow from 11.8 to 12.0 million, with a growth rate of 1 percent.
- The African-American population is projected to grow from 3.3 to 3.5 million, with a growth rate of 7 percent.
- The Hispanic population is projected to grow from 11.8 to 13.4 million, with a growth rate of 13 percent.
- The population of all the other population groups, combined, is projected to grow from 1.9 to 2.3 million, with a growth rate of 19 percent.

Over the long term, Hispanics are projected to become the largest ethnic group. They will account for 55 percent of the total population in 2050, while Anglos will account for 22 percent.

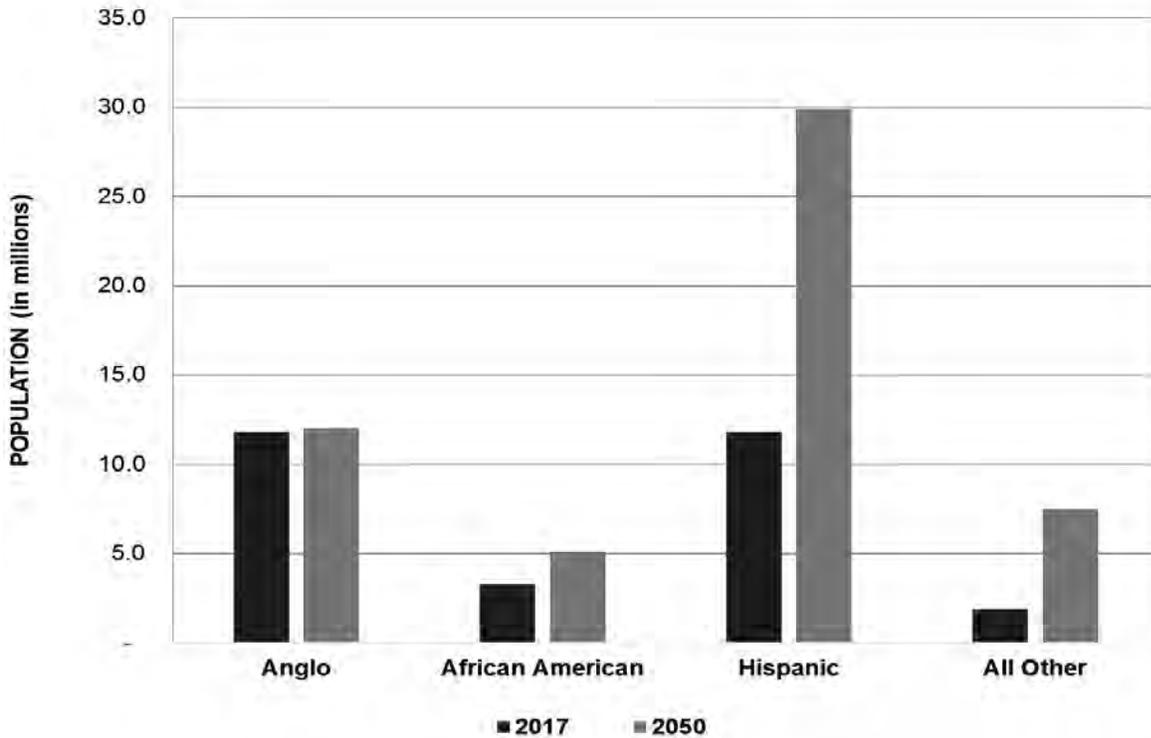
Figures E.4 and E.5 illustrate some of the projected changes in population size and population composition by race/ethnicity during the 2017-2050 period.

**Figure E.4: Percent of Population by Race/Ethnicity, 2017–2050**



Sources: SDC, Population Projections for Texas According to the 2000-2010 Migration Scenario; HHSC, Strategic Decision Support. March 2016.

**Figure E.5: Projected Population by Race/Ethnicity in 2017 and 2050**

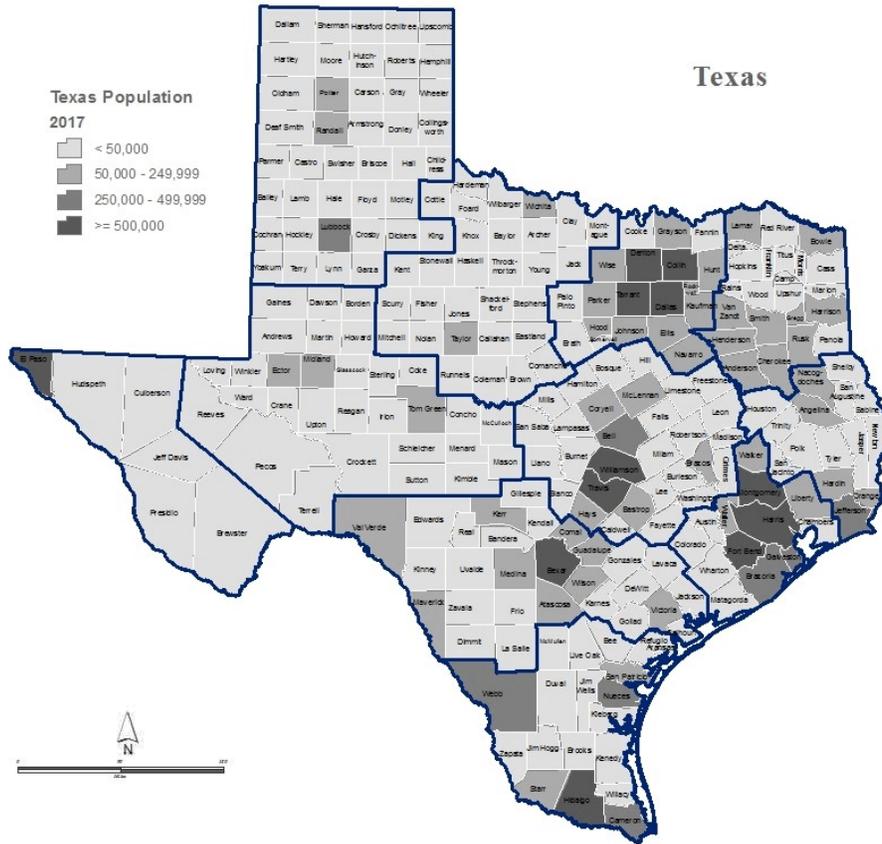


Sources: SDC, Population Projections for Texas According to the 2000-2010 Migration Scenario; HHSC, Strategic Decision Support. March 2016.

***Urban and Rural Population Trends***

The vast majority of the Texas population resides in counties that are part of a metropolitan area. The map in Figure E.6 depicts the projected total population in 2017 by county. The largest population concentrations will be found in and around the major metropolitan areas of the state, such as Houston, Dallas-Fort Worth, San Antonio, Austin, El Paso and McAllen. The counties with the smallest populations will be mostly found in the vast geographical regions of West, Central Northwest, and Northwest Texas.

**Figure E.6: Total Population By County, 2017**



**Sources: SDC, Population Projections for Texas According to the 2000-2010 Migration Scenario; HHSC, Strategic Decision Support. March 2016.**

According to the 2010 Census of Population, 3 million or 12 percent of Texans resided in non-metropolitan (rural) counties. Although these residents account for a relatively small fraction of the state's total population, the total population for those counties, when combined, exceeds the total population of many states. Residents of rural counties tend to experience challenges for the delivery of health and human services:

- Limited access to affordable health care,
- Limited number of trained health professionals,
- Increased need for geriatric services,
- Prolonged response times for emergency services,
- Limited job opportunities and other incentives for youth to stay in the community,
- Limited transportation options, and
- Limited economic development and fiscal resources.

## Economic Forecast

The relative strength and/or weakness of the economy can impact the demand for health and human services and the government's ability to obtain needed revenues to fund those services and other priorities.

The State's economy is defined by all activities and institutions associated with the production, exchange, and consumption of goods and services. In 2015, Texas had the second-largest state economy in the U.S.,<sup>5</sup> accounting for 9 percent of the national economic output. Factors such as available natural resources, human and financial capital, technology, and laws and regulations impact economic activity and outcomes.

According to the U.S. Bureau of Economic Analysis,<sup>6</sup> in 2015, Texas' gross state product, an indicator of the size of the state's economy, was \$1.64 trillion. This is the total monetary value of goods and services produced across all industries within the state during that year.

Additional analysis<sup>7</sup> reveals that the top six economic sectors, based on percent contribution to, were:

- Manufacturing—15 percent,
- Finance and insurance—14 percent,
- Professional and business services—11 percent,
- Government (including military)—10 percent, and
- Real estate and Mining (including oil and gas)—9 percent each.

If the favorable trends described below continue, they would help maintain the current economic expansion.<sup>8</sup>

- Texas' overall employment picture is encouraging. In December 2015, the seasonally adjusted unemployment rate in the State was 4.7 percent, compared to 5.0 percent for the U.S.
- The average monthly unemployment rate in 2015, 4.5 percent, was the lowest one since 2007 before the start of the last recession, when the unemployment rate bottomed out at 4.3 percent.
- From December 2012 to December 2015, the population of employed Texans grew by 523,000 or 4.4 percent, on a seasonally adjusted basis. A total of 12,486,860 Texans were employed in December 2015.
- The strong U.S. dollar and low oil prices have kept the overall consumer price index at relatively low and stable levels.
- Most of the state's counties have a relatively low unemployment rate.

<sup>5</sup> U.S. Bureau of Economic Analysis.

[http://www.bea.gov/newsreleases/regional/gdp\\_state/2016/pdf/qgsp0316.pdf](http://www.bea.gov/newsreleases/regional/gdp_state/2016/pdf/qgsp0316.pdf)

<sup>6</sup> *Ibid.*

<sup>7</sup> I H S Global Insight. Economic Forecasts for Texas and the U.S. February 2016.

<sup>8</sup> Texas Workforce Commission. Tracer2.

<http://www.tracer2.com/cgi/dataanalysis/?PAGEID=94&SUBID=120>

## ***Poverty***

Individuals and families living in poverty often rely on health and human services, so it is useful to review trends for this population and to assess potential impacts on the HHS System.

The U.S. Department of Health and Human Services defines the annual federal poverty level for family incomes for 2016 for certain family sizes as follows:<sup>9</sup>

- \$24,300 for a family of four,
- \$20,160 for a family of three,
- \$16,020 for a family of two, and
- \$11,880 for one-person households.

In 2014 approximately 4.5 million, or 17.2 percent of Texans, lived in households with income below the poverty level. The U.S. Census Bureau does not project future poverty population trends; however, if the percentage of households with income below the poverty level were to stay the same as in 2014 during the foreseeable future, the size of the Texas poverty population could potentially reach 5.0 million in 2017 and 5.4 million in 2021.

## **Health Trends**

### ***Health Risk Factors***

In 2013, the most recent year for which death data is available, chronic diseases accounted for a majority of the leading causes of death in the U.S. and in Texas. Chronic diseases are generally characterized by a long period of development, a prolonged course of illness, non-contagious origin, functional impairment or disability, multiple risk factors, and low curability. Table E.3 provides information relating to the ten leading causes of death in Texas in 2013.

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<sup>9</sup> U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation: Federal Register / Vol. 81, No. 15 / Monday, January 25, 2016 / Notices.

**Table E.3: Leading Causes of Texas Deaths, 2013<sup>10</sup>**

<b>Ranking</b>	<b>Disease</b>	<b>Percentage</b>
<b>1</b>	Diseases of the Heart	22.5%
<b>2</b>	Malignant Neoplasms (Cancer)	21.5%
<b>3</b>	Chronic Lower Respiratory Diseases	5.5%
<b>4</b>	Accidents (Unintentional Injuries)	5.2%
<b>5</b>	Cerebrovascular Diseases	5.1%
<b>6</b>	Alzheimer's Disease	3.0%
<b>7</b>	Diabetes	2.9%
<b>8</b>	Septicemia	2.2%
<b>9</b>	Nephritis, Nephrotic Syndrome, and Nephrosis (Kidney Diseases)	2.1%
<b>10</b>	Chronic Liver Disease and Cirrhosis	1.9%
	All Other Causes	28.1%
	<b>Total Deaths in 2013</b>	<b>100.0%</b>

Source: DSHS, 2016.

Four of the top five leading causes of death in Texas in 2013 have several risk factors in common. Cardiovascular disease includes heart disease, stroke, and congestive heart failure. The risk factors for cardiovascular disease include hypertension, tobacco use, high cholesterol levels, physical inactivity, poor nutrition, obesity, and environmental air quality factors, such as exposure to particulate air pollution and second-hand tobacco smoke. Risk factors associated with cancer include tobacco use, poor nutrition, physical inactivity, and obesity. Diabetes can lead to disabling health conditions, such as heart disease, stroke, kidney failure, leg and foot amputations, and blindness. Risk factors for diabetes include poor nutrition, physical inactivity, and obesity.

Understanding certain risk factors can help in developing strategies to reduce the impact of preventable or treatable chronic conditions. These risk factors are tracked

<sup>10</sup> DSHS, "Vital Statistics Annual Report: Leading Causes of Death in Texas - 2013." (<http://www.dshs.state.tx.us/chs/vstat/vs13/t16.aspx>).

at the state and national levels to understand the health status of populations and to inform policymaking. Some of these risk factors include:

- Physical inactivity,
- Obesity,
- Tobacco use,
- Substance use,
- Risky sexual behavior,
- Mental illness,
- Injuries and violence,
- Lack of immunizations,
- Environmental dangers, and
- Lack of access to health care.

### ***Mental Health***

Mental illness is a leading cause of disability in the U.S.<sup>11</sup> It is estimated that 17.8 percent of the adult U.S. population has a mental health disorder during the course of a year.<sup>12</sup> In Texas, the 2014 estimated number of adults with serious and persistent mental illness was 515,875.<sup>13</sup> Approximately 20 percent of U.S. children and adolescents have some type of mental disorder.<sup>14</sup> Federal regulations also define a sub-population of children and adolescents with more severe functional limitations, known as serious emotional disturbance (SED). Children and adolescents with SED comprise approximately 7 percent of children ages 9 to 17. In 2014, the estimated number of children with SED in Texas was 248,525.<sup>15</sup>

### ***Behavioral Risk Factors***

The leading causes of death can be linked to one or more significant behavioral risk factors. Three risk behaviors that are major contributors to cardiovascular disease and cancer include tobacco use, poor nutrition, and physical inactivity. The Texas Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS) take an in-depth look at behavioral risk factor prevalence in Texas

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<sup>11</sup> U.S. Burden of Disease Collaborators. The state of U.S. health, 1990-2010: burden of diseases, injuries, and risk factors. *JAMA*, 310(6): 591-608, 2013.

<sup>12</sup> Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (November 19, 2013). The NSDUH Report: Revised Estimates of Mental Illness from the National Survey on Drug Use and Health. Rockville, MD.

(<http://www.samhsa.gov/data/sites/default/files/NSDUH148/NSDUH148/sr148-mental-illness-estimates.pdf>)

<sup>13</sup> CMHS, SAMHSA, HHS (1999) Estimation Methodology for Adults with Serious Mental Illness (SMI). Federal Register v 64.

<sup>14</sup> National Institute of Mental Health. Any disorder among children. <http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml>. Accessed March 4 2016.

<sup>15</sup> CMHS, SAMHSA, HHS (1998) Children with Serious Emotional Disturbance: Estimation Methodology. Federal Register v63 n137, pp. 38661-38665.

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and are important tools for decision-making throughout DSHS and the public health community.<sup>16</sup>

### Substance Use

Substance use is another underlying behavior in a wide range of health problems. Certain statistics characterize alcohol abuse or use in Texas.

- In 2016, the economic impact of alcohol abuse was estimated to be \$25.6 billion, which includes health care expenditures, lost productivity, motor vehicle accidents, crime, and other costs.<sup>17</sup>
- Of the 3,538 motor vehicle fatalities in 2014, 1,446 (41 percent) were alcohol-related.<sup>18</sup>
- In 2014, 51 percent of secondary and middle school students reported they had ever used alcohol, while almost 30 percent reported past-month alcohol use.<sup>19</sup>

Drug use is costly to the individual, the family, and the state.

- In 2016, the economic impact of illegal drug use in Texas was roughly estimated to be \$14.6 billion.<sup>20</sup>
- In 2014, 51 percent of secondary and middle school students reported they had ever used an illicit drug, while 14 percent reported past-month drug use.<sup>21</sup>
- In fiscal year 2015, approximately 11 percent of all DSHS-funded substance abuse treatment clients participated in a co-occurring psychiatric and substance use disorders program.<sup>22</sup>

### Tobacco Use

Tobacco use is the single largest cause of preventable, premature death, and disease in Texas. Tobacco use is a primary contributor to lung disease, heart disease, and diseases of the mouth, breast, pharynx, esophagus, pancreas, kidney, bladder, and uterine cervix. Tobacco products are associated with the deaths of more than 400,000 people in the U.S. every year. In Texas, 24,200 adults die annually from smoking-related causes. Additionally, for every person who dies from a tobacco-related cause, an additional 20 suffer from tobacco-related diseases.

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<sup>16</sup> DSHS, BRFSS. (<http://www.dshs.state.tx.us/chs/brfss/default.shtm>).

<sup>17</sup> DSHS, Division of Mental Health and Substance Abuse Services, Office of Decision Support, January 2016.

<sup>18</sup> National Highway Traffic Safety Administration's Fatality Analysis Reporting System. Alcohol-Impaired Driving Fatalities: Texas, US and Best State. ([http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/48\\_TX/2014/48\\_TX\\_2014.htm](http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/48_TX/2014/48_TX_2014.htm))

<sup>19</sup> DSHS. Texas School Survey of Drug and Alcohol Use: 2014. [http://www.texasschoolsurvey.org/Documents/tss2014\\_state7.pdf](http://www.texasschoolsurvey.org/Documents/tss2014_state7.pdf) Accessed March 4 2016.

<sup>20</sup> DSHS, Division of Mental Health and Substance Abuse Services, Office of Decision Support, January 2016.

<sup>21</sup> DSHS. Texas School Survey of Drug and Alcohol Use: 2014. [http://www.texasschoolsurvey.org/Documents/tss2014\\_state7.pdf](http://www.texasschoolsurvey.org/Documents/tss2014_state7.pdf) Accessed March 4 2016.

<sup>22</sup> DSHS, Clinical Management for Behavioral Health Services Data.

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Tobacco use and its related health consequences take a high toll on lower-income and less-educated populations who disproportionately use tobacco products and who have less access to health care due to a lack of insurance. According to the findings from the 2014 Texas BRFSS, individuals with a less than a high school education have an 18.0 percent prevalence for smoking and a 52.2 percent prevalence for not having health insurance. This study found that those who make less than \$25,000 per year have an 18.6 percent prevalence rate for smoking and a 46.5 percent prevalence for lacking health insurance. This compares to a statewide average of a 14.5 percent prevalence for smoking and a 24.9 percent prevalence for lacking health insurance.

In addition to causing disparate harm to individuals with a lower socio-economic status, tobacco takes a profound toll on persons who also are addicted to alcohol and/or illicit drugs, and those who experience mental illness. According to the National Association of State Mental Health Program Directors, 75 percent of individuals with either addictions or mental illness smoke cigarettes, compared to 22 percent of the general population. Additionally, nearly half of all cigarettes consumed in the U.S. are by individuals with a psychiatric disorder. On average, persons with serious mental illness die 25 years younger than the general population—largely from conditions caused or worsened by smoking.

### Nutrition and Physical Activity

Poor diet and physical inactivity often lead to being overweight and obese, the second leading cause of preventable mortality and morbidity in the U.S. These factors account for more than 100,000 deaths annually, and they impose economic costs that are second only to smoking.

- The prevalence rate of adults who are either overweight or obese is rising in Texas. In 2014, 67.8 percent of Texas adults were overweight or obese.<sup>23</sup>
- In 2014, 31.9 percent of adult Texans were obese, compared to 28.9 percent nationwide.
- In 2013, 15.7 percent of high school students were obese (at or above the 95<sup>th</sup> percentile for body mass index, by age and sex).
- Male students were more likely than female students to be obese (19.4 percent vs. 11.8 percent).
- Hispanic students were more likely than Anglos to be obese (19.0 percent vs. 12.1 percent).

Regular physical activity, even in moderate amounts, has been shown to produce significant health benefits. Despite this fact, the BRFSS and YRBS showed that many adults in Texas reported little or no exercise.

- In Texas, 27.6 percent of adults reported no leisure-time physical activity in the past month, compared to 23.7 percent of adults nationwide in 2014.

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<sup>23</sup> DSHS, Center for Health Statistics, 2014 Texas BRFSS.

- Hispanics and African Americans in Texas had higher rates of no leisure-time physical activity, 34.8 percent and 30.6 percent respectively, compared to 21.9 percent of Anglos.
- In 2013, 57.9 percent of adult Texans did not meet aerobic recommendations according to the 2008 Physical Activity Guidelines for Americans.
- According to the 2013 Texas YRBS, 32.9 percent of Texas adolescents in grades 9–12 watched television for three or more hours per day on an average school day.
- African American adolescents had the highest rate of three or more hours of television time per day at 49.1 percent, followed by Hispanics at 35.2 percent, and Anglos at 25.5 percent.
- In 2013, more than one out of three Texas high school students (38.0 percent) played video games or computer games, or used a computer for something that was not for schoolwork, for three or more hours per day on an average day.

### ***Maternal and Child Health***

Improving the health and well-being of mothers, infants, and children in Texas is vitally important, because their well-being determines the health of the upcoming generation. In addition, the current health status of mothers and children can help to predict future health issues for families, communities, the health care system, and public health policymakers. Racial disparities have an impact on maternal and child health.

### **Maternal and Women's Health**

- In 2013, less than two-thirds of Texas women of childbearing age reported having a routine checkup in the past year.<sup>24</sup>
- The rate of women giving birth who received adequate prenatal care has plateaued between 2011 and 2013, with only 64.5 percent of women having a prenatal visit in the first trimester of pregnancy.<sup>25</sup>
- Approximately 61 percent of women in Texas were overweight or obese in 2013.<sup>26</sup> Rates of pre-pregnancy obesity have increased more than 22 percent for African-American and Hispanic women from 2005 to 2013, from 25.7 to 31.4 percent among African-American women, and from 21.2 to 26.8 percent among Hispanic women.<sup>27</sup>

### **Perinatal and Infant Health**

- While Texas has high rates of initiation of breastfeeding, an estimated 83.3 percent in 2012, the percent of women who exclusively breastfeed is still

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<sup>24</sup> BRFSS data, 2013

<sup>25</sup> Texas birth files, DSHS Center for Health Statistics

<sup>26</sup> DSHS Division of Mental Health and Substance Abuse Services, Office of Decision Support, January 2016.

<sup>27</sup> Texas birth files, DSHS Center for Health Statistics

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relatively low. According to 2012 National Immunization Survey results for Texas, 43.7 percent of mothers reported exclusive breastfeeding at 3 months, and 21.3 percent of mothers reported exclusive breastfeeding at 6 months.

- The preterm birth rate in Texas was 12.3 percent in 2013, which was higher than the Healthy People 2020 target and the national average (both 11.4 percent). The rate of preterm births has decreased among all race/ethnic groups from 2004 to 2013, especially among infants born to African-American mothers. However, African-American mothers still had the highest rate of preterm births in 2013 (16.1 percent).
- Texas' infant mortality rate has been lower than the national rate for the past ten years. Racial/ethnic disparities in infant mortality have persisted; the infant mortality rate for African-American mothers (11.9 per 1,000 live births) was more than 2 times higher than the infant mortality rate for Anglo mothers (5.0 per 1,000 live births) in 2013.<sup>28</sup>

The Healthy Texas Babies initiative seeks to modify maternal and infant risk factors for poor birth outcomes and infant death that exist across the lifespan, with an emphasis on persistent disparities affecting specific populations in our state. DSHS also coordinates efforts to reduce maternal mortality and severe maternal morbidity. Based upon implementation of S.B. 495, 83<sup>rd</sup> Legislature, Regular Session, 2013, DSHS has established the Maternal Mortality and Morbidity Task Force and will report findings to the Legislature.

### Child and Adolescent Health

- As in past years, child injury was the leading cause of death for children ages 1–14 in 2013, accounting for 35.3 percent of all deaths among boys and 23.7 percent of all deaths among girls of this age group.<sup>29</sup>
- Child abuse and neglect fatalities accounted for 11 percent of all non-natural deaths among children from birth through age 17 in 2014.<sup>30</sup>
- The suicide rate increased slightly for adolescents (ages 15–17) from 5.9 suicide deaths per 100,000 in 2008 to 6.9 suicides per 100,000 in 2012.<sup>31</sup>

### ***Impact of Infectious Diseases***

DSHS engages in a variety of responses to natural disasters and other public health emergencies. In recent years, the agency has not had to respond to severe storms and hurricanes, but has engaged in ongoing control and prevention activities related to emerging and re-emerging infectious diseases.

<sup>28</sup> Texas 2013 birth and death files, DSHS Center for Health Statistics

<sup>29</sup> DSHS, Texas Vital Statistics 2013 Annual Report  
(<http://www.dshs.state.tx.us/chs/vstat/vs13/data.aspx>)

<sup>30</sup> DFPS—Texas death certificate linked files, 2014

<sup>31</sup> Texas 2008-2012 death files, DSHS Center for Health Statistics

## Response to Ebola Virus Disease

The first diagnosis of Ebola virus disease in North America occurred in September 2014 in Dallas, when a traveler from Liberia was admitted to a Dallas healthcare facility. Shortly following the man's death, two nurses who had provided him direct patient care were also diagnosed with Ebola virus infection. Both nurses survived their illnesses.

DSHS coordinated with the Centers for Disease Control and Prevention (CDC) and local health departments regarding travelers in their jurisdictions. DSHS also monitored travelers through regional offices for locations where there is no health department. Travelers from West Africa were monitored for fever and other symptoms for 21 days.

DSHS provided epidemiological investigation support to follow up on potentially exposed individuals, laboratory testing, control orders, public information, media coordination, contamination remediation, biohazard waste management and disposal, veterinary support for an exposed pet, and disaster behavioral health support.

Using state and federal funding, DSHS has since focused on preparing for the emergence of high-consequence diseases such as Ebola, novel strains of influenza, and the MERS coronavirus. DSHS has held statewide workshops and exercises and has also worked to improve laboratory and epidemiological surveillance capacity. Additional funding and preparedness resources, including planning support, training opportunities, reference materials, and exercises, have also been shared across the state with local health departments and other health care organizations.

## Foodborne Outbreaks

Texas has seen many foodborne illnesses including Cyclosporiasis and Listeriosis. These illnesses are often smaller outbreaks handled locally in communities. DSHS may be involved in larger outbreaks that cross communities or that are part of a national foodborne illness investigation.

### *Cyclospora*

In June 2015, DSHS determined that more than 40 Cyclospora-positive lab reports had been submitted in one week, an exceptionally high number. Ultimately, 241 laboratory-confirmed cases of Cyclospora were reported, and 219 patient interviews completed. The Texas Rapid Response Team was activated and made possible tracebacks of foods implicated by the epidemiology investigations. The rapid, intensive work resulted in identification of cilantro from Mexico being the most probable vehicle. The U.S. Food and Drug Administration (FDA) issued an import alert detaining cilantro from Puebla, Mexico, coming into the U.S.

### *Listeria*

In March 2015, four cases of listeriosis were identified in Kansas that had specimens with genetic fingerprints matching samples of ice cream produced in a Texas facility of a Texas-based ice cream company. The ice cream samples found to be contaminated had been tested in South Carolina as part of routine sampling activities there. The ice cream company issued a limited recall and later expanded it to their entire line of products. Investigations of other previously identified listeriosis cases resulted in an increase of the case count to 10, including 3 in Texas. Three of the case-patients, all in Kansas, died. DSHS staff worked closely with the CDC and FDA to investigate the source of the infection. Staff monitored the company to ensure that it resumed ice cream production only after thorough cleaning of the plant and implementation of practices to prevent the chance of recurrence of contamination at the plant.

### Arbovirus Diseases

There is an ongoing threat of mosquito-borne diseases across Texas that includes the recurrence of West Nile virus and the emerging threats of Chikungunya, Dengue, and Zika viruses. The 2012 West Nile virus season in Texas was the most severe on record, and it provided many lessons for use in planning for and responding to future threats of arbovirus diseases. DSHS provided leadership throughout the response by maintaining situational awareness, compiling case counts, and coordinating key information with local and federal partners. DSHS completed other activities, such as conducting laboratory testing, coordinating with the Centers for Disease Control and Prevention teams to assist in outbreak analysis, providing geographic information system mapping of cases and incidence rates, developing and disseminating public outreach and education, activating vector control contracts and providing other support for ground and aerial spraying.

In May 2015, the Pan American Health Organization issued an alert regarding the first confirmed Zika virus infection (Zika) in Brazil, and on February 1, 2016, the World Health Organization declared Zika a public health emergency of international concern.

Zika is spread to people primarily through the bite of an *Aedes* species mosquito infected with the Zika virus. The most common symptoms of Zika are fever, rash, joint pain, and conjunctivitis (red eyes). The illness is usually mild, with symptoms lasting for several days to a week after being bitten by an infected mosquito. CDC has stated that Zika virus infection during pregnancy can cause a serious birth defect called microcephaly, as well as other severe fetal brain defects. There is also evidence that Zika is associated with cases of a paralytic condition called Guillain-Barré syndrome.

Local transmission of Zika has been reported in Mexico and many South and Central American countries. As of May 24, 2016, all cases in Texas have been travel-related, with one confirmed case of sexual transmission through a partner with

travel-related infection. Planning and communication strategies have been initiated to prepare for the growing threat of local Zika virus transmission.

### Healthcare-Associated Infections

Healthcare-associated infections (HAIs) and preventable adverse events (PAEs) continue as significant causes of morbidity and mortality nationally and in Texas. In the U.S., an estimated 722,000 patients acquire HAIs annually, and as many as 75,000 of those patients die during their hospital stay. In an effort to reduce HAIs and PAEs in, the Legislature mandated HAI reporting in 2007 and PAE reporting in 2009. General hospitals and ambulatory surgical centers in Texas must report certain central line-associated bloodstream infections, catheter associated urinary tract infections, and surgical site infections. Reportable PAEs not related to infections can include events resulting in patient death or severe harm, such as a fall in a health care facility or an object left in the patient after surgery. The public can view facility level HAIs and PAEs for each of these events or procedures on the public website at [www.haitexas.org](http://www.haitexas.org).

Certain multi-drug resistant organisms—bacteria that do not respond to many antibiotics—must now be reported by any health care provider, not just hospitals and ambulatory surgical centers. Well over 1,000 such infections were reported in Texas in both 2014 and 2015, making these among the most numerous of all reportable infections in Texas.

### ***Health Insurance Coverage***

The U.S. Census Bureau’s ACS gathered health insurance coverage information for 2013 and 2014. Between 2013 and 2014, the number of uninsured in Texas declined by approximately 700,000, from 5.7 million to 5 million, while the rate of people without insurance decreased from 22.1 percent to 19.1 percent. In addition, in 2014, 734,000 individuals obtained coverage through the federal marketplace. Eighty-four percent of individuals covered by plans purchased through the marketplace received federal financial subsidies.<sup>32</sup>

The population of people without health insurance in Texas in 2014 had the following characteristics.

- Approximately 784,000, or 16 percent, were children younger than age 18, and 4.2 million, or 84 percent, were ages 18 to 64.
- Fewer than 60,000 persons age 65 or older were uninsured because there is almost universal access to Medicare for this group.
- Approximately 3.5 million, or 69 percent, were U.S. citizens and 1.56 million, or 31 percent, were non-U.S. citizens.
- Approximately 2.7 million people without insurance were employed adults age 18 or older.

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<sup>32</sup> U.S. DHHS: Addendum to the Health Insurance Marketplace Summary Enrollment Report for the Initial Annual Open Enrollment Period. May 1, 2014.

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- Among people without insurance, there was disproportionate representation on the basis of race/ethnicity, as follows.
    - Anglos represented 43.4 percent of the total population but 24.6 percent of the uninsured.
    - Hispanics represented 38.8 percent of the total population but 60.9 percent of the uninsured.
    - African Americans represented 11.8 percent of the total population but 16.1 percent of the uninsured.

Between 2013 and 2014, there was increased use of most types of private health insurance and Medicare in Texas. There were variations according to age group in the percentages of people covered by private insurance versus Medicaid or the Children's Health Insurance Program (CHIP).

- Among all Texans, 60.6 percent had private insurance and 17.3 percent had Medicaid or CHIP.
- Among Texans younger than age 65, 61.2 percent had private insurance, and 17.7 percent had Medicaid or CHIP.
- Among Texans younger than age 18, 51 percent had private insurance, and 39.8 percent had Medicaid or CHIP.
- Among Texans ages 18 to 64, 65.7 percent had private insurance, and 8.1 percent had Medicaid or CHIP.

Compared to the U.S. as a whole, in 2014 a lower percentage of Texas children under age 18 and adults age 18 to 64 were covered by private health insurance; however, the percentages for Medicaid participation were more similar for children under age 18 and for adults age 65 or older.

## **E.2.2 Recent State and Federal Policy Direction**

This discussion highlights the most significant recent policy direction for the Texas HHS System as a whole.

### **State Changes to Medicaid**

#### ***Direction to Contain Medicaid Cost Growth***

As Medicaid spending continues to grow, state policy makers have directed HHSC to pursue multiple efforts to contain Medicaid spending. The 2016–2017 General Appropriations Act, H.B. 1, 84<sup>th</sup> Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 50) reduces HHSC's appropriation by \$373 million in general revenue based on development of new Medicaid cost containment initiatives, such as more appropriate rates for acute care therapy services, increased efficiencies in the vendor drug program, strengthened prior authorization and utilization review requirements, increased third-party recoveries, and increased activities to combat fraud, waste and abuse.

While recent efforts to contain Medicaid costs have produced positive results, the demand for Medicaid services continues to rise, increasing overall Medicaid costs to the state. HHSC will continue this focus on Medicaid cost containment efforts in the future.

### ***Improving Medicaid Managed Care Operations***

Over the last several sessions, the Legislature has directed HHSC to provide Medicaid services through managed care organizations (MCOs). S.B. 760, 84<sup>th</sup> Legislature, Regular Session, 2015, gives HHSC additional tools to adequately monitor contracts with the MCOs and to ensure that they are being held accountable for having adequate provider networks to deliver the care for which the state is paying. To implement the bill, HHSC is facilitating a stakeholder workgroup to discuss ways to strengthen Medicaid managed care provider networks, including online provider directories, provider access standards, and expedited credentialing.

### **State Direction for Mental Health Services**

In an effort to address behavioral health service fragmentation, Article IX, Section 10.04 of the 2016–2017 General Appropriations Act (84-R) created the Statewide Behavioral Health Coordinating Council to work collectively to develop a coordinated five-year strategic plan and a coordinated expenditure plan for FY 2017. The council's work is discussed below, in section E.4.1.

Additionally, the Texas Veterans + Family Alliance, established by S.B. 55, 84<sup>th</sup> Legislature, Regular Session, 2015, provides \$20 million of state funds to be matched with local and private funds for mental health support for veterans and their families, and it focuses on community collaborations addressing the mental health needs of veterans and their families that are not currently being met.

### **Federal Program Reauthorizations**

#### ***Temporary Assistance for Needy Families***

The Temporary Assistance for Needy Families (TANF) program requires federal reauthorization every five years. The program was scheduled for reauthorization in 2010, but has been reauthorized until September 30, 2016 through periodic short-term extensions. While Congress has not considered a bill for a full reauthorization of TANF, the U.S. House of Representatives and Senate have held hearings on how to improve TANF. These hearings have largely focused on supporting programs by states that are evidence-based and successfully help people out of poverty and move people from TANF to unsubsidized employment.

The President's federal fiscal year (FFY) 2017 budget does not provide a full TANF reauthorization proposal. The budget proposal again included a proposal to repurpose funding for the TANF Contingency Fund for the Pathway to Jobs Initiative.

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### ***Children’s Health Insurance Program***

CHIP was reauthorized for five years through the Children's Health Insurance Program Reauthorization Act of 2009. The Affordable Care Act included a two year reauthorization of CHIP, and then the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) reauthorized CHIP again through FFY 2017.

### ***Older Americans Act Programs***

In April 2016 the President signed into law a bill reauthorizing the Older Americans Act (OAA) programs through FFY 2019. The last OAA reauthorization had been in 2006. The Title III funding formulas were updated in the reauthorization to change the "hold harmless" provision that ensured every state received no less than its FFY 2006 amount. Beginning in FFY 2017, state hold harmless amounts are reduced by no more than 1 percent from the previous fiscal year. The 2016 reauthorization makes these changes to the hold harmless provision for formulas for the following OAA programs: supportive services and centers; congregate nutrition services; home delivered nutrition services; and disease prevention and health promotion services.

## **E.3 Transformation of the Health and Human Services System**

In 1991, there were 12 separate state agencies providing health and human services. A review determined that lack of coordination among them resulted in fragmentation, duplication, and inefficiency. H.B. 7, 72<sup>nd</sup> Legislature, First Called Session, 1991, was passed to address these problems by creating HHSC to facilitate coordinated planning and delivery of services. The original 12 agencies continued their existence and coordinated efforts with HHSC. Progress was made, yet redundancies and inefficiencies persisted.

A major consolidation came with the passage of H.B. 2292, 78<sup>th</sup> Legislature, Regular Session, 2003, which combined the 12 agencies into 5 and gave HHSC more responsibility and authority for providing guidance, coordination, and leadership for the system. HHSC was also made responsible for the centralization of most of the administrative support functions that had been provided individually by the majority of the 12 former agencies.

The consolidation of the agencies was accomplished by September 1, 2004, with the commencement of operations by DSHS and DADS. They joined HHSC, DARS, and DFPS in comprising the streamlined HHS System.

As a result of recommendations by the Sunset Advisory Commission, several bills were passed in 2015 to give the HHS System further opportunity to develop a more fully streamlined, efficient system that more effectively provides services and

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benefits. Together, these bills outline a phased approach to the restructuring of programs and services among agencies.

The first phase increases opportunities for streamlining by making several changes in the locations of programs. The following programs and functions will transfer to HHSC by September 1, 2016: eight functions at DARS (Autism Program; Texas Autism Research and Resource Center; Blind Children’s Vocational Discovery and Development Program; Blindness Education, Screening, and Treatment; Comprehensive Rehabilitation Services; Deaf and Hard of Hearing Services; Disability Determination Services; Early Childhood Intervention; and Independent Living Services); client services at DADS; and client services at DSHS.

Transformation efforts also address streamlining and consolidation of administrative support services, including legal, financial, contract procurement, information technology, human resources, and other administrative functions.

As a result of this transfer and the transfer of other programs to the Texas Workforce Commission, DARS will be abolished on September 1, 2016. Additionally, the Nurse Family Partnership and Texas Home Visiting programs were transferred from HHSC to DFPS on May 1, 2016, and DFPS will continue its focus on protective services and strengthen its prevention and early intervention programming.

In the second phase, DADS and DSHS regulatory programs and management of the operations of the state supported living centers and state hospitals will transfer to HHSC by September 1, 2017, and DADS will be abolished. After these transfers, DSHS will focus on its core public health functions and DFPS on child and adult protective services, including prevention and early intervention.

## **E.4 Coordination Initiatives**

To ensure the development of a comprehensive, statewide approach to the planning of health and human services, the HHS System agencies coordinate on a variety of initiatives and projects, with each other and with agencies outside the HHS System. This section describes some of the major efforts.

### **E.4.1 Statewide Behavioral Health Coordination**

Behavioral health services in Texas—which encompass both mental health and substance use treatment—have evolved and transformed over the past decade. Much of this transformation is due to the large investment and stewardship of the Governor and legislators to improve the behavioral health service delivery system. The movement toward managed care, the increased use of treatment alternatives to incarceration, the improved psychiatric crisis system, enhanced local community collaboration, and leveraged funding efforts have all contributed to significant

advancements in behavioral health care in Texas. Even with these improvements, there is room for advancement.

Texas currently invests \$6.7 billion biennially at the state level through General Revenue, Medicaid, and local and federal dollars to fund behavioral health services at various state agencies that have not always coordinated efforts. In 2013, lawmakers created a statewide mental health coordinator position through HHSC's Rider 82 of the 2014–2015 General Appropriations Act (83-R), to improve coordination among these state agencies and other entities and to provide statewide, strategic oversight on public mental health.

The Office of Mental Health Coordination (OMHC) has worked across state agencies to further these efforts through several statewide legislative initiatives. In 2015, Article IX, Section 10.04 of the 2016–2017 General Appropriations Act (84-R) created the Statewide Behavioral Health Coordinating Council, comprised of 18 state agencies that receive state funding for behavioral health services, to ensure these funds are spent efficiently and effectively. The Council was required to develop two key deliverables: a five-year strategic plan to coordinate and align behavioral health activities and an associated coordinated expenditure proposal for FY 2017. This work is guided by the Council's vision, "To ensure that Texas has a unified approach to the delivery of behavioral health services that allows all Texans to have access to care at the right time and place."

Pursuant to S.B. 55, 84<sup>th</sup> Legislature, Regular Session, 2015, the OMHC implemented the Texas Veterans + Family Alliance grant program which provides \$20 million dollars in state grant funding across Texas to improve the quality of life of Texas veterans and their families by supporting local Texas communities to expand the availability of, increase access to, and enhance the delivery of mental health services. The office also expanded Mental Health First Aid training and created a comprehensive website for behavioral health resources. In addition, the OMHC supports a system-wide Behavioral Health Advisory Committee composed of statewide stakeholders. The newly formed committee under Sunset legislation also includes stakeholder input on children and youth behavioral health issues.

## **E.4.2 Texas Promoting Independence Initiative and Plan**

The Promoting Independence Initiative began in January 2000 following the U.S. Supreme Court ruling in *Olmstead v. L.C.*, which requires states to provide long-term services and supports in the most integrated setting appropriate to the needs and wishes of individuals with disabilities. The Promoting Independence Initiative reflects the state's commitment to providing meaningful opportunities for persons with disabilities to live in the community, through the delivery of services and supports that foster independence and productivity while providing opportunities for individuals with disabilities to live in the setting of their choice. The Promoting Independence Initiative's scope is broad and includes, among other activities, the

Money Follows the Person Demonstration Project, relocation and transition services, and housing navigators.

The Money Follows the Person Demonstration Project assists residents of Medicaid-certified nursing facilities and intermediate care facilities for individuals with an intellectual disability or related condition to relocate to a community setting via a Medicaid waiver program. Relocation services ensure the provision of assessments and case management to assist nursing facility residents who choose to relocate to community-based services and supports provided through contracted relocation specialists. Transition to Living in the Community is used to address Medicaid gaps in coverage. Housing navigators work with individuals in institutional settings who want to return to the community but have lost their community home. These individuals work with public housing authorities to help in securing affordable, accessible, and integrated housing.

### **E.4.3 Border Regions**

The U.S.-México border is defined as the area 100 kilometers (62.5 miles) north and south of the international boundary, according to the La Paz Agreement. The Texas-México border is comprised of 32 counties and stretches 1,254 miles from the Gulf of México to El Paso, Texas, with a population currently of 2.9 million residents, and it is considered to be one of the busiest international boundaries in the world. It is important to recognize that most Texas border residents are Hispanic, at 88.1 percent, compared to only 34.4 percent of Texas non-border residents.<sup>33</sup> Notably, the Texas-México binational border area also includes two Native American Nations, the Kickapoo Traditional Tribe of Texas and the Ysleta Pueblo del Sur, creating tri-national regions in Eagle Pass and El Paso.

The Texas border population is characterized by high rates of poverty. Thirty percent of border residents have incomes below federal poverty guidelines compared to only 16.2 percent of Texas non-border residents.<sup>34</sup> According to the 2014 BRFSS age-adjusted estimates, 46.1 percent of Texas border residents ages 18-64 lack health insurance, compared to only 28.3 percent in the non-border counties of Texas. In Texas border counties, 32.5 percent of residents do not speak English well, compared to only 12.2 percent in Texas non-border counties.<sup>35</sup> Only 66.1 percent of Texas border residents ages 25 and older had completed a high school diploma or a general educational development test, compared to 82.7 percent of the residents of the Texas non-border counties.<sup>36</sup>

Among the most serious public health issues facing Texas border residents are certain infectious or communicable diseases, including tuberculosis (TB), and of

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<sup>33</sup> 2015 Census projections from Texas DSHS Center for Health Statistics.

<sup>34</sup> ACS, computed from 5-year estimates, based on 2009-2013 data.

<sup>35</sup> Ibid.

<sup>36</sup> Ibid.

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particular concern, the higher prevalence of obesity and diabetes. According to the 2014 BRFSS, the prevalence of obesity is significantly higher among border counties (39.2 percent) compared to the non-border counties (32.0 percent). This situation sets the stage for a chronic disease burden that persists throughout the lifespan. Diabetes prevalence as diagnosed by doctors in the border region (15.4 percent) as compared to the non-border region (10.5 percent) remains especially high. True prevalence of diabetes is likely higher, as national data indicate approximately 27.8 percent of all diabetes cases go undiagnosed.<sup>37</sup> Border-specific considerations are factored into the action items in Goal 1 on population health of the DSHS Strategic Plan.

The Office of Border Affairs was established to improve the quality of health and human services in colonias and other communities along the Texas-Mexico border through the planning and coordination of services and the utilization of Promotoras (Community Health Workers). The office's Border Specialists are located in areas from El Paso to Harlingen. The office coordinates the dissemination of information and resources and works with systems and stakeholders to increase knowledge of and access to services. Services include: distributing and explaining bilingual information; educating colonia residents on programs and services; and assisting with applications for Medicaid, CHIP, TANF, and the Supplemental Nutrition Assistance Program.

#### **E.4.4 Early Childhood Immunization**

Vaccines improve quality of life and life expectancy by achieving and maintaining an environment free of vaccine-preventable diseases. Increasing immunization rates for vaccine-preventable diseases in Texas is a collaborative effort involving parents, providers, caregivers, and public-sector institutions. A key strategy for increasing early childhood immunizations is to increase public awareness about the need and benefits of vaccinations.

Tex. Gov't Code Section 2056.0022 states that, "Each state agency that has contact with families in this state either in person or by telephone, mail, or the Internet is required to include in the agency's strategic plan a strategy for increasing public awareness of the need for early childhood immunizations." HHSC is charged to identify the state agencies to which this section applies and notify the agencies of their duties pursuant to this section.

DSHS, as delegated by HHSC, will identify the state agencies to which this section applies and notify the agencies of their duties pursuant to the section. This will be an initiative that will happen during the time frame of the 2017–2021 Strategic Plan. Opportunities for further coordination and collaboration may be identified during this timeframe, and any action plans will be developed as needed and appropriate.

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<sup>37</sup> NHANES, 2014.

### **E.4.5 Foster Care Improvements Steering Committee**

The Foster Care Improvements Steering Committee (FCISC) is an ongoing committee that was created in August 2015 to support improvements for children in foster care. The committee was created in order to ensure there was coordination and communication across all the partners who have a role in the foster care system. Leadership was chosen as co-chairs to ensure that the Committee had ample decision-making authority.

The committee assists with the coordination and alignment of the multiple initiatives to support improvements in foster care, including efforts related to serving children with high needs and ongoing work to build foster care capacity. It serves as a central point for elevation of issues, as well as for cross-system work and solutions. Through this function, FCISC addressed an issue that would have limited the possibility for successful implementation of S.B. 125, 84<sup>th</sup> Legislature, Regular Session, 2015, that required children entering foster care to receive a comprehensive assessment within 45 days.

The committee is composed of representatives from various programs within the HHS System and the STARHealth managed health plan, and it is co-chaired by the Associate Commissioner of DFPS and the HHSC Medicaid Director. FCISC successfully:

- Identifies and addresses communication gaps among partners who serve children in foster care through regional coalition-building and hosting training opportunities for internal and external staff, and
- Maintains a work plan to decrease the number of clients waiting for their Determination for Intellectual Disability, required to determine eligibility for long-term services and supports.

### **E.4.6 Women’s Health Services Coordination Initiative**

The Women’s Health Services (WHS) Division is comprised of programs committed to positively impacting women and families through quality health services. The current services and programs include the Texas Women’s Health Program, the Family Planning Program, the Expanded Primary Health Care Program, and the Breast and Cervical Cancer Screening Program. In order to receive services, clients must meet certain eligibility requirements. For all programs, eligibility is determined by residency status, income level, family size, and health care needs. The Healthy Texas Women program, set to launch on July 1, 2016, replaces the Texas Women’s Health Program and the Expanded Primary Health Care program.

WHS is responsible for the coordination and collaboration of the Better Birth Outcomes Workgroup. This workgroup holds monthly meetings with HHS agencies on women’s health issues, focusing on maternal and child health. The workgroup initiatives are intended to: increase the number of women receiving preventive care services; increase early detection of breast and cervical cancers; avert unintended

Medicaid births; reduce the number of preterm births; and reduce the number of cases of potentially preventable hospitalizations related to hypertension and diabetes. The workgroup has several successful projects in FY 2016 including the recent Long-Acting Reversible Contraceptive initiative that saves \$7 in Medicaid and healthcare for every \$1 spent on contraceptives and the Postpartum Depression Awareness campaign which highlights the importance of mental health treatment.

### **E.4.7 Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver**

The 82<sup>nd</sup> Legislature, 2011, directed HHSC to expand Medicaid managed care to achieve cost savings and to preserve hospital access to funding consistent with upper payment limit (UPL) funding. The best approach to meet legislative mandates and improve quality was to negotiate a five-year 1115 waiver that began in 2011. An 1115 waiver is a waiver under section 1115 of Social Security Act that allows the Centers for Medicare & Medicaid Services (CMS) and states more flexibility in designing programs to ensure delivery of Medicaid services. The Texas Healthcare Transformation and Quality Improvement 1115 waiver provides flexibility for Texas to preserve UPL funding while expanding risk-based managed care statewide by creating two new funding pools. The Uncompensated Care pool reimburses costs for care provided to individuals with no third-party coverage and for Medicaid costs in excess of Medicaid payments for hospital and other services. The Delivery System Reform Incentive Payment pool, a new incentive program that supports coordinated care and quality improvement goals through projects implemented in 20 Regional Healthcare Partnerships (RHPs). Texas' 1115 Waiver began December 10, 2011, and expires September 30, 2016. In May 2016, CMS approved a 15-month extension, taking the program through December 2017 and maintaining current funding. During this initial extension period, HHSC and CMS will continue negotiating a longer term extension. HHSC collaborates with many federal, state, local, and regional partners, including CMS, the Executive Waiver Committee, intergovernmental entities, anchoring entities, performing providers, external stakeholders, RHPs, and RHP participants.

### **E.4.8 STAR Kids Program**

S.B. 7, 83<sup>rd</sup> Legislature, Regular Session, 2013, directed HHSC to provide Medicaid benefits to individuals with disabilities younger than age 21. In October 2015, HHSC contracted with 10 managed care organizations (MCOs) to administer the STAR Kids program. Beginning November 2016, children and youth age 20 or younger who either receive Supplemental Security Income Medicaid or are enrolled in the Medically Dependent Children Program (MDCP) will receive all of their services through a STAR Kids health plan. Children and youth who receive services through other 1915(c) waiver programs will receive their basic health services (acute care) through STAR Kids. STAR Kids will be tailored to meet the needs of youth and

children with disabilities. The program will provide benefits such as prescription drugs, hospital care, primary and specialty care, preventive care, personal care services, private duty nursing, and durable medical equipment and supplies. Children and youth who get additional services through MDCP will receive additional long-term services and supports through STAR Kids. Through STAR Kids, families also can expect coordination of care. Each health plan will provide service coordination that will help identify needs and connect members to services and qualified providers. Each member will have service needs assessed, which will form the basis of that member's individual service plan. Children, youth, and their families will have the opportunity to choose between at least two STAR Kids health plans and will have the option to change plans after their initial selection.

Critical for successful implementation is the system automation of the STAR Kids screening assessment, which requires system development and significant coordination among several entities, including the HHSC Medicaid and CHIP Division, the HHSC Office of Social Services, HHSC IT, Texas Integrated Eligibility and Redesign System (TIERS), HHSC Communications, DADS, DSHS, MCOs, eligibility verification vendors, Medicaid Management Information Systems vendors, the STAR Kids Managed Care Advisory Committee, and the Policy Council for Children and Families. HHSC welcomes input regarding the development and implementation of the STAR Kids program.

#### **E.4.10 Veteran Services Division**

The Veteran Services Division was created in 2013 and designed to coordinate, strengthen, and enhance veteran services across state agencies. Its focus is to review and analyze current programs, engage the charitable or nonprofit communities, and create public-private partnerships to benefit those programs. The division developed and disseminated the Texas Veterans App as a free-of-charge mobile phone application for veterans, active duty military, families, providers, and any Texan who supports our military. It allows the user to obtain information about the local, state, and national resources available to Texas military veterans.