Progress Report on Transformation of the Health and Human Services System

Office of Transformation and Innovation

Health and Human Services

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Table of Contents

Table of Contents .................................................................................................................. ii

Executive Summary .............................................................................................................. 1

Introduction ............................................................................................................................. 4

Section 1 - Continuation of the Department of State Health Services ........................................ 7

Section 2 - Potential Regulatory Conflicts of Interest ............................................................. 13

Section 3 - Quality of Collaboration between HHSC and DFPS 21

Section 4 - Continuation of Health and Human Services Advisory Committees ..................................... 32

Section 5 - Assessment of Administrative Support Services Consolidation ................................. 37

Appendix A. DSHS Response to SB 1021 Report Survey ....................................................... 54

Appendix B. List of Current HHS Advisory Committees ....................................................... 64

Appendix C. Legacy Department of Aging and Disability Services Organizational Structure .................................................................

Appendix D. Health and Human Services System Organizational Structure ............................................. 68

Appendix E. Glossary of Acronyms ....................................................................................... 69
Executive Summary

Since 2015, the Health and Human Services (HHS) system has undergone extensive changes to its organizational structure in accordance with statutory changes made during the 84th and 85th legislative sessions, and based on management recommendations of the Sunset Advisory Commission issued in 2015. Collectively, these directives required the consolidation of five health and human services agencies into two, organized along functional lines, and made the Department of Family and Protective Services (DFPS) a stand-alone agency which is supported administratively by HHSC through an interagency contract. The HHS system is now comprised of the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS). The process of making these structural changes involved the transfer of over 24,000 staff positions and 100 programs. The time and resources necessary to facilitate these transfers, and the impact on staff and their ability to carry out daily tasks, cannot be underestimated.

Although the consolidation of these programs is complete, achieving the broader goals of transformation – increased accountability, the elimination of duplication and inefficiency, and a streamlined experience for our clients – is a work in progress. To accomplish these goals, the system as it currently stands must be given time to mature, particularly in light of the limited-scope Sunset review of the consolidation of the HHS system to be conducted in 2023. Stability of the organizational structure will allow all three agencies – HHSC, DFPS, and DSHS - to focus on building and maintaining open lines of communication and a relationship that is based on an understanding of our many interdependencies and mutual dedication to collaboration and coordination.

Although there are clearly significant areas for improvement in the ongoing relationship between DSHS and HHSC, the two agencies are and should remain inextricably linked due to the commonality of their missions to improve the health, safety, and well-being of Texans. The relationship between HHSC and DSHS requires significant efforts by both agencies to ensure clear lines of accountability and delegation of duties.
Although DFPS is technically no longer part of the HHS system, numerous linkages and interdependencies continue to exist between DFPS and the HHS system, requiring constant communication to ensure that our agencies are able to quickly and effectively address cross-agency issues and serve our clients.

This report serves as a status update on the comprehensive changes made to the HHS system in the past several years, and offers recommendations on some of the key issues that have emerged within the HHS system and as HHSC and DFPS forge a new contractual relationship.

Significant findings from the report include:

- DSHS should remain as a system agency in the HHS system. The two agencies should work together through a formalized process to address issues related to administrative services, the identification of efficiencies, and to ensure administrative services effectively support DSHS in achieving its public health mission.

- The consolidation of administrative support services is substantially complete. However, significant work remains to ensure ongoing collaboration between HHSC, DSHS, and DFPS. The agencies must work together to identify and implement systemic improvements and resolve internal customer service issues. All HHSC administrative support areas should consistently embrace a performance driven, customer service-oriented culture with DFPS, DSHS, and across the HHS system.

- While the potential for regulatory conflicts of interest exists at HHSC, this risk is mitigated by the greater separation of regulatory and facilities functions under HHSC, the outsourcing of independent dispute resolution, and further consolidation of ombudsman functions within HHSC.

- As part of ongoing transformation, HHS needs to build on previous and ongoing efforts to evaluate all aspects of how the agency obtains and responds to stakeholders in key areas. This will ensure the process aligns with the new HHS system and that HHS programs are able to effectively benefit from advisory committee expertise during the development of policies and procedures.
Key recommendations include:

1. DSHS should continue as a HHS system agency and the agencies should work collaboratively to identify and implement improvements to the delivery of administrative support services to achieve program and service goals.

2. The Regulatory Services Consumer Rights - Intellectual Disability unit should be transferred to the HHS Office of the Ombudsman.

3. The Regulatory Services Division should develop a uniform policy related to impartiality and independence that applies to all regulatory staff.

4. Joint Operations Coordination Committees between DFPS and HHSC and between DSHS and HHSC should be established to identify and develop action plans to address key issues related to the provision of administrative support services.

5. HHSC should perform an in-depth evaluation of the process for establishing advisory committees, how they align with the consolidated structure of the HHS system, and how they provide input to the HHS system.
Introduction

Following a Sunset Advisory Commission review, conducted in 2014, the 84th Legislature passed Senate Bill 200 (SB 200) and Senate Bill 208, requiring the HHS system to be significantly restructured. The changes were implemented in two phases as follows:

Phase 1, September 1, 2016:

- All client services programs transferred to the HHSC from the Department of Aging and Disability Services (DADS), Department of Assistive and Rehabilitative Services (DARS) and DSHS, except for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program;
- Majority of administrative services programs such as information technology and financial services were consolidated at HHSC;
- DARS was abolished and its vocational rehabilitation-related programs moved to the Texas Workforce Commission (TWC); and
- Prevention and early intervention services transferred to DFPS from HHSC and DSHS.

Phase 2, September 1, 2017:

- State hospitals, state supported living centers, and regulatory services programs from DADS, DSHS, and DFPS were transferred to HHSC;
- DADS was abolished;
- WIC program transferred to HHSC from DSHS; and
- Most remaining administrative services were consolidated at HHSC, such as the full consolidation of legal services.
More detailed information is provided in the HHS System Transition Plan, which can be found by going to the HHSC website at hhs.texas.gov, and going to the Transformation web page.¹

Senate Bill 1021 and Special Provisions Section 26 in Article II of the General Appropriations Act (GAA), both passed in 2017 by the 85th Legislature, included several reporting requirements related to consolidation and transformation. HHSC is submitting a consolidated report to the Transition Legislative Oversight Committee (TLOC) to satisfy these reporting requirements, as permitted in Special Provisions Section 26 in Article II Section 26 of the GAA.

This consolidated report includes the following required elements:

- a recommendation regarding the need to continue DSHS as a state agency separate from HHSC;
- an assessment of, and recommendations on, any known or potential conflicts of interests concerning HHSC regulatory activities and mitigation approaches;
- an assessment of, and recommendations on, the quality and consistency of data sharing, communication, and coordination between the DFPS and HHSC;
- recommendations on abolishing, consolidating, or re-establishing in rule HHS system advisory committees;
- an assessment of HHSC’s progress in transferring and consolidating HHS system administrative support services;
- a status report on consolidation of administrative support services, including identification of, and a plan for achieving potential General Revenue (GR) savings resulting from increased administrative efficiencies and the elimination of duplicative administrative support functions; and
- an examination of the effectiveness of staffing levels dedicated to administrative functions.

Approach

The HHSC Office of Transformation and Innovation (OTI) conducted the following activities during the development of this report.

Agency Surveys

- More than 260 DSHS, DFPS, and HHSC staff were surveyed in order to analyze the quality of communication and coordination between agencies, quality of support services, and initiatives resulting in more efficient and effective operations.
- The structure and administration of DFPS’ and DSHS’ surveys reflected differences in report requirements, approach, and structural relationship to the HHS system. However, both DFPS and DSHS actively participated in the development, approval, and distribution of the surveys. The agencies were also provided access to the unfiltered survey responses.
- HHSC worked with DFPS and DSHS to ensure surveys were targeted to staff actually performing functions or providing services, including regional staff, managers, directors, as well as executive leadership.

Collaboration and Coordination with Key Program Areas

- OTI staff met with DFPS, DSHS, and HHSC executive leadership and management staff during the course of survey development, data collection, development of report elements, and report drafting.
- OTI staff collected information and data from 35 different functional areas within HHSC to identify efficiencies, future planned improvements, opportunities for the elimination of duplicative functions, and cost avoidance resulting from consolidation.
- HHSC Financial Services collaborated with OTI, reviewed fiscal estimates, and provided additional information on budget issues.
Section 1 - Continuation of the Department of State Health Services

Background

In 2016, most DSHS client service programs transferred from DSHS to HHSC, and the majority of administrative support services across the HHS system were also consolidated at HHSC. In addition, during 2016-17, occupational, professional, and other regulatory programs transferred to the Texas Department of Licensing and Regulation or the Texas Medical Board.

In 2017, the remaining administrative support services were consolidated at HHSC, DSHS regulatory functions were transitioned to a new HHSC Regulatory Services Division and the state psychiatric hospitals, the Rio Grande State Supported Living Center (SSLC), and the Rio Grande State Center Outpatient Clinic transferred to HHSC’s State Operated Facilities division (SOF). Note that as of June 18, 2018, SOF was re-named the Health & Specialty Care System. In addition, the WIC program transferred to HHSC Medical and Social Services (MSS) division. These structural changes to DSHS in 2016 and 2017 relocated all non-public health functions to HHSC, allowing DSHS to focus solely on its core public health mission.

SB 1021 requires HHSC to provide a recommendation on the need to continue DSHS as state agency separate from HHSC. To respond to this requirement, OTI surveyed DSHS and HHSC staff and developed recommendations based on the survey responses and direction from executive leadership.

Survey Methodology

OTI conducted an extensive survey of HHSC and DSHS staff that focused on gathering information to answer key questions related to transformation of the HHS system, as outlined below.
DSHS’ Focus on Public Health
► Did the transfer of programs and administrative services allow DSHS to focus solely on providing public health services and what other steps could be taken to sharpen DSHS’ focus on its public health services mission?
► Are there other programmatic or administrative areas that should be consolidated to further the DSHS focus on public health?

Communication and Collaboration
► Did the transfer of programs and administrative services create opportunities to increase the amount of communication and collaboration between the agencies?
► What more could be done to increase communication and collaboration?
► What are some examples of how collaborations and partnerships have improved with HHSC, or need improvement?
► Are there other programmatic or administrative areas that need consolidating at HHSC?

Increase in Efficiency and Improved Operations
► How have the transfers of programs and administrative services to HHSC increased efficiencies, improved operations, or created challenges?
► What does an efficient system look like?

In addition to survey responses, DSHS provided HHSC an executive level response including details on the successes and challenges of programmatic and administrative services transfers to HHSC. See Appendix A for DSHS’ written executive response to HHSC.

Survey Results

As a result of Transformation, DSHS is singularly focused on its public health mission.

The majority of DSHS staff who responded to the survey believe that the 2016 and 2017 transfers positioned the agency to focus efforts solely on public health, including working more efficiently with local health departments. DSHS survey respondents felt that the transfer of programs allowed for internal restructuring and provided the agency
with an opportunity to refocus its mission and activities towards public health.

**DSHS and HHSC program areas are successfully collaborating in some areas.**

Public health and client services programs can and should work collaboratively towards shared goals. HHSC and DSHS are collaborating successfully on shared initiatives in the following areas:

- **Cancer Prevention and Treatment:** The DSHS Texas Comprehensive Cancer Control Program (TCCCP) collaboration with the HHSC Breast and Cervical Cancer Services (BCCS) program through the HHS Cancer Coordination Group and the Centers for Disease Control and Prevention funded National Comprehensive Cancer Control Grant Program.
- **Maternal and Child Health:** DSHS Maternal and Child Health (MCH) Unit collaboration with the HHSC Women’s Health Programs including BCCS, Healthy Texas Women, and the Family Planning Program, on activities including the Healthy Families project, Better Birth Outcomes workgroup, and work related to reducing maternal mortality and morbidity. Additionally, DSHS MCH Unit and WIC program collaborated on shared initiatives including Every Ounce Counts, Lactation Support Centers, and Peer Dads.

**Communication between agencies needs improvement.**

DSHS and HHSC programs and services differ in terms of focus, target populations, and funding sources. DSHS survey respondents felt that HHSC lacks sufficient understanding of public health programs and how federal rules and regulations governing these programs differ from the requirements applicable to HHSC programs. DSHS staff also expressed concerns about their ability to provide input, in advance, regarding decisions made by HHSC that directly impact their programs. DSHS noted that policies and procedures change frequently, and often without adequate notice or training.

**Ongoing issues relating to administrative support services**

DSHS staff and leadership are frustrated with the provision of some, but not all, administrative services. In general, concerns are related to
communication, process, and HHSC’s approach to the provision of these services, as summarized below.

- **Communication and Coordination**
  - Delays in responses to inquiries between agencies makes it difficult to complete essential duties.
  - Business areas have difficulty contacting staff in the new organizational structure necessary to complete essential tasks.

- **Process Issues**
  - The consolidation created more “layers” of approvals and extra steps in processes, creating frustration and inefficiency.
  - A lack of awareness of DSHS’ needs slows down processes.

- **Approach to Provision of Administrative Services**
  - A lack of inclusion in HHSC decision-making on issues impacting DSHS.
  - A lack of a culture of customer service.

Section 5 of this report provides a detailed assessment of the consolidation of administrative support services at HHSC, and includes additional feedback provided by DSHS.

**Recommendation**

1. **DSHS should continue as an HHS system agency.**

DSHS and HHSC share a common mission of improving the health, safety and well-being of Texans through good stewardship of public resources. Although their approaches towards achieving this mission differs, the state’s ability to successfully impact public and population health is inextricably linked to the acute and long term healthcare needs of the state’s most vulnerable citizens.

In addition to philosophical and programmatic links between DSHS and HHSC, there are also practical reasons to retain the current structure. Texas has a statutory regional and local public health structure, in which DSHS provides public health services where local health departments do not exist, or lack the capacity to provide these
services. This regional structure is unique to the HHS system, and further changes at this time could create a risk of disrupting this state-local service delivery system, and the close working relationships DSHS has with local health departments.

As previously mentioned, the HHS system has undergone significant changes since 2015, and a limited-scope Sunset review focusing on consolidation will occur in 2023. The current structure needs time to mature so that the results of this review can be reliably attributed to operational and strategic decisions of agency leadership, rather than to ongoing modifications to the structure of the system.

Although the initial phases of transformation related to transferring organizational structures, functions, and staff are now complete, there are significant issues to address related to administrative support services and communications. While DSHS is now focused on public health, as part of the HHS system, DSHS and HHSC must continue to work together to break down silos, strengthen linkages, and clarify programmatic and operational roles, policies, and procedures.

2. **Form a joint DSHS - HHSC Operations Coordination Committee.**

The committee would have responsibility for overseeing the ongoing operational and administrative relationship between HHSC and DSHS, including working to more clearly define each agency’s roles and responsibilities. The committee would identify operational areas of concern, diagnose specific issues related to those concerns, and develop plans of action to address the issues. This committee would improve coordination and collaboration and identify ongoing improvements in HHS system service delivery and administrative operations. Sharing best practices and working closely to identify operational efficiencies would benefit each agency and the HHS system as a whole.

This committee would develop a memorandum of understanding, or other agreement, that establishes the framework for the relationship between the agencies. This agreement would at minimum, address:

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• collaboration between the agencies regarding changes to policies and procedures that impact both agencies,
• specific coordination needs at the program level,
• collaboration on determination of support service costs; and
• provision of administrative support services, including the attachment of support service agreements (SSAs) to the agreement.

In addition to the development of the committee, HHSC will work to ensure ongoing DSHS participation in HHS Cross-Division Coordination (CDC) activities. Although the CDC function is currently being re-envisioned to better support ongoing HHS system-wide improvements, it provides a venue for the agencies to identify issues, problem-solve, and share best practices.

**Conclusion**

The current organizational structure of the HHS system is still fairly new, particularly considering the massive changes experienced by both DSHS and HHSC since 2015. While there have been positive impacts from these changes, there is still extensive work to be done to ensure both agencies are able to be effective partners and fulfill their core missions. The current system needs an opportunity to fully develop, while the agencies focus on improving coordination and communication, and developing more effective ways to deliver key services.

Both DSHS and HHSC are committed to improving the HHS system to provide the best possible services to Texans. To accomplish this goal, DSHS and HHSC must work to identify opportunities for improvement, problem-solve, and implement solutions.
Section 2 - Potential Regulatory Conflicts of Interest

Background

This section does not involve DFPS because SB 200 resulted in the transfer of DFPS’ regulatory functions to HHSC, eliminating any potential risk for conflict of interest that may have existed.

On September 1, 2017, as detailed in the HHS System Transition Plan and in accordance with SB 200 (see Figure 2), HHSC:

- Created new divisions for Regulatory Services and SOF.\(^3\)
- Abolished DADS and absorbed these functions into HHSC; and
- Transferred DSHS regulatory functions, and operation of state hospitals and SSLCs to HHSC.

Figure 2. Summary of Regulatory Services and Health & Specialty Care System Functions.

<table>
<thead>
<tr>
<th>Regulatory Services Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protects the health, safety, and welfare of vulnerable Texans and helps individuals and entities comply with state and federal laws and regulations. The division licenses, credentials, inspects and surveys, investigates, enforces, trains, and develops policies for long-term care providers and occupations, acute care facilities, certain healthcare occupations, and childcare providers.</td>
</tr>
<tr>
<td>The division also resolves complaints regarding potential consumer rights violations related to persons with an intellectual and developmental disabilities receiving certain Medicaid services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health &amp; Specialty Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operates two types of state-owned facilities – those that provide 24-hour care and inpatient psychiatric services to individuals with serious mental illness, and those that provide campus-based direct services and supports to individuals with intellectual and developmental disabilities.</td>
</tr>
</tbody>
</table>

\(^3\) Note that as of June 18, 2018, SOF was re-named the Health & Specialty Care System (HSCS).
SB 1021 requires HHSC to assess whether any known or potential conflicts of interest exist concerning HHSC regulatory services, and if any exist, to provide recommendations for mitigation. To assess possible or known conflicts of interest, OTI met with leadership or staff from Regulatory Services, the Office of the Ombudsman (OO), HSCS, the Office of the Chief Counsel, and the HHS Ethics Office. OTI also reviewed existing policies and procedures related to Regulatory Services, HSCS, and conflicts of interest.

The HHS Ethics Office, created in February 2015, is an independent office reporting to the Chief Deputy Executive Commissioner (CDEC). The Ethics Office is the designated resource in the HHS system for ethics guidance, policy interpretation, and development of the HHS Ethics Policy. The Ethics Office also provides training, responds to inquiries, and consults with HHS divisions on special projects.

First created in September, 2003, the HHS Office of the Ombudsman (OO) is an independent office that also reports to the CDEC. In September 2017, numerous HHS ombudsman functions were further consolidated within the Office. The Office advocates for consumers and is required to:

- Provide dispute resolution services for the system;
- Perform consumer protection and advocacy functions;
- Obtain complaint information and assist consumers; and
- Collect inquiry and complaint data throughout the HHS system.

**Regulatory Services Conflicts of Interest**

While the potential for Regulatory Services conflicts of interest exists, HHSC has taken several steps to mitigate these risks. HHSC:

- Provided greater organizational separation between Regulatory Services and the HSCS;
- Identified the need to update and expand policies requiring a strict separation of regulatory activities and HSCS operations, known as the “firewall”; and
- Identified the need to update the HHS System conflict of interest disclosure form and apply it to Regulatory Services staff; and
• Outsourced Independent Dispute Resolution (IDR) to an impartial third party, as directed by the Legislature.

**Greater organizational separation between Regulatory Services and the Health & Specialty Care System.**

As discussed in previous HHS System Transition Plans, HHSC acknowledges that transforming regulatory services is not without risks or challenges. Operating state facilities, while also regulating those facilities could be viewed as a conflict of interest.\(^4\) This potential for conflict extends back to the legacy DADS and DSHS structures where executive staff responsible for operating and regulating those facilities reported directly to Commissioners with the authority to make decisions on both regulatory enforcement and compliance matters, while under oversight of the HHSC Executive Commissioner.

However, compared to these legacy structures, the transformed HHS structure provides a greater separation and independence between facility operation and regulation. In the HHS system, the Deputy Executive Commissioner (DEC) of the HSCS reports to the Chief Program and Services Officer (CPSO) whereas the DEC of Regulatory Services reports to the Chief Policy Officer (CPO). As an example, the organizational charts in appendix C and D depict the legacy DADS reporting structure and current HHSC reporting structure.

Both the CPSO and CPO bring significant executive level authority and accountability for ensuring the independence and integrity of day-to-day regulatory and compliance efforts. This additional level of executive separation helps ensure that the majority of regulatory matters are resolved at the DEC, CPSO, or CPO levels and the Executive Commissioner is only engaged at the highest level of the regulatory process, such as responding to proposals for decisions issued by an Administrative Law Judge.

**Updating the regulatory “firewall”**

HHSC recognizes the need to have a clearly defined set of firewall procedures that address the dual roles of the operator of facilities

\(^4\) Report to the Transition Legislative Oversight Committee, October 2017 Addendum and August 2016 Plan, p. 46.
serving our most vulnerable clients, and the regulator, charged with protecting the health and safety of Texans. This firewall serves to ensure that communication does not occur between HSCS and Regulatory Services staff that could diminish the independence or effectiveness of the regulatory process. The legacy DADS policy requires the following.

- Inspections or surveys are unannounced;
- Complaints are forwarded to the appropriate unit for investigation;
- The identity of those filing complaints remains confidential;
- Facilities are provided due process; and
- Decision-making authority for imposing sanctions is clearly delegated to appropriate regulatory staff.

The firewall also extends to the provision of exclusive and confidential legal counsel provided to each client, whereby the Office of Chief Counsel provides a separate enforcement attorney to represent the Regulatory division and a Special Counsel to represent HSCS.

HHSC is currently updating the firewall policy to apply to all facilities operated by HSCS, and to reflect the greater level of independence afforded by the new HHS organizational structure. These revised policies will ensure that all Regulatory Services and HSCS staff understand and adhere to these requirements.

**Updating Regulatory Services conflict of interest disclosure form**

Regulatory Services is currently updating and expanding the legacy DADS conflict of interest disclosure form to cover all staff involved in regulatory activities, including those:

- Conducting surveys or inspections;
- Investigating complaints or resolving disputes;
- Recommending or approving corrective actions or sanctions; and

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5 HHS Circular c-026, Separation of Duties, Responsibilities, and Decision-making Regarding the Operation and Federal Certification of the State Supported Living Centers. Revised 10/27/15.
• Providing legal guidance or representation.

Regulatory Services staff are required to disclose real or potential conflicts of interest that could influence the objective execution of their regulatory duties. Violation of these conflict of interest provisions could result in disciplinary action including dismissal and/or conviction of a crime.

**Outsourcing independent dispute resolution**

The Legislature recognized the potential for conflicts of interest in HHS regulatory processes and took action to mitigate this risk by requiring HHSC to outsource IDR for long-term care providers, including SSLCs, to an independent third party.\(^6\) HHSC executed a contract to outsource this IDR function in July, 2017.

IDR only applies to open enforcement cases where Regulatory Services is proposing to assess fines or impose other sanctions against a regulated entity, which may be subject negotiation. To further ensure the contracted IDR is neutral, the IDR contractor is prohibited from joining provider trade organizations, lobbying on regulatory legislation, or engaging in any other activities that HHSC determines poses a conflict of interest.

**Opportunities for Further Improvements**

**Independence in the resolution of complaints related to services for people with intellectual and developmental disabilities.**

The Regulatory Services Consumer Rights - Intellectual Disability (CRID) Unit addresses issues related to persons with intellectual and developmental disabilities seeking and receiving Medicaid waiver services or services from Local Intellectual & Developmental Disability Authorities. The CRID unit serves as a mediator, and works to resolve consumer rights complaints, resolve complaints between providers, and ensures providers meet contractual obligations.

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\(^6\) Senate Bill 305, Texas Legislature, 84th Regular Session, 2015.
CRID’s functions are similar to the consumer rights, complaint resolution, and oversight functions performed by the Office of the Ombudsman for local mental health authorities. However, CRID’s current organizational placement does not provide the same degree of independence and oversight as the OO does for long-term care, managed care, behavioral health, foster care, and other programs. In carrying out its duties, the OO adheres to governmental ombudsman standards which include independence, impartiality, confidentiality, and maintaining credibility, standards that do not formally apply to CRID operations.7

**Policy on the independence and impartiality of regulatory activities**

With the consolidation of regulatory functions from legacy DADS, DSHS, and DFPS agencies, the Regulatory Services division inherited disparate policies, procedures, and business practices. For example, Child Care Licensing (CCL) has an Ethics of Regulation policy that includes elements such as not allowing political affiliations to influence regulatory decisions, and not engaging in discriminatory or differential treatment of licensees. However, other legacy regulatory areas do not have similar policies. A lack of a single, consistent policy on ethical expectations makes it difficult for the agency to communicate these expectations, gain compliance, and if needed, take action should these standards be violated.

On the other hand, the Office of Inspector General (OIG) adheres to a single set of quality standards for inspection and evaluation that enhances program effectiveness and inspection. These standards include independence in conducting inspections, and identification of specific impairments that can affect an inspector’s ability to carry out their work impartially.8 These OIG standards could serve as a model to guide Regulatory Services in adopting a similar policy.

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Recommendations

1. Transfer the Regulatory Services CRID unit to the HHS Office of the Ombudsman.

Under this management recommendation, Regulatory Services and the OO would develop a plan to incorporate CRID into the OO, similar to the previous incorporation of the behavioral health ombudsman function into the OO. This recommendation would resolve any perception of a conflict of interest in the current placement of CRID within Regulatory Services. In addition, individuals with intellectual or developmental disabilities (IDD) would benefit from the same set of standards for independence, objectivity, and advocacy that guides the OO in serving other HHS consumers.

The transition plan should take into consideration whether any portion of CRID staffing and functions related to provider oversight might remain in Regulatory or potentially be more aligned with program. The plan should also include strategies to ensure that the specialized skills and knowledge of CRID staff is retained and that consumers assisted by OO receive the same, if not enhanced, levels of service.

2. Develop a uniform policy related to regulatory impartiality and independence that applies to all regulatory staff.

This recommendation would help ensure that regulatory staff carry out their duties according to a single set of expectations for impartiality and independence that guides their work, similar to the standards that guide the OIG. The division should consult with the HHS Ethics Office, Office of Chief Counsel, and OIG when developing this policy, and it should align with relevant federal requirements and guidance. Regulatory Services could incorporate some of these standards into existing HHS policy governing the avoidance of conflicts of interest surrounding facilities operated by HHSC including SSLCs and State Hospitals, and elements may be incorporated into disclosure forms as appropriate.

The HHS Ethics Policy would continue to apply to all HHS employees, including Regulatory Services, and is not affected by this recommendation.
Conclusion

HHSC acknowledges that the potential for a conflict of interest exists when an agency both regulates and operates state facilities, and that avoiding any conflict that could impact the quality of care or safety of our clients must be mitigated. The current HHSC organizational structure provides for a greater degree of separation and independence between these functions compared to the legacy DADS organizational structure. In addition, HHSC is taking steps to revise existing policies with an eye toward strengthening regulatory independence. With transfer of Regulatory Services CRID functions to HHS Office of the Ombudsman, the Office will more comprehensively and effectively advocate for the rights and safety of all HHS consumers, including persons with IDD.
Section 3 - Quality of Collaboration between HHSC and DFPS

Background

House Bill 5 (HB 5), 85th Legislature, Regular Session, 2017, established DFPS as an independent agency outside of the HHS system. However, while DFPS is separate from HHSC, HB 5 also requires DFPS to contract with HHSC for numerous support services. Therefore, numerous critical interdependencies continue to exist between the agencies, both programmatically and operationally.

To maintain a consolidated administrative services structure, HB 5 required DFPS to contract with HHSC for the provision of shared administrative services including payroll, procurement, purchasing, contracting, information resources, and rate-setting.

The passage of HB 5 coincided with HHSC and DFPS’s planning activities for implementation of phase two of SB 200, which required consolidation of administrative support services and the transfer of DFPS regulatory functions to HHSC.

Senate Bill 11 (SB 11), 85th Legislature, Regular Session, 2017, also modified the organizational structure of the HHS system by requiring that all investigative functions related to the abuse, neglect, or exploitation of children remain at DFPS, including investigations embedded in CCL functions slated to transfer to HHSC.

The many organizational changes that have resulted from these statutory directives have redefined the relationship between DFPS and HHSC, and necessitate strong channels of communication and frequent collaboration on operational and programmatic issues. SB 1021 requires HHSC to report on the quality and consistency of data sharing, communication, and coordination between DFPS and HHSC and to make recommendations as necessary.
Transitioning the Department of Family and Protective Services to Independent Agency Status

Leadership at HHSC and DFPS have effectively collaborated on transitioning DFPS to independent agency status and ensuring continuity of services for vulnerable Texans. In general, as borne out in survey results, communication and coordination between the agencies is working well. As independent agencies, the quality of communication and coordination is even more vital. While this report highlights positive aspects of the new relationship between HHSC and DFPS, challenges remain for the agencies to jointly address.

The next stage of transition will focus on maintaining clear points of contact, reforming business processes to ensure accountability and responsiveness to both agency’s needs, and awareness of how business decisions impact both agencies. Throughout the transformation process, OTI has worked closely with DFPS staff, including meeting with DFPS executive staff, identifying needed staff transfers, and working with DFPS to identify and resolve risks and issues as they emerge.

As evidenced by formal agreements between the agencies and ongoing daily collaboration, DFPS is making good faith efforts to share information with HHSC to ensure continuity of care and the best possible coordination of resources. Additionally, HHSC is working to collaborate with DFPS to ensure the efficient provision of administrative support services by HHSC as required by statute.9

HB 5 Executive Steering Committee

Upon passage of HB 5, HHSC and DFPS established an Executive Steering Committee jointly chaired by each agency and responsible for ensuring a seamless transition of DFPS to independent status, without disrupting services to shared clients. The Executive Steering Committee first met in June 2017 to adopt a set of guiding principles and approve formation of HHSC-DFPS working groups required to ensure the agencies closely collaborate to preserve ongoing program

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9 Texas Human Resources Code, Sections 40.0512 and 40.058
linkages, determine the division of support services and staffing, and ensure identification and mitigation of risks.

**HB 5 Governance and Guiding Principles**

The Executive Steering Committee adopted an overarching governance structure and set of guiding principles to ensure close collaboration between the agencies as DFPS separated from the HHS system. The primary goal of this process was to effectively and efficiently maintain uninterrupted services for Texans, as articulated in the following guiding principles:

- Make decisions that strategically ensure each agency can continue to be successful in fulfilling its individual mission.
- If competing interpretations of statutes or legislative intent arise, DFPS and HHSC will make decisions that will ensure the best, most efficient services to clients.
- Structure roles, processes, and workflows for clear authority and accountability in decision making.
- Remain focused on maximizing efficiencies through economies of scale for services that are not unique to each agency.
- Create an efficient schedule for transfers between the agencies, including staff, budgets, support structures, and agreements for shared services.
- Reinforce these principles with all HHSC and DFPS staff to ensure that the needs of clients and intent of the legislation govern implementation.

**Implementation of SB 200**

Prior to the passage of HB 5, HHSC and DFPS were in the process of implementing the remaining provisions of SB 200 as detailed in the August 2016 HHS Transition Plan, including the centralization of HHS administrative support services within HHSC. However, HB 5 required HHSC and DFPS to reverse parts of this centralization and required DFPS to establish several of its own support services divisions.

While SB 200 required transfer of DFPS CCL and Adult Protective Services - Provider Investigations (APS-PI) regulatory functions to HHSC, the agencies also needed negotiated interim support services that DFPS would provide to HHSC Regulatory Services until HHSC could assume those functions. Services provided by DFPS to HHSC include:
• statewide intake for provider investigations and child care licensing,
• complaint referral from the Office of Consumer Relations,
• training provided through the Learning Management System,
• certain tablet and smartphone support; and
• certain records, data management, and reporting support.

HHSC and DFPS are continuing to work on transitioning these remaining functions from DFPS to HHSC. In general, the agencies have successfully transferred CCL and APS-PI functions to HHSC. This effort required execution of interagency agreements between HHSC, DFPS, and TWC to proportionally split about $18.8 million in annual federal Child Care Development Funds, a portion of which supports the CCL investigations that remained at DFPS. In addition, HHSC completed amendments to the HHSC Texas.gov contract with the Department of Information Resources to ensure CCL data continued to be available online through DFPS.

**HB 5 Memorandum of Understanding and Decision Memos**

On September 1, 2017, HHSC and DFPS executed a memorandum of understanding establishing a framework for collaboration between the agencies including detailed decision memos developed by joint HHSC-DFPS workgroups. On May 4, 2018, HHSC and DFPS executed these HB 5 decision memos detailing specific programmatic coordination, service levels for administrative supports, and the respective roles and responsibilities of the agencies. In some areas, such as Internal Audit, the agencies have achieved full separation. In other areas, such as System Support Services, significant interdependencies still exist and are under discussion by the agencies. As the relationship between DFPS and HHSC continues to evolve, these agreements will be updated.

The HB 5 decision memos address the areas listed below.

- System Support Services
  - Business & Regional Services
  - Human Resources
  - Civil Rights
- Information Technology Services
On September 5, 2017, HHSC and DFPS executed a memorandum of understanding (MOU) for confidential information exchanged between the agencies. While HHSC and DFPS have experienced some challenges with sharing data on a timely basis, these issues have not prevented the agencies from carrying out their core functions.

The MOU authorizes HHS system and DFPS access to data and information in both shared and standalone systems to ensure programmatic and operational functions continue without interruption. The MOU ensures that both agencies maintain data security and protection, and disclose information only as authorized by law.

The agencies have successfully collaborated to identify and resolve numerous information systems issues. For example, HHSC and DFPS worked to resolve issues related to DFPS’ authority to enter employment actions in the Centralized Accounting Personnel/Payroll
System (CAPPS) Human Capital Management (HCM) system. HHSC and DFPS are also working to ensure protection of other agency’s CAPPS HCM data since HHS data is still accessible to DFPS until such time as DFPS data can be segregated.

**Quality of Communication and Coordination between HHSC and DFPS**

HHSC and DFPS survey results indicate that overall communication and coordination between the agencies is working well, although there are significant issues that must be addressed to ensure the ongoing success of this new organizational structure. Collaboration is working well in numerous key areas, including the following:

- DFPS Adult Protective Services (APS) In-Home and HHSC APS Provider Investigations;
- DFPS Child Protective Services (CPS) and the HHSC Foster Care Ombudsman;
- DFPS Chief Operating Officer and Regulatory Services; and
- DFPS CPS Investigations and HHSC CCL, although some areas of collaboration between CPS and CCL could be improved.

The following provides more detailed examples of effective collaboration between the agencies since September 1, 2017.

- **Regulatory Services.** Since the transfer of DFPS regulatory functions to HHSC, the agencies have collaborated to identify and resolve issues related to the transfer of interim support services still provided by DFPS to HHSC. These DFPS supports include CCL data reporting, records management, and workforce training and certification services. HHSC and DFPS are also identifying and resolving issues related to ongoing access and reporting from shared systems such as Information Management Protecting Adults and Children in Texas (IMPACT) and the Child Care Licensing Automated Support System (CLASS).

- **Human Resources.** DFPS and HHSC System Support Services collaborated to resolve issues related to the CAPPS HCM system and DFPS authority to make proper approval and entry into the system for personnel changes. The agencies are using
Acceptable Use Agreements for designated staff to ensure confidentiality and security of the CAPPS HCM data.

- **Administrative Training.** DFPS and HHSC Learning Resources Network collaborated to establish a more effective modular administrative training system for use by DFPS and HHS system employees. This system provides access to numerous training programs that HHS system employees working on federal computer networks could not previously access due to firewalls.

- **Office of Inspector General.** As DFPS and OIG enter into a new working relationship they are collaborating on documenting and formalizing roles, responsibilities, and reporting needs between DFPS and OIG. This will help DFPS and OIG establish clear expectations and set the ground work for an effective working relationship as OIG exercises its oversight responsibilities.

- **Cross Division Coordination.** DFPS remains a standing member of the CDC group which provides a regular forum for communication between DFPS and HHSC, and allows DFPS to participate in discussions about HHS system changes that could impact DFPS. The CDC meets monthly to provide an opportunity for HHS agencies and programs to work across divisions to identify programmatic or operational improvements, coordinate on policy changes, and work on HHS system projects such as strategic planning.

**Opportunities for Improved Coordination, Communication, and Data Sharing**

While HHSC and DFPS have identified areas of effective collaboration to ensure the agencies are resolving programmatic and operational issues, the agencies have also identified areas for improvement. These areas include both transitional HB 5-related issues and pre-existing HHS system issues, which carry over into the new working relationship. These areas include the following:

- **Inconsistent Process for Identifying Cross-Agency Issues.** Once the initial HB 5 workgroups developed decision memos, further workgroup meetings have occurred on an ad-hoc basis. Some of these efforts, such as the ongoing HHSC-DFPS Regulatory Services working group, are effective. However,
HHSC and DFPS lack a more formalized approach towards ensuring that ongoing programmatic, operational, and contracting issues are systematically identified, escalated, and resolved on a timely basis between the agencies. For example, HHSC and DFPS contract with various vendors that serve the same client population. However, the agencies lack formal guidance on how they should best interact with shared vendors.

Lack of a formalized oversight and escalation process creates risks that problems may not be identified early on before growing worse, or that systemic lower-level recurring problems are not identified and resolved system wide. While OTI continues to work closely with the DFPS Chief Operating Officer (COO) on selected issues, HHSC has not designated a single lead group to facilitate joint HHSC-DFPS oversight of key operational and programmatic linkages.

- **Inconsistent Quality of Communication between the Agencies.** DFPS and HHSC surveys showed that the quality of communication between the agencies varies, and depends more on informal relationships between staff in different programmatic or support areas than on any formal structure or process. DFPS indicated that HHS system, program or operational policy changes by HHSC impacting DFPS are not always clearly communicated to the agency. The agencies lack a clear approach to communicating programmatic or operational changes, especially to staff outside of central office. In addition, DFPS staff do not always having a clear point of contact within HHSC for programmatic or support area questions.

- **Incomplete Referrals and Information.** The DFPS and HHSC surveys indicated that at times complete information is not always provided on a timely basis for referrals between the agencies, such as referrals for HHSC guardianship services, or referral of CPS investigations to CCL. For example, CCL is not able to receive timely information on the initiation of an investigation by CPS, which can hinder HHSC’s ability to take immediate action against a licensed provider if warranted. In addition, technical issues with the HHSC hosted Call Center Platform may impact the performance of DFPS Statewide Intake.

- **Information Technology Systems Issues.** DFPS relies on numerous applications supported by HHSC to conduct day-to-
day business. In turn, HHSC relies on the DFPS supported IMPACT system to access shared data and generate needed reports. Both agencies have an obligation to ensure the ongoing appropriate use and security of confidential and private information accessed by both agencies, which requires significant ongoing HHSC-DFPS collaboration.

Information systems issues can arise outside of the direct purview of HHSC’s Information Technology division. For example, DFPS has reported issues with CAPPS applications such as Financials, Human Resources and eProcurement. These issues include delayed access to CAPPS, difficulty in changing user roles, inability to validate staff certification requirements, and delays in requisition approvals. In addition, DFPS reports issues with the System of Contract Operation and Reporting (SCOR), including difficulty gaining access, viewing information and reports, and issues with security roles impacting contract management duties.

Recommendations

1. Form a joint DFPS-HHSC Operations Coordination Committee.

The Committee would have responsibility for overseeing the ongoing relationship between HHSC and DFPS as it relates to operational and administrative issues, including addressing transitional issues related to HB 5, as well as long term administrative dependencies. The recommendation would ensure that both agencies work together to:

- Resolve outstanding issues related to HB 5 implementation;
- Identify additional areas of collaboration as needed;
- Identify areas where dependencies should be separated;
- Ensure communication of policy and procedure changes;
- Identify and fulfill information and document requests as appropriate; and
- Maintain clear points of contacts.

The Committee’s membership would be decided by DFPS and HHSC executive leadership, and should include designated representation from key program and support areas. Although the committee would
primarily address administrative and operational issues, inclusion of client services program representatives from both agencies on the committee will be crucial to ensure that as administrative and support service issues are addressed, the downstream impact on programs and clients is a focal point.

The Committee would be responsible for identifying and tracking operational areas of concern, diagnosing specific issues related to those concerns, and developing plans of action to address the issues. The HHSC Office of Transformation and Innovation, in collaboration with the relevant administrative support and program areas from each agency, would then work to implement those action plans. Other responsibilities of the Committee would include:

- Development of a charter or policy to establish the Committee’s membership and purpose;
- Receipt of regular reports from DFPS and HHSC management, both central and regional, on issues impacting both agencies;
- Facilitation of discussions on policy and programmatic issues that may arise between the agencies;
- Working with programs to plan for implementation of new legislative requirements that jointly affect the agencies;
- Identifying and facilitating any necessary changes to House Bill 5 decision memos, MOUs and interagency contract (IACs); and
- Developing a communication plan for operational changes proposed by the workgroup.

The Committee should designate a sub-committee with responsibilities that would include the following:

- Identifying and overseeing development of DFPS-HHSC MOUs detailing specific roles and responsibilities between the agencies, based on House Bill 5 decision memos;
- Ensuring identification of DFPS procurement needs, including procurements or contract amendments that may jointly impact both agencies; and
- Identifying and resolving procurement and contract management issues throughout the contract lifecycle.
2. Maintain the HB 5 Executive Steering Committee to be convened on an as-needed basis.

Any issues the DFPS-HHSC Operations Coordination Committee cannot resolve would be escalated to the Executive Steering Committee for final decision. Under this recommendation, the Executive Steering Committee would be retained with its existing members, and would be available to meet should the HHSC Executive Commissioner and DFPS Commissioner need to provide high level direction to the agency staff on any issues that have been escalated, or on any new legislative requirements that impact both agencies.

Conclusion

Overall, HHSC and DFPS are successfully working to implement a major shift in the State’s approach towards protecting children and the elderly by transitioning DFPS to independent agency status. However, moving forward from this initial transition, both agencies will benefit from a more formalized approach toward overseeing the significant interdependencies that still exist between HHSC and DFPS.
Section 4 - Continuation of Health and Human Services Advisory Committees

Background

Acknowledging the need to eliminate a number of HHS-related advisory committees from statute, SB 200 and Senate Bill 277 (SB 277), 84th Legislature, Regular Session, 2015 removed 36 advisory committees from statute. SB 200 and SB 277 also authorized the HHSC Executive Commissioner to re-establish committees in rule as needed to address select issues.

In 2015, HHSC developed a cross-agency workgroup to evaluate the need for existing advisory committees. The evaluation included information on the advisory committee’s scope, reporting requirements, function, activity and the value added to the program areas. The workgroup also solicited feedback from over 200 stakeholders.

The 2015 workgroup evaluated over 130 committees across the HHS system. The workgroup recommended continuing 68. Of those, six committees transferred outside HHS and three continued for a specified amount of time. This comprehensive review led HHSC to greatly reduce the number of advisory committees through the elimination of advisory committees deemed out of date, obsolete, or unnecessary.

SB 1021 directs HHSC to further evaluate advisory committees. At the time of this report, there are 52 active advisory committees across the HHS system. 10

Stakeholder Input

As a first step in evaluating the HHS advisory committees, OTI met with executive leadership and gathered information from programs.

10 Listing of current advisory committees can be found in appendix B.
OTI is also in the process of surveying external stakeholders to gather input on the makeup and function of the current advisory committees. HHS is asking stakeholders to comment on various aspects of the advisory committee including:

- Is the advisory committee fulfilling its charge and goals?
- How does the advisory committee provide value to the HHS system and the program(s) it serves?
- How could the advisory committees be structured differently to fully leverage the membership’s expertise?
- How could the process of providing feedback and recommendations to HHS be more robust?

The current review identified several key issues relating to the HHS advisory committee structure. These include:

- Significant administrative burden as reflected in the high number of staff hours dedicated to supporting committees;
- Lack of systematic process for meaningful consideration of input and recommendations from committee members and stakeholders;
- Lack of leadership process to ensure recommendations of advisory committees are considered in executive level decision-making; and
- Limited cross sharing of information between committees serving similar populations.

These findings underscore the need to further examine the structure and functions of the HHS system advisory committees and provide input to HHS programs and leadership on how to further align these committees with the new organizational structure. Since many of the current HHS System Advisory Committees serve to provide input the DSHS Leadership and programs, HHSC will ensure that DSHS is included as a partner in this review.

**Next Steps**

Since 2016, HHS has undergone a comprehensive restructuring of its organizational structure and functions to align programs and services with similar populations within HHS. This reorganization has led to increased communication and collaboration across programs previously housed at different agencies. Accordingly, the advisory committees
that provide valuable input and expertise to inform the operation of these programs should be structured, and provide input, in a way that feeds seamlessly into this new structure and furthers the long-term goal of breaking down organizational and programmatic silos.

The HHSC Office of Policy and Rules, under the CPO has taken several steps to streamline the processes surrounding advisory committees and ensure accountability such as establishing a website for committee appointments and creating standard templates for committee bylaws. By September 1, 2018, the CPO will have completed the following activities:

- revise system policy for advisory committees;
- redesign the appointment process for appointments made by the HHS Executive Commissioner;
- implement a new advisory committee manual to provide consistent structure and stakeholder experience across all advisory committees;
- implement a new mechanism for tracking committee information, including membership appointments and term expiration dates;
- establish new requirements for all advisory committees to use available meeting facilitation services; and
- update the framework for standardizing advisory committee rules.

HHS proposes building on these accomplishments by taking a structured approach to determine the need for advisory committees on different topics and how to ensure that input from these committees is provided in the most effective and efficient way possible. Rather than simply looking at the number of current advisory committees and attempting to reduce that number, HHS will take a more thoughtful approach to improve the way advisory committees function within the system.

This will involve an extensive review of state and federal statute regarding advisory committee structure and function; a thoughtful and ongoing discussion with DSHS, stakeholders, the legislature, and the Office of the Governor about how to align our advisory committees with our reorganized structure; and continuing the efforts of the CPO as described above.
Recommendations

OTI recommends changes to three current advisory committees as detailed below. In addition, HHS agencies should evaluate how advisory committees are formed, and how they can provide the most effective expertise, recommendations, and input into the HHS system within the new consolidated organizational structure. The recommendations discussed below do not require any statutory changes.

1. **Merge two advisory committees, and allow one to expire without taking any further action.**

Given their similar purpose, OTI recommends merging the Aging Disability Resource Center (ADRC) advisory committee and Texas Respite Advisory Committee (TRAC).

Allow the Peer Support Stakeholder Workgroup to expire on September 1, 2018 without taking any further action. The Peer Support Stakeholder Workgroup’s purpose is to provide input into rules related to certification scope of practice, training, and supervision of peers. The rules for peer support will be adopted and this workgroup will no longer be needed.

2. **HHS should perform an in-depth evaluation of the structure of HHS advisory committees and how these committees provide input to the HHS system.**

HHSC, in partnership with DSHS, will conduct a review and restructuring that includes the following elements:

- The feasibility of transitioning some advisory committees to workgroup status;
- Evaluating the process by which HHS establishes advisory committees and determines committee membership and size;
- Determining the best number and type of advisory committees needed to align with the transformed HHS system structures;
- Creating a standing process for regularly reevaluating the ongoing need for advisory committees;
- Evaluating how advisory committee recommendations and reports are considered by HHSC and HHS; and
- Any statutory recommendations to the TLOC for consideration during the 87th legislative session.
Conclusion

Given recent legislation and agency efforts to consolidate and reduce the number of advisory committees, this review did not result in a significant reduction in the number of advisory committees. However, HHSC will conduct a more in-depth evaluation of the most efficient and effective way to structure our advisory committees to better align with the current organizational structure. This analysis will allow the HHS system to build upon the efforts of the Office of Policy and Rules to establish a robust structure for advisory committees to engage with HHS executive leadership.
Section 5 - Assessment of Administrative Support Services Consolidation

Background

The consolidation of administrative support services at HHSC began with Senate Bill 2292 passed by the 78th Legislature in 2003. The 2015 Sunset review refocused attention on completing centralization of these functions as directed by Senate Bill 200. As of September 1, 2017, the vast majority of the administrative services that support the system’s programs, including those at DFPS, have been consolidated and centralized at HHSC. However, DSHS and DFPS still carry out their own budget, communications, and stakeholder relations support functions.

Figure 3 shows how centralization of these services has significantly increased compared the level of centralization as initially defined and observed by the Sunset Commission during the 2014-15 review. With the abolishment of DARS and DADS, and the transfer of DSHS programs and some DFPS programs to HHSC, the HHS system has centralized a significant number of support services previously administered by these agencies. Additionally, many support services continue to be provided to DFPS through a contractual relationship based on House Bill 5.

The core of the centralized system includes the divisions of Information Technology (IT), System Support Services (SSS) including Human Resources, and Procurement and Contracting Services. The Chief Operating Officer oversees IT, SSS, and Procurement and Contracting Services (PCS) and guides their work. Additional consolidation occurred within the CPO, the Office of Chief Counsel, Internal Audit, Communications, Government and Stakeholder Relations, and the HHS Office of the Ombudsman.

11 Sunset Advisory Commission, Staff Report with Final Results, Health and Human Services Commission and System Issues, July 2015, p. 42.
Centralized administrative support services provided by HHSC include the following.

- **Under the Chief Policy Officer:***
  - Office of Policy & Rules
  - Office of Performance
  - Office of Transformation & Innovation

- **Under the Chief Operating Officer:***
  - Information Technology
  - System Support Services
  - Procurement & Contracting Services

- **Under the Chief Deputy Executive Commissioner:***
  - Financial Services
  - Communications
  - Government & Stakeholder Relations
  - HHS Office of the Ombudsman

- **Under the Office of Chief Counsel:***
  - Legal Services Division

- **Reporting to the Executive Commissioner:***
  - HHS System Internal Audit

*Figure 3. Degree of centralization of administrative support services before and after Transformation, based on support services definitions used in the 2015 Sunset Advisory Commission report.*
Consolidation of Administrative Support Services

The following section describes the status of consolidation across the HHS system.

Chief Policy Office

SB 200 required HHSC to establish an executive-level office to coordinate policy and performance across the HHS system, and serve as a think tank for innovative solutions that promote continuous improvement. As the focus of transformation shifted from merging programs and functions into further developing a culture of collaboration and continuous improvement, the agency established a new Chief Policy Office, led by the CPO who reports to the Executive Commissioner. The CPO oversees three Offices, as shown in Figure 4, which support programs and administrative service areas by facilitating data-driven decision making and continuous improvement in the HHS system. In addition, as of June 18, 2018, CPO also oversees Regulatory Services.
Figure 4. HHSC Chief Policy Officer and Offices of Policy and Rules, Performance, and Transformation and Innovation.

Centers for Coordination and Continuous Improvement

Three offices with distinct functions work closely together and partner with programs to drive system-wide improvement.

Chief Policy Officer

**OFFICE OF POLICY AND RULES**
- Driving the HHS strategic vision
  - Coordinates system policy development, evaluation and implementation
  - Coordinates HHS rulemaking and assists staff with the process
  - Ensures consistent information is shared across the system

**OFFICE OF PERFORMANCE**
- Supporting a data-driven culture
  - Develops and manages a system-wide performance dashboard for ongoing measurement
  - Conducts data management and analytics
  - Supports program evaluation and process improvement assessments

**OFFICE OF TRANSFORMATION AND INNOVATION**
- Operating as a centralized “Think Tank”
  - Spearheads process improvement and priority initiatives
  - Facilitates cross-system coordination
  - Provides project management support
  - Applies a standardized approach to change management

Chief Operating Office

**Information Technology.** The full consolidation of HHS system IT staff and functions was completed in 2017, a year ahead of schedule. Policies are in place to establish HHSC IT’s authority to oversee all IT projects and procurements in the HHS system and contracting policy has been adjusted to require HHS programs to get prior approval from IT on all project Statements of Work and IT purchases of $25,000 or more.
HHSC executive leadership established policies centralizing information systems planning authority, including the authority of HHSC IT to develop system-wide policies and procedures for the management of information technology functions. Additional internal policy has been adopted requiring HHSC IT to submit an HHS system operational plan discussing goals and major initiatives for each upcoming fiscal year. The plan identifies strategies and clearly defined activities to achieve goals and successfully implement major initiatives.

**System Support Services.** Human resources was largely consolidated in SSS since implementation of the first HHS consolidation as required by HB 2292. However, significant work was accomplished to fully consolidate Regional Administrative Services, as well as administration of internal criminal background checks, and random drug testing programs.

**Procurement and Contracting Services.** On September 1, 2016, procurement and contracting staff from the legacy DADS, DARS, and DSHS transferred to HHSC PCS, which reorganized into three core departments to form a division that fully administers, and provides technical assistance over, the full contracting lifecycle from procurement to contract management and final close out. Additionally, HHSC assumed responsibility for a high volume of former DADS enrollment contracts and former DSHS contracts.

- **Procurement Operations.** Numerous procurement teams were consolidated into a new PCS Procurement Operations unit, which supports procurement across the HHS system. This consolidation required review and standardization of numerous policies and procedures to create three procurement teams serving HHS divisions and programs.
- **Contract Administration and Management.** This department helps HHS program staff by guiding the execution of all contracts, amendments, renewals, and extensions.
- **Contract Oversight and Support.** PCS has a new consolidated Contract Oversight and Support (COS) unit that provides technical assistance, training and guidance for management and oversight of all HHS system contracts. COS was integral in developing the HHS System Contract Management Handbook and SCOR to improve contract management and reporting across the system.
Chief Deputy Executive Commissioner

**Financial Services.** Consolidation of HHSC Financial Services was primarily completed September 1, 2017, however DSHS continues to provide many of these services with its own staff. Financial Services provides for the overall financial management of the HHS system, and carries out key functions related to the HHS system including budget and fiscal policy, rate analysis, actuarial analysis, accounting, forecasting, and long-term services and supports payments.

**Communications.** Consolidation of Communications functions from DARS, DADS, and HHSC was completed September 1, 2017. However, DSHS continues to run its own communications department. HHS Communications works with HHS divisions and programs to ensure consistent branding and messaging across the HHS system. HHS Communications provides video, graphic, editorial, and translation services. HHS Communications also maintains a content management system for website updates, and has established polices for uploading of website content.

**Government and Stakeholder Relations.** Consolidation of Government and Stakeholder Relations from DARS, DADS, and HHSC was completed September 1, 2017. However, DSHS retains its own external relations department focused on public health. Government Relations functions from legacy DADS and DARS transferred to HHSC, as well as certain Government Relations functions and staff related to state hospitals formerly operated by DSHS and those related to DSHS and DADS regulatory programs. HHSC has consolidated and streamlined disparate policies and procedures and is able to more effectively meet customer needs.

**Office of the Ombudsman.** Consolidation of Ombudsman functions is primarily complete, with establishment of a single Office overseeing eligibility services, Medicaid and Children’s Health Insurance Program (CHIP) managed care services, long-term care, behavioral health, foster care, and other services. As discussed in Section 2 of this report, OTI recommends consolidating the Regulatory Services Consumer Rights - Intellectual Disability Unit into the Office. The Independent Ombudsman for SSLCs retains its separation from HHS and is only administratively attached to HHSC.
Office of Chief Counsel

Consolidation of legal services was completed on September 1, 2017. However, the Office of Chief Counsel initially maintained legacy DADS and DSHS organizational structures, where some legal divisions were organized by function and others organized by program. The DSHS General Counsel is embedded at DSHS and serves as the on-site advisor to the DSHS Commissioner, but reports to the HHSC Chief Counsel.

HHS System Internal Audit

Internal Audit was fully consolidated as of September 1, 2017, bringing in auditors from legacy DADS and DARS, as well as DSHS. To prepare for consolidation, auditors from the HHS agencies reviewed and streamlined audit and administrative policies and procedures to ensure that Internal Audit effectively works from a single set of unified policies and procedures. Internal Audit has also improved its risk assessment process to ensure emerging risks are given more immediate attention.

Administrative Support Services Concerns

The consolidation of administrative functions as described above is only the first step in fully realizing the Legislature’s vision of clearer lines of responsibility for providing administrative services, improving efficiency, and containing costs.

The most recent organizational changes have been in place less than a year, and operational challenges still exist, most notably with regard to PCS and Information Technology. HHSC recommends further work to ensure clarity in the roles and responsibilities between support areas, HHSC divisions, DSHS and DFPS to minimize the risk of duplicating work efforts, dropping essential tasks, or otherwise wasting state resources.
Procurement and Contracting Services

PCS is currently undergoing major revisions to improve their processes and ensure these activities strictly adhere to all statutory and quality assurance requirements. In June 2018, HHSC also created a new Office of Compliance and Quality Control of Procurement and Contracting Services, which reports to the Chief Operating Officer, and is charged with ensuring implementation and ongoing oversight of needed contracting reforms. This Office will work directly with a contracted independent consulting firm that will conduct an assessment of current procurement processes, conduct a root cause analysis of problems with these processes, and develop an improvement plan.

Department of State Health Services Concerns

As discussed in Section 1 of this report, OTI received significant input from DSHS related to assessing the continuing need for DSHS as a separate agency from HHSC, in addition to concerns about the effectiveness of HHSC support services. See Appendix A for additional details provided by DSHS. As DSHS notes, the consolidation of administrative support services is a significant undertaking and the goals of consolidation are not yet fully realized.

The transfer of administrative support services to HHSC has caused challenges for DSHS operations, and DSHS staff do not believe that HHSC understands their support needs. The differing focus of the two agencies contributes to difficulties in the ongoing working relationship between the agencies. According to DSHS, the agency spends significant effort educating HHSC staff on DSHS programs in order to get needed support services. DSHS also expressed concerns about the layers of approval required to conduct certain processes, and being required to utilize processes that do not align with DSHS operations.

Administrative Support Services Accountability

SB 200 requires HHSC and each agency or division within the HHS system to enter into agreements for the purpose of ensuring accountability for the provision of administrative services. To implement this requirement, HHSC adopted internal policies requiring
SSAs between all support areas, including PCS, IT, SSS, Internal Audit, Financial Services and the Office of Chief Counsel, and each HHS division, DSHS, and the Office of Inspector General.

These SSAs describe baseline services provided to all HHS agencies and divisions, any unique services required, as well as the respective roles and responsibilities of divisions and support areas. SSAs also include performance goals and measures, and an escalation process for resolving issues or problems between programs and support areas. Additionally, statute and the SSAs provide for DSHS or HHS divisions to obtain support services through alternatives if they are not satisfied with services.

However, SSAs require additional work to ensure these agreements provide sufficient clarity in roles and responsibilities, effective performance measurement, and increased accountability between program areas, support areas, and DSHS. To that end, the CPO is evaluating changes to the administration and oversight of SSAs to strengthen accountability, monitor performance, and ensure high levels of customer satisfaction with support services, and will work with DSHS on improvements to SSAs between their agency and HHSC administrative support services.

**Appropriateness of Administrative Staffing Levels**

During transformation of the organizational structure, numerous staff and vacancies were transferred between agencies, including those associated with:

- the split of legacy DARS functions between HHSC and TWC;
- the split of DSHS regulatory functions between HHSC and the Texas Department of Licensing and Regulation;
- the abolishment of DADS; and
- the reversal of the consolidation of some support services provided to DFPS.

As a result, numerous position numbers were transferred, renumbered, reclassified, and reallocated between several agencies. HHSC is not able to fully assess the net impact of these complex staff movements. Various factors have contributed to the agency’s inability to maintain sufficient administrative staffing levels. HHSC has been able to mitigate these issues through the transfer of funding and full time employees (FTEs) to administrative services areas to support
contract oversight, risk monitoring, utilization review, and licensing functions, as approved by the Legislative Budget Board.

**Potential Savings from Increased Administrative Efficiencies**

Special Provisions Section 26 of Article II of the FY 18-19 GAA required HHSC to identify and create a plan for achieving GR savings from increased administrative efficiencies and the elimination of duplicative administrative support functions. Although consolidation of administrative services has resulted in increased efficiency, the system continues to streamline processes and procedures to fully align consolidated divisions and to fully realize those efficiencies. Additionally, due to a confluence of events occurring at the same time as consolidation, including 4% budget reductions and additional structural changes required by subsequent legislation, it is difficult to identify an aggregate amount of savings specifically associated with consolidation of administrative functions.

However, HHS system agencies are continually searching for opportunities to reduce costs, improve systems and processes, and more efficiently provide services to our clients. Below are examples of increased administrative efficiencies resulting from consolidation and other efforts to streamline administrative functions, many of which have associated cost savings or cost avoidance. Many of the efficiencies identified in the report are estimates, and could not be quantified in terms of potential GR savings, as requested in Section 26.

**Reductions to Appropriations**

**HHSC and DSHS Base Appropriations Request Reductions: $207 million in GR, FYs 2018-2019.** While not specific to transformation, the HHS system was instructed to make a four percent reduction in legislative appropriation base requests, targeting administrative functions and one-time projects that would have limited impacts to system clients. HHSC’s four percent reductions provided $398 million in total savings, including $207 million in GR over the 2018-2019 biennium. In addition, DSHS reduced their base appropriations request by $25.1 million in GR funds for 2018-2019 biennium.
Cost Avoidance and Efficiencies

HHSC has identified cost avoidance and efficiencies associated with the consolidation of administrative support services over fiscal years 2016-2018. These cost containment efforts played a significant role in ensuring the HHS system could effectively allocate funds towards priority needs and operate effectively within its legislative appropriations.

Information Technology - Standardization of Telephone Services

The transfer of state hospitals provided HHSC IT an opportunity to upgrade aged telephonic infrastructure at a significant savings. Through telephone platform consolidation and standardization, IT replaced 12 outdated solutions with three standardized HHS system solutions. While this initiative started before HHS transformation, total cost avoidance is estimated at $3.2 million in FY 2016, $3.5 million in FY 2017, and $3.5 Million in FY 2018. Total Cost Avoidance: $10.2 Million for FYs 2016-18

Information Technology - Conversion of Contracted Staff to State Positions

HHSC IT has used staff augmentation contractors to obtain specific skill sets only needed for specific projects or to supplement state employed staff during times of high need. While staff augmentation is an effective and viable alternative under certain circumstances, in the spring of 2017 HHSC IT was able to convert 114 staff augmentation positions to state positions, avoiding costs of $7.3 million for FYs 2016-2017, which would have otherwise gone towards more expensive contracted positions. Total Cost Avoidance: $7.3 Million for FYs 2016-17

Information Technology - Reduced Electronic Device Service Costs

HHSC IT administers contracts for the acquisition and support of about 62,000 computing devices statewide, of which HHSC and DSHS use about 47,000 and DFPS uses the remainder. HHSC IT was able to leverage its buying power and negotiate a new Seat Management Services contract that covered the entire fleet of HHS devices,
reducing the servicing cost-per-unit by 50 percent, from $585 to $289. **Total Cost Avoidance: $800,000 for FY 2018**

**Information Technology - Improved IT Governance Structure**

HHSC IT has a new governance model for partnering with HHS divisions and DSHS, to ensure alignment of HHS system business needs with IT services. The governance structure includes six business portfolios, such as Public Health Services and MSS, and two HHS system portfolios. Each portfolio has an oversight committee that includes staff from business areas and IT that evaluate and prioritize requests for IT services within the context of each portfolio’s roadmap.

While this governance structure is still new to the HHS system, this process will build transparency into decision-making and increase accountability for the best use of IT funds. To enable the HHS system to run more efficiently, IT supports the governance portfolios with a consistent set of technical standards for security, architecture, system interoperability, and communication channels as well as shared services such as email and networking.

**Internal Audit - Reductions in Management Staff**

The full consolidation of Internal Audit allowed Internal Audit to restructure its organization and reduce the number of directors from five to three and the number of audit managers from six to four. Despite this staff reduction, Internal Audit was able to pool the talents and skills of its audit staff and provide strengthened audit coverage across the HHS system. **Cost Avoidance: $460,000 Annually**

**Financial Services - HHS System Implementation of eTravel**

Before the consolidation of HHS agencies under SB 200, the agencies relied mostly on paper-based travel approval and reimbursement processes. These processes created significant administrative burdens and inefficiencies for the agencies. With consolidation, Financial Services was able to implement eTravel across the HHS system and streamline this activity. For example, HHSC’s time to issue travel reimbursements to staff reduced from three weeks to three days. In addition, eTravel provides additional controls, documentation, and
management data to ensure the accuracy and integrity of travel reimbursements. **Cost Avoidance: $300,000 Annually**

**System Support Services - Improved Hiring for the HHSC Health & Specialty Care System**

Job Requisition Coordinators and Hiring Specialists, who support hiring in hard-to-fill, high-turnover work settings such as state hospitals and eligibility offices, are now consolidated within SSS. Standardizing hiring processes across state hospitals has enabled them to more quickly post and fill vacant positions.

**Government & Stakeholder Relations - Improved Customer Service**

HHSC has transformed the organization and workflow of Government and Stakeholder Relations, standardizing legacy policies and processes and ensuring clarity of purpose and consistency. For example, HHSC now has a single point of entry and process for tracking legislative inquiries, correspondence, and constituent cases, enabling HHSC to more effectively respond to stakeholders.

**HHS Office of the Ombudsman - Improved Tracking of Complaints**

The HHS OO has established a more effective system-wide policy for the tracking, analysis, and reporting of consumer complaints and inquires. The consolidation of the Office’s functions has enabled the Office to improve complaint and inquiry tracking and gain more comprehensive, system-wide perspective on these issues to identify emerging trends and problems.

**Future Administrative Efficiencies**

The consolidation of HHS administrative support services has created further opportunities to identify areas where remaining duplicative processes can be eliminated and consolidated systems can be leveraged to support programs. To this end, HHSC support areas have identified initiatives that could result in additional efficiencies through organizational changes, streamlining business processes, and eliminating duplicative, manual, or paper-based processes. The
following are examples of efficiencies identified for possible future implementation.

**Office of Chief Counsel - Streamlining Business Processes and Functional Reorganization**

The Office of Chief Counsel started a business process review and organizational restructuring project in April 2018 that will organize the Office of Chief Counsel along functional lines in an effort to more effectively deliver legal services. As part of this project, the Office is developing a new process and procedure manual to ensure all programs and support areas receive a consistent level of quality legal services.

To support a high level of legal involvement in procurement and contracting, the Office of Chief Counsel has also restructured and added staffing resources to its System Contracting division. This division also ensures timely updating of contract templates, data use agreements, and uniform standard terms and conditions.

**Efficiency:** Streamline legal services to provide improved customer service and gain efficiencies by reorganizing legal staff along functional lines.

**Financial Services Division - More Efficient Review of Medicaid Cost Reports**

To review and finalize Medicaid cost reports quickly and accurately, Long-Term Services and Supports (LTSS) will set up a team dedicated to providing customer service and technical assistance, including all requests from providers for cost report assistance.

**Efficiency:** Other staff in the unit will no longer have work interrupted by provider inquiries, resulting in greater operational efficiencies.

**Financial Services - More Efficient Supplemental Provider Payments**

The Rate Analysis Division plans to streamline payment processes for all hospital services and LTSS supplemental payments.

**Efficiency:** Less payment errors requiring rework and more staff time dedicated to finding other opportunities for program improvements.
Financial Services - Increase the Use of Technology to Improve Payroll, Time, Labor and Leave Activities

Payroll, Time, Labor and Leave took on the functions for state hospitals and state supported living centers, where employees work a variety of shifts, and experience high employee turnover. Financial Services plans to standardize the numerous business processes currently in use.

Efficiencies:

- Standardize business processes and increase use of technology and automation.
- Evaluate regionalizing or centralizing payroll and timekeeping production to reduce staff overtime.
- Evaluate expanding use of CAPPS at state facilities, where currently, staff have limited access to computers.

Financial Services- Streamlined Budget Structure

Currently, the HHSC budget is structured in a fragmented way that reflects the pre-transformation structure of the agency. Budget structure changes were requested to reflect the way HHSC is now organized and delivering services based on the Transition Plan approved by the TLOC. The requested changes ensured that budget strategies were grouped with the division providing those services, utilized current naming conventions, and reflected the current business models and practices. In addition, the request included new Strategies for program administration.

These new groupings and the Strategies for program administration (one per Division) would have separated client services from program administration for each Division. These changes would have allowed program administration for each Division to have the same Method of Finance (MOF) funding for all of their programs, providing more flexibility to align resources where they are most needed as business models and practices change.

Grouping the Strategies by the Division performing the services would also have allowed internal financial system reports to be written, processed and presented more easily and logically.
PCS - Contract Administration - More Efficient Submittal of Single Audit Reports

Contractors mail or email Single Audit reporting packages to PCS staff who then scan the documents into a Microsoft Access database. PCS is working with HHSC IT to develop a new Single Audit module that will allow electronic submission of reporting packages and replace the current manual process.

**Efficiency:** Technology solution will improve the management, storage and tracking of Single Audit reports and data.

**IT - Digital Fabric**

Post-consolidation, the HHS System utilizes over 400 IT applications to support the agency’s essential functions. These applications are extremely siloed, with hundreds of infrastructure systems and duplicative features and interfaces. This perpetuates the fractured nature of services and operations the Legislature sought to address in SB 200.

**Efficiency:** The IT Division has developed a long term vision for the creation of a system-wide business platform--a Digital Fabric-- that would support a more integrated, client-centric approach to health and human services delivery and management through a common data repository, shared service elements and resources, and mission specific applications capable of supporting multiple programs and missions.

Moving to a shared health and human services platform will consolidate and simplify the current complex system landscape. It will also provide multiple benefits for clients and taxpayers, including significant improvements in the efficiency and effectiveness in program operations; increased agility to respond to sudden changes in usage without disruption to service; reduction in security risks; reduction in time to implement system changes; the ability to make continuous system enhancements; and reduced cost for system maintenance. Although this initiative would require an upfront investment, it would dramatically reduce long-term expenditures.
Conclusion

Overall, the consolidation of administrative support services is primarily complete, and greater operational efficiencies are beginning to emerge, such as standardization of telephone services. Some administrative support areas identified significant cost avoidance, which contributed to the HHS system being able to operate within appropriations set by the Legislature. However, many support areas are just now emerging from the initial consolidation and are working towards making business process changes and eliminating duplicative efforts that will assist with improving support to program areas, as well as create a more efficient system for the numerous contractors and providers that interact with the HHS system.

Under the new structure, administrative support areas are better positioned to create more concrete plans for identifying further efficiencies. The HHS system will continue to identify and pursue opportunities for centralizing administrative support services, developing and sharing best practices, and streamlining operations. HHS needs to also move towards demonstrated organizational maturity in delivering its support services, including fully incorporating a strong performance driven and customer service oriented culture within all support areas.
Appendix A. DSHS Response to SB 1021 Report Survey

Department of State Health Services

Response to the Health and Human Services Commission SB 1021 Survey

Introduction

Today, DSHS is an organization solely focused on public health and is better positioned to provide statewide public health leadership. Maintaining this distinct public health function in a separate agency is key to ensuring that the health of all Texans is a priority of our Texas government. In addition, to achieve optimal progress in improving the health of Texans, HHSC and DSHS must work toward closer, more effective collaboration. Currently, the agencies work together on many programmatic issues; however, the system’s administrative supports and services are struggling under the breadth and depth of their responsibility. These administrative services are essential to DSHS’ public health mission, and the manner in which they are delivered has the potential to either make or break success for both DSHS and HHSC.

Restructured DSHS focus on advancing public and population health

DSHS fully supports and embraces its restructuring into a highly-focused public health agency, pursuant to the direction of the Texas Legislature. Recognizing the far-reaching impact of public health in every dimension of Texans’ well-being, the Legislature - through SB 200 - maintained DSHS as a separate agency and streamlined its programs and services. With the movement of many client services and regulatory functions to HHSC, DSHS has focused its energies over the last two years on accomplishing its core mission of continuously protecting Texans and improving public and population health.

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12 DSHS response to HHSC survey provided April 27, 2018.
In its 2014 staff report to the Legislature, the Sunset Commission noted that prior to the recent transformation efforts, the broad scope of DSHS programs complicated agency administration and too often diverted the agency from its core public health mission. The transfer of direct client services and regulatory functions to HHSC and other agencies has better positioned DSHS to fulfill its role as the state’s public health leader and agency.

As a part of the reorganization, DSHS completed a thorough assessment of its structure and operations with the legislative charge to operate with a laser-like focus on public health. To that end, DSHS is now aligned into four new divisions: Laboratory and Infectious Disease Services, Community Health Improvement, Consumer Protection, and Regional and Local Health Operations. These divisions fulfill the agency’s mission by preventing, detecting and responding to infectious diseases; promoting healthy lifestyles through disease and injury prevention; reducing health risks and threats through consumer protection; developing evidence-based public health interventions through data analysis and science; and providing medical response during disasters and emergencies.

As a smaller, more focused agency, DSHS is positioned to lead the state’s public health efforts and work more effectively with local health departments across the state. These efforts have only been possible because of the programmatic transfers put in motion by the Legislature and would not have been possible under the DSHS pre-transformation structure. Prior to transformation, regional offices and local health departments were forced to compete with high-need programs within DSHS for attention and resources. As a result, DSHS leadership was previously unable to ensure consistent, constructive attention to ongoing regional and local public health concerns. The reorganized DSHS, its regional offices and its local health department colleagues can better focus and optimize initiatives designed to promote the health and safety of all Texans. Additionally, as a more focused agency, communication and coordination among regional/local staff and central office subject matter experts has improved. The transformation of the HHS System enabled DSHS to undertake an efficient and deliberate reinvention of its organizational structure, which has led directly to the benefits described here.
Although the new DSHS structure has only been in place for a short period of time - approximately eight months at the time of this writing - the DSHS’ organizational reinvention is already bearing fruit:

- Agency reorganization aligning complementary functions within the same division.
- Closer collaboration among executives, resulting in improved performance within and among divisions, sections and programs.
- Focused effort to strengthen relationships with public health partners, adding value and producing tangible results.
- Conducting a data and science-driven initiative to establish statewide public health priorities.
- Collaboration with partners to assess the capabilities and capacities of Texas’ public health system and foster improved performance.
- Engagement with stakeholders to identify how DSHS can better meet their needs.
- Creation of a framework that defines DSHS’ role as a leader and facilitator of the broader public health system, and its role in directly administering public health functions.

**DSHS unique role within Texas Government and the HHS System**

DSHS plays a unique role within state government and the HHS System with respect to DSHS’ use of science and technology to meet the critical public health needs of all Texans. Within the HHS System, DSHS activities and initiatives focus on promoting and improving public and population health outcomes, while HHSC activities and initiatives focus on optimizing the functioning of health care delivery systems and the individual and aggregate health outcomes of program beneficiaries. Stated another way, DSHS programs impact the health of all Texans, whereas HHSC programs primarily provide client services to individuals meeting eligibility criteria. While the two roles are important and complementary, each approach requires different skills and professional expertise and must be organized and clearly focused on specific initiatives able to drive improvement.

Having a medical doctor serve as the DSHS Commissioner, as required by statute, provides clinical expertise and medical direction
to the work of DSHS. This expertise is further informed and bolstered by the technical knowledge of DSHS scientists, epidemiologists, physicians, nurses, veterinarians, laboratorians and other health professionals. DSHS’ ability to control communicable diseases and respond to public health emergencies relies upon its capability and capacity to apply expert clinical and scientific knowledge to timely decision-making and action. For example, the DSHS Commissioner may act as an independent authority, under Texas statute, to make rapid and scientifically informed medical decisions during infectious disease outbreaks. The DSHS Commissioner’s decision-making is supported by personal, clinical knowledge and by DSHS experts with specialized public health training and experience. DSHS’ collective expertise is critical to developing and carrying out public health interventions during emergencies such as the H1N1 influenza pandemic, or issuing control orders and managing the state’s response to high-consequence infectious diseases as during the Ebola crisis in Texas.

Because of its current size, structure and organization, DSHS is agile and quick in identifying and responding to infectious diseases, biological or chemical threats, and public health disasters. Experience has demonstrated that during public health emergencies - such as hurricanes, pandemics, or high-consequence disease outbreaks - the swift application of sophisticated public health expertise is essential for achieving the best outcomes. This agility is critical in situations where Texas lives and property hang in the balance. Operating within a relatively flat organizational structure allows DSHS to address issues at the lowest level possible, while ensuring reliable systems are in place for escalation of higher level concerns and decision-making. For example, when Hurricane Harvey hit the Texas coast with little time to prepare and with unprecedented effects, DSHS quickly activated the state medical operations center and worked with local, state and federal partners to deploy health and medical assets to assist with medical evacuations. DSHS’ ability to rapidly expand the state’s aerial mosquito vector control efforts exemplifies the agency’s capability and capacity for agile innovation and action, even when the task at hand is massive and the need is urgent.

Being science and data driven also distinguishes DSHS within the HHS System. DSHS research and analysis of health information provides key insights to help design evidence-based interventions and measure outcomes. DSHS, because of its reorganization, is
better able to address the root causes of Texas’ public health issues through scientific investigation, surveillance and data collection. DSHS’s data-driven analysis and response to maternal mortality provides an excellent example of this critical skill set. DSHS, in concert with the Maternal Mortality and Morbidity Task Force, is working to understand and explain maternal death trends and provide meaningful analysis and actionable interventions to help reduce these tragic and often preventable deaths.

**Partnerships within the HHS System**

Given the distinct, yet complementary roles of HHSC and DSHS, there are numerous areas where closer alignment and collaboration will add great value for the people of Texas. These efforts are underway, but far from finished. Indeed, the work to improve the efficiency and effectiveness of our shared work must be continuous. A culture of mutual professionalism and respect is essential for the DSHS-HHSC partnerships to flourish. Greater insight, recognition, and understanding of each agency’s unique responsibilities and experience will foster an environment in which productive partnerships can thrive. DSHS and HHSC have engaged in several such initiatives as described below:

- TCCCP coordination with BCCS program through the HHS Cancer Coordination Group.
- DSHS MCH Unit collaboration with the HHSC Women’s Health Program on items like the Healthy Families project, Better Birth Outcomes and work related to reducing maternal mortality and morbidity.
- DSHS MCH Unit and the WIC program related to the following shared initiatives: Every Ounce Counts, lactation support centers and Peer Dads.
- DSHS MCH Unit and the HHSC Children with Special Health Care Needs (CSHCN) Services Program related to case management and care coordination for clients.
- DSHS and HHSC Medicaid related to adding mosquito repellent as a Medicaid benefit to assist in the controlling the spread of the Zika virus.
- DSHS and HHSC Behavioral Health staff related to opioid crisis response efforts.
- DSHS Center for Health Statistics and Medicaid related to health care quality data.
• DSHS Center for Health Statistics and HHSC Women’s Health program related to birth outcomes and other data.
• DSHS HIV/STD program and HHSC Medicaid regarding HIV viral suppression and potential collaborations around hepatitis C.
• Regional support for HHSC programs related to health emergency preparedness and response (provide planning, training and exercise); domestic minor sex trafficking awareness training; and nursing and social worker support during HHSC emergency operations.
• HHSC Stakeholder Relations provision of facilitation services for DSHS advisory committee meetings, which allows program staff to focus their efforts on content of the meetings and needs of the committee members.

These collaborations are significant, but more can be accomplished as thoughtful, effective and highly reliable systems of teamwork are established within and between HHSC and DSHS. HHSC policies and operations have an impact well beyond the programs they administer. HHSC and DSHS must collaborate to assure that their programs work synergistically across decision-making in all sectors and policy areas.

Challenges with administrative consolidation

Administrative services are critical functions that enable DSHS to carry out its mission. Without purchasing, contracting, information technology, facilities support, human resources and other support services, DSHS could not do its jobs or carry out its mission. Moreover, these critical functions must be in complete alignment with programmatic responsibilities or risk degrading the various purposes for which they exist.

The consolidation of administrative services was, and continues to be, a massive undertaking for the HHS System and occurred while multiple programmatic functions were also transitioning. The work of consolidation is, in many ways, still ongoing. The envisioned goals of increased efficiency and focused accountability have not yet been realized. Many HHSC staff are working diligently to make this system work, but the sheer size and scope of the services appears overwhelming in some cases. DSHS actively desires to partner with HHSC administrative services to achieve overall system success. As
HHSC refines its administrative operations, DSHS is committed to working as an ally to achieve the success of these services.

Transitioning key administrative functions into the HHSC structure is further challenged by the often-conflicting roles of HHSC as overseer of HHS System, provider of direct client services and supplier of administrative support services for the HHS System. In some instances, the delivery of support services is inappropriately blended with the oversight function, such that HHSC administrative support services are directing DSHS customers and altering the agency’s program policies, priorities or services without any engagement or effort to understand customer needs.

While movement of administrative functions to HHSC has the potential to allow DSHS to hone its focus on the improvement of public health services, in practice the energies of DSHS leadership and staff must often be diverted from public health initiatives to ad hoc problem-solving to ensure continuity and adequacy of administrative services. Much effort is expended searching for the appropriate points of contact for various issues, obtaining clarification on changing policies or official communications and even ensuring that projects do not get lost among competing priorities. Consolidating administrative functions at HHSC has, in some instances, stretched effective business operations and relationships beyond the breaking point.

Ongoing challenges experienced by DSHS with HHS System administrative and support services include:

- Lack of opportunity for input into the design and operation of mission-critical business functions.
- Decreased situational awareness and communication for both day-to-day and high-volume/high-risk activities such as contracting.
- Unresolved lines of authority and continual modification of governance structures and business operations and processes.
- Increased complexity, responsibilities and requirements placed on DSHS staff and managers.
- Increasingly complex agency processes that degrade DSHS’ flexibility and responsiveness.
- Policy changes implemented without notice, often without supporting explanation and/or documentation.
- Added steps to access consolidated administrative services.
While there is ongoing engagement between the agencies to address these challenges, DSHS typically does not have a meaningful voice in decisions regarding the development and consolidation of administrative and support services. DSHS has experienced specific high-risk challenges with administrative services, as described below.

- **Procurement and Contracting Services** – Since PCS was consolidated, there has been constant change and unresolved challenges. These issues seem to originate from siloed leadership practices that limit DSHS input and perspective into formulating policy changes and are further exacerbated by frequent and inconsistent changes in policies, processes, time frames and deadlines.
  - **CAPPS Financials** – DSHS has raised a series of concerns with HHSC regarding CAPPS Financials. While the HHSC Chief Operating Office acknowledged the serious nature of those concerns, the fundamental issues remain outstanding. Most crucially, staff at all levels need comprehensive training and tools to protect HHSC and DSHS from risks due to human error, to ensure controls and to preserve accountability.

- **Information Technology Services** – HHSC IT leaders have consistently worked to communicate and collaborate with DSHS programs and leadership, and IT continues to strive to meet DSHS’ IT needs. However, it is clear that HHSC IT is struggling to maintain the technically skilled human resources necessary to cope with the size and complexity of the HHS System and its vast information technology needs. Current challenges are categorized below:
  - Incomplete or inadequate progress on critical projects, resulting in risks of delays and cost-over runs
  - Unclear IT staff contacts and lack of uniform processes and procedures
  - No standard process for notifying management and staff regarding priority issues such as outages
  - Confusion about HHSC IT contract management’s place within HHSC IT
  - Developing but still confusing, unclear and ineffective IT governance structures
  - Unclear lines of authority and responsibility
• **Delayed response times and ineffective levels of response**

**System Support Services**

► **Facility Services** – These services lack clarity in roles and responsibilities, which causes confusion and leads to avoidance of ownership on critical issues. Current DSHS challenges include:
  - Limited input regarding buildings facility maintenance contracts between HHSC and the Texas Facility Commission
  - Limited opportunity to receive updates on facility projects or discuss issues/concerns
  - Absence of or inadequate policies and procedures for space planning management and facility relocation

► **Human Resource Services** – Human resource services were consolidated at HHSC over ten years ago; however, problems persist in how these services are provided to DSHS:
  - Increasingly burdensome steps added to once-simple processes
  - Major policy changes effected with little notice and insufficient involvement of DSHS in decision-making
  - Decreasing access to consultation for personnel questions and activities
  - Lack of consistent methods for communicating critical information to DSHS

**Legal Services** – The HHS Chief of Counsel has communicated regularly and consulted with DSHS leadership on the selection of the DSHS General Counsel; however, the DSHS General Counsel and all legal staff report to HHSC. As a result, DSHS remains concerned that its General Counsel does not report to the DSHS Commissioner and legal counsel who support DSHS programs will grow increasingly distant, inexperienced and disconnected from DSHS programs and services over time. Effective legal support for DSHS requires expertise in public health law, regulation and contracting for complex public health programs activities.

Additionally, reliable processes to establish performance expectations, outcomes and accountability - such as support
services agreements - are not applied effectively to assess needs and business requirements, and measure the success of consolidated services. While support service agreements were initially developed, they are not currently used as a tool to foster knowledge exchange and drive effective customer service. As a result, these support agreements are not meaningful tools to measure the achievements or struggles of administrative services as originally conceived. Finally, DSHS has no input mechanism to address the cost and growth of consolidated functions, leaving a large portion of the DSHS budget uncertain. Although the development of a detailed oversight bill is underway, the complexity and number of changes at HHSC have made that task more complicated and limited the transparency of the true cost of services provided to DSHS by HHSC.

Conclusion

DSHS is a committed partner in the success of the HHS System. The success of this partnership will enable DSHS to optimally perform its public health mission. The linkages between the unique public health functions that DSHS provides and HHSC’s client services and regulatory functions presents opportunities to improve the health of all Texans. Achieving an optimal future state will require true teamwork, accountability and shared responsibility for outcomes, programmatically and administratively. For DSHS to have a highly reliable system for the delivery of public health services, DSHS must be able to engage in an open dialogue with HHSC about the provision of administrative services. DSHS is eager to engage in this work in order to improve the efficacy of administrative services and, thereby, the value of our agencies to the people of Texas. DSHS looks forward to working with HHSC to jointly assess the impacts of transformation and recommend ways to improve the HHS System. Like HHSC, DSHS continually seeks solutions that will improve health outcomes for Texans.
Appendix B. List of Current HHS Advisory Committees

<table>
<thead>
<tr>
<th>Name of advisory committee</th>
<th>Agency/Program Area</th>
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<tbody>
<tr>
<td>Governor’s Emergency Medical Services (EMS) and Trauma Advisory Council</td>
<td>DSHS</td>
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<tr>
<td>Healthcare Safety Advisory Committee</td>
<td>DSHS</td>
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<tr>
<td>HIV (Human Immunodeficiency Virus) Medication Advisory Committee</td>
<td>DSHS</td>
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<tr>
<td>Interagency Obesity Council</td>
<td>DSHS</td>
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<tr>
<td>Maternal Mortality &amp; Morbidity Task Force</td>
<td>DSHS</td>
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<tr>
<td>Medical Advisory Board</td>
<td>DSHS</td>
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<tr>
<td>Newborn Screening Advisory Committee</td>
<td>DSHS</td>
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<tr>
<td>Preparedness Coordinating Council</td>
<td>DSHS</td>
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<tr>
<td>Promotor(a) Community Health Worker Training and Certification Advisory Committee</td>
<td>DSHS</td>
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<tr>
<td>Public Health Funding and Policy Committee</td>
<td>DSHS</td>
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<tr>
<td>Residency Advisory Committee</td>
<td>DSHS</td>
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<tr>
<td>Sickle Cell Advisory Committee</td>
<td>DSHS</td>
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<tr>
<td>State Child Fatality Review Committee</td>
<td>DSHS</td>
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<tr>
<td>State Preventive Health</td>
<td>DSHS</td>
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<tr>
<td>Statewide Health Coordinating Council</td>
<td>DSHS</td>
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<tr>
<td>Stock Epinephrine Advisory Committee</td>
<td>DSHS</td>
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<tr>
<td>Task Force of Border Health Officials</td>
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<tr>
<td>Task Force on Infectious Disease Preparedness and Response</td>
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<tr>
<td>Texas Council on Alzheimer's Disease and Related Disorders</td>
<td>DSHS</td>
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<tr>
<td>Texas Council on Cardiovascular Disease and Stroke</td>
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<td>Texas Diabetes Council</td>
<td>DSHS</td>
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<td>Committee</td>
<td>Agency</td>
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<tr>
<td>Texas Radiation Advisory Board</td>
<td>DSHS</td>
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<td>Texas School Health Advisory Committee</td>
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<tr>
<td>Tobacco Settlement Permanent Trust Account Administration Advisory Committee</td>
<td>DSHS</td>
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<tr>
<td>Toxic Substances Coordinating Committee</td>
<td>DSHS</td>
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<tr>
<td>Youth Camp Advisory Committee</td>
<td>DSHS</td>
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<tr>
<td>Aging and Disability Resource Centers Advisory Committee</td>
<td>HHSC AES Community Access</td>
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<tr>
<td>Texas Respite Advisory Committee (TRAC)</td>
<td>HHSC AES Community Access</td>
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<tr>
<td>Texas Autism Council</td>
<td>HHSC HDIS</td>
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<td>Early Childhood Intervention Advisory Committee</td>
<td>HHSC HDIS</td>
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<tr>
<td>Board for Evaluation of Interpreters</td>
<td>HHSC HDIS</td>
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<tr>
<td>Texas Brain Injury Advisory Council</td>
<td>HHSC</td>
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<tr>
<td>State Independent Living Council</td>
<td>Independent of any agency</td>
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<tr>
<td>Behavioral Health Advisory Committee (BHAC)</td>
<td>HHSC IDD/BHS Office of Mental Health Coordination</td>
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<tr>
<td>Joint Committee on Access and Forensic Services (JCAFS)</td>
<td>HHSC IDD/BHS Behavioral Health Services Section</td>
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<tr>
<td>Mental Health Conditions and Substance Use Disorder Parity Workgroup</td>
<td>HHSC IDD/BHS - Office of Mental Health Coordination</td>
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<tr>
<td>Peer Support Stakeholder Workgroup</td>
<td>HHSC IDD/BHS</td>
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<tr>
<td>Statewide Behavioral Health Coordinating Council</td>
<td>HHSC IDD/BH - Office of Mental Health Coordination</td>
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<tr>
<td>Workgroup on Mental Health Access for First Responders</td>
<td>HHSC IDD/BH - Office of Mental Health Coordination</td>
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<tr>
<td>Drug Utilization Review Board</td>
<td>HHSC MCS</td>
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<tr>
<td>Electronic Visit Verification (EVV) Individuals/Members Workgroup</td>
<td>HHSC MCS</td>
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<tr>
<td>Palliative Care Council</td>
<td>HHSC</td>
</tr>
<tr>
<td>Policy Council for Children and Families</td>
<td>HHSC MCS</td>
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<tr>
<td>Value-Based Payment and Quality Improvement</td>
<td>HHSC MCS</td>
</tr>
<tr>
<td>Intellectual and Developmental Disability System Redesign Advisory Committee (IDD SRAC)</td>
<td>HHSC MCS</td>
</tr>
<tr>
<td>Medical Care Advisory Committee (MCAC)</td>
<td>HHSC MCS</td>
</tr>
<tr>
<td>STAR Kids Advisory Committee</td>
<td>HHSC MCS</td>
</tr>
<tr>
<td>State Medicaid Managed Care Advisory Committee (SMMCAC)</td>
<td>HHSC MCS</td>
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<tr>
<td>Texas Council for Consumer Direction (TCCD)</td>
<td>HHSC MCS</td>
</tr>
<tr>
<td>Perinatal Advisory Council</td>
<td>HHSC supports the PAC; DSHS is the dept. referenced in legislation</td>
</tr>
<tr>
<td>Aging Texas Well Advisory Committee (ATWAC)</td>
<td>HHSC MSS - Aging Coordination Services</td>
</tr>
<tr>
<td>HHSC e-Health Advisory Committee (eHAC)</td>
<td>HHSC MSS - Office of e-Health Coordination</td>
</tr>
</tbody>
</table>
Appendix C. Legacy Department of Aging and Disability Services Organizational Structure
Appendix D. Health and Human Services System Organizational Structure
# Appendix E. Glossary of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
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<tbody>
<tr>
<td>ADRC</td>
<td>Aging Disability Resource Center</td>
</tr>
<tr>
<td>APS</td>
<td>Adult Protective Services (DFPS)</td>
</tr>
<tr>
<td>APS-PI</td>
<td>Adult Protective Services-Provider Investigations</td>
</tr>
<tr>
<td>BCCS</td>
<td>Breast and Cervical Cancer Services</td>
</tr>
<tr>
<td>CAPPS</td>
<td>Centralized Accounting and Payroll/Personnel System</td>
</tr>
<tr>
<td>CCL</td>
<td>Child Care Licensing</td>
</tr>
<tr>
<td>CDC</td>
<td>Cross-Division Coordination</td>
</tr>
<tr>
<td>CDEC</td>
<td>Chief Deputy Executive Commissioner</td>
</tr>
<tr>
<td>CHIP</td>
<td>Children's Health Insurance Program</td>
</tr>
<tr>
<td>CLASS</td>
<td>Child Care Licensing Automated Support System</td>
</tr>
<tr>
<td>COS</td>
<td>Contract Oversight and Support</td>
</tr>
<tr>
<td>COO</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>CPO</td>
<td>Chief Policy Officer (HHSC)</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Name</td>
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<tr>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>CPS</td>
<td>Child Protective Services (DFPS)</td>
</tr>
<tr>
<td>CPSO</td>
<td>Chief Program and Services Officer</td>
</tr>
<tr>
<td>CRID</td>
<td>Consumer Rights-Intellectual Disability</td>
</tr>
<tr>
<td>DADS</td>
<td>Department of Aging and Disability Services</td>
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<tr>
<td>DARS</td>
<td>Department of Assistive and Rehabilitative Services</td>
</tr>
<tr>
<td>DEC</td>
<td>Deputy Executive Commissioner</td>
</tr>
<tr>
<td>DFPS</td>
<td>Department of Family and Protective Services</td>
</tr>
<tr>
<td>DSHS</td>
<td>Department of State Health Services</td>
</tr>
<tr>
<td>FTEs</td>
<td>Full Time Employees</td>
</tr>
<tr>
<td>GAA</td>
<td>General Appropriations Act</td>
</tr>
<tr>
<td>GR</td>
<td>General Revenue</td>
</tr>
<tr>
<td>HB</td>
<td>House Bill</td>
</tr>
<tr>
<td>HCM</td>
<td>Human Capital Management system (CAPPS-HCM)</td>
</tr>
<tr>
<td>HHS</td>
<td>Health and Human Services</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Name</td>
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<td>---------</td>
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</tr>
<tr>
<td>HHSC</td>
<td>Health and Human Services Commission</td>
</tr>
<tr>
<td>HSCS</td>
<td>Health and Specialty Care System</td>
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<tr>
<td>IACs</td>
<td>Interagency Contracts</td>
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<tr>
<td>IDR</td>
<td>Independent Dispute Resolution</td>
</tr>
<tr>
<td>IDD</td>
<td>intellectual or developmental disabilities</td>
</tr>
<tr>
<td>IMPACT</td>
<td>Information Management Protecting Adults and Children in Texas</td>
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<tr>
<td>IT</td>
<td>information technology</td>
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<tr>
<td>LTSS</td>
<td>Long-Term Services and Supports</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MOF</td>
<td>Method of Finance</td>
</tr>
<tr>
<td>MOU</td>
<td>memorandum of understanding</td>
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<td>MSS</td>
<td>Medical &amp; Social Services (HHSC)</td>
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<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
</tr>
<tr>
<td>OO</td>
<td>Office of the Ombudsman</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Name</td>
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</tr>
<tr>
<td>OTI</td>
<td>Office of Transformation and Innovation</td>
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<tr>
<td>PCS</td>
<td>Procurement and Contracting Services</td>
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<tr>
<td>SB</td>
<td>Senate Bill</td>
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<tr>
<td>SCOR</td>
<td>System of Contract Operation and Reporting</td>
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<tr>
<td>SOF</td>
<td>State Operated Facilities</td>
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<td>SSAs</td>
<td>Support Service Agreements</td>
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<td>SSLC</td>
<td>State Supported Living Center</td>
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<td>SSS</td>
<td>System Support Services</td>
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<td>TCCCP</td>
<td>Texas Comprehensive Cancer Control Program</td>
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<td>TLOC</td>
<td>Transition Legislative Oversight Committee</td>
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<td>TRAC</td>
<td>Texas Respite Advisory Committee</td>
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<tr>
<td>TWC</td>
<td>Texas Workforce Commission</td>
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<tr>
<td>WIC</td>
<td>Special Supplemental Program for Women, Infants, and Children</td>
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