
**TEXAS HEALTH AND HUMAN
SERVICES SYSTEM**

2012 REPORT ON CUSTOMER SERVICE

**HEALTH AND HUMAN SERVICES COMMISSION
DEPARTMENT OF AGING AND DISABILITY SERVICES
DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES
DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
DEPARTMENT OF STATE HEALTH SERVICES**

June 2012

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TEXAS HEALTH AND HUMAN SERVICES SYSTEM 2012 REPORT ON CUSTOMER SERVICE

EXECUTIVE SUMMARY

This Texas Health and Human Services System 2012 Report on Customer Service is prepared in accordance with §2114.002 of the Government Code, which requires that Texas state agencies biennially submit to the Governor's Office of Budget, Planning, and Policy and the Legislative Budget Board information gathered from customers about the quality of agency services. This report reflects the cooperative efforts of the five Texas health and human services (HHS) agencies that comprise the HHS system: the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS), the Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS), and the Health and Human Services Commission (HHSC).

In 2010, the HHS system adopted a new system vision that provides a renewed emphasis on customer service. The HHS system vision is: a consumer-focused health and human services system that provides high quality, cost-effective services resulting in improved health, safety, and greater independence for Texans.¹ Several departments exist within the HHS system to ensure that HHS agency operations are consistent with this vision: the HHSC Office of the Ombudsman; the HHSC External Relations Division; and the Centers for Consumer and External Affairs at DADS, DARS, DFPS and DSHS. In addition, one focus of the strategic planning process is to ensure that HHS agency operations are consistent with this vision.

This report is evidence of HHS agencies' continuing interest in the integration and consolidation of services and functions to improve the quality and efficiency of services provided to HHS customers in Texas. It includes 29 surveys conducted by individual HHS agencies representing the opinions and feedback of over 99,000 individuals. HHS agencies are using these customer ratings as they analyze how they can improve their customer service.

Individual Agency Surveys

HHS agencies independently conduct surveys that include questions about customer satisfaction with specific agency programs and services. This report presents the descriptions and major findings of the following surveys.

Department of Aging and Disability Services

- 2010 Long-Term Services and Supports Quality Review
- 2009 Nursing Facility Quality Review

¹ Health and Human Services System Strategic Plan 2013-2017.

Department of Assistive and Rehabilitative Services

- Division for Blind Services: Consumer Service Survey Fiscal Year 2011
- Division for Rehabilitation Services: Vocational Rehabilitation Closed-Case Consumer Satisfaction Survey Fiscal Year 2010 and Fiscal Year 2011
- Division for Rehabilitation Services: Vocational Rehabilitation Open-Case Consumer Satisfaction Survey for Post-Eligibility Consumers Fiscal Year 2011
- Division for Rehabilitation Services: Vocational Rehabilitation Open-Case Consumer Satisfaction Survey for In-Plan Consumers Fiscal Year 2011
- Division for Rehabilitation Services: Independent Living Services Consumer Satisfaction Survey Fiscal Year 2010 and Fiscal Year 2011
- Early Childhood Intervention Family Survey Results Fiscal Year 2011

Department of Family and Protective Services

- Adult Protective Services: Community Satisfaction Survey Fiscal Year 2011
- Childcare Licensing: Inspection Feedback Survey Fiscal Year 2010 and Fiscal Year 2011
- Child Protective Services: Annual Random Youth in Substitute Care Survey Fiscal Year 2010
- Child Protective Services: Contractor Satisfaction Survey 2011

Department of State Health Services

- Division for Regulatory Services Regulatory Licensing Unit: Customer Service Satisfaction Survey Fiscal Year 2011 and Fiscal Year 2012
- Mental Health and Substance Abuse Division: Adult Mental Health Survey Fiscal Year 2011
- Mental Health and Substance Abuse Division: Youth Services Survey for Families Fiscal Year 2011
- Mental Health and Substance Abuse Division: National Association for State Mental Health Program Directors Research Institute/Mental Health Statistics Improvement Project Inpatient Consumer Survey Fiscal Year 2011
- Mental Health and Substance Abuse Division: Mental Health Substance Abuse Stakeholder Survey Fiscal Year 2012
- Mental Health and Substance Abuse Division: MHSA Provider Survey Fiscal Year 2012

Health and Human Services Commission

- Office of Eligibility Services: Customer Service Survey Fiscal Year 2011 and Fiscal Year 2012.
- Children with Special Health Care Needs: Quality of Care in the Medicaid Managed Care and Children's Health Insurance Programs in Texas Fiscal Year 2009 and Fiscal Year 2010.
- The Texas Medicaid STAR+PLUS Program: Adult Member Survey Report Fiscal Year 2010.
- The Texas Children's Health Insurance Program: Established Member Survey Report Fiscal Year 2010.
- The Texas Medicaid STAR Program: Child Behavioral Health Survey Report Fiscal Year 2010.
- The Texas Medicaid STAR Program: Adult Behavioral Health Survey Report Fiscal Year 2010.
- The Texas Primary Care Case Management: Child Member Survey Report Fiscal Year 2011.
- The Texas Medicaid Managed Care: Primary Care Case Management Adult Enrollee Survey Report Fiscal Year 2009.
- The Texas STAR Managed Care Organization: Adult Enrollee Survey Report Fiscal Year 2009.
- The Texas STAR Health: Caregiver Survey Report Fiscal Year 2010.
- The Texas Medicaid STAR Program: Child Survey Report Fiscal Year 2011.

Overall, the HHS system has succeeded in obtaining feedback from a diverse group of customers. Most consumers of services provided positive feedback regarding the services and supports they received through HHS programs. Feedback that identified opportunities for improvement will be focused on in the future. These results support the HHS system vision of providing high quality, cost-effective services resulting in improved health, safety, and greater independence for Texans.

INTRODUCTION

This Texas Health and Human Services System 2012 Report on Customer Service is prepared in accordance with §2114.002 of the Government Code, which requires that Texas state agencies biennially submit to the Governor's Office of Budget, Planning, and Policy and the Legislative Budget Board information gathered from customers about the quality of agency services. This report reflects the cooperative efforts of the five Texas health and human services (HHS) agencies that comprise the HHS system: the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS), the Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS), and the Health and Human Services Commission (HHSC).

The 2003 restructuring of HHS programs and services provided many opportunities for the HHS agencies to consolidate, integrate, and better coordinate an array of administrative and program services under the leadership and oversight of HHSC.² This report is evidence of HHS agencies' continuing interest in integration and consolidation of services and functions to improve the quality and efficiency of services provided to HHS customers in Texas.

Ongoing Customer Service Activities and Functions

In 2010, the HHS system adopted a new vision that provides a renewed emphasis on customer service. The HHS system vision is: a consumer-focused health and human services system that provides high quality, cost-effective services resulting in improved health, safety, and greater independence for Texans.³ Several departments exist within the HHS system to ensure that HHS agency operations are consistent with this vision: the HHSC Office of the Ombudsman; the HHSC External Relations Division; and the Centers for Consumer and External Affairs at DADS, DARS, DFPS and DSHS. In addition, one focus of the strategic planning process is to ensure that HHS agency operations are consistent with this vision.

HHSC Office of the Ombudsman

HHSC's Office of the Ombudsman (OO) assists the public when the agency's normal complaint process cannot or does not satisfactorily resolve issues.⁴ The mission of OO is to serve as an impartial and confidential resource, assisting consumers with HHS-related complaints and issues.

HHSC External Relations Division

² The restructuring was mandated by H.B. 2292, 78th Legislature, Regular Session, 2003.

³ Health and Human Services System Strategic Plan 2011-2015.

⁴ The HHSC Office of the Ombudsman was mandated by H.B. 2292, 78th Legislature, Regular Session, 2003 and established in 2004.

HHSC's External Relations Division (ERD) is responsible for providing information to and responding to requests from elected officials, stakeholders, and HHSC council members. ERD works closely with the OO to ensure close coordination of customer service efforts.

Centers for Consumer and External Affairs

The Centers for Consumer and External Affairs at DADS, DARS, DFPS and DSHS handle customer service functions and ensure the involvement of consumers and stakeholders in improving agency services and communications. The Centers for Consumer and External Affairs work closely with the HHSC OO in an effort to ensure close coordination of ongoing customer service efforts among HHS agencies.

Strategic Planning Process

The system-wide strategic plan facilitates the implementation of the HHS vision using strategic priorities for the HHS system. In the 2011-2015 strategic plan, HHS developed a strategic priority to "deliver the highest quality of customer service." The strategic plan also presented the strategies the system would use for achieving this strategic priority. Throughout fiscal year 2011 and fiscal year 2012 the HHS system agencies implemented these strategies and integrated the new priority into their standard operating policies and procedures.

The strategic planning process involves examining HHS services to ensure they are aligned with the vision and priorities of the system. The array of HHS services is based on the strategic plan. Five appendices to this report present a description of services provided to customers from each agency by strategic plan budget strategy.⁵

Assessing Customer Satisfaction

In 2006 and 2008, HHS agencies worked together to develop a system-wide survey to assess the satisfaction of customers of each HHS agency. In 2006 and 2008, the surveys were comparable and included a unique group of enrollees identified by each agency. The survey questionnaire included questions about service access and choice, staff knowledge, staff courtesy, complaint handling, quality of information and communications, and Internet use.

For the 2010 HHS system customer satisfaction survey, a different approach was taken. HHS agencies collaborated on a system-wide survey of children with special health care needs (CSHCN) enrolled in each HHS agency. CSHCN are defined by the Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau as, "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or

⁵ See Appendix A through Appendix E of this document for Customer Inventories by Agency. This information is presented in accordance with Chapter 2113.002(a) of the Government Code.

amount beyond that required by children generally.”⁶ All five HHS agencies serve CSHCN customers through a variety of programs. The 2010 questionnaire included three HHS agency-specific customer satisfaction questions that were also used in the 2006 and 2008 customer satisfaction surveys: 1) overall satisfaction with the benefits or services received from the agency; 2) the difficulty customers had in getting needed benefits or services; and 3) the length of time customers waited to receive benefits or services.⁷ The latter two questions were selected because results from the 2008 survey showed that a lower proportion of customers were satisfied with these aspects of service delivery.

For the 2012 Report on Customer Service, each HHS agency provided the results of independent customer surveys for specific agency programs. HHS agencies independently conduct surveys that include questions about customer satisfaction with specific agency programs and services. Some surveys focus entirely on customer satisfaction while others include customer satisfaction as one of several service categories being assessed. This report presents the descriptions and major findings of the following surveys that cover customer satisfaction.

Department of Aging and Disability Services

- **2010 Long-Term Services and Supports Quality Review.** The Long-Term Services and Supports Quality Review (LTSSQR), an in-person interview-based survey, was conducted from December 2008 through March 2009 with individuals or their legally authorized representatives who were identified as receiving long-term services and supports in December 2008. The purpose of the LTSSQR was to assess customer perception of the quality of long-term services and supports administered by DADS and trends in long-term services and supports over time.
- **2009 Nursing Facility Quality Review.** The Nursing Facility Quality Review (NFQR), a chart review and in-person interview-based survey, was conducted from March 2009 through May 2009 with individuals living in Medicaid-certified nursing facilities in Texas during those months. The purpose of the NFQR was to benchmark and trend the quality of care and the quality of life for individuals who reside in nursing facilities across the state.

Department of Assistive and Rehabilitative Services

- **Division for Blind Services: Consumer Service Survey Fiscal Year 2011.** The Consumer Service Survey, a telephone-based survey, was conducted on a quarterly basis during fiscal year 2011 with individuals who completed services in the Vocational Rehabilitation, Independent Living, or Blind Children’s Vocational Discovery and Development program. The purpose of this survey was to assess the level of consumer satisfaction in terms of

⁶ U.S. Department of Health and Human Services. The National Survey of Children with Special Healthcare Needs Chart Book (<http://mchb.hrsa.gov/cshcn05/>). Last viewed 3/28/2012.

⁷ These agency-specific questions are part of a larger survey about how well available services meet the needs of CSHCN. The larger survey is an adapted version of two surveys used nationally: the National Survey of Children with Special Health Care Needs and the PedsQL. The survey was conducted by the University of North Texas Survey Research Center. The full report is available from the HHSC Center for Strategic Decision Support.

interaction with Division for Blind Services (DBS) staff and the quality and effectiveness of the services they received.

- **Division for Rehabilitation Services: Vocational Rehabilitation Closed-Case Consumer Satisfaction Survey Fiscal Year 2010 and Fiscal Year 2011.** The Vocational Rehabilitation Closed-Case Consumer Satisfaction Survey, a telephone-based survey, was conducted in fiscal year 2010 and fiscal year 2011 with Vocational Rehabilitation consumers whose cases were closed. The purpose of this survey was to provide Division for Rehabilitation Services (DRS) management and staff with ongoing feedback from Vocational Rehabilitation (VR) consumers in order to identify strengths and weaknesses, to develop strategies on providing excellent services to consumers, and to determine areas of needed improvement.
- **Division for Rehabilitation Services: Vocational Rehabilitation Open-Case Consumer Satisfaction Survey for Post-Eligibility Consumers Fiscal Year 2011.** The Vocational Rehabilitation Open-Case Consumer Satisfaction Survey, a telephone-based survey, was conducted in fiscal year 2011 to a stratified sample of current VR consumers who were determined eligible for services but for whom a signed Individualized Plan for Employment was not yet in place. The purpose of this survey was to provide DRS management and staff with ongoing feedback from VR consumers in order to identify strengths and weaknesses, to develop strategies on providing excellent services to consumers, and to determine areas of needed improvement.
- **Division for Rehabilitation Services: Vocational Rehabilitation Open-Case Consumer Satisfaction Survey for In-Plan Consumers Fiscal Year 2011.** The Vocational Rehabilitation Open-Case Consumer Satisfaction Survey for In-Plan Consumers, a telephone-based survey, was conducted in fiscal year 2011 to a stratified sample of current VR consumers who were currently receiving services at any point from the signing of an Individualized Plan for Employment until their cases are about to be closed. The purpose of this survey was to provide DRS management and staff with ongoing feedback from VR consumers in order to identify strengths and weaknesses, to develop strategies on providing excellent services to consumers, and to determine areas of needed improvement.
- **Division for Rehabilitation Services: Independent Living Services Consumer Satisfaction Survey Fiscal Year 2010 and Fiscal Year 2011.** The Independent Living Services Consumer Satisfaction Survey, a telephone-based survey, was conducted in fiscal year 2010 and fiscal year 2011 to a sample of Independent Living Services consumers whose cases were closed “successful” or “unsuccessful” with a plan during the fiscal year. The purpose of this survey was to provide DRS management and staff with ongoing feedback from Independent Living Services consumers in order to identify strengths and weaknesses, to develop strategies on providing excellent services to consumers, and to determine areas of needed improvement.
- **Early Childhood Intervention Family Survey Fiscal Year 2011.** The Early Childhood Intervention (ECI) Family Survey, a paper-based survey, was distributed by service coordinators during a home visit in February 2011 to the parents of children enrolled in the DARS ECI program during fiscal year 2011. The purpose of this survey was to assess how helpful services are for families and their child enrolled in the ECI program, families’ ability to access other services and supports, and families’ competencies in helping their child develop and learn.

Department of Family and Protective Services

- **Adult Protective Services: Community Satisfaction Survey Fiscal Year 2011.** The Community Satisfaction Survey, a web- and mail-based survey, was distributed in 2011 to members of the judiciary, law enforcement agencies, community organizations and resource groups, and Adult Protective Services (APS) community boards. The purpose of this survey was to assess overall community engagement efforts and to gather information on DFPS performance in providing investigative and protective services for adults.
- **Childcare Licensing: Inspection Feedback Survey Fiscal Year 2010 and Fiscal Year 2011.** The Inspection Feedback Survey, a mixed-mode survey (web, mail, and in-person), was distributed from January through December 2011 to providers of substitute care for children ages 0-13 years. The purpose of the Inspection Feedback Survey was to assess how professional, courteous, and helpful inspectors were with childcare and child-placing agencies; provide an outlet for childcare and child-placing agencies to document any non-regulatory concerns about an inspection or investigation; and to demonstrate that DFPS is committed to professional regulatory work.
- **Child Protective Services: Annual Random Youth in Substitute Care Survey Fiscal Year 2010.** The Annual Random Youth in Substitute Care Survey, a telephone survey, was administered from June through October 2010 to a random sample of youth ages 14 to 17 who receive substitute care services through Child Protective Services (CPS). The purpose of this survey was to rate the quality of the services youth received while in substitute care, receive suggestions for improving these services, and obtain data about their experiences with education, employment, homelessness, substance abuse services, and incarceration.
- **Child Protective Services: Contractor Satisfaction Survey 2011.** The Contractor Satisfaction Survey, a mail-based survey, was distributed from January through December 2011 to Purchased Client Services providers in CPS. The purpose of this survey was to obtain contractor feedback in order to improve the contactor monitoring experience.

Department of State Health Services

- **Division for Regulatory Services Regulatory Licensing Unit: Customer Service Satisfaction Survey Fiscal Year 2011 and Fiscal Year 2012.** The Customer Service Satisfaction Survey, an ongoing web-based survey, was launched in January 2011 on the DSHS Division for Regulatory Services website. The purpose of this survey was to measure real-time customer perceptions of DSHS including staff, forms and instructions, and the application process.
- **Mental Health and Substance Abuse Division: Adult Mental Health Survey Fiscal Year 2011.** The Adult Mental Health Survey, a mail-based survey, was distributed in May 2011 to a random sample of consumers aged 18 years or older who received a recent mental health service beyond an intake assessment. The purpose of this survey was to measure customer perceptions and satisfaction with mental health services received through the state's network of mental health care providers.

- **Mental Health and Substance Abuse Division: Youth Services Survey for Families Fiscal Year 2011.** The Youth Services Survey for Families, a mail-based survey, was distributed in April 2011 to the parents of a random sample of consumers aged 17 years or younger who received a recent mental health service beyond an intake assessment. The purpose of this survey was to measure parental perceptions and satisfaction with mental health services received through the state’s network of mental health providers.
- **Mental Health and Substance Abuse Division: National Association for State Mental Health Program Directors Research Institute/Mental Health Statistics Improvement Project Inpatient Consumer Survey Fiscal Year 2011.** The National Association for State Mental Health Program Directors Research Institute (NRI)/Mental Health Statistics Improvement Project (MHSIP) Inpatient Consumer Survey, a paper-based survey, was distributed to every client who was discharged from a state mental hospital in fiscal year 2011. The purpose of this survey was to measure their experience in the state mental hospital including their experience with staff, treatment, and the facility. It also measures the client’s participation in their treatment and their ability to function after leaving the hospital.
- **Mental Health and Substance Abuse Division: Mental Health Substance Abuse Stakeholder Survey Fiscal Year 2012.** The Mental Health Substance Abuse (MHSA) Stakeholder Survey, a web-based survey, was distributed to all stakeholders who subscribe to the government delivery notices for MHSA news updates in November 2011. The purpose of this survey was to obtain input on improving general and focused communication efforts with individuals engaged in internal and external stakeholder groups.
- **Mental Health and Substance Abuse Division: Mental Health Substance Abuse Provider Survey Fiscal Year 2012.** The MHSA Provider Survey, a mail-based survey, was distributed to 300 MHSA-funded providers in November 2011. The purpose of this survey was to obtain input on improving general and focused communication efforts with DSHS/MHSA-funded substance abuse and mental health providers.

Health and Human Services Commission

- **Office of Eligibility Services: Customer Service Survey Fiscal Year 2011 and Fiscal Year 2012.** The Office of Eligibility Services (OES) Customer Service Survey, a mail-based survey, was distributed in October 2010, June 2011, and November 2011 to every OES client that visited an eligibility office during the survey periods. The purpose of this survey was to assess the quality of service and satisfaction with wait times.
- **Children with Special Health Care Needs: Quality of Care in the Medicaid Managed Care and Children’s Health Insurance Programs in Texas Fiscal Year 2009 and Fiscal Year 2010.** This telephone-based survey was conducted from September 2008 through August 2010 with families of CSHCN enrolled in the State of Texas Access Reform (STAR), Primary Care Case Management (PCCM), STAR Health, the Children’s Health Insurance Program (CHIP), and CSHCN Services (Title V) programs during fiscal year 2009 and fiscal year 2010. The purpose of this survey was to provide demographic and health status information, including estimates of the numbers of CSHCN in each program, clinical risk group (CRG) classifications, and to assess parent-reported quality of life.

- **The Texas Medicaid STAR+PLUS Program: Adult Member Survey Report Fiscal Year 2010.** This telephone-based survey was conducted from June through November 2010 with adult members of the STAR+PLUS program who had been enrolled in STAR+PLUS for at least nine months. The purpose of this survey was to gather information about the health care experiences of adults enrolled in the program.
- **The Texas Children’s Health Insurance Program: Established Member Survey Report Fiscal Year 2010.** This telephone-based survey was conducted from November 2009 through April 2010 with families of children enrolled in CHIP in Texas. The purpose of the survey was to provide a demographic and health profile of the children enrolled in CHIP, to assess parents’ experience and satisfaction with their child’s health care, to compare findings across the 17 health plans participating in CHIP, and to compare findings to the CHIP Established Member Survey fiscal year 2008.
- **The Texas Medicaid STAR Program: Child Behavioral Health Survey Report Fiscal Year 2010.** This telephone-based survey was conducted from February 2009 through February 2010 with the parents or caregivers of children enrolled in STAR who had been diagnosed with a behavioral health condition in the past 12 months. The purpose of this survey was to assess parents’ experiences and satisfaction with their child’s behavioral health care, and to compare findings across behavioral health delivery models.
- **The Texas Medicaid STAR Program: Adult Behavioral Health Survey Report Fiscal Year 2010.** This telephone-based survey was conducted from September 2008 through February 2010 with adults enrolled in STAR who had been diagnosed with a behavioral health condition in the past 12 months. The purpose of this survey was to assess adult members’ experiences and satisfaction with their behavioral health care, and to compare findings across behavioral health delivery models.
- **The Texas Primary Care Case Management: Child Member Survey Report Fiscal Year 2011.** This telephone-based survey was conducted from May through July 2011 with families of children enrolled in PCCM. The purpose of this survey was to provide a demographic and health profile of children enrolled in the Texas PCCM program, and to assess caregivers’ experiences and satisfaction with their children’s health care.
- **The Texas Medicaid Managed Care: Primary Care Case Management Adult Enrollee Survey Report Fiscal Year 2009.** This telephone-based survey was conducted from November 2008 and June 2009 with adults enrolled in the PCCM program. The purpose of this survey was to provide a demographic and health profile of adults enrolled in the PCCM program, and to assess enrollees’ experience and satisfaction with their health care.
- **The Texas STAR Managed Care Organization: Adult Enrollee Survey Report Fiscal Year 2009.** This telephone-based survey was conducted from November 2009 through June 2009 with adults enrolled in the Texas STAR program. The purpose of this survey was to provide a demographic and health profile of adults enrolled in the Texas STAR program, and to assess members’ experience and satisfaction with their health care across the 23 managed care organization/service delivery area (MCO/SDA) groups participating in STAR.
- **The Texas STAR Health: Caregiver Survey Report Fiscal Year 2010.** This telephone-based survey was conducted from December 2009 through February 2010 with the caregivers of foster care children enrolled in STAR Health for at least six months. The purpose of this

survey was to provide a demographic and health profile of children enrolled in STAR Health, to assess caregivers' experiences and satisfaction with their children's health care, to assess changes in enrollee demographics and health status, and to assess caregiver experiences and satisfaction since the STAR Health Foster Care Caregiver Transition Survey fiscal year 2009.

- **The Texas Medicaid STAR Program: Child Survey Report Fiscal Year 2011.** This telephone-based survey was conducted from September 2010 through February 2011 with the caregivers of children enrolled in Texas STAR for at least six months. The purpose of this survey was to describe the demographic and household characteristics of child members and their families and to assess the health status of the population, including children with special health care needs. The survey was also designed to document caregiver experiences and general satisfaction with the care their children receive through STAR across four domains of care: the utilization of services, utilization of emergency services; and access to and timeliness of care.

REPORT FORMAT

This Texas Health and Human Services System 2012 Report on Customer Service presents summaries of the results of customer surveys conducted by DADS, DARS, DFPS, DSHS, and HHSC. Each summary includes the sample and methodology of the survey, the main findings and, if available, a link to the full report. These results present important information about customer satisfaction with services provided by HHS agencies.

Appendix F presents a glossary of acronyms used in this report.

DEPARTMENT OF AGING AND DISABILITY SERVICES

The 81st Texas Legislature appropriated funds for the Department of Aging and Disability Services (DADS) to assess the satisfaction and quality of care, and the quality of life of individuals who reside in nursing facilities and individuals who receive other long-term services and supports.⁸ Data collected from individuals were published in the two most current quality reviews: the 2010 Long-Term Services and Supports Quality Review (LTSSQR) and the 2009 Nursing Facility Quality Review (NFQR). Data from these reviews were presented in the Texas Health and Human Services System 2010 Report on Customer Service

Funds are appropriated for quality reviews every other year. Therefore, quality review reports are published every other year. The 82nd Texas Legislature appropriated funds for quality reviews to be conducted with individuals who reside in nursing facilities and individuals who receive other long-term services and supports.⁹ As with previously published quality reviews, the surveys will ask individuals to assess their satisfaction with their quality of care and quality of life. DADS will publish data collected from these surveys in 2013. Responses from individuals who reside in nursing facilities will be reported in the 2012 NFQR. Results from the survey of individuals who receive other long-term services and supports will be reported in the 2012 LTSSQR. The results from the 2013 LTSSQR and 2012 NFQR will be presented in the Texas Health and Human Services System 2014 Report on Customer Service.

The two reports discussed below are the two most current quality reviews: the 2010 LTSSQR and the 2009 NFQR, which provide customer satisfaction data for over 7,300 individuals receiving long-term services and supports or who are living in a Medicaid-certified nursing facility.

Survey Strategy

DADS takes a comprehensive and robust approach to assessing customer satisfaction across the service delivery spectrum. In 2009, DADS surveyed 5,332 individuals from 11 long-term services and supports programs and 2,164 individuals who resided in one of the 1,048 Medicaid-certified nursing facilities in Texas.

In order to assess the quality of life of older individuals who reside in nursing facilities, DADS adopted an instrument that was developed in 1998 by the University of Minnesota School of Public Health.¹⁰ The survey emphasized the psychological and social aspects of quality of life. DADS modified the survey by including questions about quality of care, in addition to questions about quality of life. This survey has been found to be reliable and valid in assessing customer service in long-term services and supports programs.

⁸ 2010-11 General Appropriations Act, S.B. 1, 81st Legislature, Regular Session, 2009 (Article II, Department of Aging and Disability Services, Rider 13).

⁹ 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session 2011 (Article II, Department of Aging and Disability Services, Rider 13).

¹⁰ Kane, R. A. (2003). Measures, indicators, & improvement of quality of life in nursing homes: Quality of life scales for nursing home residents. Retrieved from http://www.hpm.umn.edu/ltrsourcecenter/research/QOL/QOL_of_Scales_and_how_to_use_them.pdf.

Surveys are mailed to individuals to complete, administered in face-to-face interviews, or are done by reviewing medical charts or assessments of individuals who reside in nursing facilities. DADS draws statistically valid sample sizes that are representative of the people in each program so that the agency can confidently draw conclusions about the individuals in each program.

The sampling approach and survey instruments DADS uses helps the agency ensure that high quality data are obtained so that improvements and opportunities to improve customer service and quality of service can be identified.

2009 Long-Term Services and Supports Quality Review

Purpose

This report presents the results of the 2010 LTSSQR, which consisted of in-person interviews conducted from December 2008 to March 2009 with individuals, or their legally authorized representatives, who were identified as receiving long-term services and supports in December 2008. The purpose of the LTSSQR was to:

- inquire about customers' perceptions of the quality of long-term services and supports administered by DADS, and
- trend satisfaction results for long-term services and supports over time.

Data represent the following programs:

- Community-Based Alternatives (CBA) - Consumer Directed Services (CDS) and non-CDS option
- Community Living Assistance and Support Services (CLASS) - CDS and non-CDS
- Consolidated Waiver Program (CWP)
- Deaf Blind with Multiple Disabilities (DBMD)
- Home and Community-Based Services (HCS)
- Large Intermediate Care Facilities for People with Intellectual or Developmental Disabilities (ICFs/ID)
- Small or Medium ICFs/ID
- State Supported Living Centers (SSLCs)
- Texas Home Living Waiver (TxHmL)

What follows is a summary of the results from the 2010 LTSSQR. The full report is available at http://www.dads.state.tx.us/news_info/publications/legislative/ltssqr2010/ltssqr-2010.pdf.

Sample and Methodology

Individuals eligible for inclusion in the sample were those who were identified as receiving long-term services and supports in December 2008 and who were enrolled in one of the programs listed above.

A random sample was drawn and stratified by county. The sample was sufficient to achieve a 95 percent confidence level and 5 percent confidence interval for each program.

Individuals received one of two LTSSQR surveys: the National Core Indicators (NCI) Adult Consumer Survey or the Participant Experience Survey (PES). Families of children receiving services had the opportunity to respond to the NCI Child and Family Survey about the family's satisfaction with services.

Eighty-two percent of people randomly selected participated by completing a survey. The 2010 LTSSQR reports on data collected from 5,332 adults. Of the 5,332 surveys completed, 5,178 were validated and used for analyses.

Summary of Major Findings

General observations for the 2010 LTSSQR include:

- Long-term services and supports facilitate personal goals, health, and well-being.¹¹
 - Ninety-four percent to 99 percent of people reported that their services and supports addressed their health and well-being.
 - Eighty-nine percent to 98 percent of people reported that their services and supports helped them achieve their personal goals.
- Most people received the services they needed and were satisfied with information about how to access services and supports.¹²
 - Seventy-six percent to 98 percent of people reported that they received the services they needed.
 - Eighty-six percent to 96 percent of people reported being satisfied with information received about how to apply for services.
 - Eighty-seven percent to 97 percent of people reported being satisfied with information received about available services.
- At least three out of four people reported feeling happy.¹³

¹¹ Finding applies to 2009 data for CBA (non-CDS), CLASS (non-CDS), CWP, DBMD, HCS, TxHmL, small or medium ICFs/ID, large ICFs/ID, and SSLCs.

¹² Finding applies to 2009 data for CLASS (non-CDS), CWP, DBMD, HCS, TxHmL, small or medium ICFs/ID, large ICFs/ID, SSLCs.

¹³ Finding applies to 2009 data for CLASS (non-CDS), CWP, DBMD, HCS, TxHmL, small or medium ICFs/ID, large ICFs/ID, and SSLCs.

- Many people reported feeling lonely often.¹⁴ This finding was consistent with findings from a 2007 study on people from five states who reported feeling lonely often (Stancliffe et al., 2007).¹⁵

The following improvements ($p \leq .01$) in services and supports were observed across programs over time:

- Access to transportation.¹⁶
- Autonomy to use the phone whenever the person wanted.¹⁷
- Choice to decide how to spend free time.¹⁸

The following opportunities for improvement were observed across programs:

- Access to timely preventive care.¹⁹
- Autonomy to take risks.²⁰
- Choice of staff²¹ or case manager.²²
- Control over transportation²³ and spending money.²⁴
- Privacy when visiting with guests.²⁵

The following trends were observed ($p \leq .01$):

- The percentage of people who participated in self-advocacy activities increased from 2005 to 2009.²⁶
- The percentage of people who reported having a physical disability increased over time.²⁷
- Data suggest that people who used CDS in either CBA or CLASS, compared to those who did not use CDS, had a higher degree of awareness about choosing the staff that helps them and chose their own staff.²⁸

¹⁴ Finding applies to 2009 data for CLASS (non-CDS), CWP, DBMD, HCS, TxHmL, small or medium ICFs/ID, large ICFs/ID, and SSLCs.

¹⁵ Stancliffe et al. (2007). Loneliness and living arrangements. *Intellectual and Developmental Disabilities*, 45(6), 380-390.

¹⁶ Finding applies to CBA (non-CDS) and HCS trend data.

¹⁷ Finding applies to CWP, HCS, SSLCs, and TxHmL trend data.

¹⁸ Finding applies to DBMD, small or medium ICF/ID, SSLCs, and TxHmL trend data.

¹⁹ Finding applies to HCS, large ICF/ID, small or medium ICF/ID, and SSLC trend data.

²⁰ Finding applies to large ICF/ID and TxHmL trend data.

²¹ Finding applies to CLASS (non-CDS), HCS, and CLASS (CDS) trend data.

²² Finding refers to CLASS (non-CDS), small or medium ICFs/ID, TxHmL, and CLASS (CDS) trend data.

²³ Finding applies to CLASS (non-CDS), HCS, small or medium ICFs/ID, TxHmL, and CLASS (CDS) trend data.

²⁴ Finding applies to CLASS (non-CDS), HCS, small or medium ICFs/ID, SSLCs, and CLASS (CDS) trend data.

²⁵ Finding applies to CLASS (non-CDS), HCS, and TxHmL trend data.

²⁶ Finding applies to HCS, large ICFs/ID, small or medium ICFs/ID, and SSLC trend data.

²⁷ Finding applies to large ICF/ID and SSLC trend data.

²⁸ Finding applies to 2009 data and trend data for CBA and CLASS.

2009 Nursing Facility Quality Review

Purpose

This report presents the results of the 2009 NFQR conducted from March 2009 through May 2009 with individuals living in Medicaid-certified nursing facilities in Texas during those months. The NFQR consists of in-person interviews and chart reviews of randomly selected people living in nursing facilities. The purpose of the NFQR was to benchmark and trend the quality of care and the quality of life for individuals in nursing facilities across the state. NFQR data collected over time helps DADS to:

- track progress in quality improvement activities, and
- formulate strategies to improve both the quality of long-term services and supports and clinical outcomes of individuals.

What follows is a summary of the results from the 2009 NFQR. The full report is available at http://www.dads.state.tx.us/news_info/publications/legislative/nfqr2009/nfqr-2009.pdf.

Sample and Methodology

The sample size was based on the proportion of individuals per facility over the fourth quarter of calendar year 2008 and each individual had an equal chance of being selected into the sample.

To be eligible for inclusion in the sample, an individual (including those with Medicare, Medicaid or any other payer source) had to be living in one of the 1,048 Medicaid-certified nursing facilities in Texas when the survey was conducted (from March 2009 through May 2009).

At each nursing facility, a contracted interviewer from Nurse Aid Competency Evaluation Services (NACES) Plus Foundation, Inc. randomly selected a predetermined number of individuals to participate in the survey. In total, 2,164 individuals were randomly selected, assessed, and interviewed.

Summary of Major Findings

Observed improvements from 2008 to 2009 include the following:

- More individuals that were incontinent had a continence promotion plan.
- More individuals had treatment plans for repositioning to address risk factors related to pressure ulcers.
- More care plans addressed risk factors for pressure ulcers.
- More individuals were assessed using a valid pain assessment tool and were assessed daily.
- More individuals received the influenza and pneumococcal vaccinations.

- More individuals received care consistent with advance directives.
- More advance care plans addressed artificial nutrition and hydration.
- More individuals were assessed for risk factors for weight loss and dehydration.
- More individuals had clinical indications for prescribed typical antipsychotics.
- More individuals felt safe and secure and that their possessions were safe.

Observed declines from 2008 to 2009 include:

- More individuals had urinary tract infections.
- Fewer individuals diagnosed with an anxiety disorder had an ongoing symptom assessment every two weeks.
- More individuals on sleep medication reported continued sleep problems.
- Fewer individuals could make a private phone call.
- Fewer individuals could find a place to visit in private.

DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES

The Department of Assistive and Rehabilitative Services (DARS) submitted six reports of findings from customer satisfaction surveys for this report. Over 19,000 responses to these surveys were received. Individuals surveyed included consumers of Vocational Rehabilitation (VR), Independent Living Services (ILS), Blind Children's Vocational Discovery and Development Program (BCVDDP), and Early Childhood Intervention (ECI) services.

Division for Blind Services Consumer Service Survey September 2010 to August 2011

Purpose

The information reported below presents the results of a quarterly consumer satisfaction survey for three Division for Blind Services (DBS) programs: VR, ILS, and BCVDDP.

The purpose of this survey was to:

- assess the level of satisfaction that consumers report in terms of interactions with DBS staff members, and
- assess consumers' satisfaction with the services they received.

Sample and Methodology

To be eligible for inclusion in the survey, the consumer's case must have been closed (either successfully or unsuccessfully) after receiving services under a plan of services. This criterion was chosen to ensure that consumers fully understood the scope of the program and the intent of services at the time they were surveyed.

Because of the relatively small size of these programs, attempts were made to contact every eligible consumer rather than selecting a sample. The surveys were conducted by phone to increase the percentage of consumers responding to the survey. This is particularly important to the specific population served by DBS since most consumers have difficulty reading printed material and would be less likely to respond to a survey sent by mail.

Consumers were contacted by phone by an independent contractor between September 2010 and August 2011. The survey instrument contained 11 questions.

The survey was administered to:

- 1,140 VR consumers,
- 812 ILS consumers, and
- 81 BCVDDP consumers (or their family member).

The response rate across all programs was approximately 50 percent.

Summary of Major Findings

- Ninety-eight percent of respondents felt their overall experience with DBS was satisfactory or very satisfactory.
- Ninety-nine percent of respondents felt they were treated with courtesy and respect by DBS staff.
- Ninety-nine percent of respondents felt they had increased skills and abilities because of the assistance received from DBS.
- Ninety-eight percent of respondents felt the services were provided in a reasonable amount of time.

Division for Rehabilitation Services Vocational Rehabilitation Closed-Case Consumer Satisfaction Survey

Purpose

The information reported below presents the results of a survey of consumers who were recently closed from services from the Division for Rehabilitation Services (DRS) VR program.

The purpose of this survey was to provide DRS ongoing feedback from consumers in order to:

- identify strengths and weaknesses of the program,
- develop strategies on providing excellent services to consumers, and
- determine areas of needed improvement.

Additionally, the report complied with federal program requirements that VR programs must have a survey mechanism in place to obtain satisfaction feedback from its consumers. It also provided the state rehabilitation council (the Rehabilitation Council of Texas) regular reports to assist it in fulfilling its requirements to review and analyze consumer satisfaction with VR agency functions, VR services provided by DRS, and employment outcomes achieved by eligible individuals served by VR.

Sample and Methodology

All VR consumers who had a plan and whose cases were closed “successful” or “unsuccessful” during the fiscal year were included in this ongoing survey.

Each month, the list of closed cases was sent to the survey contractor, PVT NuStats. The contractor contacted each consumer on the list to conduct the survey over the phone. The instrument used for the fiscal year 2010 and fiscal year 2011 Vocational Rehabilitation Consumer Satisfaction Surveys contained 20 closed-ended questions and 1 open-ended question.

For the fiscal year 2010 Vocational Rehabilitation Closed-Case Consumer Satisfaction Survey, a total of 14,354 VR closure records were forwarded to the contracted survey vendor. From the pool of closure records, 7,084 surveys were completed for a response rate of 49 percent.

For the fiscal year 2011 Vocational Rehabilitation Closed-Case Consumer Satisfaction Survey, the size of the closed-case consumer satisfaction survey sample was reduced to accommodate the implementation of two new open-case consumer satisfaction surveys without increasing the survey budget. The sample methodology was amended, requiring the survey vendor to develop and survey a capped stratified sample from a pool of VR closure records forwarded to the vendor. A total of 4,029 surveys were completed by consumers whose cases were closed in fiscal year 2011. With the current sample process, response rate is not reported as in the past because the vendor is now given a cap on the number of consumers to survey and a sufficiently large sample pool is pulled to allow the vendor to survey enough consumers to achieve that target number. Because the final results for fiscal year 2011 had not been received at the time this report was initiated, only preliminary results for fiscal year 2011 are presented.

Summary of Major Findings

Results from the Vocational Rehabilitation Closed-Case Consumer Satisfaction Survey were compared to similar data from the Gallup poll. In 2010, the percent of VR consumers who responded that they were “very satisfied” or “somewhat satisfied” with their job was 85 percent, which is similar to the percent who were “completely satisfied” or “somewhat satisfied” in the Gallup poll for the same year. This comparison supports the conclusion that the rate of job satisfaction among DRS closed consumers in 2010 was similar to the job satisfaction of the general workforce in the same year as reported in the Gallup survey.

Key findings of the fiscal year 2010 survey include:

- Eighty-five percent of respondents reported that they were satisfied with the explanation of services to help them reach their goal (2.4 percent increase from fiscal year 2009).
- Sixty-four percent of respondents reported that they were satisfied with their chance for advancement (3 percent decrease from fiscal year 2009).
- Seventy-four percent of respondents reported satisfaction with their wages (2.6 percent decrease from fiscal year 2009).
- Eighty-five percent of respondents reported overall satisfaction with their job (2.3 percent decrease from fiscal year 2009).

With regard to the open-ended question, “Based on your experience, what could DRS do to improve services?” the theme that occurred most frequently in the 2010 responses concerned:

- “service issues – employment” (17.4 percent),
- “client contact issues – other” (12.7 percent),
- “VRC interpersonal skills” (9.3 percent),
- “service issues – other” (9 percent), and

- “policy and procedure issues” (8.6 percent).

The dominant theme in employment issues was jobs – finding a job, finding a better job, better paying jobs, more job alternatives, and similar suggestions and requests.

The final analysis report for fiscal year 2011 had not yet been received when this report was submitted as Gallup numbers were not yet available for comparison purposes. However, preliminary results reveal the following findings.

- Fifty-five percent of the respondents expressed satisfaction with employee benefits, compared to 51 percent in the 2010 survey.
- Seventy-seven percent of the respondents expressed satisfaction with wages, compared to 74 percent in the 2010 survey.
- Seventy-nine percent of the respondents reported that DRS returned their telephone calls no later than the next business day, compared to 76 percent in the 2010 survey.
- Compared to the 2010 survey, there was no statistically significant (2 percent or more) decrease in satisfaction for any surveyed subject area.

Division for Rehabilitation Services Vocational Rehabilitation Open-Case Consumer Satisfaction Survey for Post-Eligibility Consumers

Purpose

The information reported below presents the results of a survey of open-case consumers of the DRS VR program who had not yet developed a signed Individualized Plan for Employment.

The purpose of this survey was to provide DRS management and staff ongoing feedback from consumers at the beginning of their experience as consumers of DRS in order to:

- identify strengths and weaknesses,
- develop strategies on providing excellent services to consumers, and
- determine areas of needed improvement.

This report also complied with federal program requirements that VR program must have a survey mechanism in place to obtain satisfaction feedback from its consumers. It also provided the state rehabilitation council (the Rehabilitation Council of Texas) regular reports to assist it in fulfilling its requirements to review and analyze consumer satisfaction with VR agency functions and VR services provided by DRS.

Sample and Methodology

The sample included current VR consumers who were eligible for services but for whom a signed Individualized Plan for Employment was not yet in place.

Each month, a file of all cases in the post-eligibility phase of development was sent to the survey contractor, PVT NuStats. From this pool of cases, the contractor surveyed a capped stratified sample of consumers based on instructions from DRS. The sample was stratified by the HHS region and randomly drawn with the same proportion as the sample frame so the distribution of each month's sample by region matched the universe of consumers. For example, if 30 percent of closed cases were from Region 1, then the sample would have 30 percent from Region 1, selected randomly. The randomization was done in IBM SPSS Statistics software by assigning random numbers to each case and selecting a certain groups of numbers based on the region proportions.

This survey instrument, newly implemented in fiscal year 2011, contained ten closed-ended questions and one open-ended question.

A total of 1,377 surveys were completed by consumers whose cases were in the post-eligibility phase in fiscal year 2011.

Summary of Major Findings

The final analysis report for fiscal year 2011 had not yet been received as Gallup numbers were not yet available for comparison purposes at the time of this report. However, a cumulative detail report reveals that consumer satisfaction tends to increase as consumers move forward in the rehabilitation process. The lowest consumer satisfaction ratings of all three surveys are from consumers in the post-eligibility phase, suggesting that some consumers may become discouraged with the slowness of the eligibility process.

Division for Rehabilitation Services Vocational Rehabilitation Open-Case Consumer Satisfaction Survey for In-Plan Consumers

Purpose

The information reported below presents the results of a survey of open-case consumers of the DRS VR program who had a signed Individualized Plan for Employment in place.

The purpose of this survey was to provide DRS management and staff ongoing feedback from consumers throughout their experience as consumers of DRS in order to:

- identify strengths and weaknesses,
- develop strategies on providing excellent services to consumers, and
- determine areas of needed improvement.

The report also complied with the federal program requirements that VR program must have a survey mechanism in place to obtain satisfaction feedback from its consumers. It also provided the state rehabilitation council (the Rehabilitation Council of Texas) regular reports to assist it in

fulfilling its requirements to review and analyze consumer satisfaction with VR agency functions and VR services provided by DRS.

Sample and Methodology

The sample included current VR consumers who were currently receiving services at any point from the signing of an Individualized Plan for Employment until their cases were about to be closed.

Each month, a file of all cases in the in-plan phase of development was sent to the survey contractor, PVT NuStats. From this pool of cases, the contractor surveyed a capped stratified sample of consumers based on instructions from DRS. The sample was stratified by HHS regions and were randomly drawn with the same proportion as the sample frame so the distribution of each month's sample by region matched the universe of consumers. For example, if 30 percent of closed cases were from Region 1, then the sample would have 30 percent from Region 1, selected randomly. The randomization was done in IBM SPSS Statistics software by assigning random numbers to each case and selecting a certain groups of numbers based on the region proportions.

This survey instrument, newly implemented in fiscal year 2011, contained 18 closed-ended questions and 1 open-ended question.

A total of 2,723 surveys were completed by consumers whose cases were in the in-plan phase in fiscal year 2011.

Summary of Major Findings

The final analysis report for fiscal year 2011 had not yet been received as Gallup numbers were not yet available for comparison purposes at the time of this report. However, a cumulative detail report reveals that consumer satisfaction tends to increase as consumers move forward in the rehabilitation process. The lowest consumer satisfaction ratings of all three surveys are from consumers in the post-eligibility phase, suggesting that consumers may become discouraged with the slowness of the eligibility process. Satisfaction ratings increase as consumers become more engaged with the rehabilitation process during the in-plan phase. The highest ratings are from consumers whose cases have been closed.

Division for Rehabilitation Services Independent Living Services Consumer Satisfaction Survey

Purpose

The information reported below presents the results of a survey of consumers of the DRS ILS program who had a plan and whose cases were closed.

The purpose of this survey was to provide DRS management and staff members ongoing feedback from ILS consumers in order to:

- identify strengths and weaknesses,
- develop strategies on providing excellent services to consumers, and
- determine areas of needed improvement.

This report also complied with the federal program requirements that ILS program must have a survey mechanism in place to obtain satisfaction feedback from its consumers. Additionally, this report provided the state Independent Living Council information to assist it in fulfilling its requirements to review and analyze consumer satisfaction with the DRS ILS program.

Sample and Methodology

All ILS consumers who had a plan and whose cases were closed “successful” or “unsuccessful” during the fiscal year were eligible to be included in the sample for this ongoing survey.

The instrument consisted of 13 close-ended questions and 2 open-ended questions.

A total of 758 closed ILS cases were electronically transmitted to the survey contractor to be contacted by telephone for the 2010 survey. Several attempts via telephone were made by the vendor to reach each member of the eligible sample group during the month following the case closure. Of these potential respondents, 388 consumers completed all or part of a survey for a response rate of 51 percent.

Summary of Major Findings

- Comparing responses from the 2010 ILS survey with the 2009 survey, there was an increase in the proportion of positive responses on 4 of the 13 closed-ended questions, ranging from a low of 0.1 percent more satisfied to a high of 8.3 percent more satisfied. The only statistically significant increase in satisfaction was for the 8.3 percent increase in consumers responding: *As a result of the services I received, I can do more in the community, if I want to.*
- Five questions showed decreases in satisfaction greater than two percent from fiscal year 2009 to fiscal year 2010, including satisfaction with provider services, involvement with decision-making of provider services, satisfaction with time to receive services, choice provision by a DRS Independent Living Counselor, and overall experience with DRS.
 - **Choice Provision by DRS Independent Living Counselor.** In fiscal year 2010, 87 percent of respondents expressed satisfaction, a 2.4 percent decrease from fiscal year 2009.
 - **Satisfaction with Provider Services.** In fiscal year 2010, 91.9 percent of respondents expressed satisfaction, a 3.5 percent decrease from fiscal year 2009.
 - **Involvement with Decision-Making of Provide Services.** In fiscal year 2010, 80.4 percent of respondents expressed satisfaction, a 3 percent decrease from fiscal year 2009.

- **Satisfaction with Time to Receive Provider Services.** In fiscal year 2010, 81.5 percent of respondents expressed satisfaction, a 3.1 percent decrease from fiscal year 2009.
- **Overall Experience with DRS.** In fiscal year 2010, 93.7 percent of respondents expressed satisfaction, a 2.5 percent decrease from fiscal year 2009.
- Based on an open-ended question, what survey respondents *liked* most about their experience with DRS was that DRS was helpful (20.1 percent), that DRS was responsive (18.0 percent), that DRS treated the customer courteously (11.1 percent), and the services were liked (10.8 percent). These same four items were the top four items in 2008 and 2009.
- Based on an open-ended question, what respondents *disliked* most about their experience with DRS was the timeliness of services (14.7 percent). The issue of timeliness of services was also the issue most often mentioned on the 2008 and 2009 surveys (excluding the “No Specific Response” and “Positive Response” categories).

Early Childhood Intervention Family Survey Results Fiscal Year 2011

Purpose

The information reported below presents the results of a family survey conducted in February 2011 with the parents of children enrolled in the DARS ECI program during fiscal year 2011. The ECI program serves children birth to 36 months with developmental delays or disabilities and their families. Services are provided through a statewide system of community-based programs. The family survey is administered to a sample of parents/caregivers every year.

The purpose of this survey was to assess:

- family perceptions of ECI services, specifically, how helpful services are;
- families’ experiences with ECI services and service providers; and
- families’ reported competencies in helping their child develop and learn.

Sample and Methodology

To be eligible for inclusion in the sample, children had to be enrolled in the ECI program for at least six months. This criterion was established to ensure that the family had sufficient experience with the program to respond to the questions.

A multi-stage, stratified random sampling plan was used to select the sample. The 56 local ECI programs were stratified with respect to geographic region and size and 27 programs were randomly selected from the strata. Then, a random sample of families was proportionately selected from each of the 27 programs. The sample size was selected to provide a reasonable confidence interval for the survey responses.

The survey questionnaire was offered to 1,448 families in February 2011. Service coordinators employed at local programs gave each family a questionnaire and completed surveys were

returned by the family via mail to the ECI state office in sealed envelopes in order to maintain the families' anonymity. The survey was available in English and Spanish, though versions in other languages could also be requested. Of the 1,448 families who received the Family Outcomes Survey questionnaire, 893 returned a completed questionnaire, yielding a response rate of 62 percent.

Summary of Major Findings

- Ninety percent of families reported that ECI services helped them effectively communicate their children's needs. This is the same percentage of families who reported this in fiscal year 2010. There was some variation across local programs in fiscal year 2011: The range of results was from 70 percent to 100 percent.
- Eighty-seven percent of families reported that ECI services helped them to help their child develop and learn. This percentage is slightly higher than the 85 percent reported in fiscal year 2010. In fiscal year 2011, the range of results across local programs was from 63 percent to 100 percent.
- Families reported that ECI services helped them to identify activities that help their child learn and grow (95 percent) and helped them with ideas on how to include their child in daily activities (93 percent).
- Eighty-nine percent of families reported that ECI services helped them know their rights. This is slightly higher than the 87 percent of families who reported this in fiscal year 2010.
- A basic tenet of ECI's family-centered and team approach to intervention is for families to be involved in identifying goals for their child and to help their child develop through everyday routines and activities. Almost 96 percent of families reported they felt like important members of the team, that ECI helped them feel like important team members, and that ECI service providers listened to them and respected their choices.
- Families reported high levels of competency in their knowledge and understanding of their child's strengths, abilities and special needs: 94 percent reported understanding their child's strengths and abilities; 94 percent reported that they understood their child's delays and special needs; and 96 percent indicated they were able to tell if their child was making developmental progress.
- There were varying degrees of satisfaction with access to other resources in their communities. Eighty percent of families indicated that their child was able to participate in the community and/or social activities they want, and 90 percent of families reported they had a doctor who understands their child's special needs.

DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

The Department of Family and Protective Services (DFPS) submitted five reports containing customer satisfaction data for the current report. Over 2,800 responses were received in response to these surveys. Individuals surveyed included various stakeholders in Adult Protective Services (APS), child care providers, foster parents and caregivers, and youth in substitute care.

Adult Protective Services 2011 Community Satisfaction Survey

Purpose

DFPS developed a biennial community satisfaction survey in accordance with Human Resources Code, §48.006. The purpose was to gather information on DFPS performance in providing investigative and adult protective services. Every other year, the survey is distributed to members of the judiciary, law enforcement agencies, community organizations and resource groups, and APS Community Boards. The 2011 survey is the sixth community satisfaction survey on APS services.

APS uses results of the survey to assess overall community engagement efforts. Results offer direction for sustaining community support and planning local community engagement initiatives, to strengthen volunteer programs, and enhance resource development in the community to benefit APS clients.

What follows is a summary of the results from the 2011 Community Satisfaction Survey. The full report can be found at: http://www.dfps.state.tx.us/documents/about/pdf/2011-10-01_APS-survey.pdf.

Sample and Methodology

The 2011 survey was sent to 2,477 stakeholders. No sampling was performed; the survey was distributed to the entire population list for each stakeholder group. Responses from 530 stakeholders were received for a response rate of 21 percent.

The 2011 questionnaire consisted of Likert scale statements and open-ended questions that measured awareness of APS involvement in the community and perceptions of APS staff capability, effectiveness, and professionalism. Response categories ranged from “Strongly Agree” to “Strongly Disagree” and included a “Neutral” and “Not Applicable” category. The survey also included open-ended questions to solicit comments from respondents.

APS administered the survey in a web-based format using SurveyMonkey, an online survey development tool. An electronic message was sent to potential respondents with a link to the questionnaire and instructions on completing it. APS faxed or mailed paper surveys to individuals who did not have Internet access, based on regional staff’s knowledge of stakeholders and their experience with them.

Summary of Findings

Two questions were asked of all stakeholder groups while questions specific to each stakeholder group constituted the remainder of the questionnaire.

Across all stakeholder groups, there was high agreement to the statement, “APS ensures the safety and dignity of vulnerable adults in this community” (agreement rates ranged from 74 percent to 99 percent). All stakeholder groups also tended to agree with the statement, “There is a good working relationship between [the survey group] and APS in this community” (agreement rates ranged from 74 percent to 94 percent).

Community board members, community organizations, and law enforcement were asked to indicate their levels of agreement with the statement, “I understand APS’ mission, scope, and purpose.” Community board members and community organizations reported high levels of agreement (100 percent and 91 percent respectively) and 75 percent of law enforcement respondents agreed with the statement.

- **Judiciary Results.** The majority of the judiciary respondents reported that APS cases “rarely” or “sometimes” appear before their court (36 percent and 26 percent, respectively). Overall, the data indicated the vast majority of respondents (approximately 93 percent up to 97 percent) either “agreed” or “strongly agreed” with the survey questions, “APS is appropriate in its court actions,” and “APS staff are properly prepared in their court dealings.”
- **Law Enforcement.** The majority of law enforcement respondents reported that they “rarely” or “sometimes” work with the local APS office (24 percent and 45 percent, respectively). Approximately, 72 percent of the respondents “agreed” or “strongly agreed” that “Referrals to law enforcement from APS are appropriate.” Additionally, approximately 74 percent of respondents “agreed” or “strongly agreed” with the statement “APS staff members are prepared with information and facts when working with law enforcement on APS cases.”
- **Community Organizations.** The majority of community organization respondents reported that their agency “sometimes” or “often” interacts with APS (41 percent and 36 percent, respectively). A majority (87 percent) of respondents either “agreed” or “strongly agreed” with the statement “Referrals to my agency from APS are appropriate.” Approximately 93 percent of community organization respondents “agreed” or “strongly agreed” with the statement, “APS is an important component of my community’s resource and social service network.”
- **Community Board Members.** Approximately, 97 percent of respondents reported that they “agreed” or “strongly agreed” with the statement, “APS is an important component of my community’s resource network.” Ninety-nine percent of respondents reported that they “agreed” or “strongly agreed” with the statement, “APS ensures the safety and dignity of vulnerable adults in this community.”

The APS 2011 Community Satisfaction Survey results show that the APS community engagement efforts are effective. The results reinforce the continued need for outreach efforts and continued collaborations with the local communities. These survey results also provide valuable insight for making improvements and strengthening partnerships with civic and

professional organizations at the local and state level. APS will continue to assess, strengthen, and improve relationships with community groups.

Childcare Licensing: Inspection Feedback Survey

Purpose

The information reported below presents the results of the Inspection Feedback Survey for the DFPS childcare licensing department. The purpose of this Inspection Feedback Survey was to:

- Collect documentation about how professional, courteous, and helpful inspectors and investigators typically are to the childcare and child-placing (residential care) agency.
- Provide an outlet, other than the administrative review, for childcare and child-placing agencies to document any non-regulatory concerns about an inspection or investigation.
- Demonstrate to the public and to the childcare and child-placing providers that DFPS is committed to professional regulatory work.

Sample and Methodology

Survey respondents were providers of substitute care for children age 0 through 13 years. The survey was distributed via a website, through direct mail, in person, and as part of the regular inspection form.

Responses were gathered from June 1, 2010 through December 31, 2011. A total of 953 completed questionnaires were received. Due to the multiple methods of distribution, a response rate cannot be calculated.

Summary of Findings

Over 90 percent of providers reported that the inspection or investigation process was a positive experience for their operation and that it contributed to the increased care and safety of children.

Other results include:

- Seventy-two percent of the residential care respondents felt that the inspection helped to improve their operation.
- Eighty percent of the residential care respondents said that suggestions were made during the inspection, compared with 89 percent of the daycare respondents.
- Almost 98 percent of all respondents stated that enough information was gathered to properly assess the operation and the minimum standards being reviewed.
- Almost 97 percent of all respondents felt that their inspector conducted him or herself professionally.

- Of the 742 providers who answered the question about professionalism, only 14 (2 percent) indicated that the inspector was unprofessional.

Child Protective Services: Annual Random Youth in Substitute Care Survey Fiscal Year 2010

Purpose

The 2010 Random Youth Survey, described in the *Improving the Quality of Service to Youth in Substitute Care* report, is required by S.B. 6, 79th Legislature, Regular Session, 2005 and modified by S.B. 218, 82nd Legislature, Regular Session, 2011. The survey collects feedback about DFPS services from youth ages 14 to 17 who are in substitute care. The purpose of this survey is to:

- assess the quality of services youth received while in substitute care, including their access to financial and health benefits, and, if relevant, the adoption process;
- obtain suggestions for improving services; and
- obtain data about the youths' experiences with education, employment, homelessness, substance abuse services, and incarceration.

What follows is a summary of the results from the 2010 Random Youth Survey. The full report is available at http://www.dfps.state.tx.us/documents/Child_Protection/pdf/2011-05-18_Youth-Report.pdf.

Sample and Methodology

DFPS conducted this telephone-based survey from June 2010 through October 2010 with randomly selected youth ages 14 to 17 who received substitute care services and were in the conservatorship of DFPS.

Staff set a target sample of 358 completed surveys out of a total population of 5,307 youth. A total of 366 surveys were completed for a response rate of 7 percent.

Summary of Findings

Comparing the results of the 2010 Random Youth Survey with results of the 2008 Random Youth Survey showed some responses to questions had improved between the two survey time periods. Other responses indicated that responses were consistent between the two time periods. Below are the major findings the 2010 Random Youth Survey.

Employment, Financial, and Educational Information

Youth were asked questions about their current employment, financial assistance, and educational enrollment. Since all surveyed youth were underage, it is not surprising that the

majority (92 percent) were currently enrolled in some type of formal educational process and only 11 percent had either a high school diploma or General Equivalency Diploma.

Resources, Family, and Health Information

- Ninety-three percent of respondents said that there was at least one adult, other than their caseworker, to whom they can turn for advice or emotional support.
- Sixteen percent of respondents said they had been homeless, 12 percent said they had been referred for alcohol/drug abuse assessment or counseling, and 17 percent said they had been confined to jail, prison, or juvenile detention for alleged crime.
- Seven percent of respondents said they had given birth to or fathered a child (only asked of youth age 17) and none said he or she was married to the child's other parent when child was born.
- Ninety-six percent of respondents said they were on Medicaid.

The Adoption Process

- Thirty-one percent of respondents said they had participated in the adoption process. Of the youth who had participated in the adoption process, 42 percent rated the adoption process as “good” or “very good,” 30 percent rated it as “adequate,” and 26 percent rated it as “poor” or “very poor.”
- The results of open-ended questions suggest CPS staff need to improve communication with, and get more input from, youth throughout the adoption process.

Services and Training

- Fifty-two percent of respondents rated the Life Skills Training as “outstanding” or “good.”
- Forty-one percent of respondents rated the Educational Services Training as “outstanding” or “good.”
- Sixty-nine percent of respondents rated the Counseling, Therapy and Mentoring services as “outstanding” or “good.”
- Most youth (90 percent) did not recommend any improvements. However, several youth suggested how to improve support services which included improved relationships and communication with caseworkers, increased services to prepare for adult responsibilities, and increased financial support, among other topics.

Child Protective Services - Contractor Satisfaction Survey 2011

Purpose

The information reported below presents the results from the DFPS 2011 Contractor Satisfaction Survey. This survey was conducted from January through December 2011 by DFPS monitoring

staff of Purchased Client Services (PCS) providers in CPS. The purpose of this survey was to obtain contractor feedback in order to improve the contractor monitoring experience.

Sample and Methodology

DFPS conducted this survey during the 2011 calendar year with PCS providers in CPS in all 11 HHS regions.

The questionnaire covered the following topics:

- Planning
- Monitoring process
- Communication of results
- Overall satisfaction

Out of 155 monitoring visits conducted during 2011, staff received 68 completed survey questionnaires for a response rate of 44 percent.

Summary of Findings

Table 1 presents a summary of the results to the survey. Response options were “Strongly Agree,” “Agree,” “Disagree,” “Strongly Disagree,” “Don’t Know” and “Not Applicable.”

**Table 1. Percent of Contractors who “Agreed” or
“Strongly Agreed” with Statement**

Statement:	Percent “Agree” or “Strongly Agree”
Monitoring staff gave adequate notice of monitoring visit.	99%
Monitoring staff shared scope and objectives of the visit prior to the visit.	97%
Contractor was clear about the purpose of the monitoring visit.	96%
The scope and objectives of the monitoring were appropriate.	94%
Monitoring staff were sensitive to any concerns and observed discretion where appropriate.	92%
Monitoring visits were conducted in such a manner as to reduce disruption to day-to-day operations.	97%
Monitoring staff kept contractors up to date with progress and findings.	99%
Monitoring activities began at the scheduled time and were completed in a reasonable amount of time.	99%
Contractor and key staff members were informed of all major issues as they developed during the monitoring activities.	94%
Contractor’s comments and observations were accurately and fairly considered.	92%
Monitoring staff shared results in sufficient detail at the exit conference.	96%
The monitoring process adds value to the work provided by contractors.	93%

DEPARTMENT OF STATE HEALTH SERVICES

The Department of State Health Services (DSHS) submitted six reports containing customer satisfaction data for the current report. Over 1,600 responses were received in response to these surveys. Surveys included adults and the parents of children receiving mental health services, regulatory licensing customers, stakeholders, and providers.

Division for Regulatory Services - Regulatory Licensing Unit – Customer Service Satisfaction Survey for Fiscal Year 2011

Purpose

The information reported below presents the results from the Division for Regulatory Services Regulatory Licensing Unit's Customer Service Satisfaction survey as developed by DSHS Centers for Program Coordination, Policy and Innovation. This ongoing web-based survey was implemented in January 2011. The purpose of this survey was to:

- serve as a customer feedback tool, and
- provide a mechanism for on-line users to quickly resolve any concerns with a Program Manager.

What follows is a summary of the results from the 2011 Customer Satisfaction Survey as of March 5, 2012. The most recent data are available at

<http://www.questionpro.com/akira/ShowResults?id=1917084&mode=data>.

Sample and Methodology

This survey utilized a convenience sample in that a licensee or the public at large viewing the DSHS website may take the survey. From January 1, 2011 through March 5, 2012, 839 individuals completed the survey.

Summary of Findings

Below are findings from the survey:

- Ninety-two percent of respondents found DSHS staff helpful, courteous, and knowledgeable.
- Eighty-five percent of respondents found communicating with DSHS (via telephone, mail, or electronically) an efficient process.
- Eighty-five percent of respondents found the DSHS website user-friendly and that it contains adequate information.
- Eighty-three percent of respondents reported that their application was easy to file and was processed in a timely manner.

- Eighty-nine percent of respondents found the forms, instructions, and other information provided by DSHS helpful and easy to understand.

Overall, the majority of individuals completing the Regulatory Licensing Unit Customer Service Satisfaction Survey were satisfied with the level of customer service received.

Mental Health and Substance Abuse Division – Texas Adult Mental Health Survey Fiscal Year 2011

Purpose

The information reported below presents the results from the fiscal year 2011 Texas Adult Mental Health (AMH) Survey. This survey was designed by the federal MHSIP and is administered in Texas annually by HHSC to consumers 18 years or older who received mental health services beyond an intake assessment. The purpose of the survey was to measure:

- customer satisfaction with mental health services received through the state mental health system, and
- customer perception of these services along multiple dimensions, including access to care and outcomes of services.

Sample and Methodology

DSHS provided HHSC with a random sample of consumers selected through the agency's mental health encounter database. Consumers 18 years or older who recently received a mental health service beyond an intake assessment were eligible for inclusion. The target sample size was selected to provide a reasonable confidence interval for the survey responses, based on selected survey items with uniformly distributed responses. In total, 423 consumers completed surveys, resulting in a confidence interval of approximately 95 percent +/- 5 percent. The response rate was 20 percent.

HHSC mailed questionnaires to consumers in May 2011, informing them that the survey was voluntary, confidential, and that providers would not see their individual responses. Consumers were asked to return their completed forms directly to HHSC in a business reply envelope by August 31, 2011.

Summary of Findings

The questionnaire consists of 36 items about mental health services the consumer received over the past 12 months. Items fall into one of seven domains, shown in Table 2. Consumers rate each of the survey items on a 5-point Likert scale. Survey results focus on the domain "agreement rates" which means the percentage of consumers that reported "agree" or "strongly agree" to the items in a domain.

Highlights from the results of the fiscal year 2011 AMH survey:

- Ninety percent of consumers either agreed or strongly agreed to the survey items related to the *Satisfaction* domain.
- A majority of consumers rate the *Quality of Services* domain and the *Access to Services* domain favorably; 82 percent and 79 percent of consumers, respectively, either agreed or strongly agreed to these corresponding survey items.
- The *Outcomes of Services* domain is related to the consumer’s perceived well-being as a result of services. In fiscal year 2011, only 57 percent of respondents agreed or strongly agreed with items in the *Outcomes* domain. Similarly, the *Functioning* domain, which measures perceived improved functioning as a result of services, had an agreement rate of 62 percent.
- The *Social Connectedness* agreement rate, measuring if the consumer feels connected to friends, family, and community, was also relatively low at 58 percent.
- Agreement rates have remained fairly stable over the past five years.

**Table 2. AMH Survey Domain Agreement Rates
Fiscal Year 2007 through Fiscal Year 2011**

	Outcome	Social	Functioning	Participation	Access	Quality	Satisfaction
2007	56%	63%	58%	66%	73%	81%	86%
2008	55%	61%	57%	62%	74%	80%	85%
2009	57%	62%	60%	66%	77%	80%	84%
2010	57%	64%	60%	71%	78%	84%	89%
2011	58%	58%	62%	71%	79%	82%	90%

Mental Health and Substance Abuse Division – Youth Services Survey for Families Fiscal Year 2011

Purpose

The information reported below presents the results from the fiscal year 2011 Youth Services Survey for Families (YSSF). This survey was designed by the federal MHSIP and is administered in Texas annually by the HHSC to the parents of consumers aged 17 years or younger who received mental health services beyond an intake assessment. The purpose of the survey was to measure:

- parental satisfaction with mental health services received through the state mental health system, and

- parental perception of these services along multiple dimensions, including access to care and outcomes of services.

Sample and Methodology

DSHS provided HHSC with a random sample of consumers selected through the agency's mental health encounter database. Consumers 17 years or younger who had recently received a mental health service beyond an intake assessment were eligible for inclusion.

HHSC mailed questionnaires to the parents of child/youth consumers in April 2011, informing them that the survey was voluntary, confidential, and that their providers would not see their individual responses. Parents were asked to send the completed survey directly to HHSC in a business reply envelope by August 31, 2011. In total, 281 parents completed surveys, resulting in a confidence interval of approximately 95 percent +/- 6 percent. The response rate was 13 percent.

Summary of Findings

The questionnaire consists of 27 items about mental health services the consumer received over the past 6 months. Items fall into one of seven domains, shown in Table 3. Parents rate each of the survey items on a five-point Likert scale. Survey results focus on the domain "agreement rates" which means the percentage of parents that reported "agree" or "strongly agree" to the items in a domain.

Highlights from the results of the fiscal year 2011 YSSF:

- Approximately 88 percent of respondents either agreed or strongly agreed with *Cultural Sensitivity* items which suggest that a majority of parents perceive the mental health staff as respectful of their families' cultural needs.
- Eighty-four percent of respondents either agreed or strongly agreed with *Participation* items which suggest that they felt involved in treatment decisions.
- Just over three-quarters of the parents surveyed either agreed or strongly agreed to the items in the domains of *Social Connectedness*, *Satisfaction with Services*, and *Access to Services*.
- While parents rated services relatively positively, just over half of parents seem to perceive that their child's well being had improved as a result of these services. The *Outcomes* and *Functioning* domains were rated at only 52 percent and 53 percent respectively.
- Agreement rates have remained fairly stable over the past five years (see Table 3).

**Table 3. YSSF Domain Agreement Rates
Fiscal Year 2007 through Fiscal Year 2011**

	Outcomes	Functioning	Access	Satisfaction	Social	Participation	Cultural
2007	57%	57%	80%	80%	77%	86%	91%
2008	52%	53%	76%	78%	72%	85%	85%
2009	52%	53%	75%	77%	73%	85%	86%
2010	52%	53%	77%	78%	74%	86%	90%
2011	53%	55%	76%	76%	77%	84%	88%

Mental Health and Substance Abuse Division: National Association for State Mental Health Program Directors Research Institute/Mental Health Statistics Improvement Project Inpatient Consumer Survey Fiscal Year 2011

Purpose

The information reported below presents the results from the fiscal year 2011 NRI/MHSIP Inpatient Consumer Survey (ICS). This survey was distributed to every client who was discharged from one of the ten state mental hospitals in fiscal year 2011. The purpose of this survey was to measure the client's:

- experience in the state mental hospital including their experience with staff, treatment, and the facility;
- participation in their treatment; and
- ability to function after leaving the hospital.

Sample and Methodology

A convenience sampling method was used. When a decision was made to discharge a client, the client was to be given an opportunity to complete the survey. This process could begin as early as three or more days prior to discharge. Clients could also be given an envelope so that the completed survey could be mailed back to the Quality Assurance division of the facility after discharge. The likelihood of a returned survey is greater prior to the client leaving the facility. Clients with hospital episodes greater than one year were given a survey to complete during each annual review.

The survey includes questions based on five domains: *Outcome, Dignity, Rights, Treatment, and Facility Environment.*

- The *Outcome* domain includes questions about the effect of the hospital stay on the clients' ability to deal with their illness and with social situations.

- The *Dignity* domain includes questions about the quality of interactions between staff and clients that highlight a respectful relationship.
- The *Rights* domain includes question about the ability of clients to express disapproval with conditions or treatment and receive an appropriate response from the organization.
- The *Treatment* domain includes questions about clients' involvement in their hospital treatment as well as coordination with the clients' doctor or therapist from the community.
- The *Facility Environment* domain includes questions about feeling safe in the facility and the aesthetics of the facility.

Summary of Findings

The NRI/MHSIP ICS is used and analyzed at several different levels. For reporting to the National Association of Mental Health Program Directors Research Institute all five domains are reported but only two are used for ORYX® reporting to The Joint Commission (TJC). TJC measures are evaluated by both NRI and TJC and communication, analysis, and performance improvement are evaluated with direct communication between the individual facilities and the monitoring organizations. At the facility level the facility determines the domains used for analysis and quality improvement. Centrally, two measures are used for overall, high-level monitoring and analysis by the State Hospital Section and the governing body process.

The two central measures are: (1) the percentage of eligible clients who complete the survey and (2) the overall score (all five domains) on a five-point scale. The target for the completion measure is 25 percent of all eligible clients complete the survey and the target for the overall score is 3.6.

For fiscal year 2011, 7 of the 10 state mental hospitals achieved a completion rate of over 25 percent. A review of the 3 hospitals that did not meet the 25 percent threshold will take place at the semi-annual governing body meeting along with discussion of ways to increase the response rate. The response rate had a range of 15 percent to 85 percent.

The overall score target of 3.6 was exceeded by all 10 state mental hospitals in fiscal year 2011 with a range of 3.79 to 4.47.

Mental Health and Substance Abuse Division – Mental Health and Substance Abuse Stakeholder Survey

Purpose

The information reported below presents the results from the 2011 MHSA Stakeholder Survey. This web-based survey was distributed from November 8, 2011 through November 23, 2011 to all internal and external stakeholders who subscribe to the MHSA News listserv. The purpose of this survey was to obtain input on improving general and focused communication efforts to

individuals engaged in internal and external stakeholder groups coordinated by MHSA toward improving communication with stakeholders.

Sample and Methodology

The survey was administered via Google Survey and all stakeholders who subscribe to government delivery notices for MHSA News updates (<http://www.dshs.state.tx.us/mhsa-announcements/>) received notification of the survey and were invited to participate. Survey participation was voluntary and responses were anonymous.

The questionnaire focused on communication on the MHSA Division web pages, broadcast communications, policies and procedures, funding opportunities, and provider input on special initiatives. For each item, respondents selected the rating that most accurately reflected their level of agreement, ranging from 1 (strongly disagree) to 3 (neutral) to 5 (strongly agree), with “0” indicating that the item was “not applicable.” Demographic questions captured information about the populations providers serve and the regions they represent.

Forty-seven surveys were submitted. Fifty-four percent of respondents were identified as MHSA providers, 33 percent of respondents were advocates, and 24 percent of respondents were consumers or the family members of consumers. Respondents could have selected multiple categories when identifying their affiliation.

Summary of Findings

- Fifty-two percent of respondents reported they participate in MHSA-hosted stakeholder meetings. Of these, 11 percent “strongly agree” that these meetings are well-organized, and 24 percent did not have an opinion.
- Thirty-nine percent of respondents either “agree” or “strongly agree” that the MHSA division welcomes participation throughout stakeholder meetings and that they are confident that MHSA will consider their feedback in developing initiatives and recommendations.
- Thirty-nine percent of respondents reported they either “agreed” or “strongly agreed” with the statement, “The current DSHS MHSA web pages are easy to navigate.” Twenty-seven percent disagreed or strongly disagreed with this statement.
- Forty-six percent of respondents reported they either “agreed” or “strongly agreed” with the statement, “Information on funding opportunities is shared with my organization in a timely fashion.” Only 13 percent of respondents disagreed or strongly disagreed with this statement.
- Sixty-one percent of respondents reported they either “agreed” or “strongly agreed” with the statement, “I believe MHSA is collectively working towards its Vision, Mission, and Goals.” Only 16 percent of respondents disagreed or strongly disagreed with this statement.

Mental Health and Substance Abuse Division – Mental Health and Substance Abuse Provider Survey

Purpose

The information reported below presents the results from the 2011 MHSA Provider Survey. This web-based survey was distributed from November 8, 2011 through November 23, 2011 to 300 providers who subscribe to the Mental Health and Substance Abuse News listserv. The purpose of this survey was to obtain input on improving general and focused communication efforts with DSHS/MHSA providers.

Sample and Methodology

All MHSA providers who subscribe to the Mental Health and Substance Abuse News listserv were sent a link to the web-based survey, which was administered via Google Survey. Survey participation was voluntary and responses were anonymous. The survey focused on communication on the MHSA Division web pages, broadcast communications, policies and procedures, funding opportunities, and provider input on special initiatives.

For each item on the questionnaire, respondents selected the rating that most accurately reflected their level of agreement, ranging from 1 (strongly disagree) to 5 (strongly agree), with “0” indicating that the item was “not applicable.” Demographic questions captured information about the populations providers serve and the regions they represent.

Summary of Findings

Of the 51 responses, 76 percent of respondents primarily serve clients with substance abuse problems and 24 percent primarily serve clients with mental health issues. Although all 11 public health regions were represented, 64 percent of responses came from the major metropolitan areas in Texas (Dallas-Fort Worth, Houston, Austin, San Antonio).

Results included the following:

- Eighty-one percent agreed (57 percent) or strongly agreed (24 percent) that broadcast communications from the MHSA Division are clear and easy to understand;
- Seventy-nine percent agreed (42 percent) or strongly agreed (37 percent) that MHSA Division staff are professional and respectful when they communicate with them;
- Seventy-eight percent agreed (39 percent) or strongly agreed (39 percent) that they know which MHSA Division area or staff to contact when they have a question or problem;
- Sixty-three percent agreed (39 percent) or strongly agreed (24 percent) that MHSA Division staff responses to their inquiries are timely and informative;
- Fifty-seven percent agreed (37 percent) or strongly agreed (20 percent) that they receive broadcast communications in plenty of time to respond or take necessary action.

- Fifty-five percent agreed (35 percent) or strongly agreed (20 percent) that information on funding opportunities through the MHSA Division is shared in a timely fashion;
- Fifty-one percent agreed (33 percent) or strongly agreed (18 percent) that the MHSA Division web pages are easy to navigate and provide valuable information to them or their agency;
- Forty-five percent agreed (31 percent) or strongly agreed (14 percent) that MHSA Division solicits and is responsive to their input throughout the contracting process; and
- Forty-five percent agreed (25 percent) or strongly agreed (20 percent) that information about DSHS policies and procedures that affect their organization are easily accessible.

HEALTH AND HUMAN SERVICES COMMISSION

The Health and Human Services Commission (HHSC) submitted 11 reports containing customer satisfaction data for the current report. Over 65,000 responses were received in response to these surveys. Individuals surveyed included customers who visited benefit eligibility offices, families of children with special health care needs, and enrollees in Medicaid fee-for-service and managed care.

Office of Eligibility Services Customer Service Survey Fiscal Year 2011 and Fiscal Year 2012

Purpose

The information reported below presents the results from three OES Customer Service Surveys distributed during fiscal years 2011 and 2012. This survey has been conducted three times since its implementation: October 2010, June 2011, and November 2011. The purpose of these surveys was to assess:

- how customers feel about how they were treated,
- the wait times, and
- the overall service of the OES office.

Sample and Methodology

To implement the survey, staff members in each local eligibility office were requested to hand a postage-paid survey postcard to each OES customer receiving in-person services. Clients could submit their completed postcard either by putting it in a collection box at the office or by placing it in the mail. Offices were instructed to distribute the postcards through the end of the survey period or until they ran out of cards.

The survey time period was either one week (in the October 2010 and November 2011 survey periods) or two weeks (in the June 2011 survey period).

A response rate is unable to be calculated due to the distribution method. The number of surveys completed in each survey time period is shown in Table 4:

Table 4. Responses to the OES Customer Service Survey

	October 2010	June 2011	November 2011
Number of Completed Survey Postcards	16,394	12,109*	15,531

* The survey time period in June 2011 was for two weeks rather than one. Also, HHSC Regions 3 and 6 were exempted from participation due to preparations for Texas Integrated Eligibility System (TIERS) implementation.

The survey instrument consisted of three closed-ended questions plus an area for written comments.

Summary of Findings

Results were calculated at the state-wide level as well as at the HHSC region level and at the individual office level. The state-wide results for the three pertinent questions are provided in Table 5. The response options were “Very Good,” “Good,” “OK,” and “Bad.” The majority of respondents were satisfied with OES services and thought that staff treated them well. Fewer respondents felt that the wait time was good.

Table 5. Percent Responding “Good” or “Very Good”

	October 2010	June 2011	November 2011
How did staff treat you?	95%	94%	95%
How was the wait time?	84%	85%	83%
Overall, how was the service?	93%	92%	93%

Children with Special Health Care Needs: Quality of Care in the Medicaid Managed Care and Children’s Health Insurance Programs in Texas

Purpose

The information reported below presents the results from the Children with Special Health Care Needs: Quality of Care in the Medicaid Managed Care and Children’s Health Insurance Programs in the state of Texas. The report was prepared by the Institute for Child Health Policy (IHP) at the University of Florida, the External Quality Review Organization (EQRO) for Texas Medicaid Managed Care and CHIP. This telephone-based survey was conducted from September 2008 through August 2010 with families of children with special health care needs enrolled in STAR, PCCM, STAR Health, CHIP, and CSHCN Services (Title V) during fiscal years 2009 and 2010. The purpose of this survey was to:

- provide demographic and health status information, including estimates of the numbers of CSHCN in each program and CRG classifications, and
- assess parent-reported quality of life.

Sample and Methodology

ICHP conducted telephone surveys for the following programs and time periods:

- STAR – November 2008 to June 2009
- PCCM – November 2008 to June 2009
- STAR Health – December 2009 to February 2010
- CHIP – November 2009 to April 2010
- CSHCN Services Program – June 2010 to July 2010

To be eligible for inclusion, the child had to be enrolled in the respective program for at least nine continuous months in the year prior to the survey (or a minimum of six continuous months for children in STAR Health), and had to be currently enrolled at the time of the survey. These criteria were chosen to ensure that the family had sufficient experience with the program to respond to the questions. Selected members must not have participated in the corresponding survey from the prior reporting year (fiscal year 2007 for STAR and PCCM, fiscal year 2008 for CHIP, and fiscal year 2009 for STAR Health). For the STAR, PCCM, and STAR Health surveys, sampled members must also have been 18 years of age or younger during the eligibility period. For the CSHCN Services Program survey, sampled members must have been 21 years of age or younger.

- **The STAR Program** survey was conducted with a stratified random sample of families. The sample was stratified to include representation from the 14 MCOs serving Texas Medicaid during fiscal year 2009. Three MCOs – Aetna, Amerigroup, and Superior – were further divided by service delivery area (SDA), resulting in a total of 23 sampling strata. A target sample of 6,900 telephone surveys was set, representing 300 respondents per MCO/SDA group. There were 6,909 surveys completed with caregivers of children enrolled in STAR. For the purposes of this report, analyses were conducted at the MCO level only. The response rate was 56 percent (see Table 6).
- **The PCCM Program** survey was conducted with a simple random sample of families, with a target sample of 400 telephone surveys. There were 400 surveys completed with caregivers of children enrolled in PCCM. The response rate was 71 percent.
- **The STAR Health Program** survey was conducted with a simple random sample of families, with a target sample of 400 telephone surveys. There were 400 surveys completed with caregivers of children enrolled in STAR Health. The response rate was 59 percent.
- **The CHIP** survey was conducted with a stratified random sample of families. The sample was stratified to include representation from the 17 MCOs serving Texas CHIP during fiscal year 2010. A target sample of 5,100 telephone surveys was set, representing 300 respondents

per MCO group. There were 4,748 surveys completed with caregivers of children enrolled in CHIP. The response rate was 52 percent.

- **The CSHCN Services Program** survey was conducted with 2 simple random samples of families – one with a target sample of 300 children enrolled in the CSHCN Services Program at the time of sampling, and the other with a target sample of 100 children on the program’s waiting list. There were 302 in-program and 100 waiting list surveys completed with caregivers. This program represents a mix of children insured through Medicaid, CHIP, and commercial insurance; the survey sample therefore included caregivers of both publicly-insured and commercially-insured children. The response rate was 54 percent.

Table 6. Survey Data Collection Rates

	Response Rate	Refusal Rate
STAR	56%	17%
PCCM	71%	8%
STAR Health	59%	11%
CHIP	52%	13%
CSHCN Service Program	54%	9%

Summary of Findings

Access to and Timeliness of Care

- **Children and Adolescents’ Access to Primary Care Practitioners.** All programs performed equally well on this measure, with rates of Primary Care Practitioners (PCP) visits for children with significant acute conditions and CSHCN about 10 percent higher than rates for healthy children. Across all age categories, the percentage of CSHCN who had a PCP visit was close to 100 percent. Controlling for demographic and program membership factors, children with significant acute conditions were 4 to 10 times more likely than healthy children to have had a visit with a PCP, and CSHCN were up to 20 times more likely to have had a visit with a PCP.
 - Access to PCPs was half as likely among Black, non-Hispanic children as among White, non-Hispanic children. Children two years of age and older living in non-metro areas were also about half as likely as children living in metro areas to have had a visit with a PCP.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS)[®] Getting Needed Care.** In PCCM, the percentage of parents of CSHCN with positive experiences getting needed care for their child was significantly lower than for parents of non-CSHCN (56 percent versus 81 percent). This difference was largely due to lower parent-reported access to

care, tests, or treatment for CSHCN. Compared to parents of White, non-Hispanic children, parents of children in other racial/ethnic groups were less likely to have had positive experiences on this measure.

- **CAHPS® Getting Care Quickly.** In CHIP, the percentage of parents of CSHCN with positive experiences getting care quickly for their child was significantly higher than for parents of non-CSHCN (78 percent versus 70 percent), a difference that was largely due to better timeliness of routine care for CSHCN. In general, children with significant acute or chronic conditions were more likely than healthy children to have had good timeliness of care. Compared to parents of White, non-Hispanic children, parents of children in other racial/ethnic groups were less likely to have had positive experiences on this measure.
- **CAHPS® Prescription Medicines.** Results from fiscal year 2009 and 2010 generally show a high level of access to *Prescription Medicines* for both CSHCN and non-CSHCN. However, compared to parents of White, non-Hispanic children, parents of Hispanic and Other, non-Hispanic children were less likely to have had positive experiences.
- **CAHPS® Getting Specialized Services.** Results from fiscal year 2009 and 2010 generally show a low level of access to specialized services, which is an important quality indicator for CSHCN. Overall, children with significant acute or chronic conditions were more likely than healthy children to have had good access to specialized services. However, the percentage of parents of CSHCN in PCCM with positive experiences getting specialized services for their child was particularly low (58 percent), and was significantly lower than the percentage among parents of non-CSHCN (79 percent). This difference was largely due to lower access to special therapies for CSHCN. The likelihood of positive experiences on this measure generally decreased with the member's age.
- **CAHPS® Care Coordination.** Results from fiscal year 2009 and 2010 generally show a low level of access to care coordination, which is an important quality indicator for CSHCN. In STAR Health, the percentage of parents with positive care coordination experiences was low for both CSHCN and non-CSHCN (46 percent and 45 percent, respectively). These low rates were largely due to reduced access to care coordination from the child's health plan, doctor's office, or clinic. Compared to parents of White, non-Hispanic children, parents of Hispanic and Other, non-Hispanic children were more likely to have had positive experiences with *Care Coordination* for their child.

Patient-Centered Care

- **CAHPS® How Well Doctors Communicate.** At the program level, results for *How Well Doctors Communicate* were good for all programs, and approximately the same between CSHCN and non-CSHCN.
- **CAHPS® Health Plan Information and Customer Service.** In PCCM and STAR Health, the percentage of parents of CSHCN with positive experiences on this measure (75 percent and 78 percent, respectively) was notably higher than among parents of non-CSHCN (67 percent and 68 percent, respectively). These differences were largely due to better experiences among parents of CSHCN in getting the information they needed from their child's health plan's customer service. Parents of Hispanic children were generally more

likely than parents of White, non-Hispanic children to have had positive customer service experiences.

- **CAHPS® Personal Doctor.** At the program level, results for *Personal Doctor* were good for all programs. In STAR Health, the percentage of parents of CSHCN having positive experiences with their child's personal doctor was significantly lower than the percentage among parents of non-CSHCN (79 percent versus 87 percent). The difference was largely because families reported that their children's personal doctors did not understand how their child's condition affects the family's day-to-day life. The likelihood of positive experiences with the child's personal doctor generally decreased with the member's age.
- **CAHPS® Shared Decision-Making.** At the program level, results for *Shared Decision-Making* were good in all programs. In STAR Health, the percentage of parents of CSHCN with positive experiences was notably higher than among parents of non-CSHCN (94 percent versus 78 percent). In general, parents of children with significant acute conditions were more likely than parents of healthy children to have had positive experiences with shared decision-making.
- **CAHPS® Getting Needed Information.** At the program level, results for *Getting Needed Information* were good in all programs, for both CSHCN and non-CSHCN. Compared to parents of White, non-Hispanic children, parents of Other, non-Hispanic children were less likely to have had positive experiences on this measure.

The Texas Medicaid STAR+PLUS Program: Adult Member Survey Report

Purpose

The information reported below presents the results from the 2010 STAR+PLUS Adult Member Survey for the state of Texas, prepared by ICHP at the University of Florida. This telephone-based survey was conducted from June 2010 through November 2010 with adult members of the STAR+PLUS program who had been enrolled in STAR+PLUS for at least nine months. The purpose of this survey was to gather information about the health care experiences of adults in the STAR+PLUS program.

Sample and Methodology

Survey participants were selected from a random sample of adults 18 to 64 years old, stratified by health plan. To be eligible for survey participation, members must have been enrolled in the STAR+PLUS program for nine months or longer. Members eligible for both Medicaid and Medicare, and members who participated in the fiscal year 2009 STAR+PLUS survey were excluded.

A target of 1,200 completed telephone surveys was set, representing 300 respondents per MCO. Members of the following four STAR+PLUS health plans were surveyed: Amerigroup, Evercare Health Plans, Molina Healthcare, and Superior Health Plan. Between June 2010 and November 2010, STAR+PLUS members were surveyed by telephone. Target samples for health plans were

met, with the exception of Molina Healthcare (N=286). Across all four health plans, 1,187 members were surveyed. The response rate for the STAR+PLUS survey was 47 percent.

The fiscal year 2010 STAR+PLUS Adult Member Survey included the following questionnaires and items:

- the CAHPS[®] Health Plan Survey 4.0 (Medicaid module);
- the RAND[®] 36-Item Health Survey, Version 1.0; and
- items developed by ICHP pertaining to member characteristics and their health care experiences, including care coordination.

Summary of Findings

Descriptive analyses were performed on all survey items, with a focus on the HHSC Performance Indicator Dashboard for fiscal year 2009, and the CAHPS[®] Health Plan Survey ratings and composite measures.

Statistical tests were conducted to determine if there were differences in the results based on health plan membership and member characteristics. Analyses were also done to compare 2010’s findings with the fiscal year 2009 STAR+PLUS survey. In addition, multivariate analyses were conducted to test the influence of health plan membership on member satisfaction with their health care, and the influence of having a service coordinator on access to specialists and specialized services.

Positive Findings

- **CAHPS[®] Composites.** Among the four CAHPS[®] composites, mean scores for “How Well Doctors Communicate,” “Getting Care Quickly,” and “Customer Service” were at or above 75, indicating that members generally had positive experiences and were satisfied with their health care in these domains (see Table 7).

Table 7. Mean Scores on Four CAHPS[®] Composite

CAHPS [®] Composites	Mean (Range 0-100)
How Well Doctors Communicate	87.9
Getting Care Quickly	78.8
Customer Service	74.5
Getting Needed Care	72.3

- **Member Ratings.** A majority of members provided high ratings of their health care, personal doctor, specialist, and health plan, as indicated by a rating of 9 or 10 on a 10-point

scale (see Table 8). The highest ratings were observed for members' personal doctor and specialist, with considerably lower ratings observed for behavioral health care.

Table 8. Member Ratings

Members Rating of ...	Percent Rating Health Care Component a 9 or 10 (Range 0-10)	Mean (Range 0-10)
Personal Doctor	70%	8.79
Specialist	69%	8.67
Health Care	51%	8.05
Health Plan	51%	8.02
Behavioral Health Care	46%	7.55

- HHSC Performance Dashboard Indicators.** The STAR+PLUS program met the Dashboard standards for five of the seven performance indicators (see Table 9). The majority of members had good access to routine care, urgent care, specialist referral, and special therapies. In addition, a majority of smokers were advised to quit smoking by their provider in the past six months.

Table 9. Percentage of STAR+PLUS Members who reported they “Usually” or “Always” had the Performance Indicator

	FY 2010 STAR+PLUS	HHSC Performance Dashboard Standard	Met Standard
Good access to urgent care	79%	76%	Yes
Good access to specialist referral	71%	62%	Yes
Good access to routine care	80%	78%	Yes
No delays in health care while waiting for health plan approval	52%	57%	No
No exam room wait greater than 15 minutes	29%	42%	No
Good access to special therapies	66%	47%	Yes
Good access to Service Coordination*	64%	-	-
Smokers advised to quit smoking on a visit	68%	28%	Yes

* Good access to Service Coordination does not have a standard.

Improvement Areas

- **Delays in Health Care.** Forty-eight percent of members experienced delays in getting health care while waiting for health plan approval for care and services.
- **Exam Room Wait.** The majority of members reported they waited in the exam room for doctor's appointments for longer than 15 minutes (71 percent).
- **Getting Needed Care.** The CAHPS® composite *Getting Needed Care* was slightly below the 75-point threshold, which indicates that some members experienced difficulty in getting appointments with specialists and getting the care, tests, and treatment they needed through their health plan.
- **Getting specialized services.** Approximately one in three members reported problems getting specialized services, such as special medical equipment, home health care, and special therapy.
- **Care coordination.** Seventy-seven percent of members said they did not have a service coordinator. Among these members, 41 percent said they would like to have a service coordinator help them arrange their doctors' appointments and services.

The Texas Children's Health Insurance Program: Established Member Survey Report

Purpose

The information reported below presents the results from the 2010 CHIP Established Member Survey for the state of Texas, prepared by ICHP at the University of Florida. This telephone-based survey was conducted from November 2009 through April 2010 with families of children enrolled in CHIP in Texas. The purpose of the survey was to:

- provide a demographic and health profile of the children enrolled in CHIP,
- assess parents' experience and satisfaction with their child's health care,
- compare findings across the 17 health plans participating in CHIP, and
- compare findings to the 2008 CHIP Established Member Survey.

Sample and Methodology

Participants were selected from a random sample of 21,036 families with children enrolled in CHIP in Texas, stratified by 17 health plans. A target sample of 300 respondents per health plan was set, representing a total of 5,100 completed telephone interviews. Between November 2009 and April 2010, 4,748 parents of CHIP members were surveyed by telephone. Target samples were met for all health plans except for the Mercy Health Plans (N=30) and Molina Healthcare (N=213) health plans.

The CHIP survey instrument included the following questionnaires and items:

- the CAHPS[®] Health Plan Survey 4.0 (Medicaid module),
- the CSHCN Screener[®],
- the Pediatric Quality of Life Inventory (PedsQL[™]), Version 4.0,
- items from the National Survey of CSHCN (NS-CSHCN), and
- items developed by ICHP to assess parent and member demographic and household characteristics.

The response rate for the CHIP survey was 52 percent and the cooperation rate was 72 percent.

Summary of Findings

Descriptive analyses were performed on all survey items, with a focus on the HHSC Performance Indicator Dashboard for fiscal year 2009 and the CAHPS[®] Health Plan Survey composite measures. CAHPS[®] composite measures assess parents' experiences and satisfaction with ten different health care domains:

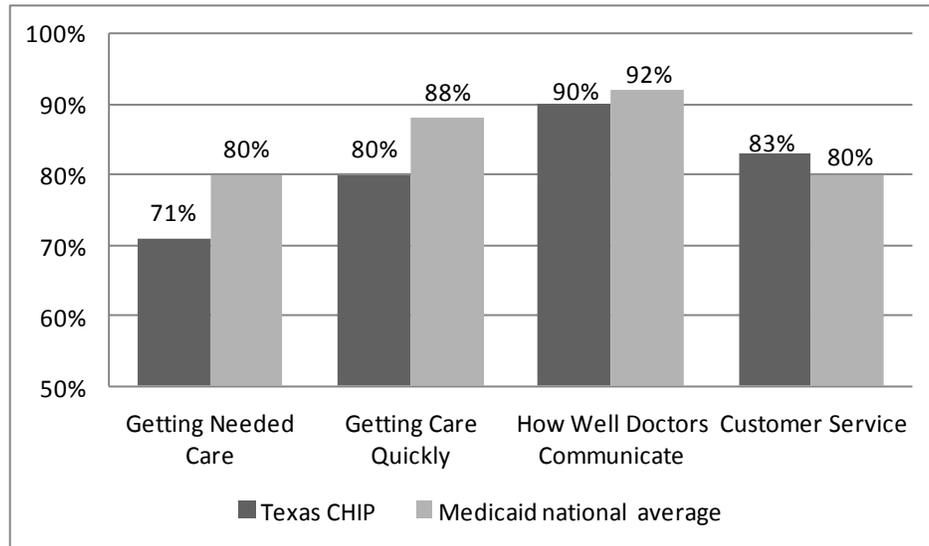
- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Health Plan Information and Customer Service*
- *Prescription Medicines*
- *Getting Specialized Services*
- *Personal Doctor*
- *Shared Decision-Making*
- *Getting Needed Information*
- *Care Coordination*

Statistical tests were conducted to determine if there were differences in the results based on health plan membership and parent/member characteristics. Multivariate analyses were also conducted to test the influence of several factors on caregiver satisfaction with their child's health care, as well as on childhood obesity.

Positive Findings

- **How Well Doctors Communicate.** Ninety percent of parents reported that they usually or always had positive communication experiences with their child's personal doctor (see Figure 1).
- **Customer Service.** Eighty-three percent of parents reported that they usually or always had positive interactions with customer service at their child's health plan (see Figure 1).

Figure 1. Percent of Caregivers who reported they "Usually" or "Always" Have a Positive Experience (CAHPS®)



- Caregiver Ratings.** The majority of parents provided high ratings of their child’s health care, doctors, and health plan, indicated by a rating of 9 or 10 on a 10-point scale (see Table 10). These ratings were equal to or greater than those published from Medicaid national data.

Table 10. Caregiver Ratings

Rating of child's...	Percent Rating Health Care Component a 9 or 10 (Range 0-10)	Percent of Medicaid Clients Nationally Rating Health Care Component a 9 or 10 (Range 0-10)	Mean (St. dev)
Health care	61%	60%	8.70 (SD = 1.58)
Personal doctor	70%	69%	8.97 (SD = 1.54)
Specialist	69%	65%	8.79 (SD = 1.75)
Health plan	70%	64%	8.98 (SD = 1.45)

Improvement Areas

- Getting Needed Care.** Seventy-one percent of parents reported that they were usually or always able to get needed care for their child, compared to 80 percent in the national Medicaid population. This suggests that nearly one-third of CHIP parents have problems

with access to care, tests, and treatment provided through their health plan or access to specialist appointments for their child.

- **Getting Care Quickly.** Eighty percent of parents reported that they were usually or always able to get care quickly for their child, compared to 88 percent in the national Medicaid population. This suggests that 20 percent of CHIP parents have problems getting timely urgent or routine care for their child.
- **HHSC Performance Dashboard Indicators.** Results on the following six performance indicators indicate that few health plans are meeting Dashboard standards (see Table 11).

Table 11. Percentage of Parents who reported their Child “Usually” or “Always” had the Performance Indicator

	CHIP	HHSC Performance Dashboard Standard	Met Standard
Good access to routine care.	72%	86%	No
Good access to urgent care.	86%	89%	No
No exam room waiter greater than 15 minutes	36%	68%	No
Good access to specialist referral	70%	77%	No
No delays in health care while waiting for health plan approval	86%	91%	No
Good access to behavioral health treatment or counseling*	62%	-	-

* Good access to behavioral health treatment or counseling does not have a standard.

The Texas Medicaid STAR Program Child Behavioral Health Survey Report Fiscal Year 2010

Purpose

The information reported below presents the results from the 2010 STAR Child Behavioral Health Survey for the state of Texas, prepared by ICHP at the University of Florida. This telephone-based survey was conducted from February 2009 through February 2010 with the parents or caregivers of child STAR members who had been diagnosed with a behavioral health condition in the past 12 months. The purpose of this survey was to:

- assess parents’ experiences and satisfaction with their child’s behavioral health care, and
- compare findings across behavioral health delivery models.

Sample and Methodology

Survey participants were selected from a stratified random sample of children enrolled in STAR for six months or longer between February 2009 and February 2010. The sample included only children with a record of one or more behavioral health diagnoses during the study enrollment period. The sample was stratified to include representation from three different behavioral health delivery models: 1) MCO; 2) Behavioral Health Organization (BHO), and 3) NorthSTAR.

A target sample of 900 completed telephone interviews was set, representing 300 respondents per delivery model. Target samples were not met for the MCO or BHO quotas, largely due to a high frequency of incorrect phone numbers (37 percent of the sample). A total of 851 telephone interviews were completed.

The fiscal year 2010 STAR Child Behavioral Health Survey included:

- the Experience of Care and Health Outcomes (ECHO[®]) Survey 3.0,
- the CSHCN Screener[®],
- the PedsQL[™], Version 4.0, and
- items developed by ICHP pertaining to parent and member demographic and household characteristics.

The response rate for this survey was 42 percent and the cooperation rate was 76 percent.

Summary of Findings

Descriptive analyses were performed on all survey items. A summary of the results is presented below.

Positive Findings

- The majority of caregivers reported timely access to routine counseling or treatment (74 percent).
- Fifty-nine percent of caregivers said their child was usually or always seen within 15 minutes of his or her appointment.
- More than three out of four caregivers reported that they did not experience problems with their child's health plan in getting the counseling or treatment their child needed (84 percent), in finding or understanding health plan information (76 percent), or in completing health plan paperwork (81 percent).
- Most caregivers said their child's clinician gave them information regarding their child's rights as a patient (86 percent), treatment goals and options (90 percent), managing their child's condition (76 percent), and potential medication side effects (84 percent).
- A slight majority of caregivers believed their child had been helped a lot by the treatment or counseling he or she received (52 percent).

- Most caregivers reported their child had experienced improved symptoms and functioning compared to 12 months ago (between 71 and 75 percent).

Improvement Areas

- Most caregivers expressed some degree of difficulty in getting the professional counseling their child needed on the telephone (70 percent).
- Thirty-seven percent reported some degree of difficulty in getting emergency counseling or treatment for their child.
- Although the majority of caregivers said it was generally not a problem to get the counseling or treatment their child needed (84 percent), a substantial minority of caregivers reported problems with the health plan in finding a clinician for their child they were happy with (47 percent); with delays in their child's counseling or treatment while waiting for health plan approval (42 percent); and with getting help for their child by calling customer service (41 percent).
- Among the 21 percent of caregivers reporting their child had exhausted his or her health plan benefits, three out of four said their child was still in need of counseling or treatment (72 percent). These findings suggest that a substantial proportion of parents may not be familiar with their child's behavioral health benefits, which allow provisions for additional treatments when medically necessary. They may also indicate that certain parents disagree with their child's doctors or health plan about what additional treatments are "medically necessary," in cases where additional treatments were requested but not authorized.
- One out of four caregivers reported their child's clinician never or only sometimes listened carefully to them (24 percent), spent enough time with them (25 percent), and gave them information about how to manage their child's condition (24 percent). These results are of concern because the multivariate analyses revealed that the strongest predictor of caregivers' perceived improvement in their child's symptoms was the quality of communication with the child's clinician.

The Texas Medicaid STAR Program Adult Behavioral Health Survey Report

Purpose

The information reported below presents the results from the 2010 STAR Adult Behavioral Health Survey for the state of Texas, prepared by ICHP at the University of Florida. This telephone-based survey was conducted from September 2008 through February 2010 with adults enrolled in STAR who had been diagnosed with a behavioral health condition in the past 12 months. The purpose of this survey was to:

- assess adult members' experiences and satisfaction with their behavioral health care, and
- compare findings across behavioral health delivery models.

Sample and Methodology

Survey participants were selected from a stratified random sample of adults enrolled in STAR for six months or longer between September 2008 and February 2010. The sample included only adults with a record of one or more behavioral health diagnoses during the study enrollment period. The sample was stratified to include representation from three different behavioral health delivery models: 1) MCO, 2) BHO, and 3) NorthSTAR.

A target sample of 900 completed telephone interviews was set, representing 300 respondents per delivery model. Target samples were not met for the three quotas, largely due to a high frequency of incorrect phone numbers (51 percent of the sample). A total of 769 telephone interviews were completed.

The fiscal year 2010 STAR Adult Behavioral Health Survey included:

- the ECHO[®] Survey 3.0;
- the RAND[®] 36-Item Health Survey, version 1.0; and
- items developed by ICHP pertaining to member demographic and household characteristics.

The response rate for this survey was 37 percent and the cooperation rate was 65 percent.

Summary of Findings

Descriptive analyses were performed on all survey items. A summary of the results is presented below.

Positive Findings

- Greater than two-thirds of members reported timely access to routine counseling or treatment (68 percent).
- Most members said it was not a problem to find or understand health plan information regarding counseling or treatment (61 percent), to fill out and complete paperwork (67 percent), or to get the counseling or treatment they needed (57 percent).
- The majority of members reported positive experiences with their clinician regarding the clinician's ability to listen carefully (75 percent), explain things well (75 percent), show respect (79 percent), and spend enough time with them (71 percent).
- Most members reported their clinician gave them information about their rights as a patient (84 percent), managing their condition (72 percent), medication side effects (76 percent), and the results of tests or assessments (81 percent).
- Over half of members reported they were a little better or much better compared to 12 months ago in their problems or symptoms (55 percent), in their ability to deal with daily problems (65 percent) and social situations (54 percent), and in their ability to accomplish things (60 percent).

Improvement Areas

- The majority of members reported some degree of difficulty in getting the professional counseling they needed on the telephone (65 percent).
- Forty-three percent of members reported experiencing some difficulty in getting emergency counseling or treatment.
- Fifty-six percent said they never or only sometimes were seen within 15 minutes of their scheduled appointment.
- One in five members stated they had used up their counseling or treatment benefits (20 percent). Among these members, 73 percent reported they were still in need of behavioral health services. These findings suggest that a substantial proportion of members may not be familiar with their benefits, which allow provisions for additional treatments when medically necessary. They may also indicate that certain members disagree with their providers or health plan about what additional treatments are "medically necessary," in cases where additional treatments were requested but not authorized.
- A majority of members reported experiencing problems with their health plan in finding a clinician they were happy with (52 percent), and waiting for health plan approval for counseling or treatment (57 percent).
- A large percentage of members reported problems with getting needed counseling or treatment through their health plan (43 percent), and getting help or information from the health plan's customer service (48 percent).
- A substantial percentage of members reported their clinicians did not inform them about their counseling or treatment options (40 percent) or about self-help or support groups (53 percent).
- Half of members reported their clinicians did not discuss with them the inclusion of family or friends in their counseling or treatment (51 percent).
- Forty-six percent of members reported their problems or symptoms were about the same or worse compared to 12 months ago.

The Texas Primary Care Case Management Child Member Survey Report

Purpose

The information reported below presents the results from the 2011 Child PCCM Member Survey for the state of Texas, prepared by ICHP at the University of Florida. This telephone-based survey was conducted from May 2011 through July 2011 with families of children enrolled in PCCM in Texas. The purpose of this survey was to:

- provide a demographic and health profile of children enrolled in the PCCM program, and
- assess caregivers' experiences and satisfaction with their children's health care.

Sample and Methodology

Participants were selected from a random sample of 1,385 families with children enrolled in PCCM in Texas. Between May and July 2011, 400 caregivers of child PCCM members were surveyed by telephone.

The PCCM Child Member Survey instrument included the following questionnaires and items:

- the CAHPS[®] Health Plan Survey 4.0 (Medicaid core and supplemental modules);
- the CSHCN Screener[®];
- items from the NS-CSHCN, addressing transition to adult care for CSHCN; and
- items developed by ICHP to assess caregiver and member demographic and household characteristics.

The response rate for the PCCM Child Member Survey was 58 percent and the cooperation rate was 79 percent.

Summary of Findings

Descriptive analyses were performed on all survey items, with a focus on the HHSC Performance Indicator Dashboard for fiscal year 2010 and the CAHPS[®] Health Plan Survey composite measures. CAHPS[®] composite measures assess caregivers' experiences and satisfaction with ten different health care domains:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Prescription Medicines
- Health Plan Information and Customer Service
- Getting Specialized Services
- Personal Doctor
- Shared Decision-Making
- Getting Needed Information
- Care Coordination

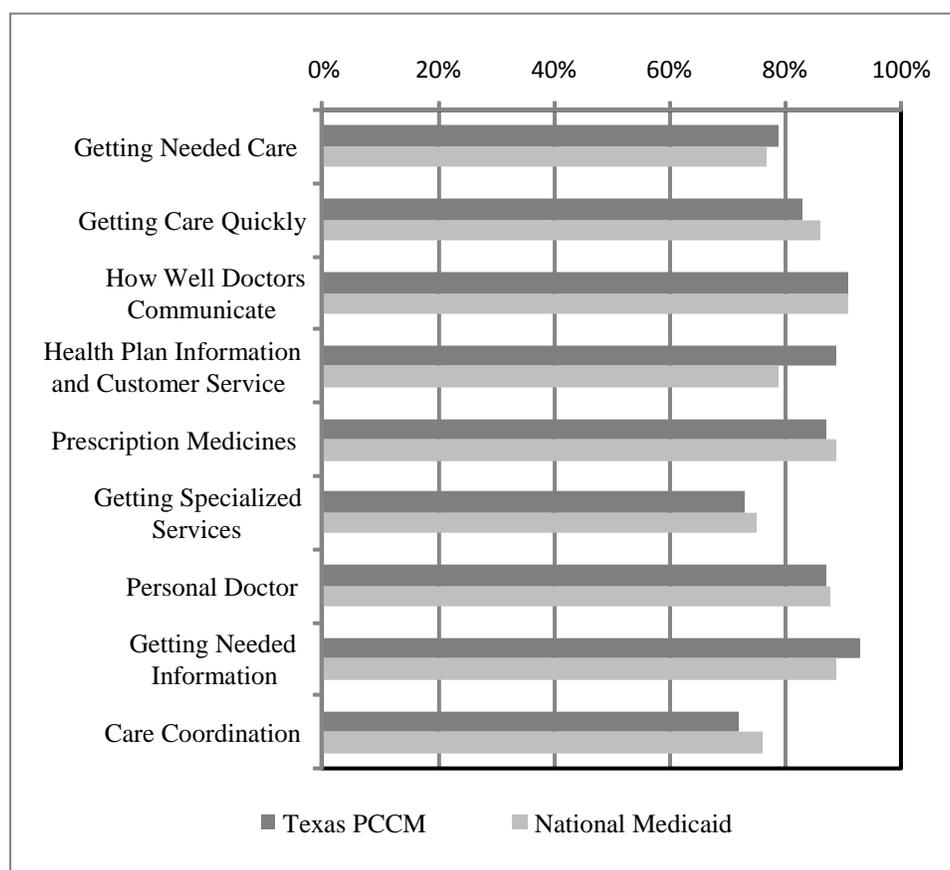
Statistical tests were conducted to determine if there were differences in the results based on caregiver/member characteristics.

Positive Findings

- **Personal Doctors.** Eighty-four percent of PCCM child members had a personal doctor. Caregivers reported good access to help or advice when calling their child's personal doctor during normal office hours (89 percent) and slightly lower access when calling after normal office hours (73 percent). Most personal doctors addressed the health literacy of caregivers and their children in positive ways during the office visit.

- **Preventive Care.** Among caregivers of children less than three years old, 84 percent received reminders to bring their child in for check-ups or immunizations. Nearly all caregivers had good access to appointments for check-ups or immunizations.
- **Specialist Care.** Access to specialist referrals for children in PCCM was particularly good, with 77 percent of caregivers saying they “usually” or “always” were able to get a specialist referral for their child when they needed it. This is higher than the HHSC Dashboard standard of 59 percent for STAR MCOs.
- **CAHPS® Composite Scores.** PCCM performed well for most child CAHPS® composites (see Figure 2). Composites equal to or greater than the national Medicaid averages included *How Well Doctors Communicate* (91 percent), *Health Plan Information and Customer Service* (89 percent), *Prescription Medicines* (87 percent), and *Getting Needed Information* (94 percent). Lower scores were observed for *Getting Specialized Services* and *Care Coordination*

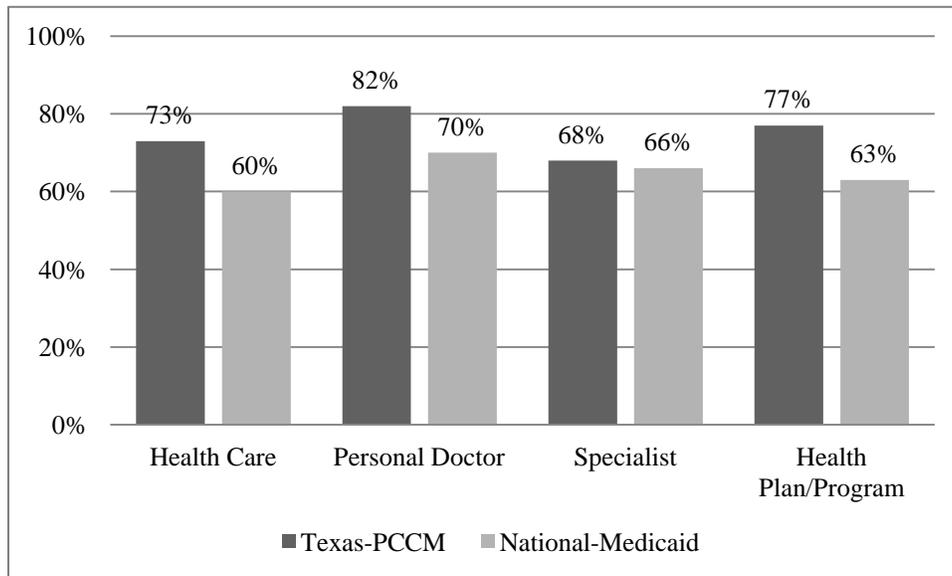
Figure 2. Percent of Caregivers who reported they “Usually” or “Always” Have a Positive Experience (CAHPS®)



- **Caregiver Ratings.** On a scale from 0 to 10, caregivers provided high mean ratings of their child’s health care (8.97), personal doctor (9.33), specialist (8.98), and the PCCM Program

(9.18). When expressed as the percentage of caregivers who indicated a rating of 9 or 10, all ratings in PCCM were equal to or greater than the averages for Medicaid plans nationally (see Figure 3).

Figure 3. Percent of Caregivers who Rated their Child’s Health Services a “9” or “10” (Range 0-10)



Improvement Areas

- Urgent Care.** Among caregivers whose child had gone to the emergency room, nearly half said their child had at least one emergency room visit because they could not get an appointment for routine care. However, one-quarter said they would “never” have taken their child to the doctor’s office or clinic instead of the emergency room, even if they were able to get a timely appointment.
- Timeliness of Care.** Approximately 42 percent of caregivers reported having some delays in their child’s treatment while waiting for approval from the PCCM Program. Among caregivers whose child was seen in a doctor’s office or clinic, only 26 percent reported waiting 15 minutes or less for their child to be taken to the exam room. Both percentages indicated lower performance in PCCM than their corresponding HHSC Dashboard standards for STAR MCOs.
- Preparing CSHCN for Transition.** Among caregivers of adolescent CSHCN who saw doctors that treated only children, 35 percent said their child’s doctors had discussed with them their child’s transition to adult care. Only one in four caregivers of adolescent CSHCN said their child’s doctors had discussed how to obtain or keep health insurance coverage for their child after the transition.

- **Care Coordination.** The CAHPS[®] composite *Care Coordination* score in PCCM was only slightly lower than the national Medicaid average (73 percent versus 76 percent). However, among caregivers whose child received health care from a health provider besides their personal doctor, only 59 percent said that someone from the PCCM program or their child's doctor's office or clinic helped them coordinate their child's care.

The Texas Medicaid Managed Care Primary Care Case Management Adult Enrollee Survey Report

Purpose

The information reported below presents the results from the 2009 Adult PCCM Enrollee Survey for the state of Texas, prepared by ICHP at the University of Florida. This telephone-based survey was conducted from November 2008 and June 2009 with adults enrolled in the PCCM program. The purpose of this survey was to:

- provide a demographic and health profile of adults enrolled in the PCCM program, and
- assess enrollees' experience and satisfaction with their health care.

Sample and Methodology

A simple random sample was used to identify potential survey participants. Between November 2008 and June 2009, 400 adults enrolled in PCCM were surveyed by telephone.

The survey questionnaire was comprised of the following sections:

- the CAHPS[®] Health Plan Survey 4.0 (Medicaid module);
- the RAND[®] 36-Item Health Survey, version 1.0; and
- items developed by ICHP to assess enrollee demographic and household characteristics.

Summary of Findings

Descriptive analyses were conducted on all survey questions, with a focus on the CAHPS[®] Health Plan Survey composite measures, access to care, specialized services, and care coordination. Statistical tests of differences were conducted between enrollees of the PCCM program and among relevant sub-groups of the sample (e.g., enrollee's race/ethnicity, health status, and education).

Positive Findings

- Eighty-six percent of PCCM enrollees reported that they had a personal doctor they went to for check-ups, advice, and treatment. The percentage of PCCM enrollees who had a personal doctor was comparable to that among Medicaid recipients nationally (84 percent).
- The majority of PCCM enrollees had a continuous relationship with their personal doctor. Among respondents who reported having personal doctors, 74 percent in PCCM had been going to their personal doctor for at least two or more years. Generally, enrollees in PCCM rated their doctors favorably.
- The majority of adults in PCCM (92 percent) visited their personal doctors at least once during the six months prior to the survey.
- Among those needing urgent care, 80 percent in PCCM "usually" or "always" received the urgent care that they needed. Rates of access to urgent care in PCCM were comparable to that reported by Medicaid members nationally (81 percent).
- Among PCCM enrollees who utilized special services (e.g., home health care, medical equipment), approximately three-quarters stated that they had good access to these services.
- The vast majority of PCCM enrollees (94 percent) who saw a provider other than their personal doctor were pleased with the care coordination that they received from their health plan, doctor's office, or clinic.

Improvement Areas

- Fifty-three percent of PCCM enrollees who reported having a personal doctor said they retained the primary care provider they had prior to enrollment. This finding indicates a need to improve the continuity of care for nearly half of new enrollees to PCCM.
- PCCM enrollee responses to the CAHPS[®] Health Plan Survey suggest the need to improve access to care in PCCM. CAHPS[®] composite scores of 75 points or greater were considered to indicate positive health experiences.
- The PCCM mean score for *Getting Needed Care* was below 75 points.
- Sixty-nine percent of PCCM enrollees reported that it was "usually" or "always" easy to get an appointment with a specialist, which is slightly lower than access to specialists among Medicaid enrollees nationally (74 percent).
- Individuals in poor health were significantly less likely (56 percent) than those in very good health (78 percent) to state that they "usually" or "always" were able to get an appointment with a specialist.

The Texas STAR Managed Care Organization Adult Enrollee Survey Report

Purpose

The information reported below presents the results from the 2009 STAR MCO Adult Enrollee Survey for the state of Texas, prepared by ICHP at the University of Florida. This telephone-based survey was conducted from November 2009 through June 2009 with adults enrolled in the Texas STAR program. The purpose of this survey was to:

- provide a demographic and health profile of adults enrolled in the Texas STAR program, and
- assess members' experience and satisfaction with their health care across the 23 managed care organization/service delivery area (MCO/SDA) groups participating in STAR.

Sample and Methodology

A stratified random sample of 4,600 adult STAR enrollees was targeted to participate in this survey. Between November 2008 and June 2009, 3,889 adults enrolled in STAR (representing members of 23 MCO/SDA groups) were surveyed by telephone.

The survey questionnaire was comprised of the following sections:

- the CAHPS[®] Health Plan Survey 4.0 (Medicaid module);
- the RAND[®] 36-Item Health Survey, version 1.0; and
- items developed by ICHP to assess member demographic and household characteristics.

Summary of Findings

Descriptive analyses were conducted on all survey questions, with a focus on HHSC Performance Dashboard Indicators for fiscal year 2009, the CAHPS[®] Health Plan Survey composite measures, access to care, specialized services, and care coordination. Statistical tests of differences were conducted between enrollees of the STAR program, among members of the 23 STAR MCO/SDA groups, and among relevant sub-groups of the sample (e.g., member's race/ethnicity, health status, and education). Multivariate analyses were also conducted to test the influence of several individual factors on health care satisfaction.

Positive Findings

- Among respondents who reported having a personal doctor, 53 percent had been going to their personal doctor for at least two or more years. Generally, enrollees rated their personal doctor favorably.
- Among those needing urgent care, 78 percent "usually" or "always" received the urgent care that they needed, which is comparable to that reported in Medicaid nationally (81 percent).

- The STAR program and 14 MCO/SDA groups met or exceeded the HHSC Performance Indicator Dashboard standard of 76 percent for good access to urgent care.
- The STAR program and 12 MCO/SDA groups met or exceeded the HHSC Performance Indicator Dashboard standard (62 percent) for the percentage of members who had good access to specialist referrals.
- The vast majority of STAR enrollees (93 percent) who saw a provider other than their personal doctor were pleased with the care coordination that they received from their health plan, doctor's office, or clinic.

Improvement Areas

- The percentage of STAR program enrollees who said they had a personal doctor (63 percent) was lower than among Medicaid enrollees nationally (84 percent), as was the percentage of members who said they had a personal doctor in each of the 23 MCO/SDA groups. Because all STAR enrollees either choose or are assigned a personal doctor upon enrollment, this finding suggests that many are not aware that they have a personal doctor.
 - Less than half of STAR enrollees (44 percent) who reported having a personal doctor said that they retained the primary care provider they had prior to enrollment. This finding indicates a need to improve the continuity of care for new enrollees to STAR.
- Sixty-seven percent of respondents had good access to routine care, which was below the HHSC Performance Indicator Dashboard standard of 78 percent. None of the 23 MCO/SDA groups met the HHSC standard for members having good access to routine care.
- Responses to the CAHPS[®] Health Plan Survey suggest the need to improve access to and timeliness of care in the STAR program. CAHPS[®] composite scores of 75 points or greater were considered to indicate positive health experiences.
 - In the STAR program, the mean score was below 75 points for *Getting Needed Care*.
 - In the STAR program overall and among 20 MCO/SDA groups, mean scores were below 75 on *Getting Care Quickly*.
- The STAR program performed lower (19 percent) than the HHSC Performance Indicator Dashboard standard (42 percent) for the percentage of enrollees waiting less than 15 minutes to be taken to the exam room. None of the 23 MCO/SDA groups were above the HHSC standard for waiting less than 15 minutes to be taken to the exam room.
- Sixty percent reported that it was "usually" or "always" easy to get an appointment with a specialist, which is slightly lower than that reported in Medicaid nationally (74 percent).
 - Eleven MCO/SDA groups did not meet the HHSC Performance Indicator Dashboard standard for access to specialist referrals, with the lowest rates found in Amerigroup - Harris, Superior - Travis, and Parkland - Dallas.
 - Individuals in poor health were significantly less likely than those in very good health to state that they "usually" or "always" were able to get an appointment with a specialist (56 percent and 78 percent, respectively).

The Texas STAR Health Caregiver Survey Report

Purpose

The information reported below presents the results from the 2010 STAR Health Caregiver Survey for the state of Texas, prepared by ICHP at the University of Florida. This telephone-based survey was conducted from December 2009 through February 2010 with the caregivers of foster care children enrolled in STAR Health for at least six months. The purpose of this survey was to:

- provide a demographic and health profile of children enrolled in STAR Health,
- assess caregivers' experiences and satisfaction with their children's health care, and
- assess changes in enrollee demographics, enrollee health status, and caregiver experiences and satisfaction since the 2009 STAR Health Foster Care Caregiver Transition Survey.

Sample and Methodology

A random sample of 1,400 children in foster care 18 years old and younger who were enrolled in STAR Health for at least six months prior to July 31, 2009 was selected for this survey. This represents 28 percent of the STAR Health population eligible for the survey. Enrollment data from the Superior Health Plan Network, which administers the STAR Health program in Texas, were used to identify the children who met the sample selection criteria. A statewide random sample of 400 completed surveys with caregivers of selected children in foster care was collected by telephone between December 2009 and February 2010.

The STAR Health Caregiver Survey is comprised of the following instruments:

- the CAHPS[®] Health Plan Survey 4.0 (Medicaid module);
- the CSHCN Screener[®]; and
- the PedsQL[™], Version 4.0.

Summary of Findings

This report highlights results from the fiscal year 2010 STAR Health Caregiver Survey.

Positive Findings

- Ninety-five percent of STAR Health enrollees reported having a personal doctor, and three out of four reported they have been seeing that same doctor for more than one year. The vast majority of caregivers (93 percent) reported that their child visited his or her personal doctor in the past six months.
 - Caregivers are generally satisfied with their child's personal doctor, providing an average personal doctor rating of 8.9 on a scale of 0 to 10.

- Waiting periods for non-urgent care are generally brief for most STAR Health enrollees. Most caregivers (76 percent) reported they were able to make an appointment for their child and see a health care provider within three days.
 - Most caregivers felt that their child’s health care provider “usually” or “always” answered their questions (91 percent).
- Among caregivers of enrollees with an urgent medical need, most reported that their child “usually” or “always” received care as soon as he or she needed (96 percent).
- Caregivers provided an average rating of their child’s health care of 8.4 on a scale of 0 to 10.
- Seventy-one percent of caregivers reported that they it was “usually” or “always” easy to get an appointment with a specialist.
 - Caregivers are generally satisfied with their child’s specialist, providing an average specialist rating of 8.9 on a scale of 0 to 10.
- The majority of caregivers (73 to 79 percent) stated that services, such as treatment or counseling, home health care, and special therapies (e.g., physical, speech), were “usually” or “always” easy to obtain for their child.
- Most caregivers reported they did not experience delays while waiting for Superior Health Plan to approve their child’s treatment or care (69 percent).
- The majority of caregivers reported that it was easy to get prescription medicine for their child through the health plan (92 percent).
- Overall, caregivers felt that customer service at the health plan treated them with courtesy and respect (96 percent).
- Most caregivers of children who received care coordination reported they were “satisfied” or “very satisfied” with the care coordination services offered through STAR Health (95 percent).
- Eighty-five percent of caregivers of children receiving service management reported they were “satisfied” or “very satisfied” with the quality of the service management services offered through STAR Health.

Improvement Areas

- Between 24 and 29 percent of STAR Health enrollees are obese, and between 19 and 21 percent of enrollees are overweight.
- Sixty-one percent of caregivers said that their child’s doctor did not provide them with choices regarding their child’s treatment and care.
- Approximately one in four caregivers reported having difficulty obtaining a referral or making an appointment with a specialist.
- Thirty-nine percent of caregivers reported having trouble getting needed medical equipment or devices for their child.
- CAHPS® composite results suggest that care coordination for enrollees is deficient.

- *Care Coordination* scores assess coordination of care with the child’s daycare or school and coordination of care across multiple providers or services by the child’s health plan, doctor’s office, or clinic. These scores were below 75 points for both CSHCN (47 percent) and children without special health care needs (57 percent).
- Few caregivers (18 percent) sought written or Internet information about their child’s health plan.
 - Caregivers with less formal education reported they were significantly less likely than those with more education to have sought information about their child’s health plan.
- Most caregivers (59 percent) reported having to place two or more calls to get the information they needed from their child’s health plan, and 16 percent reported having to make four or more calls or were still waiting for help or information.
- Almost one in three caregivers reported that their child’s personal doctor “never” or “sometimes” seemed informed and up-to-date about the care their child received from other providers.

The Texas Medicaid STAR Program Child Survey Report

Purpose

The information reported below presents the results from the 2011 Texas Medicaid STAR Program Child Survey for the state of Texas, prepared by ICHP at the University of Florida. This telephone-based survey was conducted from September 2010 through February 2011 with the caregivers of children enrolled in Texas STAR for at least six months. The purpose of this survey was to:

- describe the demographic and household characteristics of child members and their families;
- assess the health status of the population, including CSHCN; and
- document caregiver experiences and general satisfaction with the care their children receive through STAR across four domains of care: utilization of services, utilization of emergency department (ED) services, access to care and timeliness of care.

Sample and Methodology

Survey participants were selected from a stratified random sample of children enrolled in STAR for six months or longer between September 2010 and February 2011. A target sample of 4,200 completed telephone interviews with caregivers of sampled children was set, representing 300 respondents per STAR MCO. The response rate for this survey was 55 percent. A total of 4,208 telephone interviews were completed.

The fiscal year 2011 STAR Child Survey included:

- the CAHPS[®] Health Plan Survey 4.0 for child members,

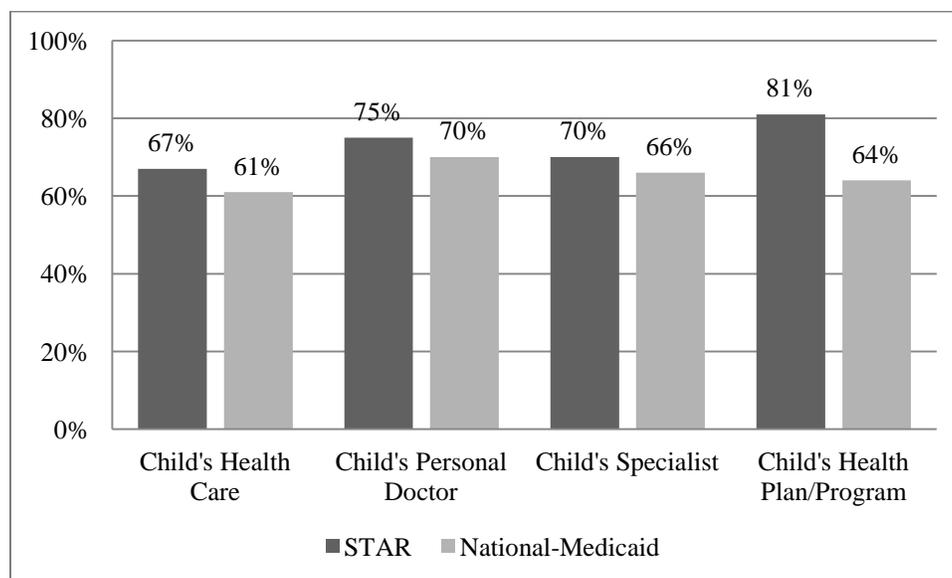
- items from the CAHPS[®] Clinician and Group Surveys,
- the CSHCN Screener[®], and
- items developed by ICHP pertaining to caregiver and member demographic and household characteristics.

Summary of Findings

Positive Findings

- **Caregiver Ratings.** The majority of caregivers provided high ratings of their child’s health care, doctors, and health plan, indicated by a rating of 9 or 10 on a 10-point scale. These ratings were greater than those published from Medicaid national data (see Figure 4).

Figure 4. Percent of Caregivers who Rated their Child’s Health Services a “9” or “10” (Range 0-10)

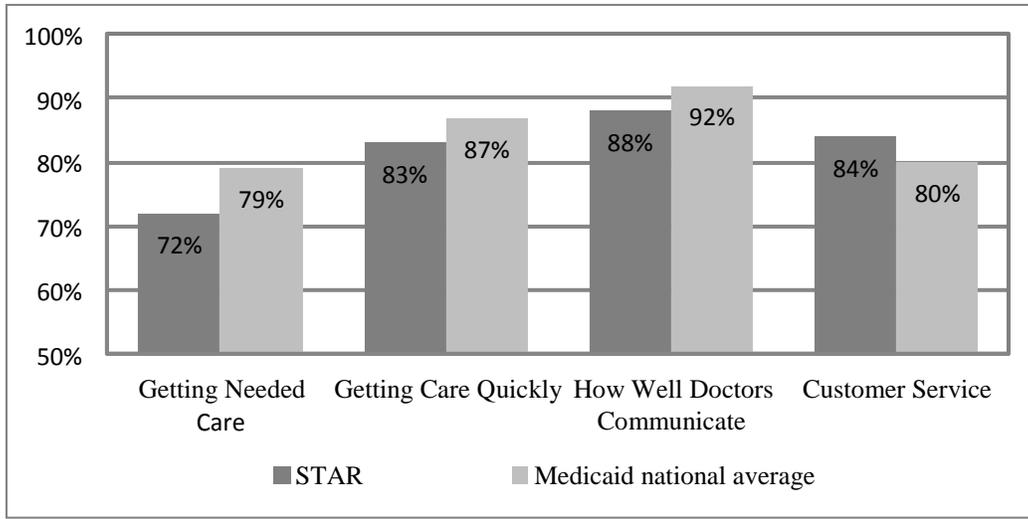


- **Access to Specialist Referral.** The majority of caregivers reported that they were usually or always able to get a referral for their child to see a specialist (69 percent). All MCOs except one met the HHSC Dashboard Standard of 59 percent for good access to specialist referrals.
- **Health Plan Customer Service.** Most caregivers reported that they usually or always had positive interactions with customer service at their child’s health plan (84 percent).

Improvement Areas

- **Getting Needed Care.** Seventy-two percent of STAR caregivers usually or always had positive experiences with *Getting Needed Care*, compared to the 79 percent reporting for Medicaid plans nationally (see Figure 5).

Figure 5. Percent of Caregivers who reported they “Usually” or “Always” Have a Positive Experience (CAHPS®)



- **Getting Care and Assistance for CSHCN.** Caregivers of CSHCN were significantly less likely than caregivers of non-CSHCN to report positive experiences with their child’s health plan and getting needed care for their child, such as appointments with specialists and tests and treatment, through the health plan.
- **Getting Specialized Services.** Although less than 10 percent of caregivers reported that their child needed specialized services, access to these services in STAR was lower than reported nationally (66 percent versus 74 percent).
- **HHSC Performance Dashboard Indicators.** Results of the following performance indicators indicate that few health plans are meeting HHSC Dashboard standards for good access to routine care, no delays in health care while waiting for health plan approval, and no exam room wait greater than 15 minutes (see Table 12).

Table 12. Percentage of Caregivers who reported they “Usually” or “Always” had the Performance Indicator

	STAR	HHSC Performance Dashboard Standard	Met Standard
Good access to routine care	79%	84%	No
Good access to urgent care	86%	86%	Yes
No exam room wait greater than 15 minutes	24%	35%	No
Good access to specialist referral	69%	59%	Yes
No delays in health care while waiting for health plan approval	63%	65%	No
Good access to behavioral health treatment or counseling	61%	-	-

* Good access to behavioral health treatment or counseling does not have a standard.

- Potentially Preventable ED Visits.** Among caregivers who took their child to the ED, over half said they visited the ED because they could not get an appointment at a doctor’s office or clinic as soon as they thought their child needed care. This type of potentially preventable ED visit was associated with lower personal doctor ratings and lower scores on doctors’ communication, independent of other demographic, health status, and health plan factors.

CONCLUSION

This Texas Health and Human Services System 2012 Report on Customer Service covered the results of 29 customer service surveys representing the opinions and feedback of over 99,000 individuals. Individuals who were surveyed cover all segments of HHS customers including consumers of services, enrollees in health plans, licensees, providers of services, and community stakeholders.

- Fourteen projects surveyed consumers of HHS services, including families of children with special needs, adults with disabilities, children and adults who received mental health and/or substance abuse services, elderly individuals residing in care facilities, and customers of eligibility offices. Overall, most respondents provided positive feedback regarding the services and supports they received through HHS programs.
- Enrollees in healthcare plans or programs such as STAR, STAR+PLUS and PCCM were surveyed through nine different surveys. Respondents included families or caregivers of enrolled children as well as enrolled adults. Across all surveys, many quality components were rated positively, meeting or exceeding dashboard benchmarks or national Medicaid standards. Components that did not meet benchmarks or standards were addressed as areas for improvement in each survey report.
- Two surveys were conducted to receive feedback from licensees – one involving the inspection process at childcare facilities and the other a general satisfaction survey of licensure services. Results of both surveys showed satisfaction among licensees.
- Providers of services were surveyed in two survey projects. The survey of contractors for CPS yielded very high satisfaction ratings. The survey of mental health and substance abuse providers showed more moderate results with some room for improvement in communications from the state program.
- Two surveys were conducted to obtain feedback from community stakeholders. Mostly positive feedback was provided by community stakeholders regarding the APS program. Opportunities for improvements in communication were found in a survey of mental health and substance about stakeholders.

Overall, the HHS system has succeeded in obtaining feedback from a diverse group of customers. Most consumers of services provided positive feedback regarding the services and supports they received through HHS programs. Feedback that identified opportunities for improvement will be focused on in the future. These results support the HHS system vision of providing high quality, cost-effective services resulting in improved health, safety, and greater independence for Texans.

APPENDIX A: CUSTOMER INVENTORY FOR THE DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)

DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET STRATEGY

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy A.1.1.: The Intake, Access and Eligibility to Services and Supports strategy provides functional eligibility determination, development of individual service plans that are based on consumer needs and preferences, assistance in obtaining information, and authorizing appropriate services and supports through effective and efficient management of DADS staff, and contracts with the Area Agencies on Aging (AAAs) and Local Authorities (LAs).</p>	<p>Direct customer groups include:</p> <ul style="list-style-type: none"> • Individuals who are older who meet specific eligibility requirements; • Individuals with physical, intellectual and/or developmental disabilities who meet specific eligibility requirements; and • Family members and caregivers of individuals who are older and those with disabilities who meet specific eligibility criteria.
<p>Strategy A.1.2.: The DADS Guardianship strategy provides guardianship services, either directly or through contracts with local guardianship programs, to individuals referred to the program by DFPS after a validated incident of abuse, neglect or exploitation.</p>	<p>Direct customer groups include:</p> <ul style="list-style-type: none"> • Individuals with diminished capacity who are older and who meet specific eligibility requirements; • Individuals with diminished capacity who have a disability and who meet specific eligibility requirements; and • Individuals with diminished capacity who are minors in CPS conservatorship.
<p>Strategy A.2.1.: The Primary Home Care (PHC) strategy provides non-skilled, personal care services for individuals whose chronic health problems impair their ability to perform activities of daily living (ADLs). Personal attendants assist individuals in performing ADLs, such as arranging or accompanying individuals on trips to receive medical treatment, bathing, dressing, grooming, preparing meals, housekeeping and shopping. On average, individuals are authorized to receive approximately 16.6 hours of assistance per week.</p>	<p>Direct customer groups include:</p> <p>Individuals 21 years of age and older who meet eligibility requirements including Medicaid eligibility, have a practitioner’s statement of medical need, and meet functional assessment criteria.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy A.2.2.: The Community Attendant Services (CAS) strategy provides non-skilled personal care services for individuals whose chronic health problems impair their ability to perform ADLs and whose income makes them ineligible for PHC. Personal attendants provide services to assist individuals in performing ADLs, such as arranging or accompanying the individual on trips to receive medical treatment, bathing, dressing, grooming, preparing meals, housekeeping and shopping. On average, individuals are authorized to receive approximately 16.4 hours of assistance per week. (Note: The term Frail Elderly is still used in federal language to refer to the law where the Federal legal authority can be located as part of the Social Security Act).</p>	<p>Direct customer groups include:</p> <p>Individuals of any age who meet specific eligibility requirements including income and resources, who have a practitioner’s statement of medical need and meet functional assessment criteria.</p>
<p>Strategy A.2.3.: The Title XIX, Day Activity and Health Services (DAHS) strategy provides licensed adult day care facility daytime services five days a week (Monday-Friday). Services are designed to address the physical, mental, medical and social needs of individuals, and must be provided or supervised by a licensed nurse. Services include nursing and personal care, noontime meal, snacks, transportation, and social, educational, and recreational activities. Individuals receive services based on half-day (three to six hours) units of service; an individual may receive a maximum of 10 units of service a week, depending on the physician's orders and related requirements.</p>	<p>Direct customer groups include:</p> <ul style="list-style-type: none"> • Title XIX: Individuals of any age who receive Medicaid and meet eligibility requirements, which include having a functional disability related to a medical condition, a need for a personal care task, and a medical diagnosis and physician’s orders requiring care or supervision by a licensed nurse. • Title XX: Individuals age 18 or older who meet specific eligibility requirements including income and resources and who have a functional disability related to a medical condition, a need for a personal care task, and a medical diagnosis and physician’s orders requiring care or supervision by a licensed nurse.

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy A.3.1: The Community Based Alternatives strategy provides services and supports to persons who are aged or with a disability as an alternative to residing in a nursing facility. Services include case management, adaptive aids, medical supplies, dental, adult foster care, assisted living/residential care, emergency response, nursing, minor home modifications, occupational therapy, personal assistance, home delivered meals, physical therapy, respite care, speech pathology and transition assistance services.</p>	<p>Direct customer groups include: Individuals 21 years of age or older who meet specific eligibility requirements including income, resource, and medical necessity requirements and who choose waiver services instead of nursing facility services.</p>
<p>Strategy A.3.2.: The Home and Community-Based Services strategy provides services and supports for individuals with intellectual or developmental disabilities as an alternative to an ICF/ID. Individuals may live in their own or family home, in a foster/companion care setting or in a residence with no more than four individuals who receive similar services. Services include case management, and as appropriate, residential assistance, supported employment, day habilitation, respite, dental treatment, adaptive aids, minor home modifications, and/or specialized therapies such as social work, behavioral support, occupational therapy, physical therapy, audiology, speech/language pathology, dietary services and licensed nursing services.</p>	<p>Direct customer groups include: Individuals of any age who have a determination/diagnosis of intellectual disability or related condition, who meet specific income, resource and level of care criteria and who choose HCS services instead of the ICF/ID program.</p>
<p>Strategy A.3.3.: The Community Living Assistance and Support Services strategy provides services and supports for individuals with related conditions as an alternative to residing in an ICF/ID. Individuals may live in their own or family home. Services include adaptive aids and medical supplies, case management, consumer directed services, habilitation, minor home modifications, nursing services, occupational and physical therapy, behavioral support services, respite, specialized therapies, speech pathology, pre-vocational services, supported employment, support family services and transition assistance services.</p>	<p>Direct customer groups include: Individuals of any age with a diagnosis of developmental disability other than intellectual disability who meet specific eligibility requirements including income, resource, and functional need, and who choose waiver services instead of institutional services.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy A.3.4.: The Deaf, Blind and Multiple Disabilities strategy provides services and supports for individuals with deaf blindness and one or more other disabilities as an alternative to residing in an ICF/ID. Individuals may reside in their own or family home or in small group homes. Services include adaptive aids and medical supplies, dental services, assisted living, behavioral support services, case management, chore services, minor home modifications, residential habilitation, day habilitation, intervener, nursing services, occupational therapy, physical therapy, orientation and mobility, respite, speech, hearing and language therapy, supported employment, employment assistance, dietary services, financial management services for the consumer directed services option and transition assistance services.</p>	<p>Direct customer groups include: Individuals of any age who are deaf, blind, and have a third disability, who meet specific eligibility requirements including income, resources and functional need and who choose waiver services instead of institutional services.</p>
<p>Strategy A.3.5.: The Medically Dependent Children Program strategy provides a variety of services and supports for families caring for children who are medically dependent as an alternative to residing in a nursing facility. Specific services include adaptive aids, adjunct support services, minor home modifications, respite, financial management services and transition assistance services.</p>	<p>Direct customer groups include: Individuals younger than age 21 who meet specific eligibility requirements including income, resource, and medical necessity criteria, and who choose waiver services instead of nursing facility services.</p>
<p>Strategy A.3.6. (New Number): The Texas Home Living strategy provides essential services and supports for individuals with intellectual or developmental disabilities as an alternative to residing in an ICF/ID. Individuals must live in their own or family homes. Service components are comprised of the CLS category and the Technical and Professional Supports Services category. The CLS category includes community support, day habilitation, employment assistance, supported employment and respite services. The Technical and Professional Supports Services category includes skilled nursing, behavioral support, adaptive aids, minor home modifications, dental treatment and specialized therapies. Coordination of services is provided by the local intellectual disability authority service coordinator.</p>	<p>Direct customer groups include: Individuals of any age who have a determination/diagnosis of intellectual disability or related condition, who meet specific eligibility requirements including income, resource and level of care criteria, and who choose waiver services over ICF/ID.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy A.4.1.: The Community Services and Supports – Non-Medicaid strategy services and supports are provided in community settings to enable individuals who are aging and those with disabilities to remain in the community, maintain their independence and avoid institutionalization.</p> <p>Services included in this strategy are Adult Foster Care, Consumer Managed Personal Attendant Services, Day Activity and Health Services, Emergency Response Services, Family Care, Home-Delivered Meals, Residential Services and Special Services for Persons with Disabilities.</p>	<p>Direct customer groups include:</p> <ul style="list-style-type: none"> • Non-Medicaid community (Title XX and general revenue funded) services are provided to individuals 18 years of age or older who meet specific eligibility requirements including income, resource and functional assessment criteria. • Older Americans Act (OAA) services are provided to individuals age 60 or older, their family caregivers and other caregivers caring for an eligible person.
<p>Strategy A.4.2.: The Intellectual Disabilities Community Services strategy implements the Health and Safety Code, §533.035, in which the LA provides individuals access to publicly funded services for individuals with intellectual and developmental disabilities. The strategy provides for the determination of eligibility and services and supports for individuals in the intellectual and developmental disabilities priority population who reside in the community, other than services provided through ICF/ID and Medicaid waiver programs. These services include service coordination, community support to assist individuals to participate in age-appropriate activities and services; employment services to assist individuals in securing and maintaining employment; day training services to help individuals develop and refine skills needed to live and work in the community; various therapies that are provided by licensed or certified professionals and respite services for the individual's primary caregiver.</p>	<p>Direct customer groups include:</p> <p>Individuals with a determination/diagnosis of intellectual disability who reside in the community.</p>
<p>Strategy A.4.3.: This strategy implements the Texas Promoting Independence Plan, developed in response to the U.S. Supreme Court ruling in <i>Olmstead v. L.C.</i> and two Executive Orders, GWB99-2 and RP13. The Promoting Independence Plan includes community outreach and awareness and relocation services. Community outreach and awareness is a program of public information developed to target groups that are most likely to be involved in decisions regarding long-term services</p>	<p>Direct customer groups include:</p> <p>Nursing Facility residents who have indicated a desire to relocate back into a community setting through either a personal request or through the Minimum Data Set 3.0 Section Q process.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>and supports. Relocation services involve assessment and case management to assist individuals in nursing facilities who choose to relocate to community-based services and supports. It includes funding for Transition to Living in the Community services to cover establishing and moving to a community residence.</p>	
<p>Strategy A.4.4.: The In-Home and Family Support – ID (IHFS-ID) strategy is a grant program that provides financial assistance to eligible persons and families for the purpose of purchasing items that meet a need that exists solely because of the person's intellectual disability or co-occurring physical disability. The program directly supports the person to live in his or her natural home, integrates the person into the community, or promotes the person's self-sufficiency. Funds may be used for services such as respite care, specialized therapies, home care, counseling and training, such as in-home parent training, special equipment, such as therapy equipment assistive technology, home modifications, transportation and other items that meet the program's criteria.</p> <p>There is a limit of \$2,500 per year, with the amount granted dependent upon on the individual's needs.</p>	<p>Direct customer groups include:</p> <p>Individuals with physical disabilities who need to purchase items above and beyond the scope of usual needs necessitated by the person's disability and directly supporting the individual's ability to live in his/her own home.</p>
<p>Strategy A.5.1.: The Program for All-Inclusive Care for the Elderly (PACE) strategy is an integrated managed care system for individuals who are aged or disabled. PACE provides community-based services in El Paso, Lubbock and Amarillo for individuals age 55 or older who qualify for nursing facility admission. PACE uses a comprehensive care approach, providing an array of services for a capitated monthly fee. PACE provides all health-related services for an individual, including in-patient and out-patient medical care, and specialty services, including dentistry, podiatry, social services, in-home care, meals, transportation, day activities and housing assistance.</p>	<p>Direct customer groups include:</p> <p>Individuals age 55 or older who are frail, qualify for nursing facility services, and receive Medicare and/or Medicaid.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy A.6.1: The Nursing Facility Payments strategy provides payments to promote quality of care for individuals with medical problems that require nursing facility or hospice care. The types of payments include Nursing Facility Care, Medicaid Swing Bed Program, Augmented Communication Device Systems, Customized Power Wheelchairs, Emergency Dental Services, Specialized and Rehabilitative Services.</p> <p>The Nursing Facility Payments provides institutional nursing care for individuals whose medical condition requires the skills of a licensed nurse on a regular basis. The nursing facility must provide for the medical, nursing, and psychosocial needs of each individual, to include room and board, social services, over-the-counter drugs (prescription drugs are covered through the Medicaid Vendor Drug program or Medicare Part D), medical supplies and equipment, personal needs items and rehabilitative therapies.</p>	<p>Direct customer groups include:</p> <p>Individuals with medical needs meeting medical necessity requirements and are eligible for Medicaid. The individuals must reside in a nursing facility for 30 consecutive days.</p>
<p>Strategy A.6.2.: The Medicare Skilled Nursing Facility (SNF) strategy covers the payment of Medicare SNF co-insurance for Medicaid recipients in Medicare (XVIII) facilities. Medicaid also pays the co-payment for Medicaid Qualified Medicare Beneficiary (QMB) recipients, and for "Pure" (i.e., Medicare-only) QMB recipients. For recipients in dually certified facilities (certified for both Medicaid and Medicare), Medicaid pays the coinsurance less the applied income amount for both Medicaid only and Medicaid QMB recipients. For "Pure" QMB recipients, the entire coinsurance amount is paid. The amount of Medicare co-insurance per day is set by the federal government at one-eighth of the hospital deductible.</p>	<p>Direct customer groups include:</p> <p>Individuals who receive Medicaid and reside in Medicare (XVIII) skilled nursing facilities, Medicaid/ QMB recipients and Medicare only QMB recipients.</p>
<p>Strategy A.6.3.: The Medicaid Hospice strategy provides services to Medicaid recipients who no longer desire curative treatment and who have a physician's prognosis of six months or less to live. Available services include physician and nursing care; medical social services; counseling; home health aide; personal care, homemaker and household services; physical, occupational, or speech language pathology services; bereavement counseling; medical appliances</p>	<p>Direct customer groups include:</p> <p>Individuals eligible for Medicaid who are terminally ill for whom curative treatment is no longer desired and who have a physician's prognosis of six months or less to live.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>and supplies; drugs and biologicals; volunteer services; general inpatient care (short-term); and respite care. Service settings can be in the home, community settings, or in long-term-care facilities.</p> <p>Medicaid rates for community-based Hospice are based on Medicare rates set by the Center for Medicare and Medicaid Services (CMS). For individuals residing in a nursing facility or an ICF/ID and receiving hospice services, the facility also receives a payment of 95% of the established nursing facility rate for that individual.</p>	
<p>Strategy A.6.4.: The Promote Independence by Providing Community-based Services strategy supports "the Money Follows the Person" provisions which allow a Medicaid-eligible nursing facility resident to relocate back into the community and to receive long-term services and supports. Dollars from this strategy specifically fund the community-based services which support the individual while he/she resides in the community setting. Services may include 1915(c) waiver or other community services and do not impact funding supported by the other community-based services.</p> <p>Assistance is available from DADS contracted relocation specialists who provide outreach, facilitation and coordination with nursing facility relocation for individuals with complex needs. In addition, the AAA provide information about community options such as housing, health care, transportation, daily living and social activities that can help individuals and their families make a decision from the planning phase to actual relocation in the community.</p>	<p>Direct customer groups include:</p> <p>Nursing Facility (NF) residents, who are Medicaid eligible, have been in the NF for 30 days and who meet community based waiver functional eligibility requirements.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy A.7.1.: The ICFs/ID strategy funds residential facilities serving four or more individuals with intellectual and developmental disabilities. Section 1905(d) of the Social Security Act created this optional Medicaid benefit to certify and fund these facilities. Each private or public facility must comply with federal and state standards, laws and regulations. These facilities provide active treatment, including diagnosis, treatment, rehabilitation, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services to help each individual function at their greatest ability.</p>	<p>Direct customer groups include: Individuals with intellectual and/or developmental disabilities who would benefit or require 24-hour supervised living arrangements and qualify for Medicaid.</p>
<p>Strategy A.8.1.: The State Supported Living Centers (SSLC) Services' strategy provides direct services and support for individuals admitted to the twelve state-supported living centers and one state center providing intellectual and developmental disability residential services. SSLCs are located in Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio. The Rio Grande State Center is in Harlingen and is operated by DSHS through a contract with DADS.</p> <p>Each center is certified as a Medicaid-funded ICF/ID. Approximately 60% of the operating funds are received from the federal government and 40% from State General Revenue or third-party sources.</p> <p>The SSLCs and the Rio Grande State Center provide 24-hour residential services, comprehensive behavioral treatment and health care services including physician, nursing and dental services. Other services include skills training; occupational, physical and speech therapies; vocational programs, employment; and services to maintain connections between residents and their families/natural support systems.</p>	<p>Direct customer groups include: Individuals who have a determination/diagnosis of intellectual disability who are medically fragile, have severe physical impairments, have severe behavioral problems, or cannot currently be served in the community. All individuals have been committed through either criminal or civil commitments.</p>
<p>Strategy A.9.1: For DADS, funding in this strategy is for the construction and renovation of facilities at the SSLCs and State-owned bond homes for individuals with intellectual and developmental disabilities. The vast majority of projects currently</p>	<p>Direct customer groups include: Individuals who have a determination/diagnosis of intellectual disability who are medically fragile, have severe physical impairments, have severe</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>funded and underway are to bring existing facilities into compliance with the requirements in the Life Safety Code and/or other critical repairs and renovations, including fire sprinkler systems, fire alarm systems, emergency generators, fire/smoke walls, roofing, air conditioning, heating, electrical, plumbing, etc.</p> <p>The large number of buildings on site at the SSLCs and the age of many of these buildings necessitates ongoing capital investments to ensure that the buildings are functional, safe, and in compliance with all pertinent standards. Compliance with such standards is mandatory to avoid the loss of federal funding for the state facilities.</p>	<p>behavioral problems or cannot currently be served in the community. All individuals have been committed through either criminal or civil commitments.</p>
<p>Strategy B.1.1.: The Facility and Community-based Regulation strategy covers the licensing and regulation of all long-term care facilities/agencies that meet the definition of nursing homes, assisted living facilities, adult day-care facilities, privately owned ICFs/ID and Home and Community Support Services Agencies (HCSSAs). Licensed facilities/agencies wishing to participate in Medicare and/or Medicaid programs must be certified and maintain compliance with certification regulations according to Titles XVIII and/or XIX of the Social Security Act. Government-operated ICFs/ID and skilled nursing units within an acute care hospital are also required to be certified in order to participate in Medicare and/or Medicaid.</p> <p>In addition to licensing these long-term care facilities and agencies, DADS responsibilities for these regulated programs include investigating complaints and self-reported incidents; monitoring facilities for compliance with state and/or federal regulations; certification review of HCS waiver contracts and TxHmL waiver contracts; investigating complaints related to HCS and TxHmL services; and receiving and following up on DFPS findings related to abuse, neglect, or exploitation investigations of persons who receive HCS or TxHmL services.</p>	<p>Direct customer groups include:</p> <ul style="list-style-type: none"> • Providers of long-term care services that meet the definitions of nursing facility, assisted living facility, adult day care facility, private intermediate care facility for persons with an intellectual disability or home and community support agency; • Persons receiving services in facilities or from agencies regulated under this strategy; • Persons eligible to receive services under TxHmL and HCS waiver contracts; and • Family and community members of persons receiving services in facilities or agencies regulated under this strategy who may obtain assurance that regulated facilities and agencies meet the minimum standard of care required by statute and regulation.

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy B.1.2.: The Credentialing/Certification strategy covers DADS licensing, certification, permitting and monitoring of individuals for the purpose of employability in facilities and agencies regulated by DADS through four credentialing programs.</p> <p>Nursing Facility Administrator Licensing and Enforcement responsibilities include licensing and continuing education activities; investigating complaints or referrals; coordinating sanction recommendations and other licensure activities; imposing and monitoring sanctions and due process considerations; and developing educational, training, and testing curricula.</p> <p>Nurse Aide Registry (NAR) and Nurse Aide Training and Competency Evaluation Program (NATCEP) responsibilities include nurse aide certification and sanction activities; approving, renewing or withdrawing approval of NATCEPs; and due process considerations and determination of nurse aide employability in DADS regulated facilities via the NAR.</p> <p>Employee Misconduct Registry (EMR) responsibilities include due process considerations and determination of unlicensed staff employability in DADS regulated facilities/agencies via the EMR. Medication Aide Program responsibilities include medication aide permit issuance and renewal; imposing and monitoring sanctions; due process considerations; approving and monitoring medication aide training programs in educational institutions; and coordinating/administering examinations.</p>	<p>Direct customer groups include:</p> <ul style="list-style-type: none"> • Persons employed or seeking employment as nursing facility administrators, nurse aides and medication aides benefit from training and from assurance that people working in the field meet minimum standards; • Providers of long-term care services that meet the definitions of nursing facility, assisted living facility, adult day care facility, private intermediate care facility for persons with an intellectual disability or home and community support agency benefit from training programs for employees, from monitoring of certification of employees and from access to misconduct registry for unlicensed employees; • Persons receiving services in facilities or from agencies regulated by DADS benefit from having a more highly qualified workforce as caregivers and administrators; and • Family and community members of persons receiving services in facilities or agencies regulated under this strategy who may obtain assurance that caregivers meet minimum standards through licensing and credentialing.

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy B.1.3.: The Long-Term Services and Supports Quality Outreach strategy performs a variety of functions designed to enhance the quality of services and supports. Quality monitors, who are nurses, pharmacists, and dietitians, provide technical assistance to long-term facility staff. The quality monitors perform structured assessments to promote best practice in service delivery. In addition, quality monitors provide in-service education programs. Quality Monitoring Team visits are also provided to facilities and may include more than one discipline during the same visit. The technical assistance visits focus on specific, statewide quality improvement priorities for which evidence-based best practice can be identified from published clinical research.</p> <p>The program works to improve clinical outcomes for individuals, such as pain assessment, pain management, infection control, appropriate use of psychoactive medications, risk management for falls, improving nutritional practices, use of artificial nutrition and hydration, and advance care planning. The purpose of the program is to increase positive outcomes and to improve the quality of services for individuals served in these settings. A related website, http://www.TexasQualityMatters.org, supports the program by providing online access to best-practice information and links to related research.</p>	<p>Direct customer groups include:</p> <p>Staff in nursing homes, SSLCs, ICFs, ALFs and the people who live in these settings. QMP staff provide in-services which are attended by the people who live there, as well as their family members.</p>

APPENDIX B: CUSTOMER INVENTORY FOR THE DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES (DARS)

DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET STRATEGY

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy A.1.1.: Comprehensive Services. Administer a statewide comprehensive system of services to ensure that eligible infants, toddlers and their families have access to the resources and support they need to reach their service plan goals.</p>	<p>Children with Disabilities & Their Families: DARS serves families with children birth to 36 months with developmental disabilities or delays and must provide early childhood intervention services to all eligible children.</p>
<p>Strategy A.1.2.: Respite Services. Ensure that resources are identified and coordinated to provide respite service to help preserve the family unit and prevent costly out-of-home placements.</p>	<p>Children with Disabilities & Their Families: DARS provides respite services to families served by the ECI program.</p>
<p>Strategy A.1.3.: Ensure Quality Services. Ensure the quality of early intervention services by offering training and technical assistance, establishing service and personnel standards, and evaluating consumer satisfaction and program performance.</p>	<p>Children with Disabilities & Their Families: DARS carries out activities required under the Individuals with Disabilities Education Act (IDEA), including ensuring the availability of qualified personnel to serve all eligible children, involving families and stakeholders in policy development, evaluating services, providing impartial opportunities for resolution of disputes, and guaranteeing the rights of the children and families are protected.</p>
<p>Strategy A.2.1.: Habilitative Services For Children. Provide information and training for blind and visually impaired children and their families so these children have the skills and confidence to live as independently as possible.</p>	<p>Blind or Visually Impaired Consumers & Their Families: DARS provides services necessary to assist blind children to achieve self-sufficiency and a fuller richer life.</p>
<p>Strategy B.1.1.: Independent Living Services – Blind. Provide quality, consumer-directed independent living services that focus on acquiring skills and confidence to live as independently as possible in the community for eligible persons who are blind or visually impaired.</p>	<p>Blind or Visually Impaired Consumers: DARS is responsible for providing services that assist Texans with visual disabilities to live as independently as possible.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy B.1.2.: Blindness Education. Provide screening, education, and urgently needed eye-medical treatment to prevent blindness.</p>	<p>Citizens of Texas: DARS provides public education about blindness, screenings and eye exams to identify conditions that may cause blindness and treatment procedures necessary to prevent blindness.</p>
<p>Strategy B.1.3.: Vocational Rehabilitation - Blind. Rehabilitate and place persons who are blind or visually impaired in competitive employment or other appropriate settings, consistent with informed choice and abilities.</p>	<p>Blind or Visually Impaired Consumers: DARS provides services designed to assess, plan, develop and use vocational rehabilitation services for individuals who are blind consistent with their strengths, resources, priorities, concerns and abilities so that they may prepare for and engage in gainful employment.</p> <p>Citizens of Texans/Taxpayers: The VR program: DARS promotes employment, often reducing dependence on state-funded programs and increasing tax revenue for the state.</p> <p>Employers: DARS work with people with disabilities and employers to identify appropriate job placements for these individuals.</p>
<p>Strategy B.1.4.: Business Enterprises of Texas. Provide employment opportunities in the food service industry for persons who are blind or visually impaired.</p>	<p>Blind or Visually Impaired Consumers: DARS provides training and employment opportunities in the food service industry for Texans who are blind or visually impaired.</p>
<p>Strategy B.1.5.: Business Enterprises of Texas Trust Fund. Administer trust funds for retirement and benefits program for individuals licensed to operate vending machines under Business Enterprises of Texas (estimated and nontransferable).</p>	<p>Blind or Visually Impaired Consumers: DARS has established and maintains a retirement and benefit plan for blind or visually impaired individuals who are licensed managers in the Business Enterprise of Texas program.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy B.2.1.: Contract Services. Develop and implement a statewide program to ensure continuity of services to persons who are deaf or hard of hearing. Ensure more effective coordination and cooperation among public and nonprofit organizations providing social and educational services to individuals who are deaf or hard of hearing.</p>	<p>Deaf or Hard of Hearing Consumers: DARS, through a network of local service providers at strategic locations throughout the state, provides communication access services including interpreter services and computer assisted real-time transcription services, information and referral, hard of hearing services, and resource specialists' services.</p>
<p>Strategy B.2.2.: Consumer and Interpreter Education. Facilitate communication access activities through training and educational programs to enable individuals who are deaf or hard of hearing to attain equal opportunities to participate in society to their potential and reduce their isolation regardless of location, socioeconomic status, or degree of disability.</p> <p>Interpreters Certification. To test interpreters for the deaf and hard of hearing to determine skill level and certify accordingly, and to regulate interpreters to ensure adherence to interpreter ethics.</p>	<p>Deaf or Hard of Hearing Consumers; DARS provides services through a statewide program of advocacy and education on topics such as ADA, hard of hearing issues and interpreter training.</p> <p>Higher Education Institutions and Students: DARS assists institutions of higher education in initiating training programs for interpreters.</p> <p>Current and Potential Interpreters: DARS provides skills building and training opportunities for interpreters and coordinates training sponsored by other entities.</p> <p>Current and Potential Interpreters: DARS administers a system to determine the varying levels of proficiency of interpreters and maintains a certification program for interpreters.</p> <p>Deaf or Hard of Hearing Consumers: DARS ensures that interpreters are able to adequately assist in the communication facilitation process for people who are deaf or hard of hearing.</p>
<p>Strategy B.2.3.: Telephone Access Assistance. Ensure equal access to the telephone system for persons with a disability.</p>	<p>Consumers with Disabilities: DARS provides vouchers for the purchase of specialized telecommunications equipment for access to the telephone network for eligible persons with disabilities.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy B.3.1.: Vocational Rehabilitation - General. Rehabilitate and place people with general disabilities in competitive employment or other appropriate settings, consistent with informed consumer choice and abilities.</p>	<p>Vocational Rehabilitation Consumers: DARS provides services leading to employment consistent with consumer choice and abilities for eligible persons with disabilities.</p> <p>Citizens of Texans/Taxpayers: The VR program promotes employment, often reducing dependence on state-funded programs and increasing tax revenue for the state.</p> <p>Employers: DARS works with people with disabilities and employers to identify appropriate job placements for these individuals.</p>
<p>Strategy B.3.2.: Independent Living Centers. Work with independent living centers and the State Independent Living Council to establish the centers as financially and programmatically independent from the Department of Assistive and Rehabilitative Services and financially and programmatically accountable for providing core services to their customers.</p>	<p>Consumers with Disabilities: Centers for Independent Living offer services to eligible consumers with significant disabilities who are interested and can benefit, regardless of vocational potential. Centers provide, at the minimum, the following core services: advocacy, peer counseling, independent living skills training, and information and referral.</p>
<p>Strategy B.3.3.: Independent Living Services - General. Provide consumer-driven and DARS counselor-supported independent living services to people with significant disabilities.</p>	<p>Consumers with Disabilities: DARS provides people with significant disabilities, who are not receiving vocational rehabilitation services, with services that will substantially improve their ability to function, continue functioning, or move toward functioning independently in the home, family, or community.</p>
<p>Strategy B.3.4.: Comprehensive Rehabilitation. Provide consumer-driven and counselor-supported Comprehensive Rehabilitation Services for people with traumatic brain injuries or spinal cord injuries.</p>	<p>Consumers with Traumatic Brain or Spinal Cord Injuries: DARS provides adults who have suffered a traumatic brain or spinal cord injury with comprehensive inpatient or outpatient rehabilitation and/or acute brain injury services.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy C.1.1.: Disability Determination Services (DDS). Determine eligibility for federal Supplemental Security Income and Social Security Disability Insurance benefits.</p>	<p>Texas Citizens Applying for SSI or SSDI: DARS determines whether persons who apply for Social Security Administration (SSA) disability benefits meet the requirements for “disability” in accordance with federal law and regulations.</p> <p>Federal government: DARS assists SSA in making disability determination decisions for this federal program in a quick, accurate and cost-effective manner.</p>
<p>Strategy D.1.1.: Central Program Support.</p>	<p>DARS Employees: DARS provides central support services for DARS employees.</p>
<p>Strategy D.1.2.: Regional Program Support.</p>	<p>DARS Employees: DARS provides central support services for DARS employees.</p>
<p>Strategy D.1.3.: Other Program Support.</p>	<p>DARS Employees: DARS provides central support services for DARS employees.</p>
<p>Strategy D.1.4.: IT Program Support Information. Technology Program Support.</p>	<p>DARS Employees: DARS provides central support services for DARS employees.</p>

APPENDIX C: CUSTOMER INVENTORY FOR THE DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (DFPS)

DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET STRATEGY

<p>STRATEGY (ABEST 2011)</p>	<p>STAKEHOLDER GROUPS/ SERVICES PROVIDED</p>
<p>Strategy A.1.1: Statewide Intake Services. Provide a comprehensive system with automation support for receiving reports of persons suspected to be at risk of abuse/neglect/exploitation and assign for investigation those reports that meet Texas Family Code and Human Resources Code definitions.</p>	<p>Children and Adults At Risk of Abuse and Neglect: Statewide Intake provides central reporting and investigation assignments so that all children at risk of abuse and neglect and all elderly and adults with disabilities who have been abused, neglected, and exploited can be protected.</p> <p>Citizens of Texas: DFPS provides confidential access to services for all citizens of Texas.</p> <p>External Partners: In providing access to DFPS services through the Statewide Intake function, DFPS interacts with law enforcement agencies, the medical sector, schools, and the general reporting public.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy B.1.1: CPS Direct Delivery Staff. Provide caseworkers and related staff to conduct investigations and deliver family-based safety services, out-of-home care, and permanency planning for children who are at risk of abuse/neglect and their families.</p> <p>Strategy B.1.2: CPS Program Support. Provide staff, training, automation, and special projects to support a comprehensive and consistent system for the delivery of child protective services.</p>	<p>Children and Families: DFPS protects children by investigating reports of abuse and neglect, working with children and families in their own homes to alleviate the effects of abuse/neglect, and providing services to prevent further abuse/neglect, and if necessary, placing children in substitute care until they can be safely returned home, to relatives, or until they are adopted.</p> <p>External Partners: Conducting investigations and providing casework for children in their own homes and children who have been removed from their homes involves many external partners, such as law enforcement agencies, the medical sector, schools, Child Welfare Boards, the judiciary, faith-based organizations, Child Advocacy Centers, children’s advocate groups, domestic violence service providers, other HHSC system agencies, and state and national child welfare associations.</p>
<p>Strategy B.1.3: TWC Foster Day Care. Provide purchased day care services for foster children where both or the one foster parent works full-time.</p> <p>Strategy B.1.4: TWC Relative Day Care. Provide purchased day care services for relative and other designated caregivers who work full time.</p> <p>Strategy B.1.5: TWC Protective Day Care. Provide purchased day care services for children living at home to control and reduce the risk of abuse/neglect and to provide stability while a family is working on changes to reduce the risk.</p>	<p>Children and Families: DFPS protects children by purchasing day care to keep a child safe in their home or to assist working foster parents.</p> <p>Other Agencies: DFPS purchases day care under a contract with the Texas Workforce Commission.</p> <p>Local Governments: Through the contract with the Texas Workforce Commission, DFPS has access to the network of child care providers managed by local workforce boards.</p>
<p>Strategy B.1.6: Adoption Purchased Services. Provide purchased adoption services with private child-placing agencies to facilitate the success of service plans for children who are legally free for adoption, including recruitment, screening, home study, placement, and support services.</p>	<p>Children and Families: DFPS increases permanency placement options for children awaiting adoption by contracting for adoption services, and helps ensure success of adoptions by providing post-adoption services.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy B.1.7: Post-Adoption Purchased Services. Provide purchased post-adoption services for families who adopt children in the conservatorship of DFPS, including casework, support groups, parent training, therapeutic counseling, respite care, and residential therapeutic care.</p>	<p>Contracted Service Providers: DFPS contracts with private child-placing agencies to recruit, train and verify adoptive homes, secure adoptive placements, provide post-placement supervision, and facilitate the consummation of the adoptions. DFPS also purchases post-adoption services from various service providers.</p>
<p>Strategy B.1.8: Preparation for Adult Living Purchased Services. Provide purchased adult living services to help and support youth preparing for departure from DFPS substitute care, including life skills training, money management, education/training vouchers, room and board assistance, and case management.</p>	<p>Youth in Substitute Care: DFPS provides services to prepare youth in substitute care for adult life. Services are also available for youth who have aged out of the substitute care system to ensure a successful transition to adulthood.</p> <p>Contracted Service Providers: DFPS purchases these youth services from various service providers.</p>
<p>Strategy B.1.9: Substance Abuse Purchased Services. Provide purchased residential chemical dependency treatment services for adolescents who are in the conservatorship of DFPS and/or parents who are referred to treatment by DFPS.</p>	<p>Children and Families: DFPS protects children by purchasing substance abuse treatment services and drug-testing services for children in the CPS system and their families.</p> <p>Contracted Service Providers: DFPS purchases these services from various service providers.</p>
<p>Strategy B.1.10: Other CPS Purchased Services. Provide purchased services to treat children who have been abuse or neglected, to enhance the safety and well-being of children at risk of abuse and neglect, and to enable families to provide safe and nurturing home environments for their children.</p>	<p>Children and Families: DFPS protects children by purchasing various types of services for children in the CPS system and their families. Services include evaluation of psychological and psychiatric functioning; individual, group, and family therapy, parenting, battering intervention, life skills, etc.</p> <p>Contracted Service Providers: DFPS purchases these services from various service providers.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy B.1.11: Foster Care Payments. Provide financial reimbursement for the care, maintenance, and support of children who have been removed from their homes and placed in licensed, verified child care facilities.</p>	<p>Children in Foster Care: DFPS provides reimbursement for the care, maintenance, and treatment of children who have removed from their homes.</p> <p>Kinship and Other Designated Caregivers: DFPS provides monetary assistance to kinship and other designated caregivers to help ensure successful placements for children removed from their homes.</p> <p>Contracted Service Providers: DFPS purchases these services from DFPS foster homes, contracted child-placing agencies, and child care facilities.</p> <p>Other Agencies: DFPS provides federal Title IV-E funding for eligible children in the custody of the Texas Youth Commission and the Texas Juvenile Probation Commission, as well as their administrative costs for reasonable candidates for foster care.</p> <p>Local Governments: DFPS provides federal Title IV-E funding to participating counties for allowable expenses for foster care maintenance and administration.</p> <p>External Partners: The foster care program would not be possible without the 24-hour residential child care providers. DFPS works closely with provider groups and associations.</p>
<p>Strategy B.1.12: Adoption/PCA Payments. Provide grant benefit payments for families that adopt foster children with special needs and for relatives that assume permanent managing conservatorship of foster children, and one-time payments for non-recurring costs.</p>	<p>Children and Families: DFPS helps ensure a permanent placement for children available for adoption with special needs by providing a monthly subsidy payment to assist with the cost of the child's special needs. DFPS also provides Permanency Care Assistance to relative caregivers that assume permanent managing conservatorship for a child.</p>
<p>Strategy B.1.13: Relative Caregiver Payments. Provide monetary assistance for children in the state</p>	<p>Kinship and Other Designated Caregivers: DFPS provides monetary</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
relative and other designated caregiver program.	assistance to kinship and other designated caregivers to help ensure successful placements for children removed from their <i>homes</i> .
<p>Strategy C.1.1: Services to At-Risk Youth Program. Provide contracted prevention services for youth ages 10-17 who are in at-risk situations, runaways, or Class C delinquents, and for youth under the age of 10 who have committed delinquent acts.</p> <p>Strategy C.1.2: Community Youth Development Program. Provide funding and technical assistance to support collaboration by community groups to alleviate family and community conditions that lead to juvenile crime.</p> <p>Strategy C.1.3: Texas Families Program. Provide community-based prevention services to alleviate stress and promote parental competencies and behaviors that will increase the ability of families to successfully nurture their children.</p> <p>Strategy C.1.4: Child Abuse Prevention Grants. Provide child abuse prevention grants to develop programs, public awareness, and respite care through community-based organizations.</p> <p>Strategy C.1.5: Other At-Risk Prevention Programs. Provide funding for community-based prevention programs to alleviate conditions that lead to child abuse/neglect and juvenile crime.</p> <p>Strategy C.1.6: At-Risk Prevention Program Support. Provide program support for at-risk prevention services.</p>	<p>Children and Families: DFPS provides funding for community-based child abuse prevention and juvenile delinquency prevention services to at-risk children and for the families of those children.</p> <p>Contracted Service Providers: DFPS contracts with various community-based organizations across the state to deliver all the prevention and early intervention services described in A.2.12 through A.2.17.</p> <p>Other Agencies: At-risk prevention services involve participation from the Texas Education Agency, Texas Juvenile Probation Commission, and Texas Youth Commission.</p> <p>Local Governments: At-risk prevention services involve participation from local juvenile probation departments. Some prevention services are provided through contracts with local governments.</p> <p>External Partners: Overseeing prevention services involves many external partners such as law enforcement agencies, schools, and children’s advocate groups.</p>
<p>Strategy D.1.1: APS Direct Delivery Staff. Provide caseworkers and related staff to conduct investigations and provide or arrange for services for vulnerable adults.</p> <p>Strategy D.1.2: APS Program Support. Provide staff, training, automation, and special projects to support a comprehensive and consistent system for the delivery of adult protective services.</p>	<p>Adults who are over 65 or who have disabilities: DFPS protects adults who are over age 65 or who have disabilities from abuse, neglect, and exploitation, and providing services to remedy or prevent further abuse.</p> <p>Contracted Service Providers: DFPS contracts with various service providers to deliver necessary emergency services for</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	<p>APS clients.</p> <p>Other Agencies: Adult protective services includes support and involvement from DADS and DARS.</p> <p>Local Governments: Providing adult protective services involves support and participation from city and county health and social services departments, and the Area Agencies on Aging.</p> <p>External Partners: Conducting investigations and providing services involves many external partners, such as law enforcement agencies, the medical sector, the judiciary, faith-based organizations, non-profit social service agencies, advocate groups for adults who are over age 65 or who have disabilities, state and national associations on aging and care for the elderly, and family and friends of APS clients.</p>
<p>Strategy D.1.3: MH and MR Investigations. Provide a comprehensive and consistent system for the investigation of reports of abuse, neglect, and exploitation of persons receiving services in mental health and mental retardation settings.</p>	<p>Persons with mental illness (MI) and/or intellectual disabilities (ID) served by or through facility settings: DFPS protects persons who have MI and ID served by or through MH and MR settings by investigating reports of abuse, neglect, and exploitation.</p> <p>Other Agencies: Adult protective services for persons served in these settings include support and involvement from DADS, DSHS, and DARS.</p> <p>Local Governments: Providing adult protective services for persons served in these settings involves support and participation from Community MHMR Centers.</p> <p>External Partners: Providing adult protective services for persons served in these settings involves many external partners, such as advocacy groups for persons with mental illness and</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	intellectual disabilities, state and national associations for mental health, and family and friends of MH and ID clients.
<p>Strategy E.1.1: Child Care Regulation. Provide a comprehensive system of consultation, licensure, and regulation to ensure maintenance of minimum standards by day care and residential child care facilities, registered family homes, child-placing agencies, and facility administrators, and child-placing agency administrators.</p>	<p>Children and Families: DFPS helps ensure the health, safety, and well-being of children in child day care and 24-hour residential child care settings by developing and regulating compliance with minimum standards and investigating reports of abuse and neglect in child care facilities.</p> <p>Other State Agencies: Child care regulation involves support and participation by Texas Workforce Commission, DSHS, and other regulatory agencies.</p> <p>Local Governments: DFPS regulation of child care facilities involves the network of child care providers managed by local workforce boards. It also includes local health agencies and fire inspectors.</p> <p>External Partners: DFPS regulation of child care facilities includes listed family homes, registered child care homes, licensed child care centers and homes, licensed residential child care facilities, and licensed child placing agencies. Other external partners in ensuring safety of children in childcare settings include parents, schools, licensed child care administrators, and children’s advocates.</p>
<p>Strategy F.1.1: Central Administration. Strategy F.1.2: Other Support Services. Strategy F.1.3: Regional Administration. Strategy F.1.4: IT Program Support. Strategy F.1.5: Agency-wide Automated System. Develop and enhance automated systems that service multiple programs (capital projects).</p>	<p>DFPS provides indirect administrative support for all programs. All stakeholder groups would be included for this group of strategies. Additionally, DFPS employees receive support services under these strategies.</p>

APPENDIX D: CUSTOMER INVENTORY FOR THE DEPARTMENT OF STATE HEALTH SERVICES (DSHS)

DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET STRATEGY

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>A.1.1 Public Health Preparedness and Coordinated Services. Provides a strong, flexible public health system necessary to be prepared for and respond to any large scale public health disaster.</p>	<p>Citizens of Texas: DSHS is responsible for public health and medical services during a disaster or public health emergency.</p> <p>Other Local, State, and Federal Agencies: Local health departments, DSHS service regions, the Texas Division of Emergency Management, Regional Advisory Councils, the Texas Association of Local Health Officials laboratories and laboratory response networks, first responders, law enforcement, environmental, veterinary, and agricultural laboratories, hospitals and healthcare systems.</p> <p>Texas-Mexico Border Residents: DSHS coordinates and promotes health issues between Texas and Mexico and identifies resources and develops projects that support community efforts to improve border health.</p> <p>Border Health Partners: DSHS provides interagency coordination and assistance on public health issues with local border health partners; binational health councils; state border health offices in California, Arizona and New Mexico; U.S.-Mexico Border Health Commission; Pan American Health Organization; México Secretaria de Salud; and other state and federal agency border programs.</p>

<p style="text-align: center;">STRATEGY (ABEST 2011)</p>	<p style="text-align: center;">STAKEHOLDER GROUPS/ SERVICES PROVIDED</p>
<p>A.1.2. Health Registries, Information, and Vital Records. Concerns the collection, analysis, and dissemination of health data to aid in monitoring, evaluating, and improving public health. Also includes the maintenance of the basic identity documents pertaining to all Texans, along with the registries that collect health information for research purposes.</p>	<p>Citizens of Texas: DSHS provides vital records needed to access benefits and services.</p> <p>Local Governments: DSHS provides vital records and health-related data for health planning and policy decisions.</p> <p>Schools of Public Health and Universities: DSHS provides statistical data to researchers to understand causes of diseases and develop prevention and control strategies.</p> <p>Other State Agencies: Office of Attorney General, DFPS, Texas Department of Transportation, Texas Workforce Commission, DARS, HHSC, Texas Commission on Environmental Quality, and the Texas Department of Agriculture.</p> <p>Federal Agencies: The Centers for Disease Control and Prevention, the Food and Drug Administration and the National Institute of Occupational Safety and Health.</p> <p>Other Stakeholders: DSHS assists a broad base of external and internal stakeholders/customers in obtaining and utilizing health data/information to make informed decisions regarding the health of Texans.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>A.2.1. Immunize Children and Adults in Texas. Provides services to prevent, control, reduce, and eliminate vaccine-preventable diseases in children and adults, with emphasis on children under 36 months of age.</p>	<p>Direct Consumers: DSHS provides immunizations for children, adolescents, and adults, and educates and performs quality assurance activities with healthcare providers vaccinating these groups.</p> <p>External Partners: The Texas Immunization Stakeholder Working Group, which includes representatives from medical societies, parents, schools, public health departments, pharmacists, nurses, manufacturers, and other organizations with a role in the statewide immunization system.</p> <p>Other State Agencies: DSHS works with DFPS and HHSC in the delivery of immunization services.</p>
<p>A.2.2. HIV/STD Prevention. Provides human immunodeficiency virus (HIV)/sexually transmitted disease (STD) surveillance, prevention and service programs, and public education about HIV/STD disease prevention.</p>	<p>Direct Consumers: DSHS provides access to HIV treatment and care services for low-income, uninsured persons.</p> <p>Local Governments: DSHS provides assistance to local governments in the delivery of services to assure that partners of persons newly diagnosed with HIV and high priority STD are notified and offered testing services.</p>
<p>A.2.3. Infectious Disease Prevention, Epidemiology and Surveillance. Plays a vital role in defining, maintaining, and improving public health response to disasters, disease outbreaks, or healthcare-associated infections and in creating plans for effective disease prevention.</p>	<p>Citizens of Texas: DSHS coordinates disease surveillance and outbreak investigations and provides information on the occurrence of disease and prevention and control measures. DSHS conducts investigations of zoonotic diseases, facilitates the distribution of rabies biologics to persons exposed to rabies, informs communities, and</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	<p>immunizes wildlife that can transmit rabies to humans, mobilizes community efforts such as pet neutering programs through the Animal Friendly grant, and maintains an investigative response team.</p> <p>Local Governments: DSHS coordinates infectious disease prevention, epidemiology and surveillance activities with local health departments.</p> <p>Other State and Federal Agencies: DSHS serves as the lead on a cooperative project with U.S. Department of Agriculture, Texas Military Forces, Texas Animal Health Commission, the Texas Parks and Wildlife Department, the Texas Veterinary Medical Diagnostic Laboratory, Texas Association of Local Health Officials, U.S.-Mexico Border Health Commission, Rotary International, the CDC, the FDA, the schools of public health in Texas, voluntary agencies, HHSC, and the federal Office of Refugee Resettlement.</p> <p>Medical Community: DSHS provides information, and consultation, to the human and veterinary medical communities and to healthcare professionals.</p>
<p>A.3.1. Chronic Disease Prevention. Provides health promotion and wellness activities for the elimination of health disparities and the reduction of primary/secondary risk factors for certain common, disabling chronic conditions that place a large burden on Texas healthcare resources.</p>	<p>Citizens of Texas: DSHS provides awareness and educational resources/materials for diabetes, Alzheimer’s disease, and cardiovascular disease (CVD). DSHS provides child safety seats to low income families with children less than 8 years of age. DSHS provides support to communities for</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	<p>planning and implementing evidence-based obesity prevention interventions through policy and environmental change.</p> <p>Councils, Task Forces, and Collaboratives: DSHS provides administrative support to the Texas Diabetes Council, Chronic Disease Task Force, Texas Council on Alzheimer’s Disease and Related Disorders, Texas Council on CVD and Stroke, Texas CVD and Stroke Partnership, CVD Data Users Group, Texas Salt Reduction Collaborative, Texas School Health Advisory Council, and the Cancer Alliance of Texas.</p> <p>Healthcare Professionals: DSHS provides toolkits that include professional and patient education materials featuring self-management training and minimum standards of care and evidence-based treatment algorithms.</p> <p>Contracted Service Providers: The Texas Association of Community Health Centers provides support and information on chronic disease self-management training via live webinars to contracted federally qualified health clinics (FQHCs) and healthcare providers.</p> <p>Schools and Communities: DSHS provides technical assistance on care of students with diabetes. The Transforming Texas Initiative provides communities less than 500,000 in population funding and support to build capacity and implement evidence- and practice-based policy, environmental, programmatic, and</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	<p>infrastructure changes to prevent heart attacks, strokes, cancer, and other leading causes of death or disability. DSHS provides child safety seats and education to community partners that assist in the distribution of the safety seats to low income families and trains nurses, police officers, and other community members to be nationally certified child passenger safety technicians.</p> <p>State Agencies: DSHS works with state agency worksite wellness coordinators, the Worksite Wellness Advisory Board.</p>
<p>A.3.2. Abstinence Education. Provides abstinence education to priority populations to decrease the birth rate among teens, decrease the proportion of adolescents engaged in sex, decrease the incidence of sexually transmitted infections in adolescents, and increase adolescents’ interest in further education.</p>	<p>Adolescents and Parents: DSHS provides abstinence education in Spanish and English through brochures, toolkits, workbooks, curricula, and online as well as service learning opportunities and leadership summit opportunities for youth in grades 5-12, and resources for parents in Spanish and English online and through booklets and DVDs.</p> <p>Contractors: DSHS contracts with providers to provide abstinence education curricula and service learning projects during in-school and after-school interventions.</p> <p>School Districts: DSHS provides workshops, webinars, trainings, toolkits, brochures, and workbooks for school districts across Texas.</p> <p>Community, Faith-based, and Health Organizations: DSHS provides toolkits, brochures, and workbooks for</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	organizations.
<p>A.3.3. Kidney Health Care. Provides health care specialty services and the infrastructure required to determine client eligibility and to process claims.</p>	<p>Direct Consumers: DSHS provides services to 1) persons with end-stage renal disease, who are receiving a regular course of renal dialysis treatments, or have received a kidney transplant; and 2) entities that directly provide services. External Partners: DSHS actively participates on the Chronic Disease Task Force.</p>
<p>A.3.4. Children with Special Health Care Needs. Provides services to eligible children with special health care needs in the areas of early identification, diagnosis, rehabilitation, family support, case management, and quality assurance.</p>	<p>Direct Consumers: DSHS provides services to 1) children with special health care needs and their families and people of any age with cystic fibrosis, 2) community-based contractors, and 3) entities that directly provide services. External Partners: DSHS actively participates on the Children’s Policy Council, Consumer Direction Workgroup, and Texas Council for Developmental Disabilities, Promoting Independence Advisory Committee, and Interagency Task Force for Children with Special Needs.</p>
<p>A.3.5. Epilepsy and Hemophilia Services. Provides treatment support and/or referral assistance to reduce disability and premature death related to epilepsy and hemophilia.</p>	<p>Direct Consumers: DSHS provides clinical and support services through contracted providers to Texas residents with epilepsy who meet specific eligibility requirements. DSHS provides financial assistance for people with hemophilia to pay for their blood factor products. Contracted Providers: DSHS contracts with a university medical center, hospital district, and non-profit organizations for epilepsy services. Local health entities, schools of public health, and universities</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	<p>may be contracted providers.</p> <p>External Partners: DSHS provides support for the Texas Bleeding Disorders Advisory Council.</p>
<p>A.4.1. Laboratory Services. Provides laboratory testing to diagnose and investigate community health problems and health hazards.</p>	<p>Citizens of Texas: DSHS provides screening to pregnant women for infectious diseases; HIV, STD, and TB testing; lead screening in children; testing bay water and milk samples for contamination; rabies testing; screening every newborn for 29 disorders; and identifying organisms responsible for disease outbreaks throughout Texas.</p>
<p>B.1.1. Provide WIC Services: Benefits, Nutrition Education & Counseling. Provides nutrition education and food assistance to eligible infants, children, and women and provides breastfeeding promotion and support. Also provides nutrition, physical activity, and obesity prevention; public health surveillance; planning and policy development; funding for community-based interventions; facilitation of state/local coalitions to promote nutrition; training for medical and public health professionals; and public education.</p>	<p>Direct Consumers: DSHS provides services to low-income pregnant and post-partum women, infants, and children up to the age 5 who meet certain eligibility requirements.</p> <p>Citizens of Texas: DSHS provides funding and support to communities through a competitive process to implement population level, evidence-based approaches to obesity prevention.</p> <p>Contracted Providers: DSHS contracts with local health departments, public health districts, hospitals, and not-for-profit organizations to provide the Women, Infants, and Children (WIC) Program.</p> <p>External Partners, healthcare professionals and other State agencies: DSHS provides subject matter expertise to a variety of external partners.</p>
<p>B.1.2. Women and Children's Health Services.</p>	<p>Direct Consumers: DSHS provides</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Provides direct, enabling, population-based, and infrastructure-building services for women and children.</p>	<p>contracted clinical, educational, and support services to Texas residents who meet specific eligibility requirements for breast and cervical cancer services.</p> <p>DSHS provides preventive oral health services to eligible children at schools with high-incidence of low-income children; provides training and certification for vision and hearing screening and makes audiometers available to schools and day care centers for their staff to conduct screenings; and provides preventive and primary care services to low-income pregnant women and children through contracts with Title V funds.</p> <p>DSHS notifies primary care physicians and families of newborns with out-of-range newborn screening results to ensure clinical care coordination to prevent development delays, intellectual disability, illness, or death.</p> <p>Contracted Providers: DSHS provides professional education to dental, medical, and case management providers through online provider education and in-person training opportunities. DSHS contracts with non-profit organizations including local health departments, hospital districts, university medical centers, Federally Qualified Health Center (FQHC)s, and other community-based organizations for breast and cervical cancer services.</p> <p>Certified Individuals: DSHS provides oversight of the training and certification</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	<p>requirements for promotores/ community health workers and training instructors.</p> <p>Texas School Health Advisory Council (TSHAC): DSHS provides administrative support to TSHAC.</p> <p>Education Service Centers (ESCs): DSHS contracts with 13 of the 20 ESCs to provide training and technical assistance to schools and provides technical assistance to the ESCs to implement evidence-based programs within the school setting on a variety of health issues.</p> <p>Schools: DSHS contracts with entities that provide primary and preventative services through school-based health centers. DSHS also provides training and technical assistance to school administrators, school nurses, and parents on the provision of health services within the school setting.</p> <p>Other State Agencies: DSHS provides subject matter expertise, including research and data analysis, on topics related to maternal and child health populations. DSHS provides initial clinical screening for all Medicaid for Breast and Cervical Cancer client applications. DSHS also collaborates with the Cancer Prevention Research Institute of Texas on cancer-related activities.</p> <p>External Partners: DSHS partners with the American Cancer Institute, Susan G.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	Komen Foundation, Lance Armstrong Foundation, and Breast Cancer Prevention Fund.
<p>B.1.3. Family Planning Services. Provides direct family planning services for women, men, and adolescents, and population-based activities.</p>	<p>Direct Consumers: DSHS provides clinical, educational, and support services through contracted providers to clients who meet specific eligibility requirements.</p> <p>Contracted Providers: DSHS contracts with non-profit organizations such as local health departments, hospital districts, university medical centers, FQHCs, and other community-based organizations.</p>
<p>B.1.4. Community Primary Care Services. Provides services to the medically uninsured, underinsured, and indigent persons who are not eligible to receive services from other funding sources; assesses the need for health care; designates parts of the state as health professional shortage areas; recruits and retains providers to work in underserved areas; identifies areas that are medically underserved; and provides funding to communities for improved access to primary medical/dental/behavioral health care.</p>	<p>Direct Consumers: DSHS provides clinical services through contracted providers to Texas residents who meet specific eligibility requirements.</p> <p>Contracted providers: DSHS contracts with non-profit organizations such as local health departments, hospital districts, university medical centers, FQHCs, and other community-based organizations.</p> <p>Local Health Departments: DSHS may recommend areas where local health entities operate for federal designation as Health Professional Shortage Areas and Medically Underserved Areas.</p> <p>Schools of Public Health and Universities: DSHS partners with these entities in recruitment activities for the National Health Service Corps and Texas Conrad 30 J-1 Visa Waiver Program.</p> <p>Other Organizations: DSHS works with communities and private or public non-</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	profit organizations to develop and expand FQHCs in Texas.
<p>B.2.1. Mental Health Services for Adults. Provides community services designed to allow adults with mental illness to attain the most independent lifestyle possible.</p>	<p>Contracted Services: DSHS contracts with local mental health centers to provide services to adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders that require crisis resolution or ongoing and long-term support and treatment.</p>
<p>B.2.2. Mental Health Services for Children. Provides community services for children and adolescents ages 3-17.</p>	<p>Contracted Services: DSHS contracts with local mental health centers to provide services to children who exhibit serious emotional, behavioral, or mental disturbances and who: 1) have a serious functional impairment, 2) are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms, or 3) are enrolled in a school system's special education program because of a serious emotional disturbance.</p>
<p>B.2.3 Community Mental Health Crisis Services. Ensures statewide access to competent rapid response services, avoidance of hospitalization, and reduction in the need for transportation.</p>	<p>Contracted Services: DSHS contracts with local mental health centers to provide crisis services to persons whose crisis screening and/or assessment indicate that they are an extreme risk of harm to themselves or others in their immediate environment.</p>
<p>B.2.4. NorthSTAR Behavioral Health Waiver. Provides managed behavioral healthcare services to persons residing in Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwell counties.</p>	<p>Contracted Services: NorthSTAR is a collaborative effort between mental health and substance abuse programs to provide a more seamless system of care to persons with mental illness and/or chemical dependency by integrating diverse</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	funding streams at the state and local level into a single managed system of care.
<p>B.2.5. Substance Abuse Prevention, Intervention and Treatment. Establishes, develops, and implements coordinated and integrated prevention, treatment, and recovery substance abuse services.</p>	<p>Contracted Services: DSHS contracts with local community providers to provide substance abuse prevention, intervention, and treatment services. Substance Abuse Prevention is targeted to school age children. HIV Outreach and HIV Early Intervention Services provide information and education for substance abusing adults at risk for HIV or who are HIV positive. Pregnant, Post-Partum Intervention Services provide case management, education, and support for pregnant and post-partum women at risk for substance abuse. Substance Abuse Treatment Programs target youth 13-17 and adults 18 or over who meet DSM-IV-R criteria for substance abuse or dependence.</p>
<p>B.2.6. Reduce Use of Tobacco Products. Provides comprehensive tobacco prevention and control activities.</p>	<p>Citizens of Texas: DSHS plays a leadership role in educating the general public about the importance of tobacco prevention and cessation.</p> <p>Contracted Services: DSHS contracts with public health regions, local health departments, local independent school districts, a media firm, a national Quitline service provider, and state institutions of higher education.</p>
<p>B.3.1. EMS and Trauma Care Systems. Develops a statewide emergency medical services (EMS) and trauma care system that is fully coordinated with all EMS providers and hospitals.</p>	<p>Citizens of Texas: DSHS insures a coordinated statewide trauma system and designates trauma and stroke facilities in Texas.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
B.3.2. FQHC Infrastructure Grants.	Not funded.
B.3.3. Indigent Health Care Reimbursement. Provides funds for unpaid health care services to expand access to health care.	University of Texas Medical Branch at Galveston: DSHS transfers funds for unpaid health care services provided to indigent patients.
B.3.4. County Indigent Health Care Services. Provides reimbursement upon request to counties not fully served by a public hospital or a hospital district once they have expended 8% of their General Revenue Tax Levy on indigent health care.	Local Governments: DSHS provides technical assistance to counties regarding program compliance and assistance with Supplemental Security Income and Medicaid claim submission.
C.1.1 Texas Center for Infectious Disease. Provides for more than one level of inpatient and outpatient care, education, and other services for patients with TB or Hansen’s disease.	Direct Consumers: DSHS directly provides inpatient and outpatient care, education, and other services for patients with TB or Hansen’s disease. Patients are admitted by court order or clinical referral for TB, Hansen’s disease or other diseases that are too severe for treatment elsewhere.
C.1.2. South Texas Health Care System. Coordinates, delivers, and supports needed public health services to care for patients in the Lower Rio Grande Valley.	Direct Consumers: DSHS offers one triple health service facility in the state. This facility directly provides inpatient and outpatient care and services in the Lower Rio Grande Valley for persons who are seriously mentally ill, diagnosed with a severe intellectual developmental disability, or who otherwise cannot obtain primary medical treatment.
C.1.3. Mental Health State Hospitals. Provides specialized inpatient services in state psychiatric facilities.	Direct Consumers: DSHS directly provides specialized inpatient services in 11 state psychiatric facilities for persons who are seriously mentally ill and are a risk to themselves or others. Individuals are on civil or forensic commitments or

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	are voluntary admissions.
<p>C.2.1. Mental Health Community Hospitals. Provides inpatient services in response to local needs through small psychiatric hospitals.</p>	<p>Contracted Services: DSHS funds four local mental health authorities and one county to provide specialized inpatient services in their communities for persons who are seriously mentally ill and are a risk to themselves or others. Individuals are on civil or forensic commitments or are voluntary admissions.</p>
<p>D.1.1. Food (Meat) and Drug Safety. Licenses, inspects, and regulates manufacturers, producers, wholesale distributors, food managers and workers, harvest areas, meat and poultry processors, rendering facilities, and retailers of foods, drugs, and medical devices.</p>	<p>Citizens of Texas: DSHS protects citizens from contaminated, adulterated, and misbranded foods by enforcing food safety laws and regulations. DSHS also protects citizens from unsafe drugs, medical devices, cosmetics, indoor tanning practices, and tattoo and body-piercing procedures through regulation. DSHS protects school age children by inspecting school cafeterias.</p>
<p>D.1.2. Environmental Health. Protects the public from exposure to asbestos, lead-based paints, hazardous chemicals and other agents through various means including licensing, inspection, investigation, collection and dissemination of data, enforcement, and consultation.</p>	<p>Citizens of Texas: DSHS provides protection and handles compliance over a broad range of commonly used consumer items including automotive products, household cleaners, polishes and waxes, paints and glues, infant items, and children’s toys. DSHS also protects and promotes the physical and environmental health of Texans from asbestos, mold, and lead. DSHS protects children attending private and university-based summer youth camps by requiring completion of certain trainings and inspections.</p>
<p>D.1.3. Radiation Control. Ensures the effective regulation of all sources of radiation.</p>	<p>Citizens of Texas: DSHS prevents unnecessary radiation exposure to the public through effective licensing, registration, inspection, enforcement, and</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	emergency response.
D.1.4. Health Care Professionals. Ensures timely, accurate issuance of licenses, registrations, certifications, permits, or documentations and investigates complaints and takes enforcement action as necessary to protect the public.	Citizens of Texas: DSHS regulates and sets standards for allied health professions, including counselors, emergency medical professionals, social workers, midwives, massage therapists, sanitarians, athletic trainers, medical radiologic technologists, and fitters and dispensers of hearing instruments.
D.1.5. Health Care Facilities. Assures quality health care delivery by regulating health facilities/entities and organizations that provide care and services to the Texas consumers.	Citizens of Texas: DSHS monitors health care delivery by regulated health care facilities to assure high quality care in hospitals, abortion facilities, birthing centers, psychiatric facilities, ambulatory surgical centers, end stage renal disease facilities, and free standing emergency medical care facilities.
D.1.6. TexasOnline. Establishes a common electronic infrastructure through which Texas citizens, state agencies, and local governments are able to register and renew licenses.	Regulated Entities: DSHS is statutorily permitted to increase occupational license, permit, and registration fees imposed on licensees by an amount sufficient to cover the cost of the subscription fee charged by TexasOnline.
E.1.1. Central Administration	DSHS Employees: DSHS provides administrative support for DSHS employees and programs.
E.1.2. IT Program Support	
E.1.3. Other Support Services	
E.1.4. Regional Administration	
F.1.1. Laboratory (Austin) Bond Debt. Pays debt service on special revenue bonds issued to build a laboratory and parking structure.	Citizens of Texas: DSHS provides testing at the Austin laboratory to diagnose and investigate community health problems and health hazards.
F.1.2. Construction - Health Care Facilities: TCID. Funded construction of a new hospital and support	Direct Consumers: DSHS directly provides inpatient and outpatient care,

<p style="text-align: center;">STRATEGY (ABEST 2011)</p>	<p style="text-align: center;">STAKEHOLDER GROUPS/ SERVICES PROVIDED</p>
<p>facility and renovation in one existing building housing the Woman’s Health laboratory and clinical support services.</p>	<p>education, and other services for patients with TB or Hansen’s disease at TCID. Facility construction was completed in fiscal year 2010.</p>
<p>F.1.3. Repair and Renovation: MH Facilities. Funds the necessary repair, renovation, and construction projects required to maintain the state’s psychiatric hospitals at acceptable levels of effectiveness and safety.</p>	<p>Direct Consumers: DSHS spends general obligation bond funds on state mental hospital buildings which are in need of ongoing repairs and maintenance. Projects include: compliance with life safety and accessibility codes; physical plant changes that help prevent suicide; utility repairs; grounds upkeep; hazardous material remediation and abatement; and roofing, heating, ventilation, and air conditioning repairs.</p>
<p>G.1.1. Office of Violent Sex Offender Management. Performs the duties related to the sexually violent predator civil commitment program.</p>	<p>The civil commitment of sexually violent predators function was transferred to a new agency, the Office of Violent Sex Offender Management effective September 1, 2011.</p>

APPENDIX E: CUSTOMER INVENTORY FOR THE HEALTH AND HUMAN SERVICES COMMISSION (HHSC)

DESCRIPTION OF SERVICES PROVIDED TO CUSTOMERS BY BUDGET STRATEGY

<p align="center">STRATEGY (ABEST 2011)</p>	<p align="center">STAKEHOLDER GROUPS/ SERVICES PROVIDED</p>
<p>Strategy A.1.1 Enterprise Oversight and Policy. Provide leadership and direction to achieve an efficient and effective health and human services system.</p>	<p>Oversight agencies and Legislative Leadership: HHSC coordinates and monitors the use of state and federal money received by HHS agencies; reviews state plans submitted to the federal government; monitors state health and human services agency budgets and programs, and makes recommendations for budget transfers; conducts research and analyses on demographics and caseload projections; and directs an integrated planning and budgeting process across five HHS agencies.</p> <p>Other HHS Agencies: HHSC provides the leadership to assist the HHS agencies in developing customer-focused programs and policy initiatives that are relevant, timely and cost-effective.</p> <p>Citizens of Texas: HHSC ensures that state and federal funds allocated to HHS agencies are coordinated and monitored, and spent in the most efficient manner.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy A.1.2. Integrated Eligibility and Enrollment Provide accurate and timely eligibility and issuance services for financial assistance, medical benefits, and food stamps.</p>	<p>Children & Families: The functions involved in both centralizing and conducting eligibility determination for HHS programs will apply to children and families seeking to participate in the Medicaid, Temporary Assistance for Needy Families (TANF), Food Stamp and other health and human services programs.</p>
<p>Strategy A.2.1. Consolidated System Support. Improve the operations of health and human service agencies through coordinated efficiencies in business support functions.</p>	<p>Other HHS Agencies. HHSC provides the leadership for consolidating across the system the functions of: information technology, human resources, civil rights, procurement, ombudsman and other services, e.g. facility management and leasing and regional operations.</p>
<p>Strategy B.1.1. Medicare and SSI. Provide medically necessary health care in the most appropriate accessible and cost effective setting to Medicaid-aged and Medicare-related persons and Medicaid disabled and blind persons.</p>	<p>Medicaid Consumers: HHSC Medicaid/CHIP division provides health care to Medicaid aged and Medicare related persons and persons who are disabled or blind.</p>
<p>Strategy B.1.2. TANF Adults and Children. Provide medically necessary health care in the most appropriate, accessible, and cost effective setting to TANF eligible adults and children.</p>	<p>Medicaid Consumers: HHSC Medicaid/CHIP division provides health care to adults and children who are eligible for TANF.</p>
<p>Strategy B.1.3. Pregnant Women. Provide medically necessary health care in the most appropriate, accessible, and cost effective setting to Medicaid-eligible pregnant women.</p>	<p>Medicaid Consumers: HHSC Medicaid/CHIP division provides health care to women who are pregnant and eligible for Medicaid.</p>
<p>Strategy B.1.4. Children and Medically Needy. Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to newborn infants and Medicaid-eligible children above the TANF income eligibility criteria, and to medically needy persons.</p>	<p>Medicaid Consumers: HHSC Medicaid/CHIP division provides health care to infants and children who are above the TANF eligibility criteria and medically needy persons.</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
Strategy B.1.5. Medicare Payments. Provide accessible premium-based health services to certain Title XVIII Medicare-eligible recipients.	Medicaid Consumers: HHSC Medicaid/CHIP division provides premium-based health services to certain Title XVIII Medicare eligible recipients.
Strategy B.1.6. STAR+PLUS (Integrated Managed Care). Promote the development of integrated managed care systems for aged and disabled clients.	Medicaid Managed-care Consumers. HHSC Medicaid/CHIP division provides acute and long-term health care to consumers who are disabled and blind and older persons who need long-term care services through Medicare.
Strategy B.2.1. Cost Reimbursed Services: Provide medically necessary health care to Medicaid eligible recipients for services not covered under the insured arrangement including: federally qualified health centers, undocumented persons, school health, and related services.	Medicaid Consumers: HHSC Medicaid/CHIP division provides health care to Medicaid eligible recipients for specific services not covered.
Strategy B.2.2. Medicaid Vendor Drug Program. Provide prescription medication to Medicaid-eligible recipients as prescribed by their treating physician.	Medicaid Consumers: HHSC Medicaid/CHIP division provides prescription medication benefits to Medicaid recipients.
Strategy B.2.4. Medical Transportation. Support and reimburse for non-emergency transportation assistance to individuals receiving medical assistance.	Medicaid Consumers: HHSC provides transportation for Medicaid recipients.
Strategy B.2.5. Medicaid Family Planning (FFS). Provide family planning services throughout Texas for Medicaid-eligible adolescents and women,	Medicaid Consumers: HHSC Medicaid/CHIP division provides family planning services for Medicaid recipients.
Strategy B.2.6. Upper Payment Limit. Provide supplemental Medicaid reimbursement to children hospitals for inpatient and outpatient services.	Hospitals/Providers: States may receive federal funding to provide hospitals supplemental payments to cover inpatient and outpatient services that exceed regular Medicaid rates.

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy B.3.1. Health Steps (EPSDT) Medical (FFS). Provide access to comprehensive diagnostic/treatment services for eligible clients by maximizing the use of primary prevention, early detection and management of health care, in accordance with all federal mandates.</p>	<p>Medicaid Consumers: HHSC Medicaid/CHIP division provides diagnostic/treatment services to Medicaid-eligible children.</p>
<p>Strategy B.3.2. Health Steps (EPSDT) Dental. Provide dental care in accordance with all federal mandates.</p>	<p>Medicaid Consumers: HHSC Medicaid/CHIP division provides dental services to Medicaid-eligible children.</p>
<p>Strategy B.3.3. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Comprehensive Care Program (FFS). Provide diagnostic/treatment services for federally-allowable Medicaid services for conditions identified through an EPSDT screen or other health care encounter but not covered or provided under the State Medicaid Plan.</p>	<p>Medicaid Consumers: HHSC Medicaid/CHIP division provides diagnostic/treatment services to Medicaid-eligible children.</p>
<p>Strategy B.4.1. State Medicaid Office. Set the overall policy direction of the state Medicaid program and manage interagency initiatives to maximize federal dollars.</p>	<p>Other HHS Agencies. HHSC provides the leadership and policy planning for administration of the state Medicaid Office across the HHS system.</p>
<p>Strategy C.1.1. CHIP. Provide health care to uninsured children who apply for insurance through CHIP.</p> <p>Strategy C.1.2. Immigrant Health Insurance. Provide health care to certain uninsured, legal, immigrant children who apply for insurance through CHIP.</p> <p>Strategy C.1.3. School Employee Children Insurance. Augment the state’s contributions for certain school employees (operational responsibility for this strategy is shared with the Teacher Retirement System).</p>	<p>Federal Government: HHSC Medicaid/CHIP division provides direction, guidance, and policy making for the Children’s Health Insurance Program, a federal program administered through states.</p> <p>Managed Care Organizations: The HHSC Medicaid/CHIP division contracts with Managed Care Organizations for the provision of the Children’s Health Insurance Program. The Medicaid/CHIP division sets policy and provides oversight for the CHIP program.</p> <p>Children and Families: The CHIP program exists to serve Texas children</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy C.1.4. CHIP Perinatal Services Provide health care to perinates whose mothers apply for insurance through CHIP.</p> <p>Strategy C.1.5. CHIP Vendor Drug Program. Provide prescription medication to CHIP-eligible recipients (includes all CHIP programs as their recipients), as provided by their treating physician.</p>	<p>and families, providing health insurance to children in families with incomes up to 200% of the federal poverty level.</p>
<p>Strategy D.1.1. TANF (Cash Assistance) Grants. Provide TANF grants to low-income Texans.</p>	<p>Children and Families. The TANF grants provide capped entitlement services, non-entitlement services, one-time payments, child support payments and payment support for grandparents to children and families.</p>
<p>Strategy D.1.2. Refugee Assistance. Assist refugees in attaining self-sufficiency through financial, medical, and social services, and disseminate information to interested individuals.</p>	<p>Children and Families. HHSC's Office of Immigration and Refugee Affairs contracts with local agencies to provide refugee clients with services that assist refugees to attain self-sufficiency and integration to their new communities through six main programs. These programs are Refugee Cash Assistance, Refugee Medical Assistance, Refugee Social Services, Special Project Grants, Unaccompanied Refugee Minor, and the Refugee Health Screening programs.</p>
<p>D.1.3. Disaster Assistance. Provide disaster assistance to victims of federally-declared natural disasters.</p>	<p>Citizens of Texas impacted by disasters: Emergency Services Program serves as the lead for the administration of federal-funded Other Needs Assistance and Disaster Case Management Programs.</p>
<p>Strategy D.2.1. Family Violence Services. Provide emergency shelter and support services to victims of family violence and their children, educate the public, and provide training and prevention support to institutions and agencies.</p>	<p>Children and Families. HHSC's Family Violence Program contracts with local agencies to provide shelter, nonresidential, and special nonresidential services. Shelter centers' services include, but are not limited to, 24-hour emergency shelter, 24-hour crisis hotline services, referrals to existing community services, community education and training, emergency medical care and</p>

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
	transportation, intervention, educational arrangements for children, cooperation with criminal justice officials, and information regarding training and job placement. Nonresidential centers provide the same services as shelter centers with the exception of the 24-hour emergency shelter component. Special nonresidential services address unmet needs or underserved populations such as immigrants or populations with limited English proficiency.
Strategy D.2.2. Alternatives to Abortion. Provide pregnancy support services that promote childbirth for women seeking alternatives to abortion.	Pregnant Women and Children: HHSC contracts for the delivery of pregnancy support services. These services include information regarding pregnancy and parenting (brochures, pamphlets, books, classes, and counseling), referrals to existing community services and social service programs (childcare services, transportation, low-rent housing, etc.), support groups in maternity homes, and mentoring programs (classes on life skills, budgeting, parenting, counseling, and obtaining a GED).
Strategy E.1.1. Central Program Support.	HHS Employees. HHSC provides central support services for HHS employees.
Strategy E.1.2. IT Program Support.	HHS Employees. HHSC provides central support services for HHS employees.
Strategy E.1.3. Regional Program Support.	Other HHS Agencies: HHSC provides the leadership to assist the HHS agencies in developing in providing to support to regional programs. Citizens of Texas: HHSC ensures that state and federal funds allocated to HHS agencies are coordinated and monitored, and spent in the most efficient manner.

STRATEGY (ABEST 2011)	STAKEHOLDER GROUPS/ SERVICES PROVIDED
<p>Strategy F.1.1. Texas Integrated Eligibility Redesign System (TIERS) and Eligibility Technologies. Texas TIERS re-design system and eligibility supporting technology capital.</p>	<p>Other HHS Agencies: HHSC provides the leadership to assist the HHS agencies in developing the TIERS system.</p> <p>Children & Families: HHSC ensures the accessibility of TIERS to children and families across Texas.</p>
<p>Strategy G.1.1. Office of Inspector General (OIG).</p>	<p>Citizens of Texas/Taxpayers: OIG serves as the lead agency for the investigation of fraud, abuse and waste in health and human services; and administers the Medicaid Fraud and Abuse Detection System technology services contract, which uses technology to identify and deter fraud, abuse and waste in the Medicaid program throughout the state.</p> <p>Medicaid Providers: OIG provides training to Medicaid providers on how to detect, prevent and report Medicaid provider fraud; and provides training on Resource Utilization Group for nursing facilities.</p> <p>Medicaid Consumers: OIG investigates fraud, abuse and waste in health and human services-related programs, ensuring integrity and efficiency in programs and the highest quality services for beneficiaries.</p> <p>Residents of Facilities: OIG monitors Utilization Review activities in Medicaid contract hospitals to ensure program integrity and improve the quality of services delivered to residents of Medicaid facilities.</p>

APPENDIX F: GLOSSARY OF ACRONYMS

AAA – Area Agency on Aging

ADL – Activities of Daily Living

AMH – Adult Mental Health

APS – Adult Protective Services

BCVDDP – Blind Children’s Vocational Discovery and Development

BHO – Behavioral Health Organization

CAHPS® – Consumer Assessment of Healthcare Providers and Systems

CBA – Community-Based Alternatives

CDS – Consumer Directed Services

CEA – Consumer and External Affairs

CHIP – Children’s Health Insurance Program

CLASS – Community Living Assistance and Support Services

CMS – Centers for Medicare and Medicaid Services

CPS – Child Protective Services

CRG – Clinical Risk Group

CSHCN – Children with Special Health Care Needs

CWP – Consolidated Waiver Program

DADS – Department of Aging and Disability Services

DAHS – Day Activity and Health Services

DARS – Department of Assistive and Rehabilitative Services

DBMD – Deaf Blind with Multiple Disabilities

DBS – Division for Blind Services

DFPS – Department of Family and Protective Services

DRS – Division for Rehabilitation Services

DSHS – Department of State Health Services

ECHO – Experience of Care and Health Outcomes

ECI – Early Childhood Intervention

ED – Emergency Department

EQRO – External Quality Review Organization

FQHC – Federally Qualified Health Clinics

HCS – Home and Community-Based Services

HHS – Health and Human Services

HHSC – Health and Human Services Commission

ICF – Intermediate Care Facilities

ICHP – Institute for Child Health Policy

ICS – Inpatient Consumer Survey

ID –Intellectual or Developmental Disabilities

IDEA – Individuals with Disabilities Education Act

ILS – Independent Living Services

LTSSQR – Long-Term Services and Supports Quality Review

MCO – Managed Care Organization

MHSA – Mental Health and Substance Abuse

NACES – Nurse Aid Competency Evaluation Services

NCI – National Core Indicators

NF – Nursing Facility

NFQR – Nursing Facility Quality Review

NRI/MHSIP – Mental Health Program Directors Research Institute/Mental Health Statistics Improvement Project

NS-CSHCN – National Survey of Children with Special Health Care Needs

OAA – Older Americans Act

OES – Office of Eligibility Services

OIG – Office of the Inspector General

OO – Office of the Ombudsman

PACE – Program for All-Inclusive Care for the Elderly

PCCM – Primary Care Case Management
PCP – Primary Care Practitioners
PedsQL™ – Pediatric Quality of Life Inventory
PES – Participant Experience Survey
PHC – Primary Home Care
QMB – Qualified Medicare Beneficiary
SDA – Service Delivery Area
SNF – Skilled Nursing Facility
SSLC – State Supported Living Centers
STAR – State of Texas Access Reform
TANF – Temporary Assistance for Needy Families
TIERS – Texas Integrated Eligibility Redesign System
TJC – The Joint Commission
TxHmL – Texas Home Living Waiver
VR – Vocational Rehabilitation
WIC – Women Infants and Children
YSSF – Youth Services Survey for Families