

INTERAGENCY TASK FORCE FOR CHILDREN WITH SPECIAL NEEDS

COLLABORATING TO IMPROVE SERVICES



FOR CHILDREN AND THEIR FAMILIES

2011-2016
five year plan

**INTERAGENCY TASK FORCE
FOR CHILDREN WITH SPECIAL NEEDS
FIVE-YEAR PLAN FOR 2012-16**

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TASK FORCE FOR CHILDREN WITH SPECIAL NEEDS

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*Special thanks to
Laura Jordon and Laura Lucinda*

*Strategic Decision Support, Texas Health and Human Services Commission
for their assistance in the development of this report.*





EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

The Interagency Task Force for Children with Special Needs was established by [Senate Bill 1824](#), 81st Legislature, Regular Session, 2009, to coordinate across agencies to improve services for children with special needs and their families. Children with special needs have one or more chronic physical illnesses, mental illnesses, or intellectual or other developmental disabilities. They and their families often need an array of services and supports, many of which are available at the state and/or community level, and some of which are less available or not available at all.

The Task Force envisions a meaningful life with a nurturing family for every child. Through the Task Force, agencies and other stakeholders are coming together to communicate, coordinate, and collaborate, to improve outcomes for children and families while being careful stewards of state resources.

The 18-member Task Force is represented by 10 voting agency leadership members from 9 state agencies, and 8 non-voting members including 4 legislators, 3 consumers/advocates, and 1 representative from one of the local agencies that administer state-funded programs for people with intellectual disabilities and/or mental health issues. The Task Force has eight statutorily mandated subcommittees: health, mental health, education, juvenile justice, crisis prevention and intervention, transitioning youth, long-term care, and early childhood intervention. The work of subcommittees is enhanced by contributions from policy makers, agency leaders, disability advocates, consumers, and subject-matter experts. The Task Force is administered by the Health and Human Services Commission.

To set a common direction for the next five years, the Task Force has developed this Five-Year Plan, articulating seven overarching goals.

- **Organized and Reliable Information:** Parents and others will have access to easy-to-find, accurate, consistent, and reliable information so they can receive the appropriate help and support that best meets their needs.
- **Prevention and Early Identification:** Disabilities will be prevented or minimized by early identification of children with or at risk of special needs, and crises will be prevented throughout the child's life.
- **Entry Points into Services:** Appropriate services will be secured when needs are first identified.
- **Comprehensive Array of Services and Supports:** A comprehensive array of services and supports will be available to support the child in or as close to home as possible.

- **Services and Supports for Transition to Adulthood:** Students will be successful in transitioning to post-school life.
- **Interagency Coordination and Collaboration:** Agencies and organizations will communicate, coordinate, and collaborate in serving children with special needs.
- **Strengthened Workforce:** The workforce of professions serving children and youth with special needs will be supported and strengthened.

The objectives and strategic direction for moving forward on each goal are described in this plan. Implementation of this work is already progressing, building on current efforts and strengths. Progress will be reported in the biennial report.

The current administrative environment presents challenges and opportunities. The Task Force is taking a team approach to ensure smooth-working relationships and cross-agency achievements, especially given ongoing changes at a number of the member agencies.

As Task Force members and related agencies work together to implement the goals, objectives, and strategies, they are committed to fulfilling the vision of the authorizing legislation. Thoughtful funding strategies will be considered throughout the implementation process to use current funding more efficiently and effectively, and invite private participation and investment in better outcomes for Texans. An accountability framework will be set up to ensure progress is made and quality is achieved. This process will include such steps as needs assessments, review of best practices, setting benchmarks, establishing a reporting process, reviewing progress, and continuous improvement. Memoranda of Understanding are being developed between and among the agencies to facilitate sharing of information and other cooperative efforts. Two areas of great importance in crafting the recommendations were to reduce unnecessary relinquishment of custody and expand cultural competency in services for special needs children. These two goals are incorporated as a foundation for all the recommendations presented. The Task Force believes that both can be accomplished through the proposed five-year goals.

The goals and objectives of the plan share common features seen in successful system change efforts. They value the child and the family, and they address the whole child in the context of the family. They confront and rethink past practices and employ the spirit of collaboration, grounded in practical approaches. Through a shared vision and plan, and with improved coordination, communication, and collaboration, the Task Force envisions a system more accountable to taxpayers, more responsive to families, and more effective in improving outcomes for children with special needs.





INTRODUCTION

INTRODUCTION

Children with Special Needs

Children with special needs are children first. They have the same general needs as all children: safe loving homes, good schools, growth-promoting play, and quality health care. However, children with disabilities and their families often face challenges that other families do not face. Caring for a child with disabilities, whether a cognitive, mental health, or physical disability, requires an effort above and beyond that required to care for a child without disabilities, and parents often cannot do it alone.

Children with special needs are children who have complex and/or chronic conditions that require a variety of services and supports for the children and their families to thrive. Most of their ongoing daily needs are in the form of supports and services that are accessed and provided separately from their medical care. Senate Bill (S.B.) 1824, 81st Legislature, Regular Session, 2009, created the Interagency Task Force for Children with Special Needs and defines this group of children as “children younger than 22 years of age diagnosed with a chronic illness, intellectual or other developmental disability, or serious mental illness.” These include disabilities such as autism, bipolar disorder, childhood schizophrenia, cerebral palsy, Down syndrome, intellectual disabilities, muscular dystrophy, and spina bifida, to name a few.

Texas is experiencing a rapid growth in the population of children with and without disabilities. In the past 10 years, the total U.S. population of children grew by 1.8 million, with more than half of that growth occurring in Texas. Of the 8.2 million children and youth under age 22 in Texas, it is estimated that 451,000 have special needs. That number is projected to grow to approximately 500,000 by the year 2020.¹

A Coordinated Approach to Serving Children with Special Needs

Families provide the overwhelming majority of support needed to care for children with special needs. Many families have some level of additional natural supports such as extended family, neighbors, and church members. These supports however, are often not enough and families must turn to a variety of public and private agencies and service providers for help.

The Task Force for Children with Special Needs heard repeatedly that children and families who seek help face a “maze” of systems that are often fragmented and where sometimes narrow eligibility criteria trumps need in determining access. Each system has its own objectives, eligibility requirements, and access pathways. No one agency is responsible for, or has adequate resources or expertise for, meeting the entire range of needs of the children it serves.



It is not only how systems are organized structurally that impedes collaboration. Differing models, philosophies, and attitudes toward special needs also present barriers to effective cross-system collaboration. Shifting the focus from one “special” characteristic of a child to the whole-child-in-the-context-of-family represents a transformation that requires attitudinal change, new skills, redeployment of resources, and time.

More than coordination, collaboration requires reconceptualization and redirection through engagement of family, local, and state level partnerships in planning and developing agreements to pool expertise, resources, and creativity. Research suggests systemic reforms are successful only in an organizational culture that affirms, supports, and accommodates them. The Task Force is dedicated to working toward that change. This plan creates a blueprint for building a more coordinated, collaborative system among agencies and providers in local communities and at the statewide level to improve outcomes for children and to use existing resources more effectively.

The Interagency Task Force for Children with Special Needs

The Task Force legislation requires a five-year plan to improve the coordination, quality, and efficiency of services for children with special needs. Task Force members discuss and plan how to align their efforts in a way that improves outcomes for children with special needs and their families. The Task Force includes both voting members and non-voting members and is comprised of:

- Representatives from state agencies that have programs serving children with special needs,
- Parents of children with special needs,
- Legislators, and
- A representative of a regional government entity that serves people with intellectual disabilities and/or mental health issues.

Voting members are key leaders from the following state entities, two of which are soon being combined into one:

- Health and Human Services Commission (HHSC),
- Department of Aging and Disability Services (DADS),
- Department of Assistive and Rehabilitative Services (DARS),
- Division of Early Childhood Intervention services at DARS,
- Department of Family and Protective Services (DFPS),
- Department of State Health Services (DSHS),



- Texas Education Agency (TEA),
- Texas Youth Commission [soon to be the Texas Juvenile Justice Department (TJJD)],
- Texas Juvenile Probation Commission (soon to be TJJD), and
- Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI).

The eight non-voting members include:

- Two members of the House of Representatives,
- Two state senators,
- Three parent representatives, and
- A representative of one of the local agencies that administer state-funded programs for people with intellectual disabilities and/or mental health issues.

The Task Force also works with other stakeholders in the lives of children with special needs. Family members, advocates, and service providers are invited to share in the Task Force's cooperative efforts, and the general public is invited to share testimony at all Task Force meetings.

To ensure improvements are made in the variety of circumstances that children with special needs experience, the statute requires eight subcommittees:

- Early childhood detection and intervention;
- Education;
- Health care;
- Transitioning youth;
- Crisis prevention and intervention;
- Juvenile justice;
- Long-term, community-based services and supports; and
- Mental health.

The subcommittees are charged with reporting findings and related recommendations to the Task Force on an annual basis, for inclusion in the biennial report to the Governor and the Legislature. The subcommittees have benefited greatly from the assistance of family members, advocates, and service providers.



The Plan—And Beyond

The agencies represented on the Task Force serve a wide variety of people, with a wide variety of programs, each focused on meeting a different need. The Task Force strategic planning process has served as a catalyst for a diverse group of people and organizations to work together, combining efforts and resources to move toward a unified vision. The Five-Year Plan addresses needs that families of children with disabilities often encounter, including conflicting requirements, gaps in services, and crisis situations that could have been prevented. These and other issues are addressed in seven distinct, but interwoven goals.

1. **Organized and Reliable Information:** Parents and others will have access to easy-to-find, accurate, consistent and reliable information so they can receive the appropriate help and support that best meets their needs.
2. **Prevention and Early Identification:** Disabilities will be prevented or minimized by early identification of children with or at risk of special needs, and crises will be prevented throughout the child's life.
3. **Entry Points into Services:** Appropriate services will be secured when needs are first identified.
4. **Comprehensive Array of Services and Supports:** A comprehensive array of services and supports will be available to support the child in or as close to home as possible.
5. **Services and Supports for Transition to Adulthood:** Students will be successful in transitioning to post-school life.
6. **Interagency Coordination and Collaboration:** Agencies and organizations will communicate, coordinate, and collaborate in serving children with special needs.
7. **Strengthened Workforce:** The workforce of professions serving children and youth with special needs will be supported and strengthened.

Coordination efforts are underway in some areas, and opportunities exist to expand and improve this work. In the current environment of fiscal challenges, the Task Force is especially committed to thoughtful stewardship of public resources to make the best investment in the health, well-being, and independence of children with special needs and their families. Part of the Task Force's charge is to establish benchmarks and accountability for improved outcomes and this framework is part of the Task Force's philosophy and ongoing efforts.



Next for the Task Force will be implementation. The 82nd Texas Legislature made difficult choices in reducing funding to a number of agencies and programs. The Task Force will undergo a deliberative process of re-assessing baseline operations, service needs, and resource capacity, as it begins to prioritize implementation of the goals and objectives in the plan. The focus will be on using existing resources more efficiently and effectively. With guidance from an outcome-oriented plan the Task Force will begin crafting a system that is flexible and responsive to the needs of this state, and to the common and unique needs of children with special needs and their families.







**VISION, PRINCIPLES, AND
DIRECTION FOR PROGRESS**

VISION, PRINCIPLES, AND DIRECTION FOR PROGRESS

VISION

A meaningful life with a nurturing family for every child.

PRINCIPLES

We value children with special needs and their families and strive to provide high-quality, timely, effective services and supports that fit their unique situations.

DIRECTION FOR PROGRESS

- Support the well-being of the **whole child** and the family, in the home and in the community.
- Transform services and supports toward a more responsive, proactive, cooperative, accessible system that achieves high-quality outcomes with more effective use of resources in order to serve more children through:
 - Prevention;
 - Early identification and action;
 - Dissemination of clear, consistent, culturally competent information about services and supports;
 - Child- and family-centered navigation of services and supports;
 - Flexibility in problem-solving; and
 - Ensuring children have the opportunity to receive the benefits of living in a nurturing family.
- Stand accountable for continuously improving outcomes through:
 - Cohesive, connected, innovative, dynamic, and effective provision of services;
 - On-going planning through partnerships among families, stakeholders, local service providers, and state agencies;
 - Needs, gap, and barrier analysis;
 - Research, selection, and implementation of best and promising practices, with attention to identifying, evaluating and reinforcing recognized quality outcome measures;
 - Collection of valid and relevant baseline data and setting of benchmarks;
 - Measurement and reporting of outcomes; and
 - Performance management for continuous improvement.





GOAL 1: ORGANIZED AND RELIABLE INFORMATION

Develop and disseminate comprehensive, accurate, consistent, accessible, easy-to-understand information through a variety of media and languages, including written material, electronic formats, the Internet, and social media, to link families to public and private services and supports.

The system of services and supports for children with special needs and their families is complex and fragmented, involving multiple agencies and programs. Families need accurate and useful information about available services so they can receive the appropriate help that best meets their needs. This need is especially acute for families as they first come to grips with a disability-related diagnosis, or for families on the verge of crisis. Delayed response to crisis intervention may result in the need for more extensive and costly services.

Agencies must identify and implement more effective ways to coordinate in order to improve the availability and dissemination of comprehensive, accurate information for all people who come into contact with children with special needs or their families. The Task Force has identified the following objectives as the highest priorities needed to achieve this goal.

OBJECTIVE 1.1: INTERNET INFORMATION SYSTEM

Provide a well branded information system focused on services and transition planning for families with children with special needs.

Issue Summary

Families of children with special needs and their service providers need specific information to best serve children. There is no single access point from which families can receive comprehensive information from state agencies, schools, local agencies, or other service providers. Families who seek long-term care services beyond a school setting frequently struggle to piece the services together themselves. This disconnected approach to service and transition planning information, leads to missed opportunities to ensure and enhance children's health, development, independence, and general well-being. Although state agencies have tried to connect parents and providers with useful information through various media sources, including websites, the results have been mixed. Many caregivers do not have the time, or resources to navigate a complex website or database. Families and providers experience frustration, stress, disconnection, and isolation, and voice a desire for a single website or source to find information about all services.



Current Efforts

State agencies and other entities are making progress in providing useful information to families and providers. However, gaps still exist and navigation of the various sources can be difficult.

- The [2-1-1 Texas Information and Referral Network \(2-1-1\)](#) website, described more under Objective 1.2, lists statewide and local resources. It is more current and comprehensive in some areas than others. Many parents are not aware of the 2-1-1 system.
- Family organizations such as Parent to Parent sometimes have their own lists of services to help each other, but not everyone is a member of these organizations or knows they exist.
- Parents receive resource information from school personnel at meetings about their children's special education programs and from school counselors and nurses. The timeliness and comprehensiveness of the information is not consistent.
- The Center on Disability and Development at Texas A & M University hosts a publicly maintained list called the [Directory of Community Resources in Texas](#), which offers information about types of services for people with disabilities. It is a publicly maintained site, similar to Wikipedia. The system is not yet comprehensive and is not known statewide.
- Various state entities who serve persons with disabilities have their own websites, including the [Texas Council for Developmental Disabilities](#) and the [Texas Autism Research and Resource Center](#).

At this time there is not a coordinated effort to develop a well-branded, easily accessible system of information that is comprehensive, accurate and current.

Strategic Direction

As the Task Force explores the best way to move forward with this very complex issue, the first step is to identify the reasons other attempts have been less than successful. The Task Force will consider establishing a workgroup comprised of consumers, family members, advocates, service providers, and website hosts and designers to explore this question and guide the process. The workgroup's charge would be to develop an Internet information system that would meet existing needs and prepare for future demands.

OBJECTIVE 1.2: INFORMATION AND REFERRAL SERVICES

Offer parents information about special needs issues and referral services available to meet those needs.



Issue Summary

To care for children with special needs, families require both information about their child's conditions and referrals for a variety of services and supports. The state's information and referral services are often fragmented and too general to provide parents with the comprehensive information they need. Texas 2-1-1 and/or current state agency website inclusion criteria may prevent a comprehensive listing of for-profit and/or faith-based providers in their databases. Parent networks, although offering excellent information and support to families, are often small organizations of volunteers and are limited in the number of families they can serve. Materials may not be available at a literacy level or in a language, especially in Spanish, that is accessible and understandable for some families.

At times, critical and accurate information is needed immediately, to avert a crisis. Despite a family's best and strongest efforts, a child or youth may become at risk of serious negative outcomes, such as health threats, parental neglect or abuse, or criminal activity, including substance abuse. There is not currently a statewide network to help parents with information, advice, mentoring, and other support in these difficult times. When the challenges seem beyond control, the family is left to call emergency services as a last resort for help.

Current Efforts

Several sources for information and referrals for children with special needs and their families are currently available in Texas.

The Texas Information and Referral Network (TIRN) is free to anyone in Texas by dialing 2-1-1. This telephone-based service provides information about various services available in Texas, and how to connect people with those services. Call specialists provide confidential information and referral seven days a week, twenty-four hours a day, helping callers find food and housing assistance, mental health services, electric utility assistance, child care, educational services, disaster assistance, and much more. The 2-1-1 number also includes an option for callers to apply for state benefits such as Medicaid and Food Stamps and to check the status of pending applications.

Each of the 25 local affiliates of 2-1-1 works with health and social agencies in their areas to maintain accurate and current information about the services available. This wide variety of collected information is entered into a comprehensive, carefully organized database that call specialists are trained to search. This database is also available on the Internet at [2-1-1 TIRN](#) for the general public to search. Basic information is relatively easy to find, and top searches are prominently displayed for quick access; however for people who are not familiar with the intricacies of the database, it can be hard to identify highly specialized services.



Strategic Direction

The Task Force is looking at several opportunities to strengthen information and referral services for children with special needs and their families. This work may coordinate with other implementation efforts, such as Objective 2.2 which concerns referrals and focuses on providers' abilities to make relevant referrals, and Objective 4.2 about having an experienced person to help parents navigate the system of programs and services. For example, if navigation services are developed, then those services would be useful resources 2-1-1 or other information and referral call specialists could mention.

Strategy 1.2.1: Improvements to the 2-1-1 Texas Information and Referral Network

Improve the 2-1-1 Texas Information and Referral Network's (TIRN's) expertise in providing information for children with special needs and their families, and increase awareness of 2-1-1 TIRN as a resource.

Improve Database Navigability

The 2-1-1 database is organized according to a nationwide taxonomy, and the terms it uses are sometimes different from the terms that parents use. Measures should be taken to close that gap. Call specialists could be trained with more specific knowledge to address the needs of children with special needs and their families. Database managers could work with parents, advocates, and others to identify terms that make their databases more parent/user friendly. Opportunities can be provided for parents and advocates to improve database functionality by contributing ideas directly to 2-1-1 administrators. This information can also be used to add resources to the database in order to represent a broader spectrum of relevant topics.

Enhanced Crisis Training

Not all call specialists are trained in handling specific issues and crises related to children with certain special needs. Through non-profit organizations or a governmental agency, local call centers could improve their ability to serve families by receiving training for call specialists specific to these types of needs. Free online training could be developed, addressing sub-topics as appropriate to meet identified needs, and this training could be mandated for all 2-1-1 staff. In the absence of identifying another reproducible crisis information model, this might be an opportunity to make an innovative contribution to the national information and referral system.

Strategy 1.2.2: Stressline and/or In-Person Network

Provide a phone-based Family Stressline with trained volunteers coordinated through current 2-1-1 services to provide specialized information to callers regarding how to prevent escalation or to de-escalate a crisis or direct callers to crisis intervention resources.



The Task Force will examine the use of a family stressline or other in-person networks as an enhancement to 2-1-1, to offer support and mentoring for families and youth to avert crises. The stressline could be anonymous to encourage parents to call when they are overwhelmed by an immediate situation with their child. The stressline should be available day and night, since crises often do not occur during conventional working hours.

The 2-1-1 TIRN could connect parents and youth with the family stressline or other support network, just as 2-1-1 does for other hotlines and services. When families in crisis call 2-1-1, a trained call specialist could: help prevent a crisis, de-escalate a crisis, direct callers to crisis intervention services, and provide a person-to-person transfer to these hotlines. Models exist for in-person networks, with mental health advocates who share their personal understanding and compassion with consumers or family members, and with Texas Parent to Parent volunteers who connect parents with mentor parents and with prevention organizations. A stressline could be a platform to follow up by connecting people to social networking to enhance family connections and to provide additional information resources.

Strategy 1.2.3: Texas Inventory of Respite Services

Provide a searchable database to help caregivers locate respite providers.

The Texas Inventory of Respite Services is a project of the Texas Respite Coordination Center under a grant from the Lifespan Respite Care Program (authorized by Congress through the Lifespan Respite Care Act in 2006). While the state of Texas operates several information and referral portals for Texans in need of services, a single statewide source of comprehensive information on respite care providers does not exist. The Texas Inventory of Respite Services will include both for-profit and/or faith-based providers, allowing the inventory to be as comprehensive as possible.

The inventory will be a single, easy-to-understand listing, providing a complete picture of the care services available, and offering direct links to provider websites, where possible. The inventory will include a variety of data for each provider, including contact information, languages spoken, care specializations, areas served, Medicaid status, and age groups served. The inventory will be user-friendly for providers as well as caregivers, as it will allow providers to add themselves to the database and to update their information independently. This feature will allow the inventory to be largely self-sustaining and up-to-date. An initial form of the inventory is expected to be online by the end of 2012.





GOAL 2: PREVENTION AND EARLY IDENTIFICATION

Prevent or minimize disabilities and delays by early identification of children with or at risk of special needs, promote the well-being of the whole child and the family, and prevent crises throughout the child's life.

Significant research exists showing the benefits of providing supports as early as possible to children with disabilities. There is an urgent and substantial need to identify young children in need of services to ensure that intervention is provided when the developing brain is most capable of change. High-quality early intervention can reduce the incidence of future problems in a child's learning, behavior, and health status. Intervention is likely to be more effective and less costly when it is provided earlier rather than later. Additionally, some developmental disabilities are wholly preventable, and a concerted effort should be made to minimize the risk of these disabilities from occurring altogether.

OBJECTIVE 2.1: PREVENTING FETAL ALCOHOL SPECTRUM DISORDERS

Work to implement use of effective screening tools and intervention programs for pregnant women at risk.

Issue Summary

Some developmental disabilities are preventable. Preventing disabilities can keep children and families from having limited choices and opportunities in life. Preventing disabilities can also preserve resources for families, communities, and governments. One of the most avoidable developmental disabilities is Fetal Alcohol Spectrum Disorders (FASD). It is caused by prenatal exposure to alcohol, and it can be prevented if the expectant mother does not drink alcohol during her pregnancy.

FASD includes conditions such as fetal alcohol syndrome (FAS), alcohol-related neurodevelopmental disorder (ARND), and alcohol-related birth defects (ARBD), all leading causes of intellectual disability and birth defects. The prevalence of FAS in the United States (U.S.) is estimated to be between 0.5 and 2 per 1,000 births. The prevalence of FAS, ARND, and ARBD combined is at least 10 per 1,000, or 1 percent of all births. Based on estimated rates of FASD per live births, FASD affects nearly 40,000 newborns each year in the U.S., and approximately 4,000 births in Texas.



Alcohol use is considered to be a major contributing factor to low birthweight. Approximately 12 percent of babies with FASD, compared with 3 percent of the general population, are born with low birthweight, which can lead to a variety of poor health outcomes. FASD also has a significant effect on brain development.

The social and economic consequences for these children, their families, and the community are serious and considerable. Children with FASD are more likely than other children to need special education and mental health services, and they are less likely to live independently as adults. A University of Washington longitudinal study of 415 people affected by FASD showed that 94 percent had mental health problems and that an estimated 80 percent of children with FASD were not raised by their birth parents. Further, they are at increased risk of involvement with the criminal justice system.

Current Efforts

The state of Texas has several ongoing efforts to reduce the incidence of low birth weight and FASD.

Holders of a license or permit authorizing the sale of alcoholic beverages are required to display signs in English and Spanish warning of the dangers associated with drinking alcoholic beverages during pregnancy. In addition, schools for sellers and servers of alcohol are required to provide training on fetal alcohol syndrome.

The Texas Office for the Prevention of Developmental Disabilities has recently developed a strategic plan to address FASD and offers public training, informational events, implementation projects, and information resources.

The Healthy Texas Babies Expert Panel is an initiative led by the DSHS Family and Community Health Services Division, HHSC and others, to help Texas communities decrease infant mortality using evidence-based interventions. The goal is to decrease preterm birth by 8 percent over 2 years, which is expected to save about \$7.2 million in Medicaid costs. The initiative has the support of many state organizations and medical professionals.

Strategic Direction

The Task Force identified FASD screening as a key issue and supports adoption of:

- A brief screening and intervention training program, for service providers;
- Development and implementation of a program plan to train practicing providers on a large scale; and
- Program assessment.

A successful screening reliably and effectively identifies pregnant women for their risks of substance use. Research has shown FASD screening tools and interventions can be highly effective.



An effective intervention and prevention program provides information about the impact of alcohol on both the mother and a fetus and uses motivational interviewing techniques to engage participants in making life changes to develop healthier behaviors.

OBJECTIVE 2.2: EARLY IDENTIFICATION OF DEVELOPMENTAL AND BEHAVIORAL DISABILITIES

Increase the use of validated developmental screening tools, including for mental/behavioral health screening, in primary care, education, and other appropriate settings.

Issue Summary

When special needs are not identified early, the ability to serve children efficiently and effectively is compromised. It is estimated that a developmental screening using a standardized tool was conducted for only 20 percent of children under age 5 who had a health care visit in 2007. Early identification of developmental delays is essential for optimal early childhood intervention and improved outcomes. The American Academy of Pediatrics has issued policy statements advocating developmental screening.

When professionals are unaware of how to identify delays and the roots of challenging behaviors, children are less likely to succeed in all areas of their lives: in the home, in child care settings, in schools, and in the community, including in the workforce. The family and child are less likely to build networks of support. Specialized training about behavioral issues is not always easily available to child-serving professionals. For example, caregivers at licensed child care centers and registered family homes are required to receive 24 hours of initial training within the first 90 days of employment and 24 hours of annual training each year, but required topics do not include caring for children with special needs.

Current Efforts

For Medicaid recipients, the Texas Health Steps' (THSteps) Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides periodic developmental screenings for children at 9, 12, 18, 24, and 30 months, and at 3 and 4 years of age. The program uses standardized assessment tools such as the Ages and Stages Questionnaire to evaluate development. THSteps also requires an autism screening for all Medicaid enrollees at 18 months.

The Even Start program administered through the Texas Education Agency (TEA) provides services and support to at-risk families. In 2009-10, Texas funded 31 Even Start local programs. Two- and three-year-olds from most families participating in Even Start receive developmental screenings using evidence-based assessments.



Both the Texas Council on Children and Families and Raising Texas, the state's early childhood comprehensive initiative, emphasize the importance of early childhood screening.

Strategic Direction

Strategy 2.2.1: Screening and Detection

Encourage screening of the whole child, ensuring that primary care physicians respond to social and emotional development needs and behavioral health needs.

The Task Force recommends improving the early identification of mental health/behavioral health issues and developmental delays. Strategies the Task Force will explore include:

- Partner with the Texas Pediatric Society to inform providers and to promote the use of validated developmental screenings to detect social, emotional, and behavioral treatment and care needs in primary care and educational settings;
- Review and analyze the effects of implementing practices consistent with evidence-based toolkits; and
- Structure reimbursement policies to improve primary care providers' abilities to conduct the screenings children need.

OBJECTIVE 2.3: HOME VISITATION PROGRAMS

Develop and implement a variety of home visitation programs that focus on families of children with special needs.

Issue Summary

Home visitation is a voluntary program administered in Texas by HHSC that matches parents with trained professionals to provide information and support during pregnancy and throughout a child's critical first five years. Home visitation programs have shown positive impacts on several important outcomes:

- Maternal, newborn, and child health;
- Positive parenting practices;
- Child well-being instead of maltreatment;
- School readiness;
- Reduced involvement in criminal justice;
- Decreased dependence on welfare; and
- Increased participant employment.



The Pew Center on the States found the highest quality home visiting programs produce positive outcomes that, over time, yield returns of up to \$5.70 per taxpayer dollar spent. These savings were achieved through reduced costs for government services and from increased tax revenue from related employment.

Through a recent federal effort, several home visitation program models have been identified as having a strong evidence-base and are recommended for state use. These program models have varying intensity and duration as well as target populations. For example, Nurse-Family Partnership (NFP) enrolls first-time mothers during the prenatal period and serves them until the child reaches age two. Parents as Teachers (PAT) enrolls families at any time from prenatal through age five. Home Instruction for Parents of Preschool Youngsters (HIPPY) has a school-readiness focus and enrolls children from age three to five. Early Head Start's (EHS) home visitation program enrolls families meeting Head Start criteria and having children from prenatal through age three, including making at least 10 percent of their enrollment opportunities available to children with disabilities who are eligible for Part C services under the Individuals with Disabilities Education Act.

Current Efforts

The state currently has several home visitation program models in operation. These include: AVANCE, EHS – Home Visiting, Healthy Families America, HIPPY, NFP, and PAT. HHSC administers the NFP Program, currently operating in 12 sites.

HHSC is also overseeing a new federal Maternal and Child Health Bureau grant initiative entitled “Maternal, Infant, and Early Childhood Home Visiting Program.” This program provides funding to support the development and implementation of evidence-based home visitation programs in communities across Texas. The funds are intended to contribute to the development of a comprehensive early childhood system that promotes maternal, infant, and early childhood health, safety, and development, and strong parent-child relationships within selected communities. As outlined in the guiding legislation, priority will be given to eligible participants that have low incomes and certain risk factors such as a history of child or substance abuse. Participants of children with developmental delays or disabilities will also be prioritized. At the time of this report, seven communities have been identified for services and expansion is planned throughout the duration of the grant period.

Strategic Direction

The Task Force supports evaluating current and planned programs and working with HHSC to determine the most effective and efficient ways of implementing one or more home visitation programs targeting families with children with special needs.



OBJECTIVE 2.4: CROSS-SYSTEM COLLABORATION

Transform provision of services and supports to prevent crises, to avoid the need to place children in large institutions, and to make more efficient use of funding and other resources, through an organizational culture shift toward greater collaboration among state and local entities.

Issue Summary

Services to children with special needs are currently delivered through multiple large and complex agencies, each with its own mandates, objectives, eligibility requirements, and access points. Limited resources, which are often tied to specific programs, make it difficult for agencies to collaborate and coordinate efforts. These realities constrain agencies to multiple but narrowly-focused efforts, leaving little opportunity to implement innovations to foster cross-agency collaboration.

Often, program response relies upon long established approaches. Some of these approaches address the needs of children only at times of crisis, which increases the likelihood of a reactive and expensive set of services, when an earlier response might have addressed a precipitating need at less cost. For example, Texas has historically invested significant resources in institutional care, even though research indicates it is generally more costly and less effective than other alternatives. While on the whole, community services may be more effective and efficient, there has been a shortage of accessible and affordable community-based services. The result, particularly in more rural areas, has been that children too often have been placed in large institutions.

Current Efforts

In recent years, state agencies have engaged in new practices to help prevent the need for many children to live in large institutions; instead, these children have been able to live successfully in the community, as near to their families as possible. Such practices include:

- Reducing unnecessary institutionalization, through activities such as the Promoting Independence Initiative;
- Implementing permanency planning requirements;
- Implementing family-based alternatives for children in institutions;
- Appropriating funds for community services to be made available to children in institutional settings;
- Dedicating waiver slots for individuals at imminent risk of institutionalization;
- Increasing state funding for community waiver services; and



- Working with consumer advocacy groups and other stakeholder organizations.

Successful system transformations in other states have included mechanisms for stakeholder partnerships in developing cross-agency funding structures, financial models, and fiscal incentives for positive outcomes. To build on these promising practices, Texas is taking steps to facilitate interagency dialogue and coordination. For example, the Task Force for Children with Special Needs, the Council on Children and Families, and the Mental Health Transformation Group have been formed to unite multiple agencies and stakeholders to solve shared and multi-faceted problems.

On the local level, Community Resource Coordination Groups (CRCGs) exist to help children and families who need services from several agencies and need those services to be coordinated to be effective. There are 160 CRCGs across the state, comprised of family members, state and local public agencies, and private organizations.

Strategic Direction

The Task Force is exploring cross-agency collaborations to prevent crises, avoid the need for children to live in large institutions, and make efficient use of funding, including the use of flexible funding. Best practices can be reviewed from Texas and other jurisdictions to seek effective programs that will do a better job of improving outcomes for children and families. Making these changes will require a significant culture shift, and the efforts listed above represent progress. For further discussion of the strategic direction to implement this cross-agency cultural shift, see Objective 6.1: Culture/Philosophy Shifts.

OBJECTIVE 2.5: CAPACITY TO IDENTIFY RISKS OF CRISIS

Expand community capacity to identify crisis in the context of children with special needs and their families, to recognize signs of potential crisis, and to offer links to services to mitigate or prevent escalation of a crisis.

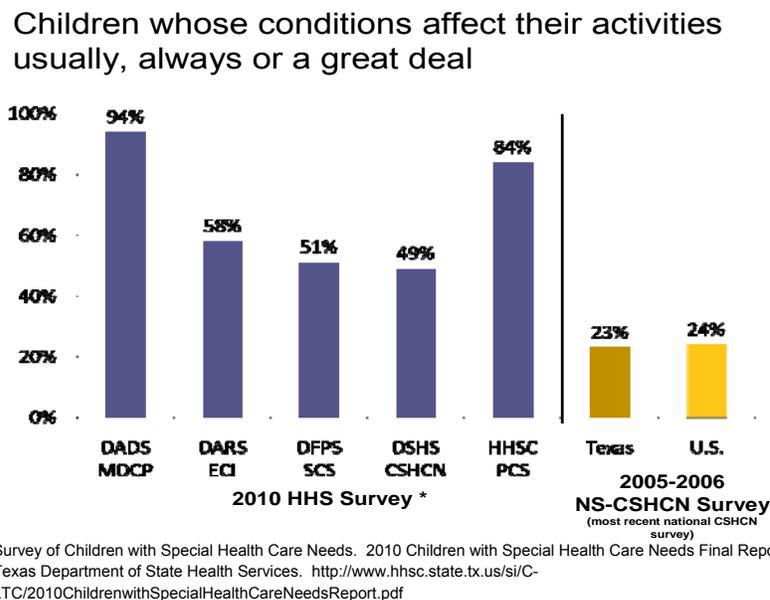
Issue Summary

A crisis represents a sudden and observable loss in mental or physical well-being. Although a crisis is often triggered by an event, it is usually the result of an accumulation of physical and/or mental health challenges that have impacted an individual's quality of life over time. Many crises can be prevented or mitigated through person-centered services designed to support the individual's emotional and physical health and well-being.



When children with special needs and their families are in crisis or facing a potential crisis, it is important that the risk is identified as early as possible. The longer children and their families go without help, the longer they are exposed to negative outcomes associated with the crisis. Community organizations that typically come in contact with families with children with special needs benefit from training to help them identify a crisis or potential crisis. Once a potential crisis has been recognized, community members need to know what to do next. Too often, child-serving professionals and other community members become overwhelmed by the different types of services available. These groups would benefit from assistance in learning how to connect families with the appropriate service for a particular need.

The following survey results indicate a large percentage of children with special needs have conditions that significantly impact their activities.



Current Efforts

Child Protective Services and law enforcement agencies have extensive experience with identifying crisis and risks of crisis. Their knowledge, tools, and experience can lend strength to future efforts to expand community capacity.

The Department of State Health Services (DSHS) provides crisis services for children and adolescents who:

- Present an immediate danger to self or others,
- Are at risk of serious deterioration of their mental or physical health,
- Believe they present an immediate danger to self or others, or
- Believe they are at risk of serious deterioration of their mental or physical health.



Once a child is at risk of crisis, a local CRCG is available to help coordinate multi-agency efforts to meet the child’s needs. The 160 CRCGs across the state are charged with providing a mechanism to enable local public and private agencies, organizations, and families to collaborate to meet the needs of individuals with multi-faceted needs.

Strategic Direction

There are many opportunity points in the social fabric of a community from which to expand capacity to recognize and to address needs before they become crises. The Task Force is evaluating approaches such as self-assessment tools, protocols for agency intake processes, and a shift from crisis management to crisis avoidance.

These efforts could be combined with other outreach and community-building efforts outlined in this Five-Year Plan, as appropriate, such as described in Strategy 1.2.2: Stressline and/or In-Person Network.

OBJECTIVE 2.6: DIVERSION FROM AND MINIMIZATION OF INVOLVEMENT IN THE JUVENILE JUSTICE SYSTEM

For youth with special needs who are at risk of being involved in the juvenile justice system, avoid or reduce their involvement in the system, including by providing behavioral health services and supports.

Issue Summary

Youth with special needs should be afforded the type, frequency, and duration of services required to avoid initial or long-term involvement in the juvenile justice system. Some of the needs most often identified in youth service delivery settings are health complications, traumatic brain injury, hearing or vision issues, emotional disturbances, and most frequently, the need for behavioral health care.

In Texas, it is estimated that almost half of the juveniles processed through the juvenile detention centers each year have a mental illness. Some of the youth appear to have been referred to the juvenile justice system as an access point for mental health services that are otherwise unavailable or inaccessible in the community. This trend has been evident at the adult level for some time and is now also being observed in the juvenile population.

The Task Force has recognized two priorities to prevent or reduce involvement with the juvenile justice system for young people with special needs. The first priority is to expand the availability of accessible behavioral health services in the community. The second priority is to individualize services, supports, and resources provided in response to delinquent conduct in order to reduce further involvement in the juvenile justice system.



It is also important that youth referred to the juvenile justice system for delinquent behavior experience consequences that are swift, certain, appropriate, fair, and consistent. The presence of a special need does not automatically excuse a youth from responsibility or from the consequences of delinquent or illegal behavior; however, it should influence the type of rehabilitative services provided to the youth.

Current Efforts

Formal statewide diversionary programs specifically for youth with special needs are in progress.

Special Needs Diversionary Program

The Special Needs Diversionary Program (SNDP) was created in 2001 to provide mental health treatment and specialized supervision to rehabilitate juvenile offenders and prevent them from penetrating further into the criminal justice system. The program is administered in a collaborative model by the Texas Juvenile Probation Commission (TJPC) and the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI). The basic programmatic structure of SNDP includes a specialized juvenile probation officer teamed with a Mental Health Professional carrying a caseload of 12 to 20 youth identified as meeting DSHS's standard for priority population diagnosis.

In state fiscal year 2010, SNDP served 1,400 juveniles in 25 counties, providing 19 programs, involving 21 departments. A total of 73 percent of juveniles discharged from SNDP successfully completed the program, and only 2 percent of those starting SNDP in state fiscal year 2009 were sent to the Texas Youth Commission (TYC) within one year.

Front-End Diversion Initiative

The Front-End Diversion Initiative (FEDI) is an initiative to divert youth with mental health needs from progressing deeper into the justice system. FEDI provides specialized mental health and case management training to specialized probation officers to help them better identify and work with youth who have mental health problems. These specialized officers supervise a reduced case load, provide intensive case management, and link and refer youth and their families to community resources as necessary. The demonstration sites are located in the following counties: Bexar, Travis, Lubbock, Dallas, and Harris.

Bexar CARES

DSHS funds a pilot behavioral health program in San Antonio, called Bexar CARES, through the Center for Health Care Services (CHCS). CHCS is one of the Local Mental Health Authorities (LMHA) contracted to provide mental health services under DSHS.



The Bexar CARES pilot program attempts to improve outcomes for children with behavioral health concerns who are at risk for removal from their community. DSHS, Department of Family and Protective Services (DFPS), Texas Education Agency (TEA), TYC, and Bexar County Juvenile Probation Department have entered into a Memorandum of Understanding which permits:

- Collaboration in the provision of uniform early intervention behavioral health services;
- Identification of children at risk for placement in an alternative setting, including juvenile justice involvement; and
- Diversion of children at risk for alternative placement to “system of care” services to provide comprehensive and efficient services.

Once children are referred to participate in Bexar CARES, services are organized through “wraparound” treatment planning for a process that is individualized, family-driven, youth-guided, community-based, and culturally competent.

Strategic Direction

The Task Force is examining the effectiveness of these and other programs to determine how to improve the outcomes for young people with special needs, including those who are at risk of entering the juvenile justice system. When the most successful programs are determined, the next step will be to see how best to implement them in additional high needs areas of the state.





GOAL 3: ENTRY POINTS INTO SERVICES

Support the whole child by improving parents' and caregivers' ability to secure high-quality, timely, flexible, individualized, and appropriate services when needs are first identified.

Children with special needs come to the state and local system of services and supports through many different entry points, including neonatal intensive care, primary medical care visits, pre-school and school enrollment, child protective services, law enforcement, and the juvenile justice system. These are crucial points at which the right information at the right time can change the trajectory of the life of a child. Without this help, key opportunities to improve outcomes are missed.

We wanted to keep our daughter at home with us, but needed some support to handle all her needs. At one point we were offered a slot in a state institution, but no one ever mentioned waiver programs or any alternative to allow her to stay at home. After years struggling in a state institution we have been able to bring our daughter home with the help of one of the waiver programs, but we don't understand why this service was never mentioned in the first place.

—Parent of a child with special needs

OBJECTIVE 3.1: REFERRALS

Ensure that at any point when a child with special needs is identified, the child's family receives appropriate information about services and supports for which the child and the family may be eligible.

Issue Summary

Public testimony received by the Task Force indicated a need for greater coordination and integration between systems. Families reported they often do not receive appropriate or timely information about available services and supports. Additional comments indicated that even when their child is receiving services, their primary service provider is often not aware of other services and supports available. This feedback indicates referrals for non-medical services are often not made in the formal office setting.



Many providers and agency employees do not have comprehensive knowledge of available services and supports in the community or in statewide programs. The quality of referral services is better at some agencies and providers than others. When a program staff member or provider fails to refer a child for appropriate services, opportunities are missed to support the child's health and wellbeing.

I learned about key programs like ECI and HCS from other parents, but was never informed about any programs by a single medical provider.

—Parent of a child with special needs

Current Efforts

The policies and procedures at agencies serving children in special education, early childhood intervention, and waiver programs (DSHS, TEA, HHSC, and DARS) require staff to refer consumers and families to appropriate early childhood detection and intervention providers in the community.

Medicaid Managed Care Organizations (MCOs) providing services to children have requirements for providing referrals for clients with delays or confirmed developmental disabilities. This includes the referral to the Early Childhood Intervention (ECI) program when a child younger than age three is identified as possibly having a delay.

The ECI program currently requires its contractors to provide ECI program information to providers of health care including hospitals, physicians, public health facilities, Children's Health Insurance Program (CHIP) providers, and certain Medicaid providers. ECI contractors are also responsible for providing program information to schools, Early Start and Head Start centers, child care providers, and other community programs. Contractors within a certain area must also coordinate to provide the medical community with a list of diagnoses that qualify a child for ECI services. Finally, contractors are responsible for promoting the involvement of health care professionals in early identification, referrals, and service provision.

Despite these policies, families and consumers report not routinely receiving appropriate referrals.

Strategic Direction

Parents report that informal contacts in the community are helpful sources for information about available services and supports. Through an improvement in the flow of information, communication, and coordination among public and private entities, children and families would be better served.



The Task Force will review how best to implement ideas such as those listed here.

- Agencies and school districts serving children with special needs may choose to include coordination among the organizations as part of their rules, policies, or procedures;
- Agencies and school districts may choose to establish and implement procedures or policies for referring children for services. This could include children who may qualify for special education services under the Individuals with Disabilities Education Act (IDEA), Part B, and;
- School districts may use the special education Admission, Review, and Dismissal (ARD) meeting as a vehicle to connect children and parents with helpful local agencies or services.

OBJECTIVE 3.2: WAIVER SERVICES

Review and improve criteria and process of interest lists for home and community-based waivers to improve timely access and outcomes for children and to avoid the need for any child to be placed in a large institution.

Issue Summary

A waiver program allows flexibility for serving people, including children and youth, through the Medicaid program. The eligibility criteria for waiver programs are similar to those for institutional programs, and the federal government allows states to waive, or set aside, certain requirements. The goal of the waiver programs is to provide people services and supports in their homes or in the community who would otherwise qualify for services in an institution. An important strength of the waiver programs is that the average cost per person is less than the average cost of services in an institution. Several waiver programs are available to children and youth.

Unlike Medicaid entitlement programs, which serve all people who meet the eligibility requirements, waiver program slots are limited by the amount of funding that the Legislature appropriates. Demand for these services continues to outpace available funding, despite significant increases from the Legislature in recent years. People who cannot be served may request placement on a list called an “interest” list. At the time of placement on the list, there is no determination of whether that person will qualify for that waiver program when the service becomes available to them. Determination of eligibility is done when the service does become available.



As of 2010, there were more than 62,000 children and youth on the interest lists. Time spent on the interest lists varies by program, but the wait for some programs can be very long. While a family waits, the child’s health conditions and abilities may deteriorate, and the family may experience intense crisis due to the strain of caregiving. By the time a child reaches the top of the list, his/her needs may have become much greater than when first placed on the list.

	Number of children enrolled in waiver (as of July 2011)
DADS Home and Community Based Waivers	
Community Living Assistance and Support Services (CLASS)	2,514
Consolidated Waiver Program (CWP)	56
Deaf-Blind with Multiple Disabilities (DBMD)	3
Medically Dependent Children Program (MDCP)	5,617
Home and Community Based Services (HCS)	2,526
Texas Home Living (TxHmL)	299
Total	11,015

Source data – Texas Department of Aging and Disability Services

Current Efforts

Although individuals on the interest lists are generally served on a “first-come, first-served” basis, the Legislature has authorized several exceptions to that policy. For the 2012-13 biennium, the 82nd Texas Legislature funded:

- 400 HCS waiver slots for children and adults residing in large intermediate care facilities (ICF) who wish to move to the community,
- 240 HCS waiver slots for children and adults at imminent risk of entering an institutional setting, and
- 192 HCS slots for children in foster care who are aging out of DFPS conservatorship and are in need of waiver services.



The 82nd Texas Legislature also authorized the following appropriations riders that provide greater flexibility or access for children to Medicaid waiver services:

- Rider 29 directs the Department of Aging and Disability Services (DADS) to provide services to a child leaving a nursing facility through any waiver program, if the child is eligible for that program and needs services only available through that program;
- Rider 30 directs DADS to provide services to a child leaving an ICF/MR facility through any waiver program, if the child is ineligible for Home and Community-based Services (HCS) but is eligible for another waiver program; and
- Rider 31 directs DADS to provide waiver slots for children seeking to move from an ICF/MR of any size to community settings.

The 82nd Texas Legislature also passed S.B. 222, which directs DADS to:

- Ensure local MR authorities (MRAs) inform and counsel individuals and their legally authorized representatives about all program and service options for which the individuals are eligible;
- Educate the public on the availability of HCS under the Medicaid state plan and waiver programs; and
- Post information about the percentages of individuals who accept the offer of a waiver slot when their name comes up on an interest list.

Strategic Direction

Among the options for addressing this challenge, the Task Force has focused on two strategic priorities.

Strategy 3.2.1: Expanded Access to Services Based on the Needs of and the Risks to the Child and the Family

Improve timeliness of access to home and community-based services for children in crisis or at risk of placement in an institution.

Additional crisis diversion slots should be made available in the HCS and other waiver programs for children who have urgent unmet needs and are at risk of being placed in an institution. If more of these slots were available, children could get the services and supports they need immediately, their health outcomes and general well-being would be improved, and more families could stay together. Funding could be spent more effectively, since providing services and supports in the home and community is often less expensive than providing services in institutions.



Strategy 3.2.2: Elimination of Interest Lists for Waiver Services

Fund waiver programs as funds become available, to more fully meet the need for home and community-based services, so that interest lists are no longer necessary.

In the larger picture, the Task Force supports a vision in which all eligible children would receive needed services and supports that their families are not able to obtain on their own. Interest lists would no longer be necessary. The Task Force commits to moving in this direction, acknowledging significant and ongoing resources will be needed to achieve this strategy.

OBJECTIVE 3.3: ENTRANCE INTO PUBLIC SCHOOL SERVICES

Educate children to their highest capacity.

Issue Summary

Eligible children with disabilities, ages 3-21, are entitled to receive a free appropriate public education (FAPE). This right is protected under the Individuals with Disabilities Education Act (IDEA). For children with special needs, education is a critical component in promoting and preparing them for successful independence as adults and integrating them into society.

All school districts and charter schools in Texas must provide special education and related services to those children who qualify. School district Preschool Programs for Children with Disabilities (PPCD) provide special education and related services for eligible children with disabilities ages three through five. Many children with disabilities in this age group are also served in daycare settings, Headstart, and private pre-schools. Eligible students with disabilities, ages 3-21 may receive special education services through instruction in the regular classroom, instruction through special teaching, or instruction through contracts.

Current Efforts

Identifying children in need of special services is a responsibility shared by multiple state programs. Programs responsible for serving identified children include: early intervention, preschool special education, Head Start, Title V programs for children with special health care needs, and state Medicaid and State Children's Health Insurance Program initiatives. The Texas Education Agency works with the regional education service centers and local education agencies (LEAs) to ensure all children with disabilities residing in the state, who are in need of special education and related services, including children with disabilities attending private schools, are identified, located, and evaluated. This process is called Child Find. For young children turning three, it is important for LEAs and Early Childhood Intervention (ECI) programs to work together to develop, maintain, evaluate, and refine their



collaboration systems for the smooth transition of children with disabilities and their families who leave ECI services and enter public school system.

Anyone involved with a child's education, including parents, legal guardians and teachers, may refer a child for a special education evaluation in the state of Texas. If a child meets the eligibility criteria for special education services, an Admissions, Review and Dismissal (ARD) Committee develops an Individualized Education Program (IEP) for that child. The IEP includes special education, related services, and supplemental aids and services to be provided to the child.

The federally mandated State Performance Plan (SPP) Indicator 11, charges states with collecting LEA data and states are required to report on the percentage of children who were evaluated for an IEP within the timeframe established by federal law. LEAs are monitored for non-compliance.

Strategic Direction

The Task Force supports improving the opportunities for families to be better informed and prepared as they participate in their child's education. This includes examining improvements that remove barriers to smooth transitions between educational levels and ensuring parents receive the information they need to participate in the planning and coordinating of their child's services.

Strategy 3.3.1: Preschool Program for Children with Disabilities

Ensure a seamless, effective transition from the Early Childhood Intervention program to the Preschool Program for Children (PPCD) with Disabilities.

To minimize gaps or delays, the Task Force will begin by examining options that may be available to remove identified barriers. These may include exploring opportunities to:

- Promote and encourage year round PPCD and its services, and
- Promote and encourage local school districts to complete evaluations, hold ARD meetings, develop IEPs, and coordinate services for children with special needs within 30 days of eligibility to PPCD, regardless of school schedule.

Strategy 3.3.2: School-Age Education Services

Provide families access to timely, appropriate, and consistent information and education services when a need is first identified.

The Task Force will work with agencies, parents and other stakeholders to identify gaps and explore options to improving statewide access.



OBJECTIVE 3.4: ENTRANCE INTO THE JUVENILE JUSTICE SYSTEM

Assess a child's needs and risks, and provide appropriate services as needed.

Issue Summary

When a young person enters the Texas juvenile justice system, the intake process focuses on assessing the youth's own risk and protective factors as well as the risk the youth presents to public safety. Protective factors are defined by the U.S. Administration on Children and Families (ACF) as conditions in families and communities that can improve the well-being and health of children and families. This individual information is then used to develop a personalized treatment plan to help increase the youth's ability to become a literate, lawful, productive, and responsible citizen and to decrease the youth's risk to re-offend or to cause harm to himself or others. Gathering information about assessments and current practices at all juvenile justice system entry points can help drive the development of improved services and supports for all youth, including those with special needs.

Current Efforts

The Texas Youth Commission (TYC) and the Texas Juvenile Probation Commission (TJPC) currently have strong and active collaborative efforts in place to assess and serve youth in the juvenile justice system, including those with special needs.

As directed by the Texas Legislature, the functions of TYC and TJPC will soon merge into a new agency, the Texas Juvenile Justice Department. This re-alignment of responsibilities provides an opportunity to capitalize on the groundwork laid by TYC and TJPC and to extend that work into local juvenile probation departments.

Strategic Direction

To improve system entry points for treatment and services for children with special needs, the Task Force intends to start by gathering baseline data for a needs assessment and gap analysis. Information-gathering steps include:

- Identifying the number of children and youth with special needs in the juvenile justice system;
- Determining the workforce available to serve these children;
- Assessing needed versus currently available services;
- Identifying any gaps in service provision,; and
- Developing recommendations on how to bridge those gaps.

Considerable thought and coordination will be needed given the evolving structures of the juvenile justice system into a new agency.



GOAL 4: COMPREHENSIVE ARRAY OF SERVICES AND SUPPORTS

Improve system capacities and coordination to support the whole child so parents and caregivers can get and maintain affordable, high-quality, timely, flexible, and individualized services and supports for children with special needs in or as close to home as possible.

Often, families caring for children with disabilities never anticipate needing to ask for help, and some may find it difficult to do so. However, the challenges that accompany raising a child with disabilities may leave them with little choice but to seek assistance and support. “Family support” is the term used to define the support and services families need to keep their child at home and to sustain the health and well-being of the family. Family support is often the “glue” that keeps a child in a loving home and is needed by families at all economic and educational levels.

The supports a child and family need vary depending on the child and family. Some families only need occasional respite allowing them to rest or spend time with other children in the family. Other families need much more extensive support in order to care for a child with significant medical, cognitive, or behavioral disabilities. The key to designing quality support systems is to ensure the systems allow children to access the services that will enable them to remain at home, be safe, and meet their potential.

OBJECTIVE 4.1: FAMILY SUPPORTS

Ensure the service system is focused on the child in the context of the family, providing high-quality, cost-effective, individualized services, resulting in improved long-term quality of life outcomes, integration, and independence.

Issue Summary

Caring for children with special needs can be complex, time-intensive, and challenging. Families often have little or no time away from the continual pressures associated with the child’s needs. All families benefit from support from time to time, and families with children with special needs may require more help than others.

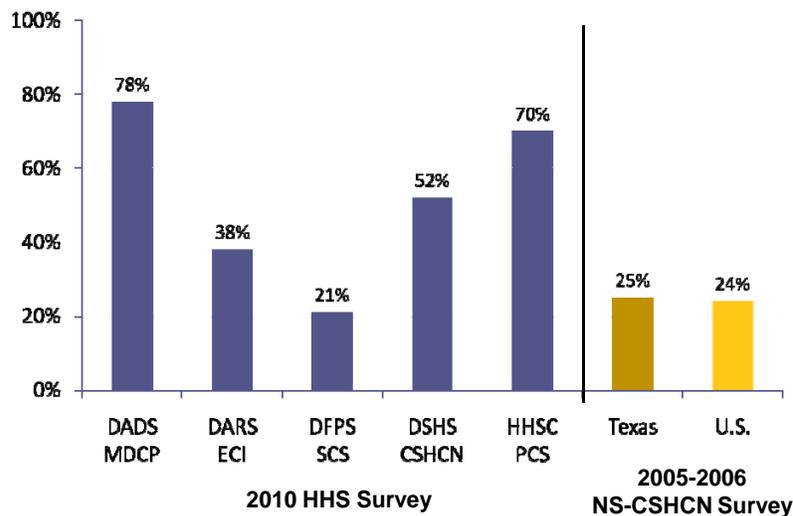
Families who do need help and who have identified a program or service must then navigate their way through the program's eligibility and initial documentation requirements. They are then generally enrolled in that program or service. Some families enroll in programs with a predetermined "menu" of services and supports offering limited choices, which may not fully account for the unique needs and abilities of the child and family. Families are creative and can sometimes find ways to stretch a budget to meet their particular needs. When that creativity is not incorporated as part of the system of services, children and families suffer, and dollars are wasted.

Families report respite care as one of their most critical needs; however, coverage for respite services can be very limited in Texas. What is available is often costly and not enough respite care providers have specialized training to assist with particular needs. Waiver programs have conflicting rules about use of respite care and do not always allow such care when and how it could be most useful to the family. Respite care should be immediately accessible, child-focused, and supportive of children with intense medical and behavioral needs. Geographically, respite care should be made available to families in their homes and also in out-of-home settings that are small and close to the child's family. Respite care is especially hard to find in rural areas.

Families of children with special needs often require support so they can work, attend school, and/or participate in job training. Most waiver programs in Texas do not offer this service, or offer it in very limited circumstances only. Other states offer habilitative child care and habilitative day care services in their 1915(c) waivers. A focused effort is needed in this area to develop creative community-based and community-supported child care and day care services.

The following survey results indicate a high number of families with children in a number of Texas programs providing services to children with special needs have had family members cut back or stop working due to the child's condition.

Children whose conditions cause family members to cut back or stop working



Survey of Children with Special Health Care Needs. 2010 Children with Special Health Care Needs Final Report. Texas Department of State Health Services. <http://www.hhsc.state.tx.us/si/C-LTC/2010ChildrenwithSpecialHealthCareNeedsReport.pdf>

Current Efforts

Different levels of efforts are underway in Texas to address each of these needs. Reflecting national service-delivery trends for people with developmental disabilities, DADS is implementing person-directed planning for individuals living in the community. The old approach of prescribing standard waiver services is giving way to a new philosophy of allowing children and families more flexibility when designing services they need.

For more than 36 years, Parent to Parent programs across the country have been providing emotional and informational support to families of children who have special needs, most notably by matching parents seeking support with an experienced, trained 'Support Parent.' Texas Parent to Parent was founded in 2002 and has a large network across the state.

The University of Houston (UH) Parent Education Project works to enhance the lives of at-risk children and families in the Greater Houston area. The UH Parent Education Project offers the following services, free of charge, to families in the Houston Area:

- Families CAN—Providing case management or other services to more than 300 families per year who are raising a child with a special health care need.
- Family Based Alternatives Project—Working with birth parents or guardians to move children out of institutions and into long-term placements with either their own family or a support family.



- **Relatives As Parents Program**—Providing information, education, case management, support groups, and other services to people who are raising children who are their extended relatives.

To enhance training opportunities, DADS hosts workshops across the state for nurses, caregivers and professionals who work with individuals who have intellectual disabilities and engage in challenging behaviors. Parents and family members are also invited to attend. The workshops are presented by instructors from the University of North Texas and the Behavior Analysis Resource Center. These workshops are free for caregivers, parents, and family.

The Texas Lifespan Respite Care Program was created in 2009, to increase the availability, quality, and awareness of respite services. In implementing this program, DADS established the Texas Respite Coordination Center (TRCC), working with the Texas Respite Coalition and local contractors. The Texas Respite Coalition is made up of 40 broadly representative organizational stakeholders and serves in an advisory capacity to the TRCC. These joint efforts include creating an inventory of current respite resources across Texas and collecting and sharing best practices from practitioners and stakeholders. Together, these organizations expect to achieve significant outcomes.

The interagency Texas Expanding Opportunities initiative is working together to expand inclusive early care and education opportunities for young children with special needs and their families. Head Start programs are available to qualified children from ages three to five. These programs offer a stimulating setting where children with disabilities can interact with typically developing preschoolers and at the same time get necessary services and supports. Family income is the primary eligibility requirement for admission into a Head Start program.

Strategic Direction

The Task Force is considering the following strategies to improve support to families.

Strategy 4.1.1: Family-Centered and Person-Centered Planning

Ensure children, youth, and families are partners in planning, caregiving, and decision-making.

The Task Force will evaluate current programs and services supporting children with special needs, including 1915(c) home and community-based waivers and case management programs to ensure they include family-centered and person-centered planning.

Strategy 4.1.2: Parent Peer Support

Develop or expand existing parent-to-parent models linking together parents of children with special needs to enhance peer learning, mentoring, training, information dissemination, and support.

The Task Force advocates supporting efforts to create new and expand existing parent-to-parent groups. This includes supporting sufficient funding for parent groups to hire paid staff to be a resource for parents, and ensuring the organizations have the latest information on available resources.

Strategy 4.1.3: Family-Based Education

Make training available to families of children with special needs, including positive behavior support, medical interventions, therapeutic techniques, and person-centered planning.

Appropriate training is very limited for families who care for children in their homes, particularly those with challenging behavioral or medical needs. The Task Force will consider methods to develop statewide training for these parents.

Strategy 4.1.4: Respite Care

Increase access to and enhance the quality of respite services across the continuum of respite models, including in-home, out-of-home, and foster home.

The Task Force will explore best and promising practices. In addition to the Lifespan Respite Care Program at DADS, the Task Force will include programs that have been implemented or are being considered in other states, including community- and faith-based programs.

Strategy 4.1.5: Additional Child Care Options

Evaluate current child care options, including amending Medicaid waivers, to support families in working, attending school, or participating in job training; develop and implement a plan to increase child care services for children with disabilities.

The Task Force will explore opportunities to develop or enhance accessible community-based and community-supported child care services. This could include amending CLASS, HCS, MDCP and DBMD 1915(c) Medicaid waivers to cover a new service that would allow families to access increased child care options.



OBJECTIVE 4.2: SYSTEMS NAVIGATION

Offer navigation services to families who need help coordinating the services and supports across the system.

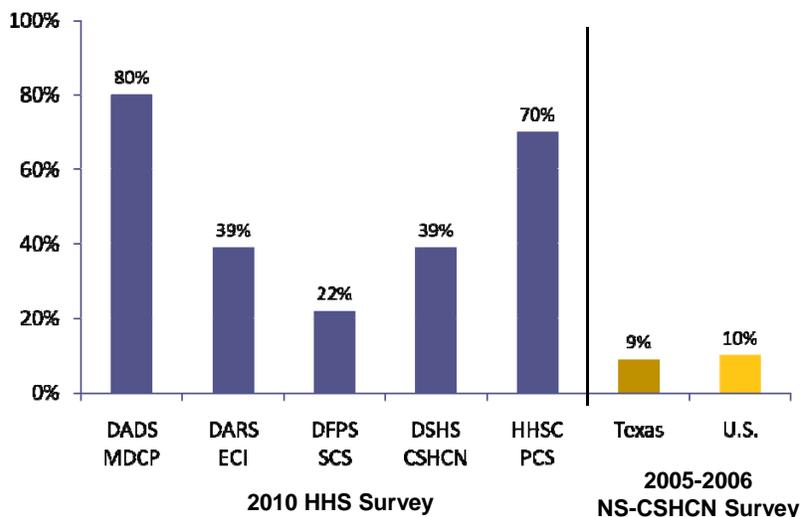
Issue Summary

Families have reported (in public testimony and in subcommittee discussions) that they need help with navigating the complex and fragmented array of services and supports available for children with special needs. Some parents have felt overwhelmed by the efforts required to follow through on the many tasks involved:

- Identifying appropriate services;
- Accessing services;
- Facilitating coordination among service providers when there are multiple providers; and
- Enabling providers to share comprehensive and accurate information that supports the health and well-being of the child and family.

Parents want help from someone who knows how the system works. The following survey results indicate the amount of time families spend providing or coordinating care.

Families that spend 11 or more hours per week providing or coordinating their child's health care



Survey of Children with Special Health Care Needs. 2010 Children with Special Health Care Needs Final Report. Texas Department of State Health Services. <http://www.hhsc.state.tx.us/si/C-LTC/2010ChildrenwithSpecialHealthCareNeedsReport.pdf>



Current Efforts

Family partners have been helpful in child and adolescent mental/behavioral health programs. A family partner is a person who has self-identified as the caregiver of a child or youth with an emotional, behavioral, or co-occurring disorder and who has successfully demonstrated the qualifications necessary to navigate the Texas system. These individuals help support family engagement and voice in the treatment and service decisions. The navigator may also be known as a peer support specialist, a parent navigator, a family navigator, or a family support specialist.

Through federal funding, DADS has established Aging and Disability Resource Centers (ADRCs) in 14 communities as the first place to go with questions about aging and disability programs and services. ADRCs provide a single, coordinated system of information and access for older persons, persons with disabilities and caregivers seeking long-term support. ADRCs are intended as a means to minimize confusion, enhance individual choice and support informed decision-making. Each ADRC is designed as a single point of entry to provide “no wrong door” access to needed services and supports

To implement House Bill (H.B.) 2610 (82nd Legislature, Regular Session, 2011), HHSC may establish a certified community-based navigator program to assist those who are using an electronic eligibility system to apply for HHSC services. The program will allow volunteers from faith- or community-based organizations to become certified as navigators for the initial eligibility process.

Navigator programs have been used in several states to help people access and navigate across complex provisions of various programs. This model has proven effective in guiding families through complex situations.

Strategic Direction

The Task Force supports pursuing two navigator models to help families sort through the array of programs and services that are available.

Strategy 4.2.1: Navigator/Coordinator Model

Review models and relevant research, and propose improvements for provision of a facilitator, navigator, or coordinator.

The Task Force proposes to research best and promising practices of models for a navigator/coordinator program to help families maneuver through the system of services. Qualified navigators would assist families in locating, securing, and coordinating services for children with special needs. The Task Force will coordinate with HHSC’s efforts to implement the provisions of H.B. 2610 to help people with eligibility applications.



Strategy 4.2.2: Mental Health Navigator Certification Program

Expand the use of family partners in child and adolescent mental/behavioral health programs by establishing certification of family members of children with special needs to serve as navigators for other families.

The Task Force supports expanding the use of family partners in child and adolescent mental/behavioral health programs and creating a Mental Health Navigator Certification Program, to qualify family members to serve as partners or liaisons to assist families in accessing services and systems. The Task Force recommends coordinating with the HHSC effort to establish a community-based navigator program.

OBJECTIVE 4.3: HEALTH COVERAGE

Assure affordable, consistent, comprehensive health coverage is available for all children and youth, including young adults transitioning into adulthood.

Issue Summary

National studies suggest that children without health insurance are less likely to receive necessary preventive and acute care, resulting in poor health outcomes.³ Access to health insurance is an essential step in receiving needed pediatric health care. Having health insurance is particularly important for children with special needs, who have increased ongoing medical needs.

In addition to health coverage, a growing body of research and experience shows integrating, or systematically coordinating, physical and behavioral health care to treat the whole person can improve health. Research also suggests integration could potentially result in long-term cost savings.

Health Coverage for Serious Emotional Disorder

Medicaid, CHIP, and the public mental health system cover treatment of serious emotional disorder (SED) in children. Private insurance plans often do not. Mental health parity law requires treatment for serious mental illness, defined as bipolar, depressive, psychotic, and autism spectrum disorders. The law does not require coverage for SED, which represents mental illness that substantially interferes with a child's ability to function successfully at home, in school, or in their communities. Children with SED often have high rates of absenteeism, school dropout rates, unemployment, and involvement with the criminal justice system.⁴ Research has shown that caring for a child with mental health concerns places considerable strain on a family's stability and financial well-being, more so than caring for a child with other special health needs.⁵ Private health insurance limitations have been identified as a factor increasing the number of children placed in child welfare and juvenile justice systems to obtain mental health services, an occurrence, not uncommon for families, across all income levels.



Child-Only Policies

The new healthcare reform law prohibits insurance companies from excluding coverage based on pre-existing conditions. As a result, most insurance plans in Texas have stopped offering new child-only policies for children under 19, because it is theorized that parents will wait until a child is sick before applying, which is not cost-effective for health plans. It is estimated that tens of thousands of children may be without coverage as a result. Included in this population are parents whose employers do not offer dependent coverage or offer it at premiums that are cost-prohibitive. Also affected are grandparents covered by Medicare who care for their grandchildren. These families may be forced to buy expensive family policies, which are much more costly than purchasing a separate policy for parents/caregivers and children.

Integrated Care

Primary care providers are often the first point of contact for families when it comes to the health and well-being of their child. They are in a key position to identify potential mental health concerns early and to communicate these concerns with families. Offering mental health treatment in primary care is convenient for patients, can reduce the stigma associated with treatment for mental disorders, and builds on existing provider-patient relationships. Although public and private healthcare service delivery systems have separated these services, there is an inherent interconnectivity between physical health and behavioral health needs. Integrated health care seeks to address this situation by taking into account the impact of behavioral health on physical health, as well as the impact of physical health on behavioral health. Research demonstrates positive outcomes for consumers obtaining integrated care, and suggests integration could potentially result in long-term cost-savings.

Current Efforts

H.B. 1951 (82nd Legislature, Regular Session, 2011), included a provision to allow the Texas Department of Insurance (TDI) to write rules to encourage insurers to re-enter the child-only health plan market.

In July 2011, Blue Cross and Blue Shield of Texas announced it would offer a new child-only health insurance plan in Texas, with an initial enrollment period from July 15 through September 15. The new plan became effective August 1, 2011.

H.B. 2196, 81st Texas Legislature, Regular Session, 2009, charged HHSC with establishing a workgroup to study and make recommendations on the integration of health and behavioral health services in Texas. The group submitted its recommendations to the 81st Texas Legislature in August 2010.

Strategic Direction

Expanding private health coverage would improve children's health outcomes and have a positive effect on their overall well-being. The Task Force supports these efforts.

Strategy 4.3.1: Coverage of Serious Emotional Disturbances

Explore options for private insurance companies to cover serious emotional disturbances (SED), including those which are a result of traumatic and acquired brain injury, in children and youth.

The Task Force, working with TDI, will review options to encourage private insurance coverage of SED. Options may include legislative or administrative rule changes. If private insurance plans covered children's SED, children could access treatment to help them succeed at home, in school and the community. Avoiding these negative outcomes would result in cost savings to public systems, such as those associated with increased school attendance and reduced involvement in more costly child welfare and juvenile justice systems. When children have access to effective treatment, families are better able to maintain stable households and employment by reducing the amount of time needed to coordinate care for their children with SED.

Strategy 4.3.2: Child-Only Policies

Explore options for private insurance companies to offer or expand child-only individual policies for children with special needs.

The Task Force will review options for encouraging private insurance companies to offer or expand child-only individual policies for children under age 19, via administrative rule or legislation. If private health plans offered child-only policies, children with special needs who are unable to obtain health coverage through other means would have access to preventative and acute care important to their health, development, and quality of life. Failure to provide child-only policies will result in children not receiving the preventative and acute care needed, resulting in negative health outcomes for children. The inability to get coverage for their children places increased stress on families' financial stability and their mental and physical health.

Strategy 4.3.3: Integrated Care

Encourage a whole-child approach to caring for children, such as ensuring primary care physicians respond to social and emotional development needs and behavioral health needs.



The Task Force supports efforts to promote and encourage integrated physical and mental health care. Although various approaches exist for integrating care, all emphasize greater collaboration and coordination between healthcare systems and providers. Moreover, the most successful integration endeavors result from effective planning developed at the local level.

OBJECTIVE 4.4: MEDICAID STATE PLAN AND WAIVER AMENDMENTS

Amend Medicaid waivers and the Medicaid State Plan as appropriate, to provide more comprehensive, responsive, and self-directed services to support children with special needs.

Issue Summary

Medicaid is a jointly funded state-federal program that provides acute and long-term services and supports. It was established in Texas in 1967 and is administered by HHSC and other health and human services agencies to which it delegates administration of specific programs. Medicaid serves primarily low-income individuals and families.

Some Medicaid services (known as “entitlement” or “state plan” services) must be provided to all individuals who meet the functional and financial criteria, regardless of the funding allocated for the program. States can limit the provision of other Medicaid programs (known as “waiver programs” or “1915(c) waivers”) based on the specific funding allocated for that program. If demand for those programs exceeds the supply, individuals may be placed on an interest list until an opening for the service becomes available and their eligibility can be determined.

Waiver programs include a comprehensive array of services that enable an individual who would otherwise be eligible for a nursing facility or intermediate care facility for persons with intellectual or developmental disabilities (known as an “ICF/MR”) to be served in the community.

In some cases the array of Medicaid services may be insufficient to meet the needs of the individual served, or program rules may not be flexible enough for the individual to receive the services they need.

Current Efforts

Federal law requires that Medicaid waiver programs include services sufficient to meet the health and welfare needs of the individual, and to enable the individual to live in the most integrated setting possible. Funding for Medicaid services is limited, and the ability of a state to expand its service array to individuals in a program must be balanced with the need to offer services to more individuals who are on the interest list.



Texas has implemented a consumer-directed services (CDS) option in its Medicaid program. CDS is a long-term services and supports delivery option in which consumers, parents of minor-aged children, or guardians have increased choice and control over the delivery of services. The CDS option allows the individual or the individual's legally authorized representative (LAR) to be the employer of record of the personal assistance or habilitation services provider, respite services provider, or in some programs, professional services provider (nursing, physical therapy, occupational therapy, and speech therapy). The individual or LAR has responsibility for hiring, training, supervising, and, when necessary, terminating the employee.

Due to funding constraints, the 82nd Legislature mandated that DADS reduce the caps (or maximum amounts allowed) on certain services provided through certain waiver programs. DADS is developing an implementation plan that will allow for exceptions to those reduced caps if the reduced service amount would endanger the individual's health and welfare in the waiver program.

Strategic Direction

The Task Force will explore options for revising waiver programs to make a broader array of services available to children with special needs in each waiver. The Task Force acknowledges that adding new or expanding current services requires re-allocating existing funding or identifying new resources. Such changes would require a sustained effort over the long-term.

Strategy 4.4.1: Hospital Level of Care Waiver

Provide a hospital level of care waiver for medically fragile children who turn 21 years of age and are no longer eligible for the Early and Periodic Screening, Diagnosis, and Treatment Program.

Some children with extensive and complex needs who receive Medicaid entitlement services lose access to some of those services when they turn 21 and may enter an adult waiver program that is not as comprehensive. The Task Force supports the continuing work by DADS and HHSC Medicaid to make comparable services available for young adults.

Strategy 4.4.2: Youth Empowerment Services Waiver

Expand the YES waiver to all areas of Texas.

The Youth Empowerment Services (YES) waiver is a pilot project to provide more comprehensive mental health, adolescent to adult transition, and other support services, to a limited number of youth in Travis and Bexar counties. The Task Force will investigate the success of the current program and will explore appropriate ways to expand the waiver to all areas of Texas.



Strategy 4.4.3: Children in Care of DFPS

Amend waivers as appropriate to include children in the care of DFPS.

The Task Force will explore options to include children in the custody of DFPS, in all available Medicaid waivers, including the YES waiver. This waiver supports children who have behavioral and mental health needs and currently excludes children in the custody of DFPS from services. Children in DFPS conservatorship often need enhanced behavioral health services. The YES waiver provides such services.

Strategy 4.4.4: Partial Hospitalization Programs

Implement partial hospitalization programs to give children access to the least restrictive environment necessary for the adequate treatment of and recovery from their acute mental health crises.

Partial hospitalization programs provide comprehensive outpatient care to people who are experiencing acute symptoms of a mental health disorder. The program can provide a transition from inpatient psychiatric hospitalization to community-based care or, in some cases, it can be an alternative for an inpatient admission. Patients receive several hours of therapy services during the day and return home at night.

The Task Force will collaborate with DSHS and the Local Mental Health Authorities to establish a statewide plan that identifies existing and potential partial hospitalization frameworks and addresses local and statewide capacity issues. The plan should ensure partial hospitalization systems, use evidence-based practices, integrate education, provide peer support, family reunification, and natural and community supports.

Strategy 4.4.5: Medicaid Home Health Aides

Include home health aides with registered nurse (RN) delegation for medically fragile children in the Medicaid State Plan, which would improve health outcomes and provide cost savings.

Many children have an ongoing need for more assistance than a personal care attendant is able to provide. The Task Force will work toward including Medicaid State Plan coverage for a home health aide with registered nurse delegation on a continuous basis. The reimbursement rate established for the service must be sufficient to attract and maintain an adequate provider base.

Strategy 4.4.6: Consumer-Directed Services

Add additional options for consumer direction and flexibility within the Consumer Directed Services program.



The Task Force supports amending the Consumer Directed Services program to provide options such as the ability to purchase allowable goods and services within one's existing budget with the option for maximum budget flexibility, and the ability to have services provided by a legally liable adult in the household. These are not options under the current waiver.

OBJECTIVE 4.5: EDUCATION SUCCESS

Improve education outcomes for children with special needs.

Issue Summary

Accountability issues regarding the Individualized Education Program (IEP) have been raised by parents, teachers, administrators, and advocates. Specifically, writing appropriate goals, data collection on goals, and oversight/enforcement to achieve goals to result in student progress were identified as recurring issues.

The Individuals with Disabilities Education Act of 2004 (IDEA 2004) requires at the beginning of each school year, that each child with a disability have in effect an IEP that is developed by the Admissions, Review, and Dismissal (ARD) Committee. The IEP must be accessible to each regular education teacher, special education teacher, related service provider, and any other service provider who is responsible for its implementation. School personnel have a responsibility to implement the IEP in order for the child with a disability to make progress in the general education curriculum.

Parents do not always agree with the IEP or the implementation of the IEP by the school. When disagreements arise between parents or adult students and school officials, the Texas Education Agency (TEA) provides programs for resolving those disagreements regarding the IEP for a child with a disability.

Bullying is an issue in our state. Children have a right to feel safe in their learning environments. Across the state, bullying and harassment of children, with and without disabilities, has been an area of concern. There are recurrent calls to address this serious and growing problem. Parents report that special needs children are not only at risk for bullying, but are also at risk for being mislabeled as bullies due to behaviors caused by a disability. Bullying occurs when a person is exposed, repeatedly and over time, to negative actions on the part of one or more other persons, and he or she has difficulty defending him or herself. Bullying is aggressive behavior that involves unwanted, negative actions, a pattern of behavior repeated over time, and an imbalance of power or strength. Cyber-bullying involves the use of information and communication technologies to support deliberate, repeated, and hostile behavior by an individual or group, which is intended to harm others.



Children in Special Education Ages 3-21	2010	
	Count	Percent
AUDITORY IMPAIRMENT	7,569	2.92%
AUTISM	29,536	11.39%
DEAF/BLIND	128	0.05%
DEVELOPMENTAL DELAY	446	0.17%
EMOTIONAL DISTURBANCE	28,939	11.16%
LEARNING DISABILITY	187,296	41.90%
INTELLECTUAL DISABILITY	30,490	11.76%
MULTIPLY DISABLED	5,576	2.15%
NONCATEGORICAL EARLY CHILDHOOD	3,776	1.46%
ORTHOPEdic IMPAIRMENT	4,287	1.65%
OTHER HEALTH IMPAIRMENT	54,436	20.99%
SPEECH IMPAIRMENT	88,958	34.31%
TRAUMATIC BRAIN INJURY	1,336	0.52%
VISUAL IMPAIRMENT	3,819	1.47%
Totals	446,592	100%

The Special
Texas Education
2011.

Education Databook.
Agency. Accessed

http://tuna.tea.state.tx.us/Tea_DataBook_Web/Forms/Default.aspx

Many of the self-contained classes have minimal expectations for the children in their programs. I think the children are sold short on many occasions. Yet the entry into general education requires the parent to be informed and forcefully and actively advocating for their children. General education should be the standard placement.

—Parent of a child with special needs



Current Efforts

TEA has in place a dispute resolution process for parents/adult student and schools to settle differences. This includes voluntary mediation, informal special education complaint investigation, or a formal due process hearing. TEA's policy is to encourage resolution of disputes at the local level if possible. In Texas, TEA has approached IEP facilitation by providing support and grants for regional educational service centers to implement a plan specific and customized to the geographical region. Facilitated IEP meetings hold promise for better outcomes for students with disabilities by shifting the dispute resolution to a local focus, which results in improved ARD meetings and relationships between parents and school staff.

Reporting of data collected from school districts and charter schools is addressed extensively by TEA. TEA currently provides a number of reports regarding the progress of local education agencies (LEAs), including the Performance-Based Monitoring Analysis System (PBMAS), which is an automated data system that reports annually on the performance of school districts and charter schools in selected program areas (bilingual education/English as a second language, career and technical education, special education and certain Title programs under the No Child Left Behind Act).

The Individuals with Disabilities Education Act of 2004 (IDEA 2004), Section 616(b), requires each state to develop a six-year performance plan. This State Performance Plan (SPP) evaluates the state's efforts to implement the requirements and purposes of IDEA and illustrates how the state will continuously improve upon this implementation. The state is required to submit an Annual Performance Report regarding the 20 identified indicators. States are also required to make annual determinations about the performance of the LEAs using the categories of Meets Requirements, Needs Assistance, Needs Intervention, and Needs Substantial Intervention. As implied, these categories represent various intensities of required technical assistance and/or intervention. States are required to make a determination using these categories for every LEA within the state annually.

Across the state, bullying and harassment of children, with and without disabilities, has been an area of concern. TEA addresses bullying through Coordinated School Health—Bullying and Cyberbullying http://www.tea.state.tx.us/CSH_Bullying.html. This website provides definitions, statutory references and requirements, guidance documents, presentations and other resources and materials related to bullying and cyberbullying.

In addition, TEA has a statewide initiative to address this issue. The purpose of the [Bully Prevention State Initiative](#) is to provide information to school districts, parents, and students to help prevent, identify, and respond to bullying behavior. This



initiative has been decentralized to Region 14 Education Service Center in collaboration with TEA. <http://www.esc14.net/preview.aspx?name=bullying>.

The Texas Behavior Support Initiative (TBSI) is a resource designed to build capacity in Texas schools for the provision of positive behavioral interventions and supports (PBIS) to all students. PBIS employs a range of systemic and individualized strategies to achieve social and learning results in order to address problem behavior. For more information, see [Positive Behavior Support](#).

Passage of H.B. 1942 (82nd Texas Legislature, First Called Session, 2011) incorporates many new requirements that school districts will be implementing to prevent and address bullying. In addition, S.B. 1788 (82nd Texas Legislature, Regular Session, 2001) requires that TEA develop a model form for use in developing IEPs that is clear, concise, well-organized, and understandable to parents and educators.

Strategic Direction

The Task Force supports a public school environment based upon individual need, maximized opportunities for inclusion and instruction in the least restrictive settings, and built on existing natural supports for children with special needs. Determining options for improving the educational experience with improved outcomes for children with special needs may include the following:

Strategy 4.5.1: Accountability for Serving Children in Special Education

Assure accountability across the public school system to support high-quality education that is responsive and individualized so children achieve meaningful progress.

The Task Force will work with agencies and stakeholders to explore options to:

- Increase responsiveness of local school districts to coordinate services for all children with special needs, and to maintain consistency in their goals, strategies and activities, including those identified by a parent or caretaker;
- Encourage districts provide all evaluations, testing, IEP recommendations prior to the ARD Committee meeting; and
- Emphasize the importance and successful outcomes of inclusion for students with special needs, not only in general education classrooms, but also in extracurricular activities, to the maximum extent possible in order to obtain successful outcomes.



Strategy 4.5.2: Addressing Bullying Behavior

Protect children with special needs from bullying and ensure children with special needs are not labeled and punished as bullies when a disability is the root of the behavior.

Special needs children may exhibit behaviors that are misunderstood and may result in ticketing by school officials and involvement with the juvenile justice system. The Task Force will explore opportunities that support preventative efforts through information sharing and improved de-escalation skills. These efforts may include:

- Requiring all school resource officers to receive 40 hours of crisis intervention training;
- Increasing diversion opportunities for juveniles in the justice system with special needs;
- Exploring effective methodologies for collecting relevant data on bullying, including cyber bullying, ;
- Providing for parent notification requirement regarding on-campus bullying; and
- Collecting data on school ticketing and arrests, and make school disciplinary data publicly available so that districts may assess how they compare to other school districts.

OBJECTIVE 4.6: CRISIS INTERVENTION

Ensure caregivers, parents, and youth in all Texas communities have the capacity and resources, including emergency respite and other emergency out-of-home living arrangements, to intervene successfully when crises occur.

Issue Summary

Crisis prevention and intervention are crucial services to families and children with special needs. Awareness of, and the availability and access to, support from all entities both public and private is essential for intervention when crisis or the potential for a crisis occurs. This includes respite care, out-of-home living arrangements, and emergency medical services.

Crisis response and planning at the state and community level must function more effectively. A proactive approach to prepare families for crisis intervention and mitigation includes focusing on: preparedness through systems of care, individualized crisis planning, adoption of positive behavioral support, and expanded training for families.



Respite care is a frequently sought resource to families of children with special needs. A study conducted by the National Resource Center for Community Based Family Resources and Support shows that families in crisis who receive respite care had a great reduction in their levels of stress, leading to less need for out-of-home living arrangements. By contrast, families who do not receive respite care at times of crisis may not get the break needed to prevent a full-blown crisis, and placement of a child in an out-of-home living arrangement may be required. Availability of this important resource is limited.

When out-of-home living arrangements, either temporary or longer term, are necessary, the availability of qualified treatment facilities and other qualified caregivers for children with special needs is crucial to mitigating the crisis. Ideally, these living arrangements should be close to the family's home and community. When out-of-home living arrangements for children with special needs are a significant distance from their home, it is harder for the child's family and friends to visit and for the child to interact with the community. Long-distance visiting may present an unsustainable financial burden on the child's family.

In certain crisis situations, emergency medical services (EMS) for children with special needs can be crucial. Currently, EMS is not required to carry essential pediatric equipment and supplies. Not all EMS professionals are trained in providing services to special needs children and managing their unique healthcare requirements. Lack of proper equipment, supplies, or training can exacerbate a crisis.

Current Efforts

The Texas Lifespan Respite Care Program is increasing the availability, quality, and awareness of respite services, as discussed under Objective 4.1: Family Supports.

The Texas Department of Family and Protective Services under S.B. 218 (82nd Texas Legislative Session) is redesigning the foster care program so children with special needs who have been abused or neglected and must be removed from the home have more opportunities to be placed closer to their home and communities.

Strategic Direction

The Task Force supports the following to address crisis intervention efforts:

- Focusing on crisis intervention at the community level, a central tenet of which is that all service system providers have the necessary skills to engage at-risk families in developing an individualized crisis plan and support systems;



- Providing families access to training that will prepare them for identifying and effectively dealing with potential crisis, mitigate escalation, and have a crisis plan in place that engages all supports; and
- Exploring options to improve emergency medical services for children with special needs by addressing equipment, training, and medical direction.

OBJECTIVE 4.7: CONTINUUM OF NEEDED SERVICES IN THE JUVENILE JUSTICE SYSTEM

Provide high-quality services to children and youth with special needs to improve their outcomes within the juvenile justice system and upon re-entering their communities.

Issue Summary

Many youth entering the juvenile justice system have a variety of special needs that must be addressed in order to successfully rehabilitate the youth. The best way to address those needs is to ensure the provision of treatment and services is seamless and comprehensive, and includes coordinated access to medical, dental, psychiatric and psychological care, specialized treatment when necessary, educational programs, and skills-building curricula. To be effective, treatment must engage families in the planning and delivery of these services. Finally, re-entry planning, which begins the day a youth enters the juvenile justice system, ties all the pieces together to build a complete and integrated array of services designed to meet the specific needs of the youth. In addition to addressing a young person's needs as they enter the system, other needs must be addressed as they leave the system and return to the community.

Current Efforts

The Texas Juvenile Probation Commission (TJPC) and Texas Youth Commission (TYC) both have a number of programs designed to provide a continuum of services for juveniles while they are in the justice system. Generally speaking programs in the juvenile justice system include the following:

- Community services addressing substance abuse, mental health, and other special needs;
- Residential services that address substance abuse, mental health, and; other special needs.

The upcoming merger of TJPC and TYC presents an excellent opportunity to review services being provided to youth in the juvenile justice system who have special needs, and to identify ways to improve those services.



Strategic Direction

The strategies listed below are designed to improve the continuum of services for juveniles in the justice system.

Strategy 4.7.1: Local Community Corrections Programs

Support successful community programs tailored to the needs of children and the resources of the communities, including diversionary programs for children with special needs.

Local juvenile justice community corrections programs help rehabilitate youth with a variety of special needs. The emphasis is on keeping youth in the community while treating their special needs. Local juvenile probation departments administer or contract for these programs based on the resources available in their communities and the needs of the youth they serve. Outpatient substance abuse services as well as group and individual counseling to treat mental health issues are examples of some of these services. A more comprehensive list of these services can be found on the TJPC Program Registry at: www.tjpc.state.tx.us/programregistry.aspx.

Strategy 4.7.2: Adequate Conditions and Services

Ensure all facilities have adequate conditions of confinement and appropriate services for children and youth with special needs, including mental health services.

In a May 2010 research and program brief, Texans Care for Children noted that “merely incarcerating youth with underlying (mental health) problems has proven ineffective at changing behavior once they are released back into their homes and communities.” The Task Force recognizes that all facilities must have adequate conditions of confinement and appropriate services for youth with special needs, including behavioral health services. The Task Force is committed to youth with special needs in the juvenile justice system having access to the services, supports, and resources they need to become productive and responsible citizens.

Strategy 4.7.3: Return to the Community

Identify and improve re-entry services and supports for children and youth with special needs, including transition and housing needs.

Providing youth with access to the skills, supports, and resources he or she needs to be successful is paramount to sound re-entry planning. A smooth re-entry to home, school, and community requires advance planning and commitment to a young person’s success. Planning ahead ensures that the youth and family can maintain access to the services and supports they need to succeed at home, including behavioral health treatment, continuous health coverage, enrollment in school, and job skills. The Task Force recognizes the need to identify and improve re-entry services and supports for youth with special needs, including transition and housing needs.



Strategy 4.7.4: Juvenile Justice Gap Analysis

Determine the number and needs of children with special needs in the juvenile justice system, assess the professional workforce available to serve these children, and assess the services provided.

While the process of providing services indicates that many juveniles in the justice system have special needs, there currently is not an established data-capturing mechanism in place to describe the numbers of youth in the juvenile justice system who have special needs, what specific types of needs they have, their locations, or the type, intensity, frequency, or duration of services they receive.

Comprehensive data analyses are necessary to enable policymakers and planners to better describe the population of youth with special needs involved in the juvenile justice systems, identify the gaps in services and programs by region for this population, and assess the availability and accessibility of the professional workforce available to serve these youth.



GOAL 5: SERVICES AND SUPPORTS FOR TRANSITION INTO ADULTHOOD

Improve students' success in transitioning to post-school life.

The Individuals with Disabilities Education Act (IDEA) defines transition as a coordinated set of activities designed to help a student move from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment), adult services, independent living, and community participation. The success of youth with disabilities after leaving high school depends not only on employment or post-secondary education opportunities, but also depends on access to an array of community-based services that allow the individuals to remain in their communities. Many agencies may provide services needed by a young person who is moving toward adulthood. Navigating this maze of service agencies is challenging for students and their families and may result in students leaving the public school system without the assistance they need as young adults.

OBJECTIVE 5.1: SELF-DIRECTION FOR YOUNG ADULTS WITH SPECIAL NEEDS

Advance self-sufficiency, empowerment, person-centered planning, and leadership development for transition-age youth, including personal engagement in decision-making.

Issue Summary

Current transition efforts, to plan for a youth's life after high school, do not always begin prior to age 16. The issue of when and how to start this process has been the focus of many different workgroups of agency and school staff, parents, youth, and advocates. The general consensus among these groups is if young people are to become more empowered and self-sufficient, then self-direction must begin much earlier than age 16. Passage of S.B. 1788, 82nd Texas Legislature, Regular Session, 2011, established the transition age to begin no later than age 14.

Effective transition planning requires time and effort to coordinate medical, transportation, housing, recreation, higher education, employment, and other services. Some schools provide better transition planning than others. There are no standard criteria for what kinds of information, services, or resources are to be included as part of the transition process.



Some school districts in Texas have person-centered planning as part of their transition strategy while others do not. Many students exit from high school ill-equipped to access adult services leading to greater independence and health. When self-sufficiency, empowerment, and person-centered planning are not addressed in high school, a young person may struggle to reach independence and full potential.

Current Efforts

Transition planning is included in the Admission, Review, and Dismissal (ARD) process, which is required as part of the federal Individuals with Disabilities Education Act, also known as special education.

More schools in Texas are beginning to use person-centered planning as a tool. Using this strategy early in a child's life allows sufficient time to build the wrap-around services many youth with disabilities need.

Strategic Direction

The Task Force will explore options for a collaborative process to review the efficacy and equality of transition planning services and to identify opportunities to support self-direction for youth with disabilities. The Task Force also supports increased consumer direction, as outlined in Strategy 4.4.6: Consumer-Directed Services.

OBJECTIVE 5.2: CENTERS-BASED SERVICE MODEL

Explore options to provide comprehensive transition services through a centers-based service model for children served by health and human services, workforce, and juvenile justice agencies, and implement the model if feasible.

Issue Summary

There is no centralized, comprehensive transition process for youth involved in different agency systems such as education, juvenile justice, and foster care. Schools provide a transition process, but services are inconsistent among different regions of the state.

Current Efforts

The school system provides transition services through established ARD meetings. Youth aging out of the foster care system have access to several transition services. DFPS has specially trained caseworkers who create and monitor transition plans for teens in state conservatorship, including children with special needs. Transition plans are developed by the young person, with help from teachers, family, mentors, and any other individual in their life that has been identified as a support. If they



remain in school, current and former foster youth receive assistance with tuition and limited cost-of-living expenses. Legislation passed by the 81st Texas Legislative, Regular Session, 2009, also extended Medicaid benefits to former foster youth in school up to their 25th birthday. Additionally, some private entities, such as the Casey Family Foundation, provide transition services for foster youth.

In 2011, TYC in partnership with TJPC, Bexar County Juvenile Probation Department, and the Baptist Children and Family Services' Health and Human Services, applied for and received grant funds from the US Department of Labor to open a transition center that provides a "one-stop shop" for foster youth and young people returning from detention or incarceration in the juvenile justice system. The partnership among state, local, and private agencies represents a rare collaboration across sectors to provide comprehensive transition services.

Strategic Direction

The Task Force will examine the feasibility of creating a regionalized, centers-based service model to complement education transition planning and to provide comprehensive transition services for children with disabilities without regard to an originating agency. This approach could require multi-agency collaboration and reorganization of staff to operate. The concept advocates a statewide all-inclusive service center approach that could provide or coordinate access to an array of transition services made available based on an individual child's strengths and needs.

OBJECTIVE 5.3: TRANSITION AND EMPLOYMENT MANUAL

Develop and distribute a Texas-specific, comprehensive transition and employment manual.

Issue Summary

A single resource manual that would guide and inform parents and transitioning students is not available. Creation of such a resource will improve information dissemination, increase agencies' staff members' expertise, and expand community-based knowledge concerning available transition services and where they are being provided.

Current Efforts

The Texas Council for Developmental Disabilities recently released an online comprehensive guide for students and families considering post-secondary education, the Resource Guide on Higher Education for People with Disabilities, available at <http://www.txddc.state.tx.us/resources/publications/collegehtml.asp>; however, presently, no efforts are underway to produce a comprehensive transition and employment manual.



Strategic Direction

The Task Force supports developing a web-based comprehensive transition and employment resource. This would require a collaborative effort between state agencies serving children with special needs. The manual could provide a statewide comprehensive guide and process for students/parents and teachers and applicable agencies' staffs to be well-informed as they develop and implement appropriate transition goals in a students' IEP or other transition plan. Further, creating a manual can ensure all parents/students eligible for special education services have opportunities to receive up-to-date, uniform, comprehensive information on transition planning and services.

OBJECTIVE 5.4: SCHOOL-BASED TRANSITION SERVICES

Improve services to and outcomes for students with disabilities as they transition out of the public school system.

Issue Summary

Current strategies to connect youth to adult services may be documented in the transition planning process, but are often not implemented in actual practice. There is not a consistent system to insure a student is linked to adult services. The outcome of transition services is only apparent once the youth has left school. If transition services have not been adequately provided in school, the lack of skills, knowledge, training and exposure to practical job experiences, can diminish success in adulthood. Increased levels of support and services must be provided by the family, community agencies, and programs serving adults while in school, to assist young adults in developing the skills necessary for independence and employment after leaving school.

Current Efforts

The IDEA requires schools to report the percentage of youth who are no longer in secondary school, had IEPs in effect at the time they left school, and were:

- Enrolled in higher education within one year of leaving high school;
- Enrolled in higher education or competitively employed within one year of leaving high school; and
- Enrolled in higher education or in some other postsecondary education or training program; or competitively employed or in some other employment within one year of leaving high school.

Strategic Direction

The Task Force supports the following strategies.

Strategy 5.4.1: Requirement to Begin Services No Later than Age 14

Make transition services available to students with special needs at an age at which the student and family deem appropriate, no later than age 14.

The Task Force supports implementation of recent legislation requiring schools to begin students' education transition planning no later than age 14.

Strategy 5.4.2: Pilot Project to Re-Envision Vocational Success

Design a results-oriented regional pilot to allow cooperative vocational and transition services for youth with disabilities, focusing on the youth's individual abilities, inclinations, and needs, starting at middle school age.

The Task Force supports exploring options for modifying the way services and dollars are distributed for vocational rehabilitation services for young people. This will include examining recommendations such as:

- Proportionate cost per person vocational rehabilitation allowances that take into account a person's prior work history and future work potential resulting in more effective distribution of funding;
- Removing identified barriers to vocational success such as off campus work restrictions and others;
- Development of a regional pilot, gradually to enable providing some transition vocational rehabilitation (VR) and independent living for services for youth beginning in middle school.

Strategy 5.4.3: Transition Specialists

Ensure school districts, special education co-ops, and all relevant agencies have personnel with the knowledge, skills, experience, and expertise in transition planning and services to provide leadership, training, and collaboration with local high school personnel, parents, students, and agency personnel.

The Task Force supports a bilateral approach to fostering transition expertise among staff in both schools and in the agencies that serve youth who are transitioning into adulthood. These transition specialists would enable training, collaboration, planning, and information-sharing to assist students/parents with transition planning/services. Each health and human services agency and other appropriate agencies would identify personnel as transition contacts to develop collaborative relationships with the school personnel assigned to transition and other appropriate agency personnel.



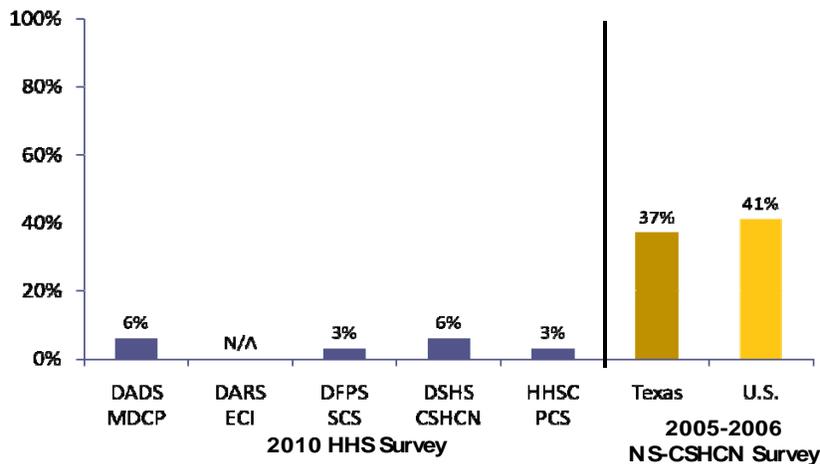
OBJECTIVE 5.5: ACCOUNTABILITY

Develop appropriate indicators and performance management processes to measure transition outcomes, and use data to create systems/services to ensure successful long-term outcomes for students with disabilities.

Issue Summary

As indicated by the survey results depicted in the chart below, students with special needs are not receiving services necessary to successfully prepare them for transition to adulthood and independent living. Transition skills are essential for integration into the community in a meaningful way that builds natural supports, meaningful employment and the skills needed to access necessary services. Although the educational system tracks and monitors performance and program effectiveness of local school districts, outcomes are lacking and special needs children may have a greater dependency on community and state resources as a result.

Youth ages 12-17 who receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence



Survey of Children with Special Health Care Needs. 2010 Children with Special Health Care Needs Final Report. Texas Department of State Health Services. <http://www.hpsc.state.tx.us/si/C-LTC/2010ChildrenwithSpecialHealthCareNeedsReport.pdf>

Current Efforts

Currently, districts are required to report on youth with IEPs aged 16 and above with an IEP that includes appropriate measurable postsecondary goals that are annually updated and based upon an age appropriate transition assessment, transition services, including courses of study, that will reasonably enable the student to meet those postsecondary goals, and annual IEP goals related to the student's transition services needs as stated in the SPP Indicator 13. Districts that are out of compliance with this indicator are required to submit a corrective action plan to the Performance-Monitoring and Interventions (PMI) Division.

As required in SPP Indicator 14, districts are required to submit data, based on a sampling plan, regarding post school outcomes. The data specifically reports students who, within one year of leaving high school, were enrolled in higher education or some other postsecondary education/ training, or who were competitively employed or in some other employment.

The Performance-Based Monitoring and Analysis System (PBMAS) manual is a comprehensive resource designed to explain the PBMAS, which is used by TEA as one part of its overall annual evaluation of the performance and program effectiveness of LEAs. The PBMAS is a district-level, data-driven analysis system developed and implemented annually since 2004 by the PMI Division in coordination with other divisions of TEA.

Strategic Direction

Passage of S.B. 1788, 82nd Texas Legislature, Regular Session, 2011, established the transition age to begin no later than age 14. Providing services at an earlier age may allow students with special needs opportunities to receive greater transition services and gain more life experience to better prepare them for adult independence. The Task Force will examine ways to support school districts in their efforts to improve and equalize transition services and provide better long-term outcomes for students.

OBJECTIVE 5.6: ARD MEETING ATTENDANCE BY AGENCY REPRESENTATIVES

Improve attendance of appropriate, family-approved agency representatives at "Admission, Review, and Dismissal" (ARD) meetings regarding transition into adulthood.



Issue Summary

Under the IDEA, a child's special education services are planned by parents, educators, and others who support the child. ARD meetings are used to develop this education plan, to review progress, and to adjust services. As a child grows into young adulthood, it becomes increasingly important to have representatives from agencies providing transition services participate in the meetings, but barriers often inhibit this practice.

For an agency representative to attend an ARD meeting, several factors must be in place:

- Students' or parents' knowledge of which agencies could help;
- Invitations to be sent reasonably in advance;
- Parents' signatures on permission forms in advance of every meeting, to authorize the release of legally protected personal information; and
- A mutually agreeable time for all parties to meet.

Current Efforts

DARS has designated a number of transition counselors who offer flexible schedules to meet with working parents and their children. A majority of these designated counselors are school-based, allowing transition services to be provided to youth earlier in and more consistently throughout their school careers. To increase the capacity of all VR counselors, DARS is expanding use of tools and strategies proven to achieve success with students earlier in their lives.

Strategic Direction

The Task Force will explore how to improve the ways in which the ARD meetings proceed, to support students' successful transition outcomes. The goal is to review and modify current statewide procedures to ensure timely, appropriate ARD meeting invitations to parents, agency personnel, and other appropriate organizations or professionals to discuss transition planning and services.

OBJECTIVE 5.7: PREPARATION FOR HEALTH CARE IN ADULTHOOD

Assure youth and young adults with special needs have materials available and learn about health and wellness and health transition services and receive services through medical homes, and have health insurance benefits and coverage to meet their needs.



Issue Summary

Evidence suggests that when school-based curricula for students with special needs include material about health and health care transition, the students experience improved outcomes.⁷ This kind of material is not used consistently across the state. Transition services for youth with special needs usually include general education, employment, and independent living skills, but they do not always include education on health, wellness, health care systems, and transitioning from pediatric to adult health service providers. There is a significant need for transition services to include an equal and consistent emphasis on health care and its related components.

Medical services for special needs children are complex, often involving multiple service providers. This challenge is magnified for youth who are transitioning out of the array of services and supports they have received as children and into adult care, where they must establish coordinated services and build relationships with new adult serving providers. Information and education about comprehensive health care is a necessity to avoid gaps in coverage and to be able to access quality health care.

Current Efforts

To help meet needs for health care transition for some children with special needs, the Children with Special Health Care Needs Services program at DSHS publishes information on its website including transition pages in English and Spanish.⁸

Medicaid staff is exploring possibilities for implementing the medical home model. Recent legislation underscores the importance of this effort. With the passage of S.B. 7, 82nd Texas Legislature, First Called Session, 2011, Texas has committed to building a person-centered medical home model. The legislation encourages managed care organizations to provide medical homes to clients.

The Texas Chapter of the American College of Physicians, with numerous professional and industry stakeholders is convening the Texas Medical Home Initiative, to facilitate increased clinical quality and efficiency, improved patient and physician experience of care, and overall care coordination and integration within and among participating practices. Part of this initiative will focus on young adults with special health care needs, from ages 14 to 24, if transferring from pediatric practices.

VR counselors at DARS provide students with disabilities services to help them transition from high school into employment or other aspects of adulthood, according to the young person's abilities and aspirations. There are 100 transition-dedicated counselors who are linked to specific schools or districts. The array of services varies according to each student's goals, capabilities, and needs. These services have been expanding over the past few years, and an opportunity exists to improve them by making health status and access to health insurance a priority for this work.



Strategic Direction

The Task Force supports an approach that elevates transition health and wellness instruction in the educational system to be equal with other core services and curricula that prepare young people for independence.

Strategy 5.7.1: Health Education

Assure youth and young adults with special needs have materials available and learn about wellness and health transition services available to meet their needs.

Transition programs should be centered on and driven by an educational system that comprehensively addresses all identified individual achievements and functional needs. This includes a change in curriculum, to include information on health and wellness, health care delivery systems, and adolescent-to-adult health care transition. This may include a change in curriculum, the inclusion of information on health and wellness, health care delivery systems, and adolescent-to-adult health care transition.

Strategy 5.7.2: Medical Homes

Assure youth and young adults with special needs receive wellness and health care transition services through a medical home model.

To ensure children and youth with special needs have their complex medical needs met, services are best provided through a medical home. The medical home brings together all appropriate medical resources specific to an individual's needs, and it eliminates service duplication. The medical home model is also discussed in Objective 6.3: Medical Home Program Office.

Strategy 5.7.3: Health Coverage into Adulthood

Work to ensure young adults transitioning into adulthood can access appropriate health coverage.

The Task Force envisions that all youth and young adults with special needs should have affordable, consistent, comprehensive health insurance benefits and coverage to meet their needs. Opportunities exist to encourage the private and public sector health insurance providers to improve their coverage and benefits. These changes could take place in the context of managed care, accountable care organizations, or other comparable care delivery systems. Prevention and care management efficiencies could result in reduced emergent or acute care costs and improved cost management, generally.



GOAL 6: INTERAGENCY COORDINATION AND COLLABORATION

Improve outcomes for children and families by improving communication, coordination, and collaboration among various entities serving children with special needs, with involvement from families.

As evidenced in part by the Texas Legislature’s creation of the Task Force, there is growing recognition that children’s programs could benefit greatly from increased coordination and collaboration. We are at a critical crossroads for improving the way programs are designed and implemented for children and their families and have an unprecedented opportunity to adjust the current “silo” approach. During this time of expanding demand for children’s services and severe constraints on federal, state and local budgets, there are numerous administrative approaches that can improve collaboration and integration across programs serving children with special needs and their families, resulting in improved outcomes for child health and well-being.

Programs serving children with special needs are best administered when using a multi-sector approach that acknowledges children are touched by sectors across health, education and social services. Programs should reflect engagement by key stakeholders, include a focus on a community-based approach whenever possible, and should be designed and implemented in order to generate and use the best available evidence and develop best practices. Integrating child-serving systems has the potential to maximize the effectiveness of programs and services. Through these efforts, more children can be reached, families can find supports more readily, and duplication of effort can be reduced. There is also growing evidence that this comprehensive approach results in improvements to child health and well-being outcomes.⁹

OBJECTIVE 6.1: CULTURE/PHILOSOPHY SHIFTS

Reconceptualize service delivery by recognizing disability as a natural part of life and providing services accordingly to improve outcomes for children and families.

Issue Summary

Differing missions, philosophies, and models for serving children with special needs can present barriers to effective cross-system collaboration. Each health and human services agency or program is usually developed to meet a very specific need, and each has specific objectives, eligibility requirements, and access pathways. These agencies and programs are not always designed or funded in a



compatible way. Children with special needs sometimes require services from more than one agency or program, and the services too often are not coordinated and do not serve the child well. Serving these families successfully requires a commitment to serving the whole child, in the context of the family, through practical, collective problem-solving.

Current Efforts

Initiatives across the state health and human services system have demonstrated how a new approach underpinned by a cultural shift has shown success:

- Family Group Decision Making in DFPS,
- Person-Centered Planning and Consumer-Directed Services in DADS,
- Mental Health Transformation Workgroup in DSHS, and
- The creation of the Center for Elimination of Disproportionality and Disparities at HHSC.

HHSC has also recently applied for a federal systems of care planning grant to expand and sustain systems of care practices for children and youth with serious emotional disturbances (SED).

Empowered with flexible resource use, these efforts have harnessed the creativity of families and agency allies in problem-solving, and they have prevented residential admission, overcome cross-agency barriers, and built supports that acknowledge and fit the unique needs of individual children and their families.

Strategic Direction

The following strategies share common features with other objectives and strategies contained in this plan. They value and support the whole child in the context of the family. They move beyond traditional practices and employ the spirit of collaboration and practical approaches to help create a system that is more flexible and responsive to the common and unique needs of children and their families.

Strategy 6.1.1: System of Care

Incorporate the “system of care” collaborative organizational philosophy and framework in programs serving children and youth with special needs to improve access and expand the array of coordinated services and supports within the community.

The system of care model is an organizational philosophy and framework involving collaboration across agencies, families, and youth for the purpose of improving services and access and expanding the array of coordinated, community-based, culturally and linguistically competent services and supports. The Task Force supports HHSC’s efforts to expand and sustain systems of care practices for children and youth with SED through its application for a federal planning grant, and will work with HHSC and its partners to develop a plan to implement the model.



Strategy 6.1.2: Positive Behavioral Support

Support statewide use of positive behavior support as an evidence-based approach to prevent and reduce challenging behavior across all disability groups and service systems.

The Task Force supports positive behavior support (PBS), a multifaceted evidence-based intervention approach to promoting positive behavior and preventing and addressing problem behaviors across populations and setting. PBS is a strategy that includes the promotion of desirable behavior and skill development, increased attention to children at risk of developing challenging behavior, and intervention for children engaging in challenging behavior. PBS develops a person-centered approach for organizing the physical, social, educational, biomedical, and logistical supports needed to achieve desired lifestyle goals while reducing problem behaviors that pose barriers to those goals and has been widely and successfully used in schools across Texas.

Strategy 6.1.3: Public and Professional Sensitivity and Awareness

Increase public and professional sensitivity and awareness concerning children with special needs and their families.

Mutual respect and understanding contribute to an inclusive society. Therefore, it is important to improve public and professional understanding of disability, confront negative perceptions, and represent disability fairly. The Task Force is considering the following options:

- Collaborating among all child-serving agencies in the development and production of public service messages and the implementation of cross-agency training and professional development opportunities. Such collaboration will help to optimize resources and avoid duplication. Topics specific to children with special needs and their families might include: cultural competency, person-first language, and other topics vital to understanding the dynamics of serving this population.
- Developing public service messages focusing on the importance of family-centered care, support community-based programs that strengthen parenting skills, and promote healthy child and adolescent development, providing parents, including teen parents, with relevant parenting information and skills.
- In developing messages and training for professionals, targeting not only providers (including behavioral health providers), but also other professionals (such as attorneys, accountants, financial planners, clergy, and educators), community leaders, consumers, and others, and draw from expertise within professional groups, such as the Texas School Nurses Organization and the Texas Council of Administrators of Special Education.



For more information, see also Objective 7.5: Broad-Based Awareness and Training for Child-Serving Professions.

Strategy 6.1.4: Disability-Related Language

Use person-first language, and use “intellectual disability” instead of “mental retardation,” in all communications.

The Task Force supports promoting the use of person-first language and more sensitive terms, such as “intellectual disabilities” instead of mental retardation. Like other minority groups, people with disabilities have developed preferred terminology known as person-first language. Person-first language is a respectful way of communicating about disabilities that removes slang and stereotypes and focuses on the person rather than the disability. Rather than saying “a disabled person,” person-first language refers to the person first and the disability second, saying instead, “a person with a disability.” The Task Force will work with member agencies to:

- Respond to H.B. 1481, 82nd Texas Legislature, Regular Session, 2011, by systematically revising rules, policies, and procedures and conducting other reviews according to the provisions in the legislation.
- Explore developing or contracting for the development of public service messages and/or publicly accessible online training modules concerning the use of “intellectual disabilities” and “person-first language.”

OBJECTIVE 6.2: COMMUNITY ENGAGEMENT

Promote local interagency planning and coordination, in partnership with faith and community-based organizations, by mobilizing existing or creating new collaborations to maximize efficiencies, outcomes, and resources for children with special needs and their families.

Issue Summary

Government-funded services alone cannot meet all of the needs of children with special needs and their families. The large numbers of individuals on interest lists for waiver services are only one indicator of the unmet needs. With public funding for health and human services constrained, an opportunity exists for local community resources, including public-private partnerships, volunteer efforts and informal support networks, to be engaged and partnered with in planning and developing agreements to pool expertise, resources, and creativity as a foundation for collaborative change.



Current Efforts

DADS, through its Volunteer and Community Engagement unit, is developing partnerships with public, private, non-profit, and faith-based organizations to help create awareness of the agency's programs and services and to expand and enhance existing resources. DADS relies on community partnerships to enhance public awareness, outreach, and funding of services. For example, DADS has developed a partnership with Sam's Club Pharmacy. The partnership supports the health and wellness of Texas families by creating awareness of long-term services and supports through ongoing in-store events across the state and by distributing educational and health promotion materials.

HHSC's Office of Early Childhood Coordination is promoting coordinated cross-agency early childhood systems at the local level and is utilizing federal home visiting funding to develop and implement these systems in several Texas communities. The Texas Council on Children and Families, in their December 2010 Legislative Report, recommended the development of Regional Leadership Councils on Children and Families to promote improved local cross-agency, cross sector planning and service delivery for children.

A Microboard[®] is an innovative support model that brings together a person with a disability a small group of committed family and friends to form a non-profit organization for his or her care. This group develops a person-centered plan called a PATH (Planning Alternative Tomorrows with Hope) to support the individual's goals and needs. The board, created through the model, manages all aspects of the individual's care, including seeking resources and hiring staff, whom the board may pay with Medicaid waiver program funding.

Strategic Direction

The Task Force recommends the following two strategies to address the need for greater community engagement.

Strategy 6.2.1: Volunteer Advocates

Recruit and support volunteer advocates (natural supports), including family members of children with special needs, who provide guidance, advice, and other support to children with special needs and their families.

The Task Force will research best practices for involving natural supports and other volunteer advocates for children with special needs and their families and will work to implement successful models.

Strategy 6.2.2: Community Support Systems

Cultivate partnerships with faith-based communities, school systems, non-profit agencies, civic organizations, and similar support systems to serve children with special needs.

The Task Force will research best practices and explore opportunities to cultivate faith and community-based partnerships, and it will work with existing initiatives, such as HHSC's efforts to establish community-based comprehensive early childhood systems, to promote opportunities to improve multi-sector, public-private approaches to serving children with special needs.

OBJECTIVE 6.3: MEDICAL HOME PROGRAM OFFICE

Establish a centralized Medical Home Program Office in HHSC, for the development of a medical home model for children with special needs; engage in ongoing, meaningful quality outcomes measurement; and develop a system that publicly recognizes health care providers who are designated as a medical home.

Issue Summary

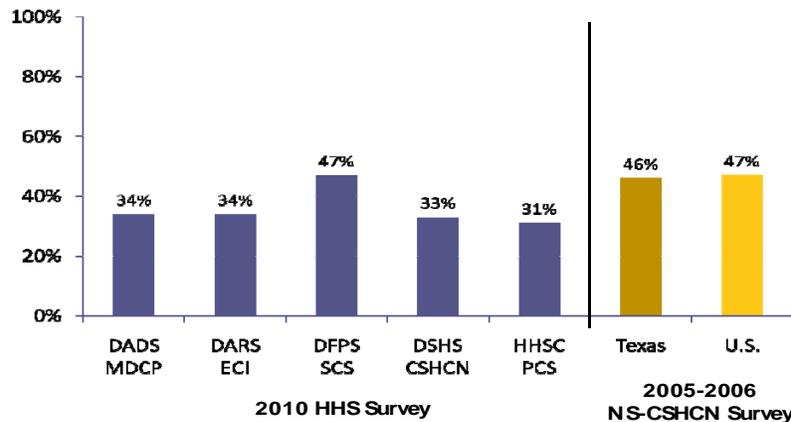
Children and youth with special needs often have exceptional requirements for coordinated and integrated health care delivery. Their complex medical and other needs may require services from multiple health care providers. Integration of social, emotional, and vocational needs must be considered along with the needs and abilities of the family. Responsibility for managing this complex and often daunting task falls primarily to the families of children with special needs. Without coordination by a single, knowledgeable health care professional, children with special needs may receive inadequate treatment or may receive treatments that are inappropriate or duplicated when considered in the context of all other health care measures in place at one time. Patient-centered medical homes are integral to and should be integrated within the service system for all children.

Effective medical home delivery models utilize reimbursement methods that honor the comprehensive nature of services provided and endorse and reflect standardized measures of health care quality. Such measures incorporate evaluations that compare public, private, and multi-sector payers and payment methods and their relationships to health care quality indicators; that quantify population-based social/demographic determinants of health; and that analyze family impact outcomes.



At present, there is no Medical Home Program Office (MHPO), and the development of the medical home concept and the evidence for its broad application in Texas suggest that the best way forward is to direct and evaluate future expansion of this concept in a coordinated, cohesive way.

Children who receive coordinated, ongoing, comprehensive care within a medical home



Survey of Children with Special Health Care Needs. 2010 Children with Special Health Care Needs Final Report. Texas Department of State Health Services. <http://www.hhsc.state.tx.us/si/C-LTC/2010ChildrenwithSpecialHealthCareNeedsReport.pdf>

Current Efforts

The Children with Special Health Care Needs (CSHCN) program at DSHS has sponsored the Medical Home Work Group, an ad hoc affiliation of both public and private sector representatives and family members from around the state, as a means to enhance the development of medical homes within primary care settings for CSHCN in Texas.

Texas manages Title V block grant funding and general revenue to support services for children with special health care needs. One of the national performance measures addresses the medical home concept. The 2011 Title V Five-Year Needs Assessment identified ten state priority needs, one of which emphasizes the continued emphasis on creating a medical home for all children.

In 2008, the Texas Medical Association and the Texas Pediatric Society convened a multi-agency group, with significant participation from stakeholders, as a forum to begin creating an ongoing health care quality outcomes measurement project. The resulting report, “Core Health Outcome Measures for Children with Special Health Care Needs: Consensus Recommendations,” often references medical home and provides a guide for future evaluations of state programs serving children and youth with special needs.

Several Medicaid initiatives are exploring the medical home model. In the provider arena, the Texas Medical Home Initiative has been launched by the Texas Chapter of the American College of Physicians, with numerous primarily professional and industry stakeholders. The initiative supports: increasing clinical quality and efficiency, improving patient and physician experience of care, and coordinating care and integration within and among participating practices. In addition, there will be a focus on young adults with special health care needs aged 14-24, if transferring from pediatric practices.

S.B. 7,81st Legislature, First Called Session, 2011, includes provisions for promotion and principles of patient-centered medical homes. Not later than December 31, 2013, HHSC must submit a report to the Legislature regarding progress in ensuring that Medicaid managed care organizations (MCOs) promote the development of patient-centered medical homes.

Strategic Direction

The Task Force supports improving the coordination and integration of health services for children with special needs. It will examine the best approaches for creating a centralized Medical Home Program Office (MHPO), which would be the focus for expertise and the recognized authority concerning the medical home principles and practice that impact coordinating health care in Texas. The design of this office ideally would reorganize selected health and human services staff into a newly created MHPO which then would function as the focal point for future accreditation, coordination and promotion of patient-centered medical home across Texas and for ongoing health care quality measurement initiatives.

OBJECTIVE 6.4: INFORMATION SHARING

Share information as appropriate to support positive outcomes for children with special needs, while protecting families' rights to privacy.

Issue Summary

Children with special needs and their families often work with multiple agencies and organizations in order to receive the support needed. These entities may gather information separately about the children and their families in order to satisfy their own requirements for data and service eligibility. Information obtained by one organization frequently could be valuable to another organization and prevent duplication of efforts and services.



Barriers in the form of federal and state privacy laws, as well as agencies' internal data-sharing policies, often prevent the simple flow of information between agencies. Legislation, such as the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA), exists to protect sensitive and confidential information. However, the laws and rules can also become barriers to rendering the most effective services and making the best use of resources.

Current Efforts

There are many Memoranda of Understanding (MOUs) between organizations that allow for exchange of certain information. One example is the MOU between DFPS and Texas Court Appointed Special Advocates (CASA) that defines specifically what can be shared between the two organizations. This MOU is shared with all employees so they have knowledge of what can and cannot be shared.

Currently, DFPS shares data with TYC concerning juveniles being served by both agencies. Also, TJPC has an MOU with DFPS that allows for the exchange of some information on juveniles involved in DFPS prevention and intervention programs.

Texas statutes provide for the exchange of information between agencies and organizations. For example, S.B. 1106, 82nd Texas Legislature, Regular Session, 2011, relates to the exchange of confidential information concerning certain juveniles. This new law:

- Requires school districts to share education records with a juvenile justice agency when requested by the juvenile justice agency;
- Allows juvenile service providers to share among each other information related to multi-system children;
- Allows Children's Advocacy Centers to share information with local, not just state, service providers; and
- Allows municipal, county, and justice courts exercising jurisdiction over a child in a truancy case to obtain Juvenile Justice Information System information regarding that child.

S.B. 717, 82nd Texas Legislature, Regular Session, 2011, adds a charge to the Council on Children and Families to “promote the sharing of information regarding children and their families among state agencies,” and to “identify technological methods to ensure the efficient and timely transfer of information among state agencies providing health, education, and human services to children and their families.”



Strategic Direction

The Task Force supports the following strategies.

Strategy 6.4.1: Single Release Granting Data-Sharing Permission

Pursue policy to allow parents to sign a single release statement to allow agencies to share information to support transition planning, within federal law.

The Task Force will work with the Council on Children and Families to explore opportunities to expand and improve information sharing between agencies to alleviate duplicated efforts and inefficient service delivery due to lack of information and coordination on special needs children who receive services through more than one agency.

Strategy 6.4.2: Youth under Supervision of Both Juvenile Probation Departments and DFPS

Expand the current collaborative partnership and data-sharing arrangements between TYC and DFPS related to the youth who are under the co-occurring supervision of both agencies, to include youth under juvenile probation supervision.

The Task Force supports the efforts of DFPS and the juvenile justice agencies to expand data-sharing with DFPS as the TJJD establishes itself.

GOAL 7: STRENGTHENED WORKFORCE

Support and strengthen the workforce, at all levels of employment, of all professions serving children and youth with special needs.

Caring for children with special needs can be demanding and requires a workforce that is knowledgeable and readily available. This concept of workforce includes direct support workers, health care professionals, school personnel, professionals in the juvenile justice and courts systems, child care workers, and agency employees who staff special needs programs. Texas faces serious challenges in meeting the needs for a stable, adequate workforce.

OBJECTIVE 7.1: DIRECT SUPPORT WORKERS

Ensure a well trained and professional workforce of direct support workers.

Issue Summary

Children and families with special needs may require help from well trained direct care workers with specialized knowledge and skills. Currently, not all direct care workers receive training that adequately prepares them to serve children with special needs. Often, these positions do not pay well or include additional benefits like health insurance. They are also often high-stress, which results in a significant turnover rate among workers. Workers who are passionate about caring for children with special needs must often look elsewhere for better pay and a chance for career advancement. Worker turnover leaves families in situations where it is difficult to find and secure qualified direct support workers for their children.

Current Efforts

There are numerous efforts across agencies to strengthen the workforce. For example, DADS hosts workshops across the state for nurses, caregivers, and professionals who work with people with special needs. Parents and family members are also invited to attend. These workshops are free for caregivers, parents, and family. In 2010, DADS developed two 15-20 minute videos for agencies and individuals hiring direct service workers, to share with people interviewing to be direct support workers. The first video is entitled “Working with People with Intellectual and Developmental Disabilities.” The second video is entitled “Working with Older Adults and Individuals with Physical Disabilities.” The goal of the videos is to reduce turnover among direct service workers. In response to legislation, DADS has also created a career ladder for certain direct support professionals in the 1915(c) Medicaid Deaf Blind and Multiple Disabilities (DBMD) Waiver program.



Strategic Direction

A stable, well trained workforce provides better care and a stable and trusted relationship for children with special needs and their families. The Task Force supports strong training and career-ladder opportunities to increase staff retention and improve service quality.

Strategy 7.1.1: Training

Ensure direct care workers receive training and technical assistance to serve children with special needs, including services to support children's mental health.

The Task Force is considering how to engage child-serving agencies in developing training for direct support workers. This training could be built on the core elements similar to those included in the College of Direct Support's curriculum. The College of Direct Support is a web-based resource, backed by nationally recognized curricula, to promote a values-based profession of direct support. These curricula are currently being used in 30 states, including Texas. Core values include a strong philosophical base around inclusion and the rights of individuals to make their own choices and supporting persons with disabilities to live safe and healthy lives.

Strategy 7.1.2: Career Advancement

Ensure direct support workers have appropriate training and career advancement opportunities.

The Task Force will consider recommendations from the Texas Direct Services Workforce Initiative to promote investments in direct service workers through efforts supporting livable wages, benefits, and educational opportunities.

OBJECTIVE 7.2: HEALTH CARE PROFESSIONALS

Increase the availability and special needs competencies of all health care professionals, especially where critical gaps exist, including but not limited to mental health, dental health, physical therapy, occupational therapy, and speech therapy services.

Issue Summary

The significant shortage of health care professionals in Texas limits the state's capacity to provide care to people who are uninsured, underinsured, or recipients of Medicaid. A lack of cultural competency also limits effective access to health care. Without access to health care services, children with special needs experience poor health outcomes.



Specific shortages in Texas include:¹⁰

- Direct patient care physicians,
- Primary care physicians,
- Psychiatrists,
- Physician assistants,
- Nurse practitioners,
- Dentists,
- Occupational therapists,
- Physical therapists, and
- Psychologists.

Shortages are more acute in some geographic areas than in others. Given the general pattern of where health professionals choose to practice, some rural areas and some low-income inner city neighborhoods have few or no professionals to meet residents' health care needs. Some health care providers choose certain practice limitations, and these preferences may result in exclusion of children with special needs.

A shortage of specialists and sub-specialists is also a barrier to accessing care. In any given geographic location, there may be few or no professionals with the expertise to serve children with complex and/or chronic conditions. The result is long waiting periods and/or long travel distances to reach a specialist.

Providing culturally competent services is widely recognized as a critical component of quality care, yet professional training programs do not always develop adequate cultural competence among graduates.

Current Efforts

The DSHS Community Center system in Texas continues to increase its use of video-conferencing for provision of psychiatric services. This methodology has been highly effective in maximizing the utilization of a growingly scarce resource – psychiatrist availability. The service design has been well received by consumers and families, has maximized psychiatrist productivity, and has increased treatment options for remote/rural locations.

At DSHS, the Health Professions Resource Center (HPRC), conducts research and analysis to assess the health care demands of a growing population and to recommend solutions. The work of the HPRC includes addressing the availability of and access to quality health care providers for children with special needs.



Health care professionals have been offered opportunities to learn more about families' experiences and caring for children with significant disabilities in real-life settings, to add to the health care professionals' experience with children as patients. Examples are described below.

Two programs currently give medical residents a comprehensive understanding of what life with a child with special needs is like through an elective experience that incorporates trained family members as faculty. The experiences typically include special presentations, home visits, and school visits, to teach the skills needed to work in partnership with a family. The two programs are:

- Project DOCC (Delivery of Chronic Care) in Houston at Baylor College of Medicine; and
- The Texas Parent to Parent MEd (Medical Education Program), in three cities:
 - Austin—at Dell Children's Medical Center and the Blackstock Clinic (Seton Healthcare Network),
 - Temple—at Scott and White Hospital, and
 - Amarillo—at the Texas Tech Health Science Center.

A third program of interest is the Transition Medicine program at Baylor College of Medicine in Houston, which provides a medical home to young adults with special needs and their families. The program assists with the transition from pediatric to adult health care settings, and it incorporates specialized training for Meds-Peds (internal medicine and pediatrics) residents. Funding to support the training is typically grant-based and therefore limited in both amount and duration.

Strategic Direction

The Task Force is reviewing the information from the HPRC. Developing solutions will include looking at evidence-based methods to increase the numbers of providers, and expanding training, competencies, and scope of practice for assistants and paraprofessionals to broaden the availability of services.

OBJECTIVE 7.3: SCHOOL PERSONNEL

Provide training for teachers, administrators, resource officers, aides, bus drivers, and other personnel to serve children with special needs more effectively and responsively.

Issue Summary

The Task Force understands and supports the need for professional development and training for administrators, teachers, and other staff who serve students with disabilities. Ongoing professional development and training for administrators, teachers, and other staff who serve students with disabilities is a requisite to provide them with the skill level to effectively interact with and meet the needs of children with disabilities. Training specific to the educational needs of students with disabilities is currently provided through the 20 educational service centers (ESCs) located throughout Texas. Online training is available in an effort to accommodate school district/staff time and budgets in these difficult economic times.

Current Efforts

Each ESC provides leadership, training, and technical assistance in the area of special education for students with disabilities in accordance with TEA's focus on increasing student achievement and having access to the general education curriculum. Each regional ESC continues to serve as first point of contact for all school personnel, parents, and other community stakeholders.

Strategic Direction

To improve the systemic approach in providing professional development and training to the various staff who serve students with disabilities, the Task Force will examine opportunities to develop and incorporate additional trainings with the inclusion of follow-up coaching.

Strategy 7.3.1: In-Service Training in Special Needs Issues

Provide school personnel training and best practice tools and resources to work with and to teach students with special needs, with follow-up coaching to ensure successful implementation.

The Task Force supports an expanded and comprehensive training effort to improve the educational experience and outcomes for children with special needs. These areas may include topics such as behavior supports, research-based interventions, and implementing the IEP. Additional training areas recommended for consideration include:

- District cross-department collaboration regarding universal lesson plan design/development and instruction delivery to include specialized teaching techniques and accommodations/modifications;
- Research-based best practices;



- Training school and other education staff to know when and how to refer children and families for Early Childhood Detection and Intervention (ECDI) services; and
- Skills to educate, serve and support individuals with disabilities to receive appropriate health, education and transition services

Strategy 7.3.2: Pre-Service Training in Special Needs Issues

Ask universities to include special needs curricula for candidates for education-related degrees, covering such topics as Positive Behavioral Interventions and Supports (PBIS), mentoring, and other support.

Students with disabilities need teachers with more specialized training, mentoring, modeling of strategies, and support. The Task Force supports and will explore the potential for including special needs training as a requirement for certification of educators.

Strategy 7.3.3: School Safety Training

Include training in PBIS when implementing an anti-bullying program, and mandate all school resource officers to receive 40 hours of crisis intervention training.

Special needs students in some districts are ticketed and enter into the juvenile justice system because their behavior is not understood or school personnel do not have the skills to recognize and de-escalate a situation. The Task Force supports and will examine:

- Stronger campus training requirements for PBIS and anti-bullying efforts;
- Standards or legislation requiring all school resource officers receive 40 hours of crisis intervention training; and
- Options to collect state data on school ticketing and arrests and to make school disciplinary data publicly available so that districts may assess how they compare to other school districts.

OBJECTIVE 7.4: JUVENILE JUSTICE SYSTEM

Educate personnel in law enforcement, jails, courts, and all entities in the juvenile justice system on serving children with special needs.

Issue Summary

Each youth with special needs in the juvenile justice system presents a unique set of challenges. Behavior that may appear to be disrespectful or defiant may actually be an expression of a young person's mental illness. There is a need to increase availability of consistent, accurate information for judges and attorneys in municipal, criminal, and juvenile proceedings regarding youth with special needs, including traumatic brain injury, mental illness and intellectual and developmental disabilities. The goal is to improve these professionals' understanding of how to recognize a youth's special needs and how to respond appropriately.

Current Efforts

TJPC and TYC both conduct trainings across the state regarding services for youth with special needs. Several professional associations also conduct similar training.

Strategic Direction

The Task Force proposes an approach that will enhance understanding for professionals who work with juveniles with special needs in the justice system. It is important to collaborate with professionals to ensure they receive relevant and accurate information about different types of special needs.

Strategy 7.4.1: Mental Health

Expand current provision of mental health training curriculum for trainers.

The current provision of mental health training curriculum in the juvenile justice system for trainers must be expanded and funding strategies developed for further implementation. The Task Force will explore which training programs are most effective and which are best suited for different types of professionals. Gaps in training must be identified so training efforts can be targeted to where they will be most effective.

Strategy 7.4.2: Court System Personnel

Select and implement best-practices training for judges and attorneys with regard to children and youth with special needs.

A number of state agencies and professional associations offer training about interacting with juveniles with mental health, intellectual, and developmental disabilities. The Task Force will build relationships with judges and attorneys to identify existing training and opportunities for improvement. Best practices for this type of training will need to be identified and implemented.



OBJECTIVE 7.5: BROAD-BASED AWARENESS AND TRAINING FOR CHILD-SERVING PROFESSIONS

Increase awareness of resources and provide training so all child-serving professionals are better able to serve children with special needs.

Issue Summary

Child-serving professionals can help detect developmental delays, but when these opportunities are missed, children may fall further behind than they would have if they received appropriate help at the right time. Child-serving health care professionals know about a wide range of health conditions, but they do not always have expertise about children with non-medical special needs. Increasing awareness among child serving professionals requires extra effort, including time, expertise, and resources.

State and other agencies provide a variety of resources for children with special needs and their families, but the employees at these agencies are not always aware of what other agencies provide. This incomplete knowledge base diminishes the agencies' abilities to communicate with parents or with each other, and as such, it is a barrier to coordination and collaboration that could improve children's outcomes and the cost-effectiveness of services.

“The programs that are out there are not told to us, the people who need them. For some reason the people who are sent by the agencies act like they are here for our best interest, but fail to tell us, the consumer about any of the programs available until we ask.”

—Parent of a child with special needs

When child-care and other professionals have identified delays and the roots of challenging behaviors, they next have an opportunity to connect the family with needed services and supports. Not all child-serving professionals are aware of services and supports available, leaving children's and families' needs unmet.

Some children, youth, and families who need health and human services have experienced trauma, and to help them, providers must understand how the impact of violent experiences and damaging relationships harms a person's physical, mental, and emotional wellbeing. By facilitating healing through trauma-informed care, consumers' health risk behaviors from unaddressed trauma can be minimized, promoting wellness for children and youth with special needs, their families, and overall community.



Current Efforts

HHS and other agencies have improved training and awareness in a number of different policies and initiatives, although more efforts are needed.

To increase awareness about resources available to children with special needs and their families, Medicaid pediatric health-care providers in the program called Texas Health Steps are provided with free online training modules about developmental screenings, mental health screenings, and on mental, emotional, and behavioral health in general. These voluntary training modules address referral processes, preventing crisis escalation, systems of care, and determining when emergency intervention is required.

The Texas Expanding Opportunities Interagency Team is a multi-agency effort to increase access to community-based programs and services for quality early care and education for young children with disabilities. The Team also makes their findings and resources available to other states. This national initiative was begun in 2005 and includes members from a wide variety of state agencies, and federal child-serving programs offer technical support.

Progress in the field of child care is being made in training and awareness that supports children with special needs and their families. Licensed child-care facility employees are required to receive 24 hours of annual training, in addition to the 24 hours of initial training. Training must cover child growth and development, guidance and discipline, age-appropriate curricula, and teacher interaction. Child-care facility directors must receive 30 total hours of training per year. To assist in making quality, comprehensive training available:

- HHSC is training child health care consultants/trainers on the Caring for Our Children National Health and Safety Standards and other information, and
- DFPS and DSHS have published online training modules for child care providers, parents, and guardians on child health, safety, and development, including specialized trainings on caring for children with special health care needs.

The use of trauma-informed care has been identified as a best practice for child protective services and was included in legislation passed by the 81st Texas Legislature. Trauma from child abuse or neglect, or removal from one's home can cause trauma that impacts a child's physical and behavioral health. "Trauma-informed care" refers to treatment or care that is provided by individuals who understand the impact of the trauma on the individual's physical, mental and emotional health and behaviors. DFPS and the juvenile justice agencies have begun implementing trauma-informed care.



Another best practice is positive youth development, which focuses on building the positive attributes young people need in order to be successful as they transition through various stages of their development. In the juvenile justice system, youth protective factors and risk factors are assessed, and a case plan is developed to meet his or her needs. Youth attitudes, behaviors employment skills, independent living skills, relationships, use of free time, and living arrangements are addressed throughout the youth's supervision and during the youth's re-entry into the community.

Strategic Direction

The Task Force will examine opportunities to increase awareness and training to support children with special needs and their families. Child-care professionals can enhance their capacities to serve children with special needs in ways that improve early interventions, allow for better outcomes in their current settings, and by helping connect them to other qualified providers to meet their unique individual needs. Experts can assist child-serving professionals by making trainings more accessible and customizable.

To support health care providers' understanding of these issues, sustained effort is required to advise them of emerging treatments and resources available for children with special needs.

Strategy 7.5.1: Cross-Agency Training

Educate staff at all related agencies on serving children with special needs, including topics related to accountability, expectations, and collaboration.

Employees at each agency will improve services to children with special needs by learning about the programs other agencies provide. The Task Force will consider how to develop and disseminate appropriate training for employees at all levels of the agencies: central office, regional staff, and contracted service providers. Effective training would also include communication of expectations of the employees and what their roles are in serving children with special needs. This training would provide a foundation for the coordination and collaboration that must take place to reduce duplication and to make the best use of resources, while improving outcomes for children. Accordingly, this training would support crisis prevention efforts under Objective 2.4: Cross-Agency Collaboration.

Strategy 7.5.2: Training and Awareness of State and Local Community Resources

Increase training and awareness among families, health care providers, and other child-serving professionals of how to link families with appropriate resources.



There are several cost-effective ways the state could improve communication to families, providers, and others about resources available. Goal 1 of this Strategic Plan outlines several ideas, one of which is improving the 2-1-1 Texas Information and Referral Network to help expand and streamline how families learn about available resources. Other ideas are discussed below.

The Texas Health Steps program has also been identified as a means for better connecting families to key information on services for their children's specific needs.

Community health workers (CHW) and peer support specialists (PSS) present another resource for linking families and providers to appropriate resources. As described by DSHS, a CHW or PSS can be defined as:

A person who, with or without compensation and with or without certification, provides cultural mediation between communities and health and human services systems; informal counseling and social support; culturally and linguistically appropriate health education; advocates for individual and community health needs; assures people get the health services they need; builds individual and community capacity; or provides referral and follow-up services.

Certified and non-certified CHWs and PSSs have a presence across the state. The Task Force is exploring various ways to utilize CHWs and PSSs to help increase awareness about special needs among families and health care providers, as well as a means to link families with resources.

There are already several efforts underway to connect CHWs and PSSs to children with special needs. Funds from the Mental Health Transformation grant created a certification program for family partners and peer specialists to support child and youth mental health consumers, and for their families. The program provides peer support to help children and families manage symptoms, develop coping skills and strategies for improvements.

The Children with Special Health Care Needs Services Program provides case management services to children with special health care needs and their families through DSHS staff in all of the health and human services regions and through contracts with community-based organizations in 7 of the 11 regions. Additionally, DSHS has initiated the placement of CHWs in emergency rooms for the purpose of disseminating information about Texas Health Steps and other resources.



The Task Force will continue to explore effective ways to work with CHWs and PSSs to link children, youth and their families to resources. For example, CHWs and PSSs could connect families of children with special needs to key services and providers through a specialized training track. CHWs and PSSs could also be trained to help inform providers about training opportunities and/or new and effective pediatric screening tools.

Strategy 7.5.3: Trauma-Informed Care and Positive Youth Development

Support enhanced training for professionals who work with youth, including training in trauma-informed care and positive youth development.

The Task Force supports the use of trauma-informed care and positive youth development in all appropriate areas of serving children with special needs.





MOVING FORWARD
Direction of Desired Improvements

MOVING FORWARD

Over the next five years the Task Force is charged with implementing its recommendations to improve the coordination, quality and efficiency of services for children with special needs. This process will be complex and require a well coordinated and dedicated effort between the Task Force members, agencies, stakeholders, partners and parents as the implementation plan is developed and shaped over the next 12-18 months. Many of the ideas put forth by the Task Force and its subcommittees challenge the way the system currently operates. They offer dynamic opportunities to reshape the way services are delivered to children with special needs and do so in a thoughtful, prudent and deliberative manner.

The attached chart is representative of the vision and direction for progress the Task Force intends to move towards, as it works to better coordinate across agencies, provide for more efficiencies in the service delivery system, and improve outcomes for children with special needs.

Direction of Desired Improvements

Starting Assumptions

Families need to:

- Obtain many kinds of information, in many kinds of formats, with varying levels of urgency
- Have the assistance of a trusted person to help them think through what they need and what would help meet their need
- Plan within family-level budget constraints
- Respond quickly to changing circumstances

Systems need to:

- Account for use of funds
- Plan within macro budget constraints
- Track outcomes
- Respond to quickly changing circumstances



Direction of Improvements

FROM CHARACTERISTICS COMMON IN CURRENT SYSTEM	TO CHARACTERISTICS OF AN IDEAL FUTURE SYSTEM
Overarching Framework	
Child as service recipient	Child in context of their family as focus of support
Federal entitlement to institutional care but not for community-based support	Community-based supports available promptly for all children and families in need
Continuum of services	Array of supports (which may include services)
Out of home placement	Quality of life in supported family environment
Reactive	Proactive
Disincentives or lack of incentives for desired outcomes	Incentives aligned with desired outcomes
Characteristics of System	
System characterized by complexity, fragmentation, inflexibility	System characterized by integration, collaboration, flexibility, cultural competence
Resources and expertise compartmentalized within serving agencies	Creative braiding of resources and sharing of expertise, functions may cross systems
System entry: “Where to go to get a service”	System entry: “ How to get needs met”
Progress may result in ineligibility for services	Progress results in valuing achievements and adjustments to support plan, including natural supports.
Service coordinator responsible for gate-keeping	Facilitation of supports separate from resource approval process



FROM CHARACTERISTICS COMMON IN CURRENT SYSTEM	TO CHARACTERISTICS OF AN IDEAL FUTURE SYSTEM
Medical model - led by professionals with input from family	Child development model—family-driven with input from team with relevant expertise
Professional credential-based workforce	Well-trained workforce with a variety of experiences including peer to peer
Planning	
Case-manager responsible to provider	Supports facilitator responsible to needs of child and family
Intake and referral frequently menu driven	Discussion and problem-solving guided by supports facilitation
Information focus is on programs	Information focus is on child development
Starting place for planning is program eligibility	Starting place for planning is understanding needs of child and family
Access	
Waiting list for services managed by order of sign up only	Consideration of need and urgency affect access to services
Narrow program eligibility limits creative solutions	Flexibility encourages creative solutions
Diagnosis based access	Needs-based access
Case manager determines service plan	Family engaged in collaborative problem solving
Resources	
Resources applied only in crisis	Resources invested in early intervention
State does not incentivize resource constraint	State, communities, and families partner in responsibility for prudent resource constraint

FROM CHARACTERISTICS COMMON IN CURRENT SYSTEM	TO CHARACTERISTICS OF AN IDEAL FUTURE SYSTEM
Rule exception discouraged, limiting creative options	Imagination and creativity encouraged and incentivized
Accountability	
Accountability based on rule compliance	Accountability based on outcomes
Performance measured by regulatory compliance	Quality and success measured by outcomes
Top-down accountability	Reciprocal partnerships, shared accountability through partnerships



ENDNOTES

¹ Analysis by the Strategic Decision Support Department of the Texas Health and Human Services Commission, based on statistics derived from the U.S. Census Bureau's 2009 American Community Survey for Texas) and Texas State Data Center, at the University of Texas San Antonio

² Developmental Screening: Texas," National Survey of Children's Health, Data Resource Center. Accessed 07/02/10 at <http://www.nschdata.org/Content/Default.aspx>

³Busch, S., and C. Barry. (2009) "Does Private Insurance Adequately Protect Families of Children With Mental Health Disorders?" PEDIATRICS Vol. 124 Supplement December 2009, pp. S399-S406.

⁴U.S. General Accounting Office. (2003) CHILD WELFARE AND JUVENILE JUSTICE: Several Factors Influence the Placement of Children Solely to Obtain Mental Health Services Testimony before the Committee on Governmental Affairs, U.S.Senate. <http://www.gao.gov/new.items/d03865t.pdf>

⁵ Busch, S., and C. Barry. (2009)

⁶ U.S. General Accounting Office. (2003)

⁷Hess, Janet S. Brief Report: Preliminary Findings from a Pilot Health Care Transition Education Intervention for Adolescents and Young Adults with Special Health Care Needs. Journal of Pediatric Psychology, pp. 1-7, 2010. doi:10.1093/jpepsy/jsqo91.

⁸Department of State Health Services. Children with Special Health Care Needs (CSHCN) Services Program. Transition Information. <http://www.dshs.state.tx.us/cshcn/transinfo.shtm>.

⁹Glanz, K., Rimer, B., & Viswanath, K. (Eds.). (2008). Health Behaviors and Health Education: Theory, Research, and Practice. San Francisco, CA: Jossey-Bass.

¹⁰Department of State Health Services. Health Professional Resource Center, Center for Health Statistics. Supply trends among licensed health professions Texas, 1980-2009. December 2009. Accessed 07/08/11 at <http://www.dshs.state.tx.us/chs/hprc/publicat.shtm>.







ATTACHMENTS

ATTACHMENT A – GLOSSARY OF ACRONYMS

ACRONYM	FULL NAME
2-1-1	2-1-1 Texas Information and Referral Network
2-1-1 TIRN	2-1-1 Texas Information and Referral Network
ABD	Aged, Blind, and Disabled (Medicaid Clients)
ACF	U.S. DHHS Administration for Children and Families
ADRC	Aging and Disability Resource Centers
ARBD	Alcohol-Related Birth Defects
ARD	Admission, Review, and Dismissal
ARND	Alcohol-Related Neurodevelopmental Disorder
CASA	Court Appointed Special Advocates
CBCAP	Community Based Child Abuse Prevention
CCL	DFPS Child Care Licensing
CCP	Comprehensive Care Program
CDS	Consumer-Directed Service
CHCS	Center for Health Care Services
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CLASS	Community Living Assistance and Support Services
CPS	DFPS Child Protective Services
CRCG	Community Resource Coordination Group
CRS	DARS Comprehensive Rehabilitation Services
CSHCN	Children with Special Health Care Needs
CWP	Consolidated Waiver Program

ACRONYM	FULL NAME
DADS	Texas Department of Aging and Disability Services
DARS	Texas Department of Assistive and Rehabilitative Services
DBMD	Medicaid Deaf-Blind with Multiple Disabilities
DBS	DARS Division of Blind Services
DFPS	Texas Department of Family and Protective Services
DHHS	DARS Deaf and Hard of Hearing Services
DOCC	Delivery of Chronic Care
DRS	DARS Division for Rehabilitation Services
DSHS	Texas Department of State Health Services
ECI	DARS Early Childhood Intervention
ECDI	Early Childhood Detection and Intervention
EHS	Early Head Start
EMS	Emergency Medical Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ESC	Education Service Center
ETV	Education and Training Vouchers
FAPE	Free Appropriate Public Education
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorders
FEDI	Front-End Diversion Initiative
FERPA	Family Educational Rights and Privacy Act
FIEP	IEP facilitation
FPL	Federal Poverty Level
FS	Family Strengthening

ACRONYM	FULL NAME
GAA	General Appropriations Act
H.B.	House Bill
HCS	Home and Community-Based Services
HHSC	Texas Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
HIPPY	Home Instruction for Parents of Preschool Youngsters
HMO	Health Maintenance Organization
HPRC	Health Professions Resource Center
ICF-MR	Intermediate Care Facility for Persons with Mental Retardation
ICF-MR/RC	Intermediate Care Facility for Persons with Mental Retardation or Related Conditions
ICM	Integrated Care Management
IDD	Intellectual and Developmental Disabilities
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Program
IL	Independent Living
ITFCSN	Interagency Task Force for Children with Special Needs
LAR	Legally Authorized Representative
LEA	Local Education Agency
LMHA	Local Mental Health Authority
LON	Level of Need
MCH FFS	Maternal and Child Health Fee-for-Service
MCO	Managed Care Organization
MDCP	Medically Dependent Children Program
MEd	Medical Education Program

ACRONYM	FULL NAME
MHPO	Medical Home Program Office (proposed)
MOU	Memorandum of Understanding
NFP	Nurse-Family Partnership
NSB	Newborn Screening Benefits Program
OPCCY	HHS Office of Program Coordination for Children and Youth
OECC	HHS Office of Early Childhood Coordination
PAL	Preparation for Adult Living
PAT	Parents as Teachers
PATH	Planning Alternative Tomorrows with Hope
PBIS	Positive Behavioral Interventions and Supports
PBMAS	Performance Based Monitoring and Assessment System
PBS	Positive Behavioral Supports
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PEI	DFPS Prevention and Early Intervention
PEIMS	Public Education Information Management System
PHCP	Primary Health Care Program
PPCD	Preschool Programs for Children with Disabilities
PSS	Peer Support Specialists
S.B.	Senate Bill
SED	Serious Emotional Disorder
SNDP	Special Needs Diversionary Program
SNP	Special Needs Plan
SPP	IDEA required State Performance Plan for Texas

ACRONYM	FULL NAME
SSLC	State Supported Living Center
TBSI	Texas Behavior Support Initiative
TCOOMMI	Texas Correctional Office on Offenders with Medical or Mental Impairments
TDI	Texas Department of Insurance
TEA	Texas Education Agency
TEHDI	Texas Early Hearing Detection and Intervention
TFTS	Texas Families Together and Safe
THSteps	Texas Health Steps
TIRN	2-1-1 Texas Information and Referral Network
TJJD	Texas Juvenile Justice Department
TJPC	Texas Juvenile Probation Commission
TRCC	Texas Respite Coordination Center
TxHmL	Texas Home Living Waiver Program
TYC	Texas Youth Commission
UH	University of Houston
U.S.	United States
U.S. DHHS	U.S. Department of Health and Human Services
VR	Vocational Rehabilitation
YES	Youth Empowerment Services

ATTACHMENT B – SUBCOMMITTEE MEMBERS

Task Force for Children with Special Needs

Mental Health		
Member Name	Role	Location
BJ Wagner	Chair	Austin
Dr. Tracy Levins	Vice-Chair	Austin
Jon Weizenbaum	Vice-Chair	Austin
Terry Crocker	Public Member	Edinburg
Debbie Berndt	Subject Matter	Austin
Colleen Horton	Relevant council, parent, subject matter, non-profit	Austin
Cynthia Henderson	Relevant council and parent	Austin
Josette Saxton	Non-profit	Austin
Dr. Laurie Seremetis	Parent, subject matter, non-profit, other	Austin
Marissa Ortiz Patrick	Non-profit	San Antonio
Miriam Nisenbaum	Subject matter and non-profit	Austin
Robert Hamilton	Relevant council, subject matter, non-profit, other	Aubrey
Barbara Moss	Relevant council, subject matter	Irving
Dr. Richard Adams	Relevant council, subject matter, other	Dallas
Jessica Allison	Relevant council, subject matter	Austin
Brandice Mueller	Subject matter	Fort Worth
Michael Hastie	Subject matter	Austin
Sherry Cusumano	Subject Matter	Dallas
Rachel Deason	Representing Rep. John Davis	Austin
Lauren Rose	Subject Matter	Austin
Health		
Member Name	Role	Location
Evelyn Delgado	Chair	Austin
Cecile Young	Vice-Chair	Austin

Health (continued)		
Member Name	Role	Location
Manny Vela	Public Member	Harlingen
Marianne Nevil	Relevant council, parent	McKinney
Deborah Cortez	Subject matter, non-profit, other	Harlingen
Dr. Robert Warren	Relevant council, subject matter, non-profit	Houston
Belinda Carlton	Parent, subject matter, non-profit, other	Austin
Jeff Miller	Relevant council, parent, subject matter, non-profit	Austin
Dr. Jerald Zarin	Subject matter	Houston
David Hagerla	Subject matter	Austin
Dr. Barry Lachman	Relevant council, subject matter, other	Dallas
Melody Hellsten	Subject matter, non-profit	San Antonio
Chava White	Relevant council, parent, subject matter, other	Houston
Dr. Lesa Walker	Relevant council, subject matter	Austin
Sergio Zarate	Parent	Rio Grande Valley
Transition		
Member Name	Role	Location
Audrey Deckinga	Chair	Austin
Barbara Madrigal	Vice-Chair	Austin
Tarsha Jackson	Public Member	Houston
Kathy Albers	Subject Matter Reg. 11 SC	Ft. Worth
Candace Towe	Subject matter, non-profit	Austin
Erin Wilder	Subject matter	Austin
Rona Statman	Relevant council, subject matter, non-profit	Austin
Dr. Cynthia Peacock	Subject matter, other	Houston
Kathy Griffis- Bailey	Subject matter, other	Austin

Transition (continued)		
Member Name	Role	Location
Monte Osburn	Parent, subject matter, non-profit, other	Port Arthur
Maria Garcia	Relevant council, parent, non-profit, subject matter	Amarillo
Ana Calvo	Relevant council. Parent, subject matter, non-profit	Houston
Melanie Knapp	Parent and non-profit	Sugar Land
Sarah Abrahams	Subject matter and other	Austin
Amy Mizcles	Subject matter and non-profit	Austin
Early Childhood		
Member Name	Role	Location
Barbara Madrigal	Chair	Austin
Kim Wedel	Chair	Austin
Kathy Clayton	Vice-Chair	Austin
Dawn Choate	Subject matter and non-profit	Austin
Angela Lello	Parent, subject matter, non-profit, other	Austin
Dr. Cathleen Roberts	Subject matter	Dallas
Harvey Salinas	Relevant council, parent, other	Corpus Christi
Erin Sefcik	Parent	Lucas
Bea Vargas	Relevant council, parent, subject matter, non-profit	El Paso
M. Connie Almeida	Relevant council, subject matter, non-profit	Richmond
Suvi Aika	Parent, non-profit	Austin
Drusilla Knight-Villarreal	Relevant council, other	Corpus Christi
Brandi Couch	Relevant council, parent, subject matter	Amarillo
Suzanne LeBel Corrigan, M.D.F.A.A.P.	Relevant council, parent, subject matter	Coppell
Long-Term Care		

Member Name	Role	Location
Jon Weizenbaum	Chair	Austin
Evelyn Delgado	Vice-Chair	Austin
Susan Murphee	Subject matter, non-profit	Austin
Stacy Mayfield	Parent	Denton
Roger Webb	Subject matter, non-profit, other	Austin
Elizabeth Tucker	Relevant council, subject matter, non-profit, other	Austin
Carl Tapia	Relevant council, subject matter, non-profit	Houston
Clay Boatright	Parent, non-profit	Plano
Mary Klentzman	Relevant council, parent, subject matter, non-profit	Temple
Stephen Schoen	Subject matter and non-profit	Austin
Larry Swift	Relevant council, subject matter	Austin
Dr. Richard Garnett	All	Fort Worth
Jane Boutte	Relevant council, subject matter, non-profit	Dallas
Dorothy Gipson	Subject matter, other	Austin

Education

Member Name	Role	Location
Kathy Clayton	Chair	Austin
Linda Brooke	Vice-Chair	Austin
Kim Wedel	Vice-Chair	Austin
Manny Vela	Public Member	Harlingen
Diane Taylor	Relevant council, subject matter	Stephenville
Stephanie Blanck	Relevant council, subject matter	Georgetown
Paula Long	Subject matter	Harlingen
David Thomas	Relevant council, parent, subject matter, non-profit, other	Dallas
Christine Givens	Parent, non-profit	Spring

Education (continued)		
Member Name	Role	Location
Julia Erwin	Relevant council, parent, subject matter	Montgomery
Paul Watson	Relevant council, parent, subject matter, non-profit	Flower Mound
Deborah Fowler	Subject matter and non-profit	Austin
Mary Eberlein	Parent, subject matter, other	Austin
Bonnie Gradt	Parent	Forney
Rebecca Ryan	Parent, subject matter, non-profit	Austin
Dr. Jan Wheeler	Parent, subject matter, non-profit, other	Pasadena
Dr. Elaine Adams	Relevant council, parent, subject matter, non-profit	Houston
Crisis Prevention		
Member Name	Role	Location
Cecile Young	Chair	Austin
Audrey Deckinga	Vice-Chair	Austin
Donna McCamant	Public Member	Austin
Nancy Rosenau	Subject matter, non-profit, other	Austin
Jana Campbell	Parent, subject matter, non-profit	Canyon
Molly Lopez	Subject Matter	Austin
Cheryl Ray	Relevant council, subject matter	Amarillo
Janet Sharkis	Parent, subject matter	Austin
Jacqueline Lopez	Subject matter, non-profit	Laredo
Meridith Taylor	Parent, non-profit	Austin
Juvenile Justice		
Member Name	Role	Location
Tracy Levins	Chair	Austin
Linda Brooke	Chair	Austin
BJ Wagner	Vice-Chair	Austin
Marc Levin	Subject matter and non-profit	Austin
Kathy Grant	Relevant council and parent	Houston

Juvenile Justice (continued)

Member Name	Role	Location
Maricela Morales	Subject matter	San Antonio
Jodie Smith	Subject matter and non-profit	Austin
Monica Thyssen	Parent and subject matter	Austin
Vonzo Tolbert	Subject matter	Austin
Bettie Beckworth	Subject matter, other	Austin
Vivian Dorsett	Consumer, subject matter, non-profit	Hockley
James Taylor	Parent and subject matter	De Kalb
Nagla Moussa	Parent, non-profit, other	Plano
Ana Yanez-Correa	Subject matter and non-profit	Austin

ATTACHMENT C – STATE PROGRAM DESCRIPTIONS

This Appendix describes state programs that serve children, including children with special needs. Additional information about these and other state programs may be found in these documents:

- [The Texas Health and Human Services Strategic Plan for 2011-15](#)
- [Texas Medicaid and CHIP in Perspective, Eighth Edition, \(The “Pink Book”\)](#)
- [DADS Reference Guide, 2011](#)
- Child serving Agency websites

Health and Human Services Commission

2-1-1 Texas Information and Referral Network

The 2-1-1 Texas Information and Referral Network (2-1-1 TIRN) is a service for the public to communicate accurate, well-organized, and easy-to-find information from more than 60,000 state and local health and human services programs via phone or by Internet. Anyone may dial 2-1-1, 24 hours per day, 7 days per week, to receive referrals to health and human services on the local, regional, state, and national levels. TIRN has established a service level agreement that 80 percent of calls will be answered in 60 seconds or less. In 2009, 2-1-1 TIRN handled more than 2.4 million calls for comprehensive information and referral, with an average of approximately 201,588 calls per month, and the website received 690,331 visits.

Medicaid

Medicaid is a state and federally funded entitlement program that provides coverage of health care services to qualifying individuals. Title XIX of the Social Security Act is the legal basis under which HHSC administers the Medicaid program. Children enrolled in Medicaid receive six months of continuous coverage for services provided through Texas Health Steps (THSteps) and the Comprehensive Care Program (CCP). THSteps services include periodic medical screenings, vision, hearing, and dental preventive and treatment services. CCP services include any other medically necessary services such as medical treatment. There are three different models for the delivery of care: fee-for-service, health maintenance organization (HMO) coverage in most metropolitan areas, and Primary Care Case Management (PCCM) coverage in most rural areas.

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, elderly, and people with disabilities. Women and children account for the largest percentage of the Medicaid population. In fiscal year 2007, children age 1-5 represented about 26 percent of the Medicaid population; about 57 percent of the Medicaid population was female.

Children's Health Insurance Program (CHIP)

CHIP is designed for families whose income exceeds Medicaid limits and who cannot afford to buy private insurance for their children. Title XXI of the Social Security Act defines CHIP. Texas CHIP provides eligible children a basic set of health care benefits that are focused on primary health care needs and contain the cost of the benefit package. Covered services may be subject to certain limitations and include, but are not limited to the following: inpatient and outpatient services, physician and surgical services, prescription drug coverage, laboratory and radiological services, behavioral health services, dental and vision care, rehabilitation services, clinic and community-based services, emergency services, and hospice care.

Primary Care Case Management

Medicaid Primary Care Case Management (PCCM) is a non-capitated model in which participants are assigned to a primary care provider (PCP) who serves as the client's medical home by providing comprehensive preventative and primary care and making referrals for specialty care. PCPs contract directly with the state and can refer patients to any Medicaid specialist. HHSC operates PCCM in 202 counties throughout the state. PCCM is not available where the STAR program operates.

STAR+PLUS

STAR+PLUS is the agency's program for integrating the delivery of acute and long-term care services to older people, blind people, and people with disabilities through a managed care system. STAR+PLUS operates in the Bexar, Harris, Harris Expansion, Nueces, and Travis service areas. Acute and long-term care services are provided through capitated MCOs.

NorthSTAR

NorthSTAR is an integrated behavioral health delivery system for Medicaid recipients in the Dallas service area. It is an initiative of the Department of State Health Services (DSHS). Services are provided via a fully capitated contract with a licensed behavioral health organization. STAR members in a seven-county area around Dallas receive behavioral health services through NorthSTAR.

STAR+PLUS Expansion

In May 2009, HHSC and its vendor agreed to end their contract for the operation of the Integrated Care Management (ICM) program, which provided services to more than 75,000 aged, blind, and disabled (ABD) Medicaid clients in the Dallas and Tarrant service delivery areas. Subsequently, the 2010-11 General Appropriations Act (GAA) (Article II, Special Provisions, Section 46, Senate Bill (S.B.) 1, 81st Legislature, Regular Session, 2009), directed HHSC to implement the most cost effective integrated managed care model for this population.

Approved by the HHSC Executive Commissioner in July 2009, the expansion of STAR+PLUS into the Dallas and Tarrant service areas occurred in early 2011. The STAR+PLUS expansion will provide the ABD Medicaid population in the Dallas and Tarrant service delivery areas with a proven, cost-effective model that will provide better integration of long-term and acute care services to dual eligible members.

HHSC requires that the STAR+PLUS managed care organizations (MCO) be Dual Eligible Medicare Special Needs Plans (SNPs). SNPs are a type of Medicare Advantage Plan for people with certain chronic diseases and conditions or who have specialized needs. As such, the STAR+PLUS MCOs will be able to provide both Medicaid and Medicare services to STAR+PLUS dual eligibles, should the members choose to enroll in the MCO's SNP. This option will facilitate the MCOs' ability to ensure that all STAR+PLUS members receive appropriate, effective care in the most integrated setting possible which ensures their health and safety.

Office of Program Coordination for Children and Youth (OPCCY)

OPCCY assists in coordinating programs and initiatives that serve children and youth across HHS systems. The goal of OPCCY is to improve the coordination of service delivery for children, youth, and their families across Texas so that children and youth can thrive in healthy relationships with their families and friends.

OPCCY oversees the operation of various children's programs and initiatives including:

- Office of Early Childhood Coordination (OECC),
- Council on Children and Families,
- Children's Policy Council,
- Task Force for Children with Special Needs,
- System of Care for Children's Mental Health, and
- Children's long-term care (Children's Policy Council, Permanency Planning).

The OECC works to promote an integrated and seamless delivery of health and human services to all children younger than six years of age to ensure that all children are prepared to succeed in school. The OECC oversees three main initiatives, Raising Texas, the Texas Home Visiting Program, and Healthy Child Care Texas, in addition to serving the needs of young children through other coordinated efforts.

The Council on Children and Families is charged with coordinating and improving efficiencies in the state's health, education, and human services systems to ensure children and families have access to needed services, thus facilitating an integrated approach to providing services to children and families. The Children's Policy Council is an advisory committee with a majority membership from parents of children with special needs. The Children's Policy Council provides recommendations to the agencies and to the Legislature on a biennial basis, and works closely with the Interagency Task Force for Children with Special Needs to help provide an additional parent oriented perspective to the work of the Task Force.

Department of Aging and Disability Services

Medically Dependent Children Program (MDCP)

MDCP serves individuals from birth to 21 years of age who are medically fragile and living in the community, by providing several different services to the child or their family. Respite care is a service that provides temporary relief from care giving to the primary caregiver of a

waiver participant during times when the participant's primary caregiver would normally provide care. Adjunct support services are direct care services needed because of an individual's disability that help an individual participate in child care, post-secondary education, or independent living, or that support an impending move to an independent living situation, and that may vary by child, provider, and setting. Adjunct support services may be used when the primary caregiver is working, attending job training, or attending school. Parents are still responsible for normal child care expenses. Adaptive aids are devices necessary to treat, rehabilitate, prevent, or compensate for conditions resulting in disability or loss of function. Adaptive aids enable people to perform the activities of daily living or control the environment in which they live. Minor home modifications are a physical modification to a participant's home, required by the participant's Individual Plan of Care, which is necessary to prevent institutionalization or support deinstitutionalization. Transition Assistance Services help people who reside a nursing facility and who are Medicaid-eligible to set up a household in the community if the person will be enrolling in one of the Medicaid waiver programs upon discharge from the nursing facility. Financial Management Services provides assistance to individuals with managing funds associated with the services elected for self-direction. The service includes initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers.

Community Living Assistance and Support Services (CLASS)

CLASS provides home- and community-based services to people with related conditions as a cost-effective alternative to placement in an intermediate care facility for persons with a diagnosis of mental retardation or a related condition (ICF-MR/RC). A related condition is a disability, other than mental retardation, that originated before age 22 and that affects the ability to function in daily life. Services and supports include habilitation, minor home modifications, nursing, specialized therapies, respite and case management.

There is no age limit; however, the onset of the disability must have been before age 22. Individuals must have a DADS-approved initial individual service plan that does not exceed the program's cost ceiling; they must meet ICF/MR level of care criteria, have a demonstrated need for ongoing habilitation services, and have chosen the CLASS program over an ICF/MR program.

Deaf Blind with Multiple Disabilities (DBMD)

Home and community based services for persons who have legal blindness; a chronic, severe hearing impairment; or a condition that leads to deaf-blindness and a third disability that results in impairment to independent functioning. This program is an alternative to institutional care and offers services such as habilitation, orientation and mobility, and assisted living.

Home and Community-Based Services (HCS)

HCS provides services and supports available in a person's own home or family home, or in a small residential program. Services include day habilitation, employment assistance, respite and specialized therapies. There is no age limit. Recipients must not be enrolled in another Medicaid waiver program, must have had a determination of mental retardation made in accordance with state law or have been diagnosed by a physician as having a related condition, must meet specific requirements for intelligence quotient (IQ), must have

chosen the HCS Program over the Intermediate Care Facilities for Persons with Mental Retardation Program, and must have an individual plan of care that does not exceed a specific annual cost limit.

Intermediate Care Facility for Persons with Mental Retardation (ICF Program)

ICF/MRs provide 24-hour residential and habilitation services in home settings for groups ranging in size from six to more than 100 people. Recipients must have a determination of mental retardation or documentation from a physician of a related condition, must meet specified level of care criteria, and must be in need of and able to benefit from the active treatment provided in a 24-hour, supervised ICF/MR setting.

Intellectual and Developmental Disabilities (IDD) Community Services (MR Authority Services)

MRAs provide services and supports, such as day habilitation, employment assistance and respite provided to assist persons to live in the community. They serve as the point of entry for publicly funded IDD programs, whether the program is provided by a public or private entity. MRAs provide or contract to provide an array of services and supports for persons with intellectual and developmental disabilities; are responsible for enrolling eligible people into ICFs, State Supported Living Centers; Home and Community-based Services (HCS); Texas Home Living (TxHmL); and are responsible for Permanency Planning for consumers under 22 years of age who live in an ICF/MR, nursing facility or a residential setting of the HCS Program.

To be eligible, an individual must be a member of the DADS priority population, which consists of: persons with intellectual disabilities or a pervasive developmental disorder, including autism; persons with a related condition who are eligible for, and enrolling in the ICF Program, HCS Program, or TxHmL Program; nursing facility residents who are eligible for specialized services for mental retardation or a related condition; and children who are eligible for Early Childhood Intervention Services through the Texas Department of Assistive and Rehabilitative Services (DARS).

State Supported Living Center (SSLC)

The state operates 13 state supported living centers that provide 24-hour residential and habilitation services for people with intellectual and developmental disabilities, or those people with intellectual disabilities who are medically fragile or have behavioral problems. Each facility is certified as an intermediate care facility for persons with intellectual disabilities (ICF/MR).

Texas Home Living Program (TxHmL)

Texas Home Living provides services and supports, such as day habilitation, respite and employment assistance, for people with intellectual and developmental disabilities who live in their own home or their family's home. There is no age limit. Recipients must have a determination of mental retardation made in accordance with state law or have been diagnosed by a physician as having a related condition, must not be assigned a pervasive plus level of need (LON 9), must live in their own home or with their family, must not be enrolled in another Medicaid waiver program, must have a plan of care that does not exceed

the specific program annual cost limit, and must have chosen TxHmL over the Intermediate Care for Facility program.

Department of Assistive and Rehabilitative Services

Texas Early Childhood Intervention Services (ECI)

Texas ECI is a statewide program for families with children birth to 36 months with disabilities and developmental delays. The program provides family support and specialized services to strengthen the family's ability to access resources and improve their child's development through daily activities in order for the children to reach their potential. It is state and federally funded through the Individuals with Disabilities Act (IDEA, P.L. 108-446). Services are provided by a variety of local organizations across Texas in the home and in community settings such as child care facilities and play groups. Families and professionals, representing multiple disciplines, work together as a team to plan appropriate services based on the unique strengths and needs of the child and family.

ECI determines eligibility for infants and toddlers based on the following criteria: developmental delay - children with a developmental delay that affects functioning in one or more areas of development including cognition, motor, communication, social-emotional, and adaptive/self-help skills; medically diagnosed condition – children who have a medically diagnosed condition that has a high probability of resulting in developmental delay; auditory or visual impairment - children who have an auditory or visual impairment as defined by the Texas Education Agency rule at 19 TAC Section 89.1040.

Autism Program

The Autism Program provides services for children three through eight years of age with an autism spectrum disorder. An autism spectrum disorder incorporates diagnoses of Autistic Disorder, Pervasive Developmental Disorder – Not Otherwise specified, Rett's Disorder, Asperger's Disorder, and Childhood Disintegrative Disorder. The Autism program provides the following services, as determined by the individual needs of the child: assessments; applied behavior analysis treatment; audiology evaluations; psychological testing; speech-language therapy; physical therapy; occupational therapy; home-based services.

Vocational Rehabilitation (VR)

The Vocational Rehabilitation (VR) program helps people with disabilities prepare for, find and keep jobs. Work related services are individualized and may include counseling, training, medical treatment, assistive devices, job placement assistance, and other services. Eligibility criteria for this program include: the presence of a physical or mental disability that results in a substantial impediment to employment, whether the individual is employable after receiving services, and whether services are required to achieve employment outcomes. The program also helps students with disabilities plan the transition from school to work. DRS VR counselors provide consultative and technical assistance to public school personnel in planning the move from school to work for students with disabilities. DRS Regional Transition Specialists assist VR counselors in coordination with schools, independent school districts, and regional Educational Service Centers.

Deaf and Hard of Hearing Services

The DARS, Division for Rehabilitative Services, Office for Deaf and Hard of Hearing Services (DHHS) works in partnership with people who are deaf or hard of hearing to eliminate societal and communication barriers to improve equal access for people who are deaf or hard of hearing. DHHS advocates for people of all ages who are deaf or hard of hearing to enable them to express their freedoms, participate in society to their individual potential, and reduce their isolation regardless of location, socioeconomic status, or degree of disability.

Services for the Blind and Visually Impaired

The DARS Division for Blind Services (DBS) assists blind or visually impaired individuals and their families. Depending upon their goals and needs, DBS offers services to help regain independence or find a job. DBS staff work in partnership with Texans who are blind or visually impaired to get high quality jobs, live independently, or help a child receive the training needed to be successful in school and beyond.

The Blind Children's Vocational Discovery and Development Program assists children who are blind and visually impaired to develop their individual potential. Emphasis is on restoring vision, encourage independence, and preparing for vocational success. Children between the ages of birth and 22 years who live in Texas and have a vision impairment are eligible for services.

Comprehensive Rehabilitation Services

Comprehensive Rehabilitation Services (CRS) helps people with spinal cord and brain injuries receive intensive therapies to increase independence. The goal of the CRS program is to help people be more independent in their homes and communities. CRS covers in-patient comprehensive medical rehabilitation, outpatient services, and post-acute traumatic brain injury services. In order to receive services, the consumer must: have a traumatic brain injury, a traumatic spinal cord injury, or both; be at least 16 years old by the time they finish the program; be medically stable enough to participate in rehabilitation activities; and agree to participate in the services offered by the DARS CRS program.

Independent Living (IL) Services and Centers

The Independent Living (IL) Services and Centers concentrate on self-sufficiency and quality of life, even if work potential is limited. Independent Living Centers and Services promote self-sufficiency despite significant disability - providing people with disabilities with improved mobility, communication, personal adjustment and self-direction. Independent Living Centers are operated by and for people with disabilities throughout the state to provide assistance through peer counseling, information and referral, advocacy support and other measures that encourage people to make their own decisions.

Department of Family and Protective Services

Child Care Licensing (CCL)

CCL regulates all child-care operations and child placing agencies to protect the health, safety, and well being of children in out of home care, largely by reducing the risk of injury,

abuse, neglect, and communicable disease. CCL develops minimum standards and monitors operations for compliance with licensing standards, rules, and law. The CCL Division within DFPS is a regulatory program charged with protecting the health, safety, and well-being of children, ages birth through 17 years, who reside in out-of-home care for all or part of the day.

Child Protective Services (CPS)

CPS becomes involved with a family when a report is received of child abuse and/or neglect. Upon investigation of the report, CPS can provide services to families at any time in the life of the case. The target population is any child under the age of 18. However, children who are in the conservatorship (foster care) of CPS at the age of 18 can remain in care until 22 years of age to complete high school. Contract services are obtained for children that include mental health, education, daycare, parenting education and support, health care, and developmental delay services. These services are accessed through the case management model of service provided by the Investigation, Family Based Safety Services and Conservatorship caseworkers. DFPS/CPS refers children with developmental delays age birth through three to Early Childhood Intervention (ECI) for assessment, evaluation, and services. Under 2007 state legislation (Texas Education Code § 29.153), all children who are in or were ever in the conservatorship of DFPS/CPS are eligible for enrollment in the free pre-kindergarten programs offered through Texas public schools. CPS will also refer children age three to five to Head Start and Early Head Start for children under the age of three. Children in the conservatorship of CPS have priority enrollment status.

Transitional Living Services

DFPS provides Chafee Foster Care Independence Program services through its Transitional Living Services programs. These programs include Preparation for Adult Living (PAL), Education and Training Vouchers (ETV), and other related services and support of young people 16 to 21 years of age who are currently or formerly in foster care, or transitioning out of care.

DFPS established a Transitional Living Services Initiative as part of CPS Reform efforts. The general objective of the initiative has been to implement a systemic and integrated approach in transition planning and services affecting youth aging out of state foster care.

Prevention and Early Intervention (PEI)

PEI has four providers under the Community Based Child Abuse Prevention (CBCAP) program, two providers with the Texas Families Together and Safe (TFTS) program, and four providers with the Family Strengthening (FS) program that provide services for families with children under the age of six. Using evidence-based programs targeting families with young children, the providers offer various services that may include parent education, case management, counseling, concrete supports, and home visitation, among others. Not all services are available in each of the three programs. The programs are designed to reduce child abuse and neglect; therefore, services often focus on the caregivers of the child, with the child receiving few direct services.

Department of State Health Services

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women provides services to children with a health condition/health risk, birth through 20 years of age and to high-risk pregnant women of all ages, in order to encourage the use of cost-effective health and health-related care. Together, the case manager and family shall assess the medical, social, educational and other medically necessary service needs of the eligible recipient. The program provides services to Medicaid-eligible children with a health condition/health risk, birth through 20 years of age, and to high-risk pregnant women of all ages.

Youth Empowerment Services (YES) Waiver

The YES Waiver is a 1915(c) Medicaid program that allows for more flexibility in the funding of intensive community based services for children and adolescents with severe emotional disturbances and their families. The waiver is available in Travis and Bexar Counties, and serves child and adolescents between the ages of 3-18 years who have severe emotional disturbance. Recipients must meet DSHS clinical criteria (including, but not limited to risk of self-harm, risk of severe disruptive or aggressive behavior, family resources, and risk of school behavior); and there must be a reasonable expectation that, without Waiver services, the child or adolescent would qualify for inpatient care under the Texas Medicaid inpatient psychiatric admission guidelines. Services provided include: respite; community living supports; family supports; transitional services; adaptive aids & supports; minor home modifications; non-medical transportation; paraprofessional services; professional services; and supportive family based alternatives.

Children with Special Health Care Needs (CSHCN) Services Program

The CSHCN Services Program supports family-centered, community-based strategies for improving the quality of life for children and their families. The CSHCN Services Program covers health care benefits for children birth to age 21 with extraordinary medical needs, disabilities, and chronic health conditions who are not eligible for such coverage through another payer and who meet the program's age, residency, medical, and income eligibility requirements; however, individuals may be dually eligible for Medicaid, CHIP, and private insurance. DSHS regional staff and community-based contractors serve a broader range of children with special health care needs birth to 21 who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Health care benefits include a broad array of medical care and related services, including evaluation and diagnosis; physician visits; inpatient and outpatient hospital services; orthotics and prosthetics; medical equipment and supplies; nutritional supplements and counseling; medications; speech, language, physical, and occupational therapy; meals, lodging, and transportation to receive medical treatment; and family supports. The program contracts with community-based organizations in many parts of the state to provide case management, family supports, community resources, and clinical services to children with special health care needs and their families. The CSHCN Services Program also provides case management services through DSHS staff based in regional offices. Program staff actively collaborates with consumers, providers, other state agency staff, and interested

stakeholders to ensure a system of care is in place to meet the needs of children and their families, and to make progress toward the six national Title V outcomes for children with special health care needs.

Community-Based Mental Health Services

DSHS, through the Local Mental Health Authorities (LMHAs), provides an array of core services to eligible Texas children, ages 3-17, through the Resiliency and Disease Management Model that includes: crisis hotline; screenings; pre-admission assessments; treatment planning (routine/intensive case management/wraparound); respite; medication-related services; intensive crisis residential/inpatient services; counseling; family case management; family training; family partners; parent support group; flexible community support; and skills training.

DSHS provides mental health care for any children and adolescents between the ages 3 through 17 who have a diagnosis of mental illness (excluding a single diagnosis of substance abuse, mental retardation, autism or pervasive development disorder), who exhibit serious emotional, behavioral, or mental disorders, and who: (1) have a serious functional impairment; or (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 serious emotional disturbance.

Newborn Screening Benefits Program (NSB)

The NSB Program provides laboratory testing to confirm a genetic disorder identified through the Newborn Screening Program. All infants born in hospitals offering obstetrical services must be provided the opportunity to receive a hearing screening, either in the birthing hospital or in a referral facility. Follow-up and intervention services are provided from birth to three years of age. Services include clinical evaluations and follow-up care; medications; vitamins; and dietary supplements (metabolic foods, low-protein foods). If the child has a confirmed diagnosis of a disorder screened by the NSB Program and continues to meet the eligibility criteria, the child can continue to be eligible until age 21.

NorthSTAR

NorthSTAR provides an array of mental health and substance abuse services under a managed care model, including services for children such as therapeutic foster care, early intervention for children age's three to five, and mental health services for children ages birth to six. The service area for the program includes counties in the Dallas area.

Primary Health Care Services

Primary Health Care Services include: diagnosis and treatment; emergency services; family planning; preventative health services, including immunizations; health education; and laboratory, x-ray and other related services. Additional optional services may also be provided, including: nutrition services; health screening; home health care; dental care; transportation; prescription drugs, devices, and durable supplies; environmental health services; podiatry services; and social services.

Children represent a very small portion of the Primary Health Care Program (PHCP) population that is served. PHCP generally serves adults. However, children not eligible for

the other programs such as CHIP, Medicaid, County Indigent Health Care Program, or Children with Special Health Care Needs are eligible to be provided primary care services.

State Hospitals

The State Hospital program provides inpatient psychiatric treatment for persons with mental illness who are a danger to themselves or others.

Texas Early Hearing Detection and Intervention (TEHDI)

The TEHDI Program is the state's universal newborn hearing screening, tracking and intervention program. DSHS is the oversight agency and provides no direct clinical services.

Texas Health Steps/Medicaid (THSteps)

THSteps is for children and youth from birth through age 20 who have or are eligible for Medicaid. THSteps provides regular medical checkups and dental checkups and treatment for babies, children, teens and young adults. An expanded portion of the Texas Health Steps program, called the Comprehensive Care Program, includes treatment in freestanding psychiatric hospitals, developmental speech therapy, developmental occupational therapy, augmentative communication devices/systems, and private duty nursing.

Title V Maternal and Child Health Fee-for-Service (MCH FFS)

The MCH FFS program provides child/adolescent health care including primary care services for infants, well-child examinations, sick child and follow-up visits, nutritional visits, immunizations, case management, and prenatal care for adolescents. Dental services for children and adolescents include periodic oral evaluation, fluoride treatments, sealants, and extraction as needed. Laboratory testing services are provided by DSHS laboratories in Austin and San Antonio to Title V eligible clients through Title V-funded providers.

The Title V-funded contractors provide child health and dental services to infants and children in the birth to age six age range, who are not eligible for Medicaid or CHIP. Eligibility includes children without insurance at or below 185 percent federal poverty level (FPL).

Vision and Hearing Screening Program

The Vision and Hearing Screening Program was implemented for the early identification of individuals who have special senses and communication disorders, and who need remedial vision, hearing, speech or language services. The program provides training to providers of THSteps, schools of nursing, volunteer groups, child care licensing groups, and school districts that perform vision and hearing screening. Screening is performed on children ages 4 years and older receiving day care and all school age children through 20 years of age.

Bexar CARES

The Department of State Health Services (DSHS) funds a pilot behavioral health program in San Antonio, called Bexar CARES, through the Center for Health Care Services (CHCS). CHCS is one of the Local Mental Health Authorities (LMHA) contracted to provide mental health services under DSHS.

The Bexar CARES pilot program attempts to improve outcomes for children with behavioral health concerns who are at risk for removal from their community. DSHS, Department of

Family and Protective Services (DFPS), Texas Education Agency (TEA), TYC, and Bexar County Juvenile Probation Department have entered into a Memorandum of Understanding which permits:

- Collaboration in the provision of uniform early intervention behavioral health services,
- Identification of children at risk for placement in an alternative setting, including juvenile justice involvement, and
- Diversion of children at risk for alternative placement to “system of care” services to provide comprehensive and efficient services.

Once children are referred to participate in Bexar CARES, services are organized through a “wraparound” treatment planning process, for a service plan that is individualized, family-driven, youth-guided, community-based, and culturally competent.

Texas Education Agency

Preschool Program for Children with Disabilities

Eligible children with disabilities, ages 3-21, are entitled to receive a free and appropriate public education (FAPE) under the Individuals with Disabilities Act (IDEA). In Texas, school district Preschool Programs for Children with Disabilities (PPCD) provide special education and related services for eligible children with disabilities ages three through five. PPCD refers to the services provided by the school district, not to the place where they are provided. Eligible children may receive PPCD services in variety settings such as pre-kindergarten, resource, and self-contained classrooms or in community settings such as Head Start and pre-school.

School-Age Education Services

Special Education

Special Education is specially designed instruction, at no cost to parents, to meet the unique needs of a child with a disability, including instruction conducted in the classroom, in the home, and in other settings.

Texas Correctional Office on Offenders with Medical or Mental Impairments

Community Based Interventions

TCOOMMI programs provide a wrap-around, case management philosophy and managed care practices, with a strong emphasis on flexible programming. TCOOMMI contracts with local DSHS Community Centers to provide wrap-around services for juvenile probationers, and wrap-around services for TYC youths on parole.

The juvenile probation service programs are designed as a family-based, multi-service approach to meet the mental health needs of juvenile offenders. Services are targeted for

youth in the Texas juvenile justice system, ages 10-18, who have been assessed with severe emotional disturbances. Service components include: assessments; service coordination and planning; medication and monitoring; individual and/or group therapy and skills training; in-home services such as Multi-Systemic Therapy or Functional Family Therapy; family focused support services; benefit eligibility services, and; transitional services.

The services to TYC juveniles are targeted for youth released on parole who have a serious mental illness that requires post release treatment. They include a Continuity of Care system and include DSHS community based services: individualized assessments; service coordination; medication monitoring; advocacy services; transitional services to other treatment programs, and; benefit eligibility

Texas Juvenile Probation Commission (to become the Texas Juvenile Justice Department)

Special Needs Diversionary Program

The Special Needs Diversionary Program (SNDP) was created in 2001 to provide mental health treatment and specialized supervision to rehabilitate juvenile offenders and prevent them from penetrating further into the criminal justice system. The program is administered in a collaborative model by TJPC and the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI). The basic programmatic structure of SNDP includes a specialized juvenile probation officer teamed with a Mental Health Professional (MHP) carrying a caseload of 12 to 20 youth identified as meeting DSHS's standard for priority population diagnosis.

Front-End Diversion Initiative

The Front-End Diversion Initiative (FEDI) is an initiative to divert youth with mental health needs from progressing deeper into the justice system. FEDI provides specialized mental health and case management training to specialized probation officers to help them better identify and work with youth who have mental health problems. These specialized officers supervise a reduced case load, provide intensive case management, and link and refer youth and their families to community resources as necessary. The demonstration sites are located in the following counties: Bexar, Travis, Lubbock, Dallas, and Harris.

Texas Youth Commission (to become the Texas Juvenile Justice Department)

CoNEXTions©

CoNEXTions© is an integrated, system-wide rehabilitative program offering various therapeutic techniques and tools that are used to help individual TYC youth. The name, CoNEXTions©, stems from the basic goal of the program – to prepare youth to take the NEXT step, to connect youth to healthy, law-abiding relationships with their peers, families, and communities. The name symbolizes the hope that once youth are properly connected with other people, they are in a better position to connect to their futures, or the NEXT phase of their lives, with an optimistic and realistic outlook. Specialized treatment is provided for

youth identified as having a significant need in a specific area, including mental health treatment. In the specialized treatment programs, youth receive intensive treatment services from specially trained or licensed staff and participate in programming that is designed around their specific needs in that target area. Youth in specialized treatment programs receive ongoing support and staff receive specialized training to maintain the advanced skills and knowledge needed to work with special-needs populations.

Specialized Correctional Treatment for Offenders with Mental Health Impairment

Youths who are diagnosed with severe mental health problems and/or illnesses may receive specialized treatment at Corsicana Residential Treatment Center. Those with unstable mental illnesses who are also dangerous to themselves or others receive care at the Corsicana Stabilization Unit. The immediate goal for this group is treating the basic mental health problem or illness and allowing the youths to regain control over their behavior. Once this is accomplished, the young person is better prepared to benefit from treatment that focuses on changing the delinquent and criminal patterns of behavior. The final goal concerns reintegrating the young person with his or her family and community in a program that addresses his or her mental health and correctional therapy needs, conditions of emotional disturbance, learning disabilities, and other health impairments.



ATTACHMENT D - LONG TERM CARE SUBCOMMITTEE MEMBER MINORITY REPORT

In order to represent alternative view points, the Task Force agreed to accept minority reports if any subcommittee member(s) felt strongly about presenting recommendations that the majority of the subcommittee chose not to present or chose to present differently than the member's perspective. The following report represents a minority report submitted by a member of the Long Term Care Subcommittee. It represents an individual member's point of view and is not representative of the subcommittee recommendations submitted. These recommendations are presented in their original text.

Long Term Care Subcommittee Member Minority Report

March 11, 2011

Recommendations

GOAL: Build capacity in the long term service and support system in order to ensure all options are identified and immediately provided for to meet the unique, individualized needs of the special needs' child and their families.

Objective 1.1: Texas must ensure a comprehensive set of services to support children with special needs. In so doing, we recommend providing the parents/families of children with special needs accurate information about and access to all options to provide appropriate care to meet their specific child's need.

Strategy 1.1.1: We support and recommend adherence to the legal statute that per the Texas State Statute Ch. 533 subchapter A(d), person with mental retardation, or a person's legally authorized representative, seeking residential services shall receive a clear explanation of programs and services for which the person is determined to be eligible, including state schools, community ICF-MR programs, waiver services under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)), or other services. The preferred programs and services chosen by the person or the person's legally authorized representative shall be documented in the person's record. If the preferred programs or services are not available, the person or the person's legally authorized representative shall be given assistance in gaining access to alternative services and the selected waiting list

Strategy 1.1.2: We recommend that all Texas 1915(c) Home and Community-Based waivers that support children including waivers for children who meet a nursing facility level of care must have a flexible array of services that includes family support, personal care services, therapy, nursing, home health aides, family-based residential options, home modifications, assistive technology, respite, supported employment, behavioral supports, crisis

intervention, orientation and mobility, as well as a set of goods and services designed to meet the unique needs of children and families.¹

Strategy 1.1.3: We recommend that all Special Needs Children have access to an enhanced level of support in the home including the support of additional paid direct care trained individuals when more than one caregiver is needed or when the primary caregiver needs additional support.²

Strategy 1.1.4: We recommend that medically fragile children have access to a hospital level of care in a 1915(c) waiver when they turn 21.³

Strategy 1.1.5: We recommend that the Special Needs Children have home health aides available as a cost effective benefit for medically fragile children in the Texas Medicaid State Plan. The ability to request a home health aide with RN delegation on a continuous basis would be of great benefit to many children that have an ongoing need for more assistance than a personal care attendant is able to provide. The rate set for the service must be sufficient to support RN delegation and an adequate provider base.

Strategy 1.1.6: We recommend that all Special Needs Children, including children in the custody of the Texas Department of Family and Protective Services, be eligible for Medicaid waiver services including the Youth Empowerment Services waiver. This waiver supports children who have behavioral and mental health needs and currently excludes children in the custody of DFPS from services. Children in DFPS conservatorship need enhanced behavioral health services and need the services offered under the YES waiver.

Strategy 1.1.7: We recommend reviewing and possibly adopting the recommendations from the Texas Direct Services Workforce Initiative related to livable wages, benefits, and investments in direct service workers. We need to ensure that the front line workforce serving children have appropriate training and technical assistance to adequately support the Special Needs Children.

Strategy 1.1.8: We recommend empowering families to select their own services by adding additional options for consumer direction in Texas, such as the ability to purchase allowable goods and services within one's existing budget, the option for maximum budget flexibility through an "individualized budget" option, and the ability to receive services in one's own home or family's home provided by a legally liable adult in the household including one's spouse or parent of a minor child. These services can be implemented by incorporating these allowable options into the existing Medicaid 1915 (c) Texas Home Living Waiver (TxHmL).

Objective 1.2: Texas must provide families of children with special needs flexible, yet targeted family support.

Strategy 1.2.1: Families of children with special needs require support in order to function as a normal family unit. We recommend implementing habilitative child and day care in the 1915(c) waivers.⁴

Strategy 1.2.2: We recommend the development and implementation of a variety of home visitation programs focusing on families of children with chronic illness and disability. We recommend a carefully designed Nurse-Family Partnership to help educate and empower the parents and families. We also recommend reviewing the programs supported by the American Academy of Pediatricians as an effective way to ensure ongoing parental support.

Strategy 1.2.3: We recommend providing families access to flexible respite services. Respite must be available to families in their homes and in out-of-home settings that are small, geographically close to the child's family, child focused, and are able to support children with the appropriate medical and behavioral needs.

Strategy 1.2.4: We recommend that families have access to training to support their children. Training topics can include such areas as Positive Behavior Support, medical interventions, therapeutic techniques, etc.

Strategy 1.2.5: We recommend that all programs and services that support families of children with special needs must be based on person centered planning.

Strategy 1.2.6: We recommend that families who are identified through home visitation programs, training programs, care coordination, etc, have a mechanism to access a Medicaid 1915(c) Home and Community -Based Services waiver.

Objective 1.3: Texas must provide families of children with special needs a child and family focused comprehensive service system that provides high quality, appropriate value added services that are unique to each child's needs, resulting in early intervention for improved long-term quality of life outcomes.

Strategy 1.3.1: We recommend a review of the "waiting list" of Special Needs Children currently waiting to take advantage of the option of services offered that is appropriate to their individual level of care. This is needed to verify and prevent unnecessary duplication, as well as a cost-effective means of building on our existing current capacity.

Strategy 1.3.2: We recommend continuing the implementation of the Medicaid Buy-In for Children in Texas.

Strategy 1.3.3: We recommend ensuring that flexible state funded options remain available to Special Needs Children, such as In Home and Family Support, wrap-around supports and blended funding options at the appropriate need-level basis.

Strategy 1.3.4: We recommend offering a Medical Assistance (MA) – TEFRA option to families of children with disabilities whose income is too high to qualify for Medicaid, but who can't afford the high cost of services.⁵

Strategy 1.3.5: We recommend implementing a balanced funding approach to:

- “Do no harm” to individuals’ current services and maintain flexible state funded services without eliminating critical family support programs, such as State Supported Living Centers, In-Home and Family Support, and other critical state funded “safety” net services.
- Increase operational efficiencies, improving service options through building capacity in existing programs, by the optimizing of organizational span of control, and eliminating administrative redundancy.

Strategy 1.3.6: We recommend providing housing assistance to families appropriate for children who can successfully transition from facilities. We recommend a review of the Texas Department of Housing and Community Affairs (TDHCA) and the U.S. Department of Housing and Urban Development (HUD) which would allow Special Needs Children access to the Project Access housing vouchers.

Strategy 1.3.7: We recommend improving services for individuals with specific disabilities such as Autism, Traumatic Brain Injury, Fetal Alcohol Syndrome, etc. See previous reports to develop and apply child appropriate recommendations that will create and strengthen services while addressing gaps in services. Two report examples include:

- a. The Texas Department of Aging and Disability Services Study on the Costs and Benefits of Initiating a Pilot Project to Provide Services to Adults with Autism Spectrum Disorders and Related Disabilities as mandated by HB 1574 of the 81st Texas Legislature, Regular Session as it relates to children and their preparation for life as an adult.² Service options include a pilot program for adults that can inform services and benefit children and youth in the future such as:
 - specialized supports coordination and vocational assessment, training, and support
 - meaningful activities for individuals for whom employment is not a goal
 - promotion of individual development
- b. We recommend reviewing the September 2010 Traumatic Brain Injury (TBI) Feasibility Study mandated by Rider 66 of the 81st Texas Legislature³ regarding appropriate services and a high quality provider base for individuals with Traumatic Brain Injury. This would ensure that any new service or program would be available to Special Needs Children. The top five long-term residential and community services for traumatic brain injury survivors listed by the study’s survey respondents in descending order of preference are:
 - Therapies (physical, occupational and speech/language)
 - Behavioral Support Services (counseling, psychological services, or behavioral support)
 - Family-Based Alternatives
 - Structure Day Services
 - Cognitive Rehabilitation

References

¹Texas currently has a number of Medicaid waiver programs serving children with disabilities including Home and Community Services (HCS), Community Living Assistance and Support Services (CLASS), Medically Dependent Childrens Program (MDCP), Deaf/Blind with Multiple Disabilities (DB/MD), Youth Empowerment Services (YES) and Texas Home Living (TxHmL). All of the waivers have a different set of eligibility requirements and offer varying arrays of services. Some of the services that a child might need may not be in the waiver for which they are eligible, therefore all of the waivers must have a comprehensive set of services that meet the needs of child regardless of his/her disability.

²Missouri offers a specialized medical/behavioral personal assistance benefit in their Medicaid waiver serving children and adults with developmental disabilities. The state has an established set of provider qualifications for these individuals listed in Section 13.31 of their waiver manual. The waiver allows for the provision of Personal Assistance to individuals receiving residential services if the team can show need and non-duplication of services, 13.31.A(4) <http://dmh.mo.gov/docs/dd/sec13ServiceDescriptiondraft.pdf>

³When children turn 21 and age out of the Early Periodic Screening, Diagnosis and Treatment provisions of Medicaid they lose access to Private Duty Nursing and depend more heavily on Texas Medicaid waivers to meet their needs. Texas' current adult waivers waive off of nursing facilities and intermediate care facilities instead of hospitals and therefore the individual cost caps are lower. Sometimes these low cost caps make it difficult for a person who is medically fragile to get the services he/she needs.

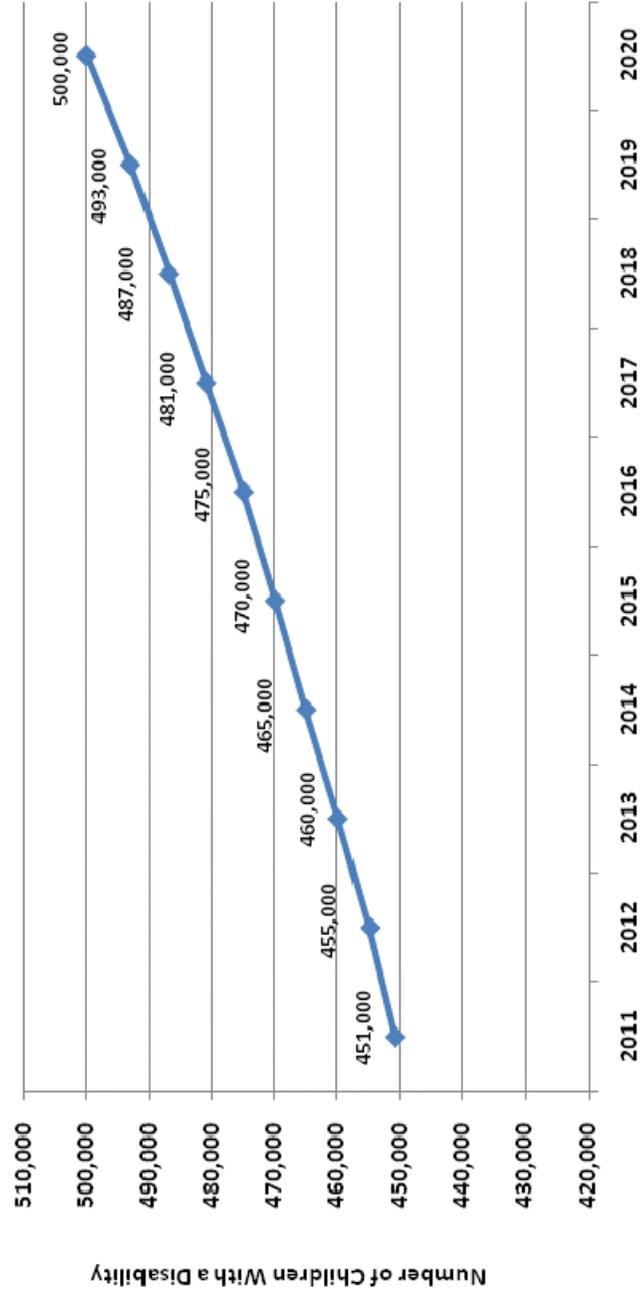
⁴Nebraska 1915(c) waivers allow for habilitative child care and habilitative day care, http://www.sos.state.ne.us/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-480/Chapter-6.pdf and http://www.sos.state.ne.us/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-480/Chapter-5.pdf

⁵TEFRA is the Tax Equity and Fairness Responsibility Act. Only the child's income is counted for eligibility and there is no asset limit. The Minnesota Department of Human Service has a TEFRA program. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_007117



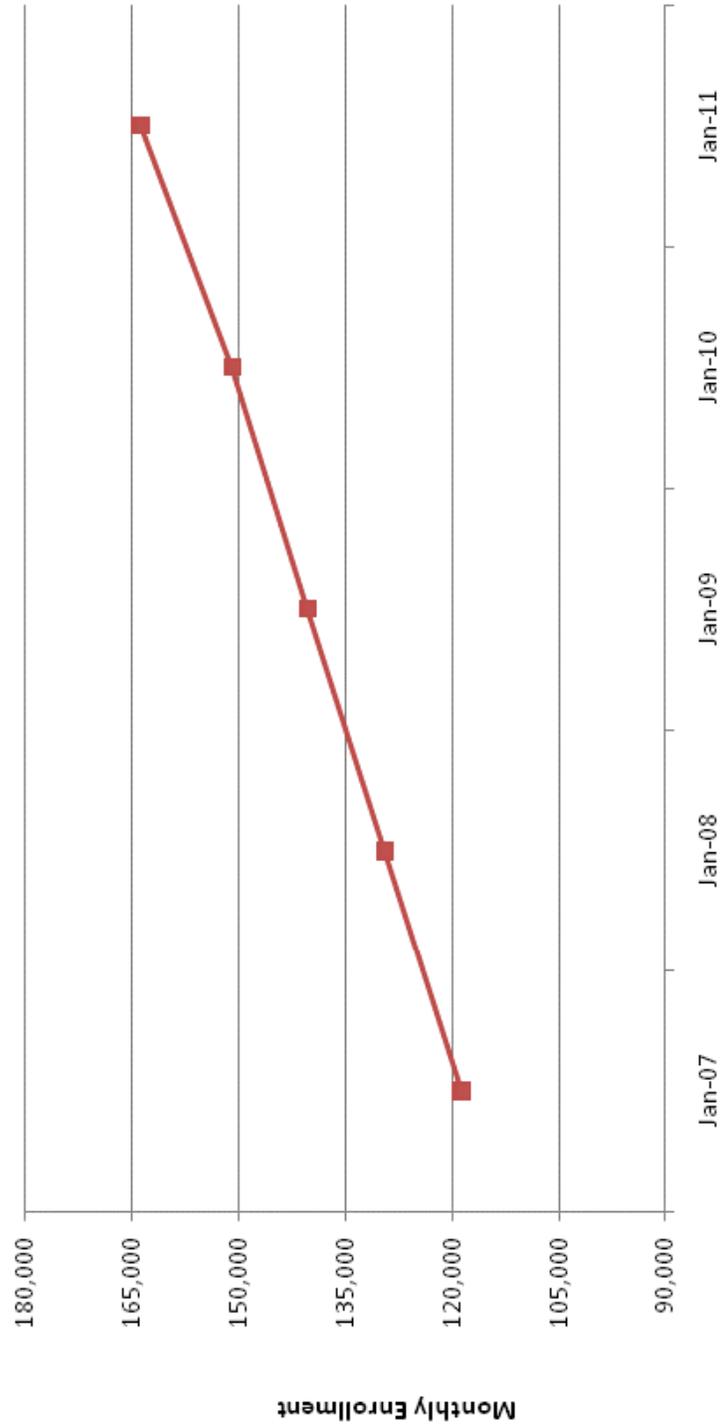
ATTACHMENT E: CHARTS AND MAPS

Projected Population of Texas Children Under Age 22 With a Disability, Years 2011-2020



Projections Developed By: Demography Team. Strategic Decision Support. Texas Health and Human Services Commission.

Texas Medicaid Monthly Enrollment Trend: Blind or Disabled Children Under Age 22

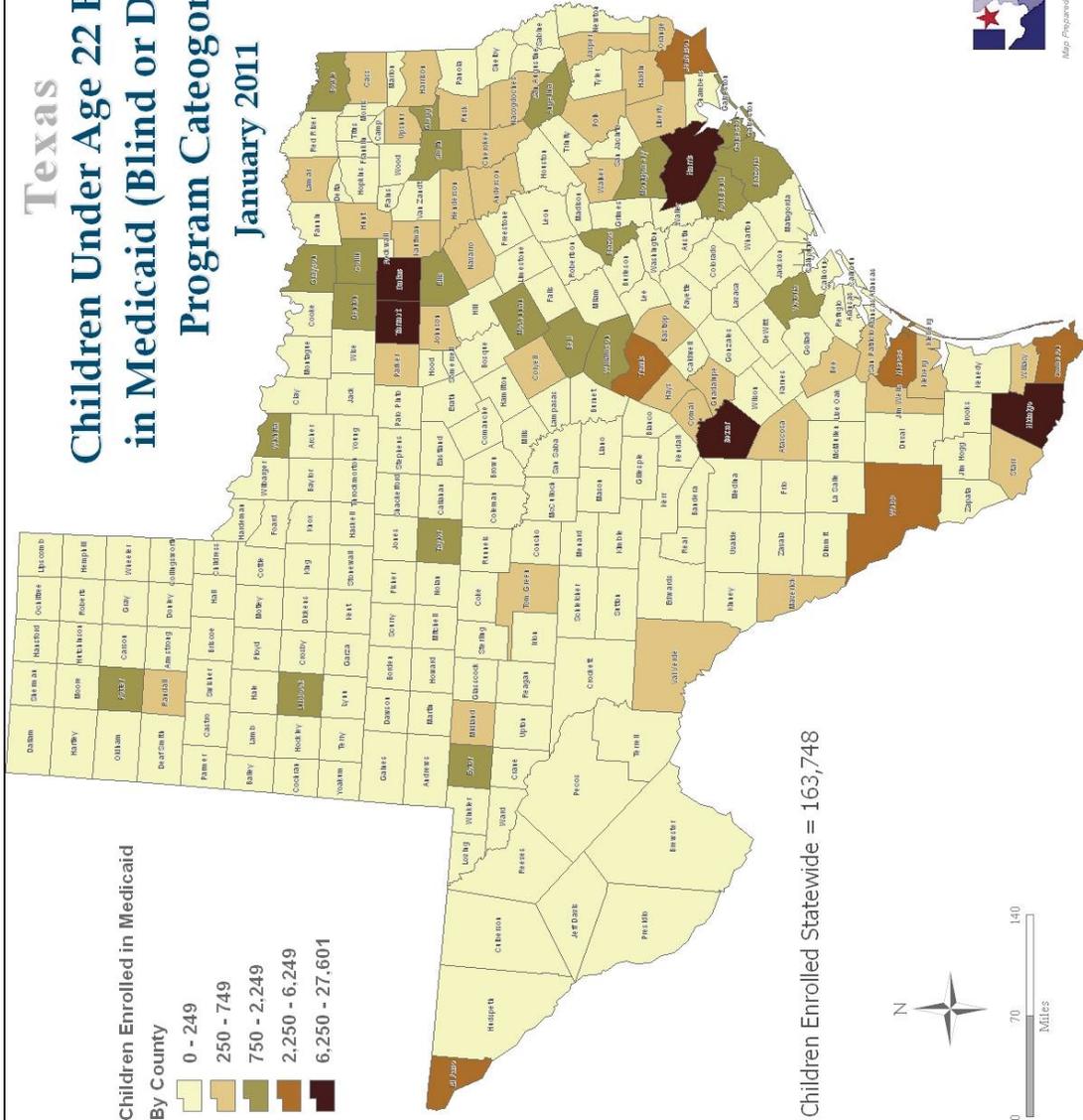


Data Source: Demography Team. Strategic Decision Support. Texas Health and Human Services Commission.

Texas

Children Under Age 22 Enrolled in Medicaid (Blind or Disabled) Program Categories

January 2011



Map Prepared by HHSC, Strategic Database, October, April 2011.

ATTACHMENT F: PLANNING PROCESS

ITFCSN Draft Plan

Appendix A

Description of Planning Process

The Interagency Task Force for Children with Special Needs (ITFCSN) began its planning process at the meeting in September 2009. Over the next several months the Task Force determined its operating process and organized the subcommittee process and approach for its eight subcommittees.

The eight subcommittees were each chaired and vice chaired by an agency member of the Task Force. In order to be inclusive of a wide array of expertise and voice from both the public and private sector, nominations were widely solicited for subcommittee members. The resulting subcommittees were comprised of a broad spectrum of stakeholders from the special needs community, parents, advocates, subject matter experts, providers and state staff.

Each subcommittee created and submitted recommendations to the Task Force relevant to their area of study. A comprehensive, multi-partner review process was conducted, including review and input from the Children's Policy Council, as required by SB 1824 Legislative intent. Based upon the reviewer input, the subcommittee recommendations were revised, compiled and sent to the nine Task Force agencies for formal review and input, including an impact statement and a high level resource estimate for each recommendation.

Task Force staff worked with HHSC strategic planners to develop a draft of the Plan elements that encompassed the broad subcommittee recommendations. Seven goals with associated objectives were identified and developed as the core Plan elements, as listed below.

- Goal 1: Organized and Reliable Information
- Goal 2: Prevention and Early Identification
- Goal 3: Entry Points into Services
- Goal 4: Comprehensive Array of Services and Supports
- Goal 5: Services and Supports for Transition to Adulthood
- Goal 6: Interagency Coordination and Collaboration
- Goal 7: Strengthened Workforce

In a public meeting on May 25, 2011, the Task Force reviewed the draft Plan elements and made revisions. Public comment from stakeholders and Task Force members was incorporated into the elements after that meeting. On June 3, 2011 the Task Force made further revisions and voted to approve the final draft elements, including a revised statement of vision, principles, and direction for progress. This approved version of the draft was posted on the Internet for public review. At a public hearing on June 21, 2011, stakeholders praised the draft material and made helpful suggestions for improvement.

Task Force members determined that the comments from public testimony could best inform the planning work on the implementation level, and no changes were made to the draft Plan elements.

The Task Force agency staff drafted narrative language for each of the objectives in the draft plan based upon the approved recommendations. These were compiled and edited into a final draft of the comprehensive Plan, which was approved by the Task Force. This completed final draft plan was submitted electronically to the 82nd Legislature and published on the agency website as required by the authorizing legislation.

The Task Force is sensitive to the programmatic and operational adjustments the agencies are identifying and making for the next biennium and the resulting impact to the original direction set out in the bill. In response, the Task Force is focusing the initial 12-18 months beginning in fiscal year 2012, on determining what and how processes can be put into place in order to move incrementally toward achieving each of the goals. While agencies will focus some energies on implementing components that can be readily accomplished within current resources, a majority of the effort will be on producing a longer term implementation plan. Updates to the Plan along with a progress report will be submitted by 8/31/13, as required under the Task Force's authorizing legislation.



ATTACHMENT G: SUMMARY OF ELEMENTS

On June 22, 2011 The Task Force for Children with Special Needs adopted the original outline for its 5 year plan. This document formed the basis for creating the final narrative version.

Interagency Task Force for Children with Special Needs

DRAFT Strategic Plan Outline

June 22, 2011

GOAL 1: ORGANIZED AND RELIABLE INFORMATION. Develop and disseminate comprehensive, accurate, consistent, accessible, easy-to-understand information through a variety of media and languages, including written material, electronic formats, the Internet, and social media, to link families to public and private services and supports.

Objective 1.1: Internet Information System. Provide a well branded information system focused on services and transition planning for families with children with special needs.

Objective 1.2: 2-1-1 Texas Information and Referral Services. Improve the 2-1-1 Texas Information and Referral Network's (TIRN's) expertise in supporting children with special needs and their families, and increase awareness of 2-1-1 TIRN as a resource.

Strategy 1.2.1: Stressline and/or In-Person Network. Provide a phone-based Family Stressline with trained volunteers coordinated through current 2-1-1 services to provide specialized information to callers regarding how to prevent escalation or de-escalate a crisis or direct callers to crisis intervention resources.

Objective 1.3: Public Outreach. Develop and disseminate helpful information to various audiences in the general public, via printed and electronic media, to increase understanding and to inform providers.

Objective 1.4: Accurate Information from Agencies. Improve quality of information provided by agency staff, service coordinators, intake staff, providers of services, etc. to ensure that families receive accurate and comprehensive information when seeking assistance.

GOAL 2: PREVENTION AND EARLY IDENTIFICATION. Prevent or minimize disabilities and delays by early identification of children with or at risk of special needs, promote the well-being of the whole child and the family, and prevent crises throughout the child's life.

Objective 2.1: Preventing Fetal Alcohol Spectrum Disorders. Work to implement use of effective screening tools and intervention programs for pregnant women at risk.

Objective 2.2: Referral Policies for Programs and Providers Serving Children. Ensure child-serving programs and providers have policies and practices that share appropriate information with families and promptly refer for services and supports.

Objective 2.3: Early Identification of Developmental and Behavioral Disabilities. Increase the use of validated developmental screening tools, including for mental/behavioral health screening, in primary care, education, and other appropriate settings.

Objective 2.4: Home Visitation Programs. Expand home visitation programs, such as the Nurse-Family Partnership and Parents as Teachers programs, to include families of children with special needs.

Objective 2.5: Cross-System Collaboration. Transform provision of services and supports to prevent crises, to avoid the need to place children in large institutions, and to make more efficient use of funding and other resources, through an organizational culture shift toward greater collaboration among state and local entities.

Objective 2.6: Capacity to Identify Risks of Crisis. Expand community capacity to identify "crisis" in the context of children with special needs and their families, recognize signs of potential crisis, and offer links to services to mitigate or prevent escalation of a crisis.

Objective 2.7: Diversion from and Minimization of Involvement in the Juvenile Justice System. For youth with special needs who are at risk of being involved in the juvenile justice system, avoid or reduce their involvement in the system, including by providing behavioral health services and supports.

GOAL 3: ENTRY POINTS INTO SERVICES. Support the whole child by improving parents' and caregivers' ability to secure high-quality, timely, flexible, individualized, and appropriate services when needs are first identified.

Objective 3.1: Referrals. Ensure that at any point when a child with special needs is identified, the child's family receives appropriate information about services and supports for which the child and the family may be eligible.

Objective 3.2: Waiver Services. Review and improve criteria and process of interest lists for home and community-based waivers to improve timely access and outcomes for children and to avoid the need for any child to be placed in a large institution.

Strategy 3.2.1: Expanded Access to Services Based on the Needs of and the Risks to the Child and the Family. Improve timeliness of access to home and community-based services for children in crisis or at risk of placement in an institution.

Strategy 3.2.2: Elimination of Interest Lists for Waiver Services. Fund waiver programs fully, to meet the need for home and community-based services, so that interest lists are no longer necessary.

Objective 3.3: Entrance into Public School Services. Educate children to their highest capacity.

Strategy 3.3.1: Preschool Program for Children with Disabilities. Ensure a seamless, effective transition from the Early Childhood Intervention program to the Preschool Program for Children with Disabilities.

Strategy 3.3.2: School-Age Education Services. Provide families access to timely, appropriate, and consistent information and education services when a need is first identified.

Objective 3.4: Entrance into the Juvenile Justice System. Assess a child's needs and risks, and provide appropriate services as needed.

GOAL 4: COMPREHENSIVE ARRAY OF SERVICES AND SUPPORTS.

Improve system capacities and coordination to support the whole child so that parents and caregivers can get and maintain affordable, high-quality, timely, flexible, and individualized services and supports for children with special needs in or as close to home as possible.

Objective 4.1: Family Supports. Ensure that the service system is focused on the child in the context of the family, providing high-quality, cost-effective, individualized services, resulting in improved long-term quality of life outcomes, integration, and independence.

Strategy 4.1.1: Family-Centered and Person-Centered Planning. Ensure children, youth, and families are partners in planning, caregiving, and decision-making.

Strategy 4.1.2: Parent Peer Support. Develop or expand existing parent-to-parent models that link together parents of children with special needs to enhance peer learning, mentoring, training, information dissemination, and support.

Strategy 4.1.3: Family-Based Education. Make training available to families of children with special needs, including positive behavior support, medical interventions, therapeutic techniques, and person-centered planning.

Strategy 4.1.4: Respite Care. Increase access to and enhance the quality of respite services across the continuum of respite models, including in-home, out-of-home, and foster home.

Strategy 4.1.5: Additional Child Care Options. Evaluate current child care options, including amending Medicaid waivers, to support families in working, attending school, or participating in job training; develop and implement a plan to increase child care services for children with disabilities.

Objective 4.2: Systems Navigation. Offer navigation services to families who need help coordinating the services and supports across the system.

Strategy 4.2.1: Navigator/Coordinator Model. Review models and relevant research, and propose improvements for provision of a facilitator, navigator, or coordinator.

Strategy 4.2.2: Mental Health Navigator Certification Program. Expand the use of family partners in child and adolescent mental/behavioral health programs by establishing certification of family members of children with special needs to serve as navigators for other families.

Objective 4.3: Health Insurance Coverage. Assure affordable, consistent, comprehensive health insurance benefits and coverage are available for all children and youth, including young adults transitioning into adulthood.

Strategy 4.3.1: Coverage of Serious Emotional Disturbances. Explore options for private insurance companies to cover serious emotional disturbances (SED), including those which are a result of traumatic and acquired brain injury, in children and youth.

Strategy 4.3.2: Child-Only Policies. Explore options for private insurance companies to offer or expand child-only individual policies for children with special needs.

Strategy 4.3.3: Transition into Adulthood. Work to ensure that young adults transitioning into adulthood can access appropriate health coverage.

Objective 4.4: Medicaid State Plan and Waiver Amendments. Amend Medicaid waivers and the Medicaid State Plan as appropriate, to provide more comprehensive, responsive, and self-directed services to support children with special needs.

Strategy 4.4.1: Hospital Level of Care Waiver. Provide a hospital level of care waiver for medically fragile children who turn 21 years of age and are no longer eligible for the Early and Periodic Screening, Diagnosis, and Treatment Program.

Strategy 4.4.2: Children in Care of DFPS. Amend waivers as appropriate to include children in the care of DFPS.

Strategy 4.4.3: Youth Empowerment Services Waiver. Expand the YES waiver to all children in the care of DFPS.

Strategy 4.4.4: Partial Hospitalization Programs. Implement partial hospitalization programs to give children access to the least restrictive environment necessary for the adequate treatment of and recovery from their acute mental health crises.

Strategy 4.4.5: Medicaid Home Health Aides. Include home health aides with registered nurse (RN) delegation for medically fragile children in the Medicaid State Plan, which would improve health outcomes and provide cost savings.

Strategy 4.4.6: Consumer-Directed Services. Add additional options for consumer direction and flexibility within the Consumer Directed Services program.

Objective 4.5: Education Success. Improve education outcomes for children with special needs.

Strategy 4.5.1: Accountability for Serving Children in Special Education. Assure accountability across the public school system to support high-quality education that is responsive and individualized so children achieve meaningful progress.

Strategy 4.5.2: Reporting. Require school districts to publish special education data.

Strategy 4.5.3: Addressing Bullying Behavior. Protect children with special needs from bullying and ensure that children with special needs are not labeled and punished as bullies when a disability is the root of the behavior.

Objective 4.6: Crisis Intervention. Ensure that caregivers, parents, and youth in all Texas communities have the capacity and resources, including emergency respite and other emergency out-of-home living arrangements, to intervene successfully when crises occur.

Objective 4.7: Continuum of Needed Services in the Juvenile Justice System. Provide high-quality services to children and youth with special needs to improve their outcomes within the juvenile justice system and upon re-entering their communities.

Strategy 4.7.1: Local Community Corrections Programs. Support successful community programs tailored to the needs of children and the resources of the communities, including diversionary programs for children with special needs.

Strategy 4.7.2: Adequate Conditions and Services. Ensure that all facilities have adequate conditions of confinement and appropriate services for children and youth with special needs, including mental health services.

Strategy 4.7.3: Return to the Community. Identify and improve re-entry services and supports for children and youth with special needs, including transition and housing needs.

GOAL 5: SERVICES AND SUPPORTS FOR TRANSITION TO ADULTHOOD. Improve students' success in transitioning to post-school life.

Objective 5.1: Self-Direction for Young Adults with Special Needs. Advance self-sufficiency, empowerment, person-centered planning, and leadership development for transition-age youth, including personal engagement in decision-making.

Objective 5.2: Centers-Based Service Model. Explore options to provide comprehensive transition services through a centers-based service model for clients of health and human services, workforce, and juvenile justice agencies, and implement the model if feasible.

Objective 5.3: Transition and Employment Manual. Develop and distribute a Texas-specific, comprehensive transition and employment manual.

Objective 5.4: School-Based Transition Services. Improve services to and outcomes for students with disabilities as they transition out of the public school system.

Strategy 5.4.1: Requirement to Begin Services No Later than Age 14. Make transition services available to students with special needs at an age at which the student and family deem appropriate, no later than age 14.

Strategy 5.4.2: Pilot Project to Re-Envision Vocational Success. Design a results-oriented regional pilot to allow cooperative vocational and transition services for youth with disabilities, focusing on the youth's individual abilities, inclinations, and needs, starting in middle school.

Strategy 5.4.3: Transition Specialists. Ensure school districts, special education co-ops, and all relevant agencies have personnel with the knowledge, skills, experience, and expertise in transition planning and services to provide leadership, training, and collaboration with local high school personnel, parents, students, and agency personnel.

Objective 5.5: Accountability. Develop appropriate indicators and performance management processes to measure transition outcomes, and use data to create systems/services to ensure successful long-term outcomes for students with disabilities.

Objective 5.6: ARD Meeting Attendance by Agency Representatives. Improve attendance of appropriate, family-approved agency representatives at "Admission, Review, and Dismissal" (ARD) meetings regarding transition into adulthood.

Objective 5.7: Preparation for Health Care in Adulthood. Assure that youth and young adults with special needs have materials available and learn about health and wellness and health transition services and receive services through medical homes, and have health insurance benefits and coverage to meet their needs.

Strategy 5.7.1: Health Education. Assure that youth and young adults with special needs have materials available and learn about wellness and health transition services available to meet their needs.

Strategy 5.7.2: Medical Homes. Assure that youth and young adults with special needs receive wellness and health care transition services through a medical home model.

Strategy 5.7.3: Health Coverage into Adulthood. Work to ensure that young adults transitioning into adulthood can access appropriate health coverage.

GOAL 6: INTERAGENCY COORDINATION AND COLLABORATION.

Improve outcomes for children and families by improving communication, coordination, and collaboration among various entities serving children with special needs, with involvement from families.

Objective 6.1: Culture/Philosophy Shifts. Reconceptualize service delivery by recognizing disability as a natural part of life and providing services accordingly to improve outcomes for children and families.

Strategy 6.1.1: System of Care. Incorporate the “system of care” collaborative organizational philosophy and framework in programs serving children and youth with special needs to improve access and expand the array of coordinated services and supports within the community.

Strategy 6.1.2: Positive Behavior Support. Support statewide use of positive behavior support as an evidence-based approach to prevent and reduce challenging behavior across all disability groups and service systems.

Strategy 6.1.3: Public and Professional Sensitivity and Awareness. Increase public and professional sensitivity and awareness concerning children with special needs and their families.

Strategy 6.1.4: Disability-Related Language. Use person-first language, and use “intellectual disability” instead of “mental retardation,” in all communications.

Strategy 6.1.5: Integrated Care. Encourage a whole child approach to caring for children, such as ensuring that primary care physicians respond to social and emotional development needs and behavioral health needs.

Objective 6.2: Community Engagement. Promote local interagency planning and coordination, in partnership with faith and community-based organizations, by mobilizing existing or creating new collaborations to maximize efficiencies, outcomes, and resources for children with special needs and their families.

Strategy 6.2.1: Volunteer Advocates. Recruit and support volunteer advocates (natural supports), including family members of children with special needs, who provide guidance, advice, and other support to children with special needs and their families.

Strategy 6.2.2: Community Support Systems. Cultivate partnerships with faith-based communities, school systems, non-profit agencies, civic organizations, and similar support systems to serve children with special needs.

Objective 6.3: Medical Home Program Office. Establish a centralized Medical Home Program Office in HHSC, for the development of a medical home model for children with special needs; engage in ongoing, meaningful quality outcomes measurement; and develop a system that publicly recognizes health care providers who are designated as a medical home.

Objective 6.4: Information Sharing. Share information as appropriate to support positive outcomes for children with special needs, while protecting families' rights to privacy.

Strategy 6.4.1: Single Release Granting Data-Sharing Permission. Pursue policy to allow parents to sign a single release statement to allow agencies to share information to support transition planning, within federal law.

Strategy 6.4.2: Youth under Supervision of Both Juvenile Probation Departments and DFPS. Expand the current collaborative partnership and data-sharing arrangements between TYC and DFPS related to the youth who are under the co-occurring supervision of both agencies, to include youth under juvenile probation supervision.

Objective 6.5. Needs, Gap, and Barrier Analysis. Conduct needs assessments and gap analyses, analyze current practices, and develop systems changes with involvement from families to determine where services fail to meet children's and families' needs, and use the information as appropriate to improve outcomes for children and families. See supporting material cited below.

Strategy 6.5.1: Barriers to Support. Involve families in identifying and removing systemic barriers that they encounter when seeking support, from intake and referral through all stages of service provision.

Strategy 6.5.2: Juvenile Justice Gap Analysis. Determine the number and needs of children with special needs in the juvenile justice system, assess the professional workforce available to serve these children, and assess the services provided. Juvenile Justice Gap Analysis.

Strategy 6.5.3: Transition across Services over Time. Assess gaps in transition process and identify solutions.

Objective 6.6. Geographic Boundaries. Explore co-location of offices and the use of complementary geographic boundaries for all agencies on the ITFCSN, and implement changes where useful.

GOAL 7: STRENGTHENED WORKFORCE. Support and strengthen the workforce, at all levels of employment, of all professions serving children and youth with special needs.

Objective 7.1: Direct Support Workers. Ensure a well trained and professional workforce of direct support workers.

Strategy 7.1.1: Training. Ensure direct care workers receive training and technical assistance to serve children with special needs, including services to support children’s mental health.

Strategy 7.1.2: Career Advancement. Ensure direct support workers have appropriate training and career advancement opportunities.

Objective 7.2: Health Care Professionals. Increase the availability and special needs competencies of all health care professionals, especially where critical gaps exist, including but not limited to mental health, dental health, physical therapy, occupational therapy, and speech therapy services.

Objective 7.3: School Personnel. Provide training for teachers, administrators, resource officers, aides, bus drivers, and other personnel to serve children with special needs more effectively and responsively.

Strategy 7.3.1: In-Service Training in Special Needs Issues. Provide school personnel training and best practice tools and resources to work with and to teach students with special needs, with follow-up coaching to ensure successful implementation.

Strategy 7.3.2: Pre-Service Training in Special Needs Issues. Ask universities to include special needs curricula for candidates for education-related degrees, covering such topics as Positive Behavior Interventions and Support (PBIS), mentoring, and other support.

Strategy 7.3.3: School Safety Training. Include training in PBIS when implementing an anti-bullying program, and mandate all school resource officers to receive 40 hours of crisis intervention training.

Objective 7.4: Juvenile Justice System. Educate personnel in law enforcement, jails, courts, and all entities in the juvenile justice system on serving children with special needs.

Strategy 7.4.1: Mental Health. Expand current provision of mental health training curriculum for trainers.

Strategy 7.4.2: Court System Personnel. Select and implement best-practices training for judges and attorneys with regard to children and youth with special needs.

Objective 7.5: Broad-Based Awareness and Training for Child-Serving Professions. Increase awareness of resources and provide training so all child-serving professionals are better able to serve children with special needs.

Strategy 7.5.1: Cross-Agency Training. Educate staff at all related agencies on serving children with special needs, including topics related to accountability, expectations, and collaboration.

Strategy 7.5.2: Cultural Competency. Increase cultural competency for personnel in child-serving systems across the state.

Strategy 7.5.3: Awareness of State and Local Community Resources. Increase awareness among families, health care providers, and other child-serving professionals of how to link families with appropriate resources.

Strategy 7.5.4: Trauma-Informed Care and Positive Youth Development. Support enhanced training for professionals who work with youth, including training in trauma-informed care and positive youth development.

Strategy 7.5.5: Crisis Prevention and De-Escalation. Provide training in de-escalation and crisis intervention for professionals and volunteers who are currently serving children or who are likely to interact with children or families in crisis.

ATTACHMENT H – AGENCY CROSSWALK

Strategic Plan Outline Elements	Impacted Agencies									
	HHSC	DADS	DARS	DSHS	DFPS	TEA	TYC	TJPC	TCOUMMI	
1. ORGANIZED AND RELIABLE INFORMATION										
1.1 Internet Information System.	x	x	x	x	x	x	x	x	x	x
1.2 1-1 Texas Information and Referral Services.	x	x	x	x	x	x	x	x	x	x
1.2.1 Stressline and/or In-Person Network	x			x	x					
1.3 Public Outreach Campaign	x	x	x	x	x	x	x	x	x	x
1.4 Accurate Information from Agencies	x	x	x	x	x	x	x	x	x	x
2. PREVENTION AND EARLY IDENTIFICATION										
2.1 Preventing Fetal Alcohol Syndrome Disorder	x	x	x	x	x	x	x	x	x	x
2.2 Referral Policies for Programs and Providers Serving Young Children	x	x	x	x	x	x	x	x	x	x
2.3 Early Identification of Developmental and Behavioral Disabilities	x	x	x	x	x	x				
2.4 Home Visitation Programs	x		x	x	x					
2.5 Cross-System Collaboration to Prevent Crisis	x	x	x	x	x	x	x	x	x	x
2.6 Capacity to Identify Risks of Crisis	x	x	x	x	x	x	x	x	x	x
2.7 Diversion from and Minimization of Involvement in the Juvenile Justice System				x		x	x	x	x	x
3. SYSTEM ENTRY POINTS										
3.1 Referrals.	x	x	x	x	x	x	x	x	x	x
3.2 Waiver Services	x	x								
3.2.1 Access to Services Based on the Needs of and Risk to the Child and the Family										
3.2.2 Timely Access to Waiver Services	x	x								
3.3 Entrance into Education Services	x									
3.3.1 Preschool Program for Children with Disabilities			x			x				
3.3.2 School-Age Education Services	x					x				
3.4 Entrance into the Juvenile Justice System							x	x	x	x

Strategic Plan Outline Elements	Impacted Agencies											
	HHSC	DADS	DARS	DSHS	DFPS	TEA	TYC	TJPC	TCO	O	M	M
4. COMPREHENSIVE CONTINUUM OF SERVICES												
4.1 Family Support	x	x	x	x	x	x	x	x	x			x
4.1.1 Family-Centered and Person-Centered Planning	x	x	x	x	x	x	x	x	x			x
4.1.2 Parent Peer Support	x	x	x	x	x	x	x	x	x			x
4.1.3 Family-Based Education	x	x	x	x	x	x	x	x	x			x
4.1.4 Respite Care	x	x	x	x	x	x	x	x	x			x
4.1.5 Additional Child Care Options	x	x	x	x	x	x	x	x	x			
4.2 Navigator/Coordinator												
4.2.1 Primary Navigator/Coordinator	x	x	x	x	x	x	x	x	x			
4.2.2 Mental Health Navigator Certification Program	x	x	x	x	x	x	x	x	x			
4.3 Adequate Coverage in Health Insurance												
4.3.1 Coverage of Serious Emotional Disturbances	x			x								
4.3.2 Child-Only Policies	x			x								
4.3.3 Transition into Adulthood	x		x	x								
4.4 Medicaid State Plan and Waiver Amendments	x	x		x								
4.4.1 Hospital Level of Care Waiver	x	x	x	x								
4.4.2 Children in Care of DFPS	x				x							
4.4.3 Youth Empowerment Services Waiver	x	x	x	x								
4.4.4 Partial Hospitalization Programs	x			x								
4.4.5 Medicaid Home Health Aides	x	x	x	x								
4.4.6 Consumer Directed Services	x	x		x								
4.5 Education Success												
4.5.1 Accountability for Serving Children in Special Education										x		
4.5.2 Addressing Bullying Behavior										x		
4.6 Crisis Intervention	x	x	x	x	x	x	x	x	x	x		x
4.7 Continuum of Needed Services in the Juvenile Justice System	x	x	x	x	x	x	x	x	x	x		x
4.7.1 Adequate Conditions and Services											x	x
4.7.2 Local Community Corrections Programs											x	x
4.7.3 Return to the Community	x	x	x	x	x	x	x	x	x	x	x	x

Strategic Plan Outline Elements	Impacted Agencies										
	HHSC	DADS	DARS	DSHS	DFPS	TEA	TYC	TJPC	TCOOMMI		
5. SERVICES AND SUPPORTS FOR TRANSITION TO ADULTHOOD											
5.1 Transition and Employment Manual	x	x	x	x	x	x					
5.2 School-Based Transition Services											
5.2.1 Requirement to Begin Services No Later than Age 14.			x			x					
5.2.2 Pilot Project to Re-Envision Vocational Success		x	x	x	x	x					
5.2.3 Transition Specialists	x	x	x	x	x	x					
5.3 Accountability.											
5.4 ARD Meeting Attendance by Agency Representatives		x	x	x	x	x					
5.5 Preparation for Health Care in Adulthood	x	x	x	x	x	x					
5.5.1 Health Education.		x	x	x	x	x					
5.5.2 Medical Homes	x	x	x	x	x	x					
5.5.3 Health Coverage into Adulthood	x	x	x	x	x	x					
5.6 Centers-Based Service Model.	x	x	x	x	x	x	x	x	x	x	x
5.7 Self-Direction for Young Adults with Special Needs	x	x	x	x	x	x	x	x	x	x	x
6. INTERAGENCY COORDINATION											
6.1 Community Engagement											
Volunteer Advocates	x	x	x	x	x	x	x	x	x	x	x
Community Support Systems	x	x	x	x	x	x	x	x	x	x	x
6.2 System of Care	x	x	x	x	x	x	x	x	x	x	x
6.3 Medical Home Program Office	x	x	x	x	x	x	x	x	x	x	x
6.4 Information Sharing											
6.4.1 Single Release Granting Data-Sharing Permission	x	x	x	x	x	x	x	x	x	x	x
6.4.2 Youth under Supervision of Both TYC and DFPS											
6.5 Needs, Gap, and Barrier Analysis											
6.5.1 Barriers to Support	x	x	x	x	x	x	x	x	x	x	x
6.5.2 Juvenile Justice Gap Analysis											
6.5.3 Transition across Services over Time	x	x	x	x	x	x	x	x	x	x	x
6.6 Culture/Philosophy Shifts											
6.6.1 Public and Professional Sensitivity and Awareness	x	x	x	x	x	x	x	x	x	x	x
6.6.2 Disability-Related Language	x	x	x	x	x	x	x	x	x	x	x
6.6.3 Integrated Care	x	x	x	x	x	x	x	x	x	x	x
6.7 Geographic Boundaries	x	x	x	x	x	x	x	x	x	x	x

Strategic Plan Outline Elements	Impacted Agencies										
	HHSC	DADS	DARS	DSHS	DFPS	TEA	TYC	TJPC	TCOUMMI		
7. STRENGTHENED WORKFORCE											
<i>7.1 Direct Support Workers</i>											
<i>7.1.1 Training</i>		x	x	x	x	x	x	x			x
<i>7.1.2 Career Advancement</i>		x	x	x	x	x	x	x			x
<i>7.2 Health Care Professionals</i>	x	x	x	x	x	x					
<i>7.3 School Personnel</i>						x					
<i>7.3.1 In-Service Training in Special Education Issues</i>						x					
<i>7.3.2 Pre-Service Training in Special Education Issues</i>						x					
<i>7.3.3 School Safety Training</i>				x		x					
<i>7.4 Juvenile Justice System</i>											
<i>7.4.1 General</i>				x				x		x	x
<i>7.4.2 Mental Health</i>				x				x		x	x
<i>7.4.3 Court System Personnel</i>				x	x			x		x	x
<i>7.5 Broad-Based Awareness and Training for Child-Serving Professions</i>											
<i>7.5.1 Cross-Agency Training</i>	x	x	x	x	x	x		x		x	x
<i>7.5.2 Awareness of State and Local Community Resources</i>	x	x	x	x	x	x		x		x	x
<i>7.5.3 Trauma-Informed Care and Positive Youth Development</i>	x	x	x	x	x	x					x
<i>7.5.4 Positive Behavioral Support</i>	x	x	x	x	x	x					x
<i>7.5.5 Crisis Prevention and De-Escalation</i>	x	x	x	x	x	x					x
<i>7.5.6 Cultural Competency</i>	x	x	x	x	x	x					x
<i>7.5.7 Serving Children and Youth with Disabilities</i>	x	x	x	x	x	x					x

